

Thursday, 22 May 2025

1
2 (10.00 am)
3 **LADY HALLETT:** Ms Cartwright.
4 **MS CARTWRIGHT:** My Lady, could Mr Hancock please stand
5 whilst he's sworn. Thank you.
6 **MR MATT HANCOCK (affirmed)**
7 **LADY HALLETT:** Mr Hancock, thank you for coming back. I do
8 understand how difficult it must be for you to keep
9 coming back and we do appreciate your continued help.
10 **Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 7**
11 **MS CARTWRIGHT:** Thank you. Please can you tell the Inquiry
12 your full name.
13 **A.** Yes. I'm Matthew John David Hancock.
14 **Q.** Mr Hancock, can I firstly thank you on behalf of
15 Module 7 for the provision of your ninth witness
16 statement.
17 If that could be displayed, please, INQ000587294,
18 and if we could move, please, to page 96 where we see
19 it's dated 7 April 2025, and can I ask you to confirm,
20 are the contents of that statement true to the best of
21 your knowledge and belief?
22 **A.** Yes, of course.
23 **Q.** Thank you. Mr Hancock, that statement will be
24 published, so the full context of the additional
25 evidence you've given in respect of Module 7 will be

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1 a meeting on getting the vaccine going to a meeting on
2 non-pharmaceutical interventions, and there is an
3 interaction between them all.
4 **Q.** Thank you. Well, let's then just identify who you are
5 and the roles you were performing for the context and,
6 again, it's right, isn't it, that from July of 2018 you
7 were Secretary of State for Health and Social Care?
8 **A.** Yes.
9 **Q.** And I think the full detail of your portfolio before
10 that time is within your witness statement. Is there
11 anything else you'd wish to say about your previous
12 knowledge and experience that's going to be relevant to
13 the topics we're going to deal with today?
14 **A.** Not over and above what's in the written statement.
15 **Q.** Thank you. Can I then start with the first topic,
16 please, of preparedness and preparedness in the context
17 of test, trace and isolate.
18 **A.** Yes.
19 **Q.** And to do that, can we go, please, to your paragraph 62
20 which is at page 20. Thank you.
21 Now, you've given a section of your statement over
22 to assist with your views on preparedness and capacity
23 in the context of test, trace and isolate. You detail
24 that you reiterate the concerns you set out in the
25 respect of the weaknesses in preparedness and capacity

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1 available, because I appreciate today there will be
2 topics we can cover but the full detail you've provided
3 is set out in that statement.
4 **A.** Yeah.
5 **Q.** Thank you.
6 Now, Mr Hancock, having identified that you've
7 given, now, nine witness statements, it's right also
8 that you have now given evidence to every one of the
9 modules to date in the Inquiry.
10 **A.** So far.
11 **Q.** And in making that point, I just want to make, perhaps
12 what's an obvious point, but it's right, isn't it, that
13 today we're going to be dealing with test, trace and
14 isolate, but when we consider those issues in focus
15 today, the full context is that you had, essentially,
16 a portfolio that covered many areas that this Inquiry
17 has been examining and I think you're particularly
18 anxious that the full context of your work during the
19 pandemic is not forgotten.
20 **A.** Well, it's more that when considering lessons for the
21 future, it's important not to take each module in
22 isolation. I understand why it's been looked at in
23 isolation, each one, but -- because all of these
24 decisions, in fact, in reality, run concurrently and you
25 go from a meeting on test, trace and isolate to

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1 for testing and tracing in an earlier statement.
2 And please, if you could display the next paragraph.
3 You say:
4 "The UK's flawed doctrine had consequences that led
5 to weaknesses in our readiness for a pandemic because of
6 the wrong attitude and because of operational
7 weaknesses."
8 **A.** Yes.
9 **Q.** And the next paragraph, again, please:
10 "In respect of both testing and contact tracing
11 there was no capacity for expansion to industrial scale:
12 we had to build both."
13 **A.** Yes.
14 **Q.** And so before we get into the detail, can I ask you,
15 first of all, from the perspective of the relevant
16 minister with the relevant responsibility, can you give
17 your perspective at January 2020 of the readiness and
18 preparedness relating to, first of all, testing?
19 **A.** Well, I'm really glad that you've come to this first,
20 and if this module of the Inquiry is to conclude
21 anything, I think it is absolutely critical that it
22 concludes on this point: the doctrine that we had, going
23 into the pandemic, that was shared by most of the
24 western world and the World Health Organisation, was
25 wrong, because it essentially dealt with how to cope

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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

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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

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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

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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

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

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

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

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

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

25 A. Oh, yes --

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

7 A. Yeah.

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

16 A. Well, you've answered the question, really. Of course
17 I appreciated that. There was one person in each of the
18 upper tier local authorities, and therefore around
19 100 people.

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

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

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

4 A. No problem.

5 So the concluding sentence of that answer, if you
6 like, is that I wasn't the only one with this
7 frustration, and Number 10 organised a meeting on
8 17 March to bring things to a head.

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

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

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

21 A. Yes.

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

23 A. Okay.

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

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

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

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

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

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

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

25 Q. Thank you.

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

5 A. Yes.

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

10 A. Yes.

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

13 A. Yes.

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

16 A. Yes.

17 Q. -- to work in the call centres.

18 A. Yeah.

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

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

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

21 Q. Whilst we deal, again, with the contact tracers and the
22 numbers recruited, I think we see it in the strategy, of
23 20,000 having been identified as being necessary?

24 A. Yeah.

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

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

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

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

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

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

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

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

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

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

21 A. Yeah.

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

25 A. Yes, yeah.

16

1 Q. And so is your first headline, from what you said, is
 2 for contact tracing, essentially, in a pandemic needs
 3 a combination of the local skills but also centralised
 4 contact tracers, as well?
 5 A. Yes, and critically, the data structures to allow that
 6 integration to work.
 7 Q. Thank you.
 8 Now, can I just on preparedness, ask you a follow-up
 9 question, please. Can you assist us as to what
 10 contingency plans and framework were already in place to
 11 ensure that the TTI could be implemented equitably
 12 across all population groups including minority ethnic
 13 communities in January 2020, please?
 14 A. The whole purpose of contact tracing is to try to
 15 protect those who are most vulnerable to catching the
 16 virus. And therefore, it's vital that contact tracing,
 17 to be done well, is understood and the messages are
 18 received by those who are being contacted.
 19 And, you know, it's not what you say; it's what
 20 people hear. So therefore it's vital that the contact
 21 tracing happens in such a way as those who are being
 22 contacted will act upon the advice that they're given.
 23 So naturally, it is critical that this takes into
 24 account the diversity of communities that are -- that
 25 are being contacted.

17

1 A. Yeah.
 2 Q. But I wonder whether you can assist from your
 3 perspective.
 4 A. Yeah.
 5 Q. So the Inquiry has heard lots of evidence about
 6 different data systems not -- essentially operating
 7 interoperably --
 8 A. Yeah.
 9 Q. -- in terms of, particularly where it was patient
 10 details, so the Lighthouse laboratories, for example,
 11 they didn't -- there had to be systems that to make sure
 12 the results could be shared.
 13 A. Yeah.
 14 Q. We've heard from the National Police Chiefs' Council
 15 that he was pushing for data from the Department of
 16 Health and Social Care that he needed --
 17 A. Yeah.
 18 Q. -- that was never forthcoming. And we've also heard
 19 about how, even when there were pilots such as the
 20 Liverpool Pilot, where they needed access to the data on
 21 hospitalisation in that trial --
 22 A. Yeah.
 23 Q. -- that was not forthcoming for months and months.
 24 A. Yeah.
 25 Q. And that data was hugely helpful when it arrived many

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

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1 months after --
 2 A. Yeah.
 3 Q. -- to inform just how successful that trial had been.
 4 A. Absolutely.
 5 Q. So is there any insight or assistance you can give
 6 around the issue of data blockages that seems to be
 7 a constant theme across the different --
 8 (overspeaking) --
 9 A. It was absolutely constant. It was terrible.
 10 I personally dealt with a whole series of them to try to
 11 unblock these data blockages. Previously, I'd been the
 12 Digital Secretary and I'd taken the data sharing
 13 legislation through Parliament and, indeed, GDPR, so
 14 it's an area I know extremely well, and it was deeply
 15 frustrating at the lack of appropriate data sharing,
 16 which was for, in some cases, for technological reasons,
 17 but actually there were far fewer blockages due to poor
 18 technology than due to over-officious and absurd, in
 19 some cases, data rules.
 20 All of this data was protected under GDPR. GDPR is
 21 a more than adequate protection of personal data, health
 22 data is not special or different, it's just personal
 23 sensitive data. It needs to be treated with respect and
 24 it needs to be treated with sensitivity.

25 Probably the single best thing that we did in this

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

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

14 Q. Thank you.

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

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

3 A. Yeah.

4 Q. -- to identify the positivity or infectivity?

5 A. Yeah.

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

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

13 You tell us:

14 "I have covered this subject extensively in my
 15 earlier statements, and again invite the Inquiry to
 16 consider the statements of the [Chief Medical Officer]
 17 about asymptomatic transmission ... As the CMO makes
 18 clear, it was a gradual process of accumulation of
 19 evidence that led to asymptomatic transmission being
 20 considered a major part of the force of transmission of
 21 the virus. I agree with the views set out by the [Chief
 22 Medical Officer], which should not be surprising as we
 23 discussed it regularly during this period."

24 A. Yes.

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

23

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

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

9 A. Yeah.

10 Q. And it seems that you endorse that position.

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

12 Q. Thank you.

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

15 A. Sure.

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

18 A. Okay.

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

22 A. Absolutely.

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

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1 build on the topic, please.

2 "As I have explained above, the initial, very clear,
 3 scientific advice was not to test those without
 4 symptoms. I was told categorically by PHE that the
 5 tests would not work on people without symptoms, and
 6 that to test someone without symptoms would risk a false
 7 negative, ie, someone incubating the virus could be
 8 given a negative test result. I was advised that this
 9 would be even more dangerous than not being tested, as
 10 it would give a false assurance."

11 A. Yes.

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

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

19 A. Yes.

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

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

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1 transmission and recognising that there was
 2 a possibility of asymptomatic transmission is absolutely
 3 at the heart of this challenge.
 4 **Q.** Thank you. Well, let's, then, move forward to 11 March.
 5 And I think we're going look together at the WhatsApp
 6 exchange that took place about a public statement
 7 concerning the Prime Minister's contact with Nadine
 8 Dorries.
 9 **A.** Yeah.
 10 **Q.** Was in the context of the positive case.
 11 And can we perhaps work through the messages, which
 12 are said to be supportive, from Lord Vallance's
 13 perspective, of you not having that full understanding
 14 of asymptomatic testing being capable of being picked up
 15 on a PCR test.
 16 **A.** Yes.
 17 **Q.** Can we please display INQ000102697. And it's page 16
 18 within that document I want to go to.
 19 **A.** Okay.
 20 **Q.** That's INQ000102697. Thank you.
 21 Now, if we can pick up, I think at the ... perhaps,
 22 in fact, can we go to the page before, just to start the
 23 story, at page 15, please. Thank you.
 24 **A.** Ooh, maybe not.
 25 **Q.** Maybe not. Let's go to page 16, thank you.

25

1 a test.
 2 "The PM was not in close contact with
 3 [Nadine Dorries]. The advice is that you would have to
 4 be within 2 metres of someone for more than 15 minutes
 5 to pass it on. It is also worth restating the advice on
 6 washing hands -- which the PM does regularly."
 7 And then I think if we follow that down, I think we
 8 get your entry at 10:28.
 9 Thank you. 10:28:17.
 10 So Mr Hancock, MP:
 11 "I'm content with this line. We clearly need to
 12 clear up the testing for non symptomatic people.
 13 "Having spoken to Chris Whitty and PHE [people] I'm
 14 with now, Patrick what you've said is not right.
 15 "The clinical advice I've had is that the test is
 16 NOT reliable on people without symptoms. The reason is
 17 that there are so many false negatives when there are no
 18 symptoms that testing is counter productive.
 19 "Can the scientists please clear this up urgently."
 20 Then if we follow that through, we see the
 21 conversation continues at the bottom of that page, and
 22 I don't know if you want to speak us through this
 23 exchange, because it suggests -- we can then see
 24 Chris Whitty saying:
 25 "Not reliable is correct. It can pick up some

27

1 **A.** Well, it's quite important, page 15.
 2 **Q.** Thank you.
 3 Well, Mr Hancock, if there's further context that's
 4 assessed in a slower time as being relevant to Module 7,
 5 that will be disclosed, but I think we can capture the
 6 sense of this.
 7 So we can see, we follow the story:
 8 "In this case it is the contact tracing aspect that
 9 is the key to who gets tested."
 10 Then we see:
 11 "Do we have a clear view on when Nadine first became
 12 symptomatic? My understanding is that she felt a little
 13 under the weather ..."
 14 And so on.
 15 Then James Slack, who I think is your special
 16 adviser, is that right?
 17 **A.** No, Jamie Njoku-Goodwin was my special adviser.
 18 James Slack was the director of Communications at
 19 10 Downing.
 20 **Q.** I do apologise. And it says:
 21 "Final below. Line on test not working removed ...
 22 "Re the PM on background.
 23 "We follow the advice of Public Health England and
 24 the [Chief Medical Officer].
 25 "The PM has no symptoms so there is no need for

26

1 asymptomatic cases. But not advised."
 2 **A.** Yes.
 3 **Q.** You then say:
 4 "No. We cannot say this. She has told people she
 5 had symptoms on Thursday. We must not cover anything
 6 up."
 7 **A.** That's about a different part of the exchange.
 8 **Q.** Thank you.
 9 Then Mr Whitty says:
 10 "Patrick and I will do a joint note not on WhatsApp
 11 on testing."
 12 But again it's right, isn't it, that Mr Vallance was
 13 effectively saying in this that it could detect -- or
 14 you tell us your interpretation of the exchange.
 15 **A.** Yeah, so there's two further things needed before we can
 16 address this. Over the page --
 17 **Q.** Thank you. Let's go to there now. On page 17 --
 18 **A.** At 10:47, Patrick Vallance:
 19 "Agree 'not reliable' not 'does not work'.
 20 **Q.** So let's just pause there.
 21 **A.** Yes. And --
 22 **Q.** So -- so he's -- so --
 23 **A.** And for page 15, which isn't shown on here -- I won't
 24 read it out, but, for context, Number 10 had proposed
 25 a line saying "Testing does not work" and Chris Whitty

28

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

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

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

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

18 "Can the scientists please clear this up urgently."

19 And Chris Whitty said:

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

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

29

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

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

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

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

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

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

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

31

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

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

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

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

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

30

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

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

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

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

32

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

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

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

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

15 **A.** Yes.

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

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

25 But the thing that frustrates me looking back, and
 33

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

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

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

7 **THE WITNESS:** Hmm.

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

11 **A.** Yes.

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

14 **A.** Yeah.

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

21 **A.** Mm.

22 **Q.** So --

23 **A.** What was the date of that?

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

35

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

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

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

12 **Q.** Can I --

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

18 **Q.** Mr Hancock, I --

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

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

24 **Q.** Mr Hancock --

25 **A.** "This is obviously a good positive step and we must put
 34

1 **A.** Okay.

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

7 **A.** Yeah.

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

10 **A.** Yeah.

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

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

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

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

36

1 the policy.

2 **A.** Sure.

3 **Q.** So please can we display -- first of all, can we display

4 please, INQ000292606. No, I do apologise, INQ000093326.

5 I do apologise.

6 **A.** Okay.

7 **Q.** That's INQ000093326.

8 Apologise for the delay, Mr Hancock, because there

9 have been late additions, we are not as agile as we

10 usually are with the exchanges.

11 So it should be INQ000093326.

12 **LADY HALLETT:** You're getting a message that we don't have

13 it loaded.

14 **MS CARTWRIGHT:** Well, we'll deal with this as a topic,

15 Mr Hancock.

16 **A.** Okay.

17 **Q.** We'll deal with it as a topic, as a piece, after the

18 break when it's been uploaded.

19 **A.** Okay.

20 **Q.** Let's go to the letter from the Crick, then.

21 **A.** Okay.

22 **Q.** And it's evidence we've heard last week from Sir Paul

23 Nurse, that the letter that was sent to you from

24 himself, please. If you just allow me a moment.

25 It's INQ000587060. That's INQ000587060.

37

1 healthcare workers and patients."

2 **A.** Yeah.

3 **Q.** And then we can see it goes on to say:

4 "We assume this has already been debated amongst

5 [His Majesty's] -- Her Majesty's, at that time --

6 government advisers and you might feel that appropriate

7 responses have already been considered. However, there

8 are several reasons for our concern and for writing to

9 you directly in this way. These are as follows ..."

10 And you can see.

11 **A.** Yes.

12 **Q.** "Our perception is that, at present, there is reticence

13 about doing more widespread testing of healthcare

14 workers. It will clearly be expensive and yet another

15 challenge for hospitals that are already under pressure.

16 Some have privately expressed their concern that making

17 a positive diagnosis in asymptomatic healthcare workers

18 who might otherwise continue to work will deplete

19 staffing levels at a time of need. Whilst perhaps

20 understandable, these concerns are not productive in

21 terms of the overall goal of controlling the epidemic.

22 Rather it will result in recurrent problems of seeding

23 fresh outbreaks with staff absences and the potential

24 for infecting non-Covid patients in the healthcare

25 environment."

39

1 And Mr Hancock, the full context of this letter will

2 be understood when, after the break, we've gone through

3 the text messages you want to detail.

4 **A.** Yeah, okay.

5 **Q.** Thank you.

6 **A.** The critical thing to note is, I guess, in terms of

7 timing is they are both -- this is sent on the same day

8 as the advice changed early in the morning.

9 **Q.** Understood, Mr Hancock. But it's right to say that

10 certainly Sir Paul Nurse had been seeking to make

11 contact to share the work of the Crick from February

12 onwards, but this is the formal letter that identified

13 what they had found. And as you can see, Mr Hancock,

14 the concern in particular with this letter was that what

15 had been said on April 6 at the House of Commons select

16 committee, and it details this:

17 "We followed the Committee's debate on the adequacy

18 or otherwise of testing capacity within the NHS, but

19 were surprised that, as far as we could hear, no mention

20 was made in that assessment, of the need to test

21 asymptomatic or oligosymptomatic individuals, be they

22 healthcare workers or patients. This is of great

23 concern in view of emerging evidence that a high

24 proportion of infections are asymptomatic, obviously

25 entraining a high risk of transmission between and among

38

1 **A.** Yeah.

2 **Q.** "Importantly we consider that these concerns can only be

3 overcome by a clear central directive from you as

4 Minister."

5 **A.** Yeah.

6 **Q.** And then you can see it goes on to identify the

7 operational issue.

8 **A.** Yeah.

9 **Q.** And repeated testing for healthcare workers:

10 "We are concerned that this may not have been fully

11 appreciated. To avoid delays, it is essential that this

12 is done in parallel with the development of testing

13 capacity itself."

14 And again we can see:

15 "The most accurate interpretation of testing results

16 is only likely to be achieved by systemic repeat testing

17 in vulnerable groups. Such data collections will be

18 essential for accurate assessment of whether and for how

19 long a particular titrate of antibody against a partial

20 viral antigen is indicative of protective immunity."

21 **A.** Yeah.

22 **Q.** And then over the page, please, you can see the

23 conclusion and in particular:

24 "Our concern is that if this is not done, the

25 current initiative to expand testing itself will not

40

1 achieve the desired effect and the 'breathing space'
 2 potentially achieved by the 'lockdown' will not have
 3 been used effectively."
 4 **A.** Yeah.
 5 **Q.** So can I ask you, did you receive this letter from
 6 Sir Peter Ratcliffe, Dr Sam Barrell, and Sir Paul Nurse?
 7 **A.** I don't recall seeing it at the time, but in a way, I am
 8 not surprised. It would have gone to my correspondence
 9 unit and they would have read it, and I agree with all
 10 of it, and we were already acting on these points, and
 11 you can tell that by the fact that we were, on that very
 12 day, the day this was written, we were already acting on
 13 the, as he puts it, the emerging evidence of
 14 asymptomatic testing, and you've got to recall the
 15 timing is absolutely critical here, that the CDC had
 16 come out with the first concrete evidence just under two
 17 weeks before on 2 April.
 18 And I've -- since this was --
 19 **Q.** Mr Hancock, can I just pick you up on that. So you've
 20 just identified that the CDC had picked up on the first
 21 concrete evidence of 2 April --
 22 **A.** Published about the first concrete evidence, yes.
 23 **Q.** So with that answer, can you help, then, why that had
 24 not resulted in action before 14 April?
 25 **A.** Well, we had -- the moment that the CDC publication came
 41

1 **Q.** And you've identified that these are eminent scientists,
 2 both Sir Peter Ratcliffe and Sir Paul Nurse are Nobel
 3 Laureates. Was that known and appreciated by you in
 4 April of 2020?
 5 **A.** Well, of course it was, but it was also irrelevant.
 6 What mattered, given how unbelievably pressured
 7 everybody in the system was, was: is there new
 8 information, and how credible is that new scientific
 9 information? And from what I've read of the paperwork,
 10 that which I was aware of at the time, and that which
 11 I was not aware of at the time, it wasn't my decision
 12 not to see the letter, obviously. But it was the
 13 correct decision not to show it to me because it didn't
 14 bring any further insight, over and above that which
 15 Chris Whitty and Patrick Vallance had already brought to
 16 me in doing, as Chris put it, the evidence review, and
 17 therefore changing policy.
 18 So what happened, my summary of the timeline here is
 19 that evidence accumulated of asymptomatic transmission.
 20 The CDC publication on 2 April was critical. As it
 21 happened on the same day, the WHO reiterated its
 22 position that there was no asymptomatic transmission, so
 23 you've got to think about the global context here. We
 24 acted immediately upon that new evidence. Chris Whitty
 25 did an evidence review and 12 days later he came forward
 43

1 out, we took immediate action to consider the impact of
 2 that on all the policy that we had, and the publication
 3 with respect to asymptomatic testing and care homes, as
 4 you can see, I was -- the formal advice was changed to
 5 me, following Chris Whitty's evidence review on
 6 14 April. So 12 days later.
 7 This letter, I understand having -- I was a bit
 8 surprised to see the reference to it on Friday, because
 9 I knew that Paul Nurse was talking to Lord Bethell, who
 10 was my junior minister on this area and was absolutely
 11 brilliant throughout this period, and I've since
 12 discovered that the day after this letter was sent,
 13 Paul Nurse and James Bethell had a discussion about it.
 14 So the letter was clearly acted upon within the
 15 department despite the fact that, as you can see from
 16 the other paperwork, all of the points in it were
 17 already under consideration at that time.
 18 So essentially, my reading of it is that the team at
 19 the Crick, the eminent scientists, had come to
 20 essentially the same conclusion in essentially the same
 21 period of time as Chris Whitty had, and we were acting
 22 upon those, upon the new evidence and the insights in
 23 the letter already, and therefore my -- the team in the
 24 department must have decided not to put the letter up to
 25 me because it didn't contain any new information.
 42

1 with his evidence review. It took into account the
 2 points made by these and many other, no doubt, eminent
 3 scientists, and on 15 April, so the day after the
 4 evidence review was concluded, we changed the policy.
 5 I think, having considered this and looked back on
 6 it, would it have been better, with hindsight, to have
 7 assumed asymptomatic transmission from January? Yes,
 8 because there was asymptomatic transmission. Were we on
 9 that issue all the time considering all the evidence?
 10 Yes, we were considering it, we were debating the exact
 11 nuance of how to describe it. And as soon as the
 12 concrete evidence came through, we then changed policy
 13 within 12 days. That's what happened.
 14 **Q.** Mr Hancock, you've characterised that it was the right
 15 decision for this correspondence not to be placed before
 16 you.
 17 **A.** Yes.
 18 **Q.** But particularly Sir Peter Ratcliffe is one of the
 19 preeminent experts in this area.
 20 **A.** Yes.
 21 **Q.** And set against a background of you having had
 22 conflicting or differing advice on a key and important
 23 issue of policy, at the very least should this letter
 24 have not potentially supported you reaching out to these
 25 eminent Nobel Laureate experts to seek their input or
 44

1 views to assist you in decisions of policy and strategy?

2 **A.** I guess the answer to that question explains why the
3 contextual piece at the start of this discussion was
4 important, because on 14 April, I'm driving the vaccine
5 push, we're in the middle of the work to reach
6 100,000 tests. We are a month into -- no, we're
7 three weeks into lockdown, so the number of cases will
8 just have been turning. We were working on the --
9 expanding the Nightingale project to ensure that there
10 was bed capacity -- which was used, by the way. An
11 often forgotten fact.

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

18 So, you know, I could have spent my whole pandemic
19 corresponding with former Nobel Laureates. They're
20 amazing people. They've done incredible work. But to
21 complain about the actions of the correspondence unit
22 when they got a call from the minister the very next
23 day, I think is a bit much.

24 **Q.** Can we then look at the response that followed on
25 6 July, please, INQ000587061.

45

1 **Q.** Mr Hancock, just to complete the issue, and then I'll
2 take you to the document, the reference is the Crick,
3 are you able to help as to why this correspondence
4 responding made -- didn't address at all the issue that
5 they had been raising and flagging around the issue of
6 asymptomatic transmission?

7 **A.** No, I've not seen this letter before today, but -- all
8 I can reiterate, and I'm sorry to bore on about this, is
9 that, in the department, what we were doing was
10 everything we possibly could to save lives. If
11 something didn't have an impact on saving lives, it
12 wasn't a priority.

13 And of course there were many bruised egos in this
14 whole process, but my total focus was on saving lives.
15 And the team would have known that, and -- you know,
16 that's -- and that's -- that's the answer. We got the
17 information that we needed. There was engagement with
18 the appropriate person. And no doubt there was
19 engagement with the scientific team with Chris Whitty.
20 I know for a fact, because I've seen it, there was
21 engagement with the junior minister. This Inquiry
22 should be about how we respond next time, not how the
23 correspondence unit acted during
24 the -- (overspeaking) --

25 **LADY HALLETT:** Can I just interrupt, Mr Hancock. You said

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

5 Can you assist as to, firstly, why it took until
6 July for the response to what were clearly concerning
7 issues for the Crick to be responded to?

8 **A.** Well, obviously you're not calling the Departmental
9 Correspondence Unit but in their defence -- and I feel
10 quite strongly about this -- in their defence we were
11 unbelievably busy, there was a global pandemic, and the
12 amount of correspondence that the department received
13 increased enormously, and critically, most of the jobs
14 that most of the people in the department were doing at
15 this point directly affected how many people died. How
16 quickly we replied to eminent scientists and their team
17 on matters that had already been taken into account,
18 were already in the scientific advice, were already in
19 the government policy, was not going to save anybody's
20 life.

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

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

5 Now, I understand the arguments you made, I just
6 wanted to correct the bruised egos point. That wasn't
7 the point that was being made.

8 **A.** Well, in that case, how it was put was very unusual,
9 because what matters is, if they had valuable additional
10 evidence, that it was brought to bear. Right? And they
11 were engaging with my scientific team, they were
12 engaging with my ministerial team, the information was
13 already being taken into account, it was already being
14 put into government policy.

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

17 What mattered was the quality of the insight, not
18 the number of letters after people's names.

19 **MS CARTWRIGHT:** Mr Hancock, this not an issue about
20 a correspondence, this is about expertise in London that
21 had identified that asymptomatic healthcare workers did
22 have Covid. They had identified it on the tests that
23 they were running, and they had sought, from February
24 onwards, to communicate that, and then, latterly with
25 this direct letter to you, with a desire to influence

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1 and change policy and strategy. So it's not about
2 correspondence or egos.
3 **A.** Well, you say that, but this letter, the incoming letter
4 on 14 April was written after the contents of the letter
5 had been inculcated into government policy, so I just
6 don't know why we are getting so caught up on it. If
7 you have evidence that they -- that the Crick had
8 concrete evidence of asymptomatic transmission in
9 February that I don't know about, then I wish I'd known
10 about that at the time. It wasn't brought to me.

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

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

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

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

5 **A.** Yeah.

6 **Q.** -- for places like the Crick?

7 **A.** Yeah.

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

11 **A.** Yeah.

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

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

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

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

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

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

10 Thank you.

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

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

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

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1 scale up to deliver the testing programme.

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

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

10 **A.** The big one as well.

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

13 **A.** Yeah, yeah.

14 **LADY HALLETT:** -- whilst we built --

15 **A.** Yeah.

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

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

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

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

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

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

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

20 Sir Paul Nurse has indicated it would have been --
21 they would have had an ability, improving on the sort of
22 3,000, 4,000 tests that they got to, to get pretty
23 quickly to 10,000 tests.

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

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

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

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

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

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

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

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

2 **A.** 100,000 tests, yes.

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

5 **A.** Yes.

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

16 **A.** Yes.

17 **Q.** So at any point when you were seeking to achieve the
18 100,000 as quickly as possible, that was needed
19 urgently, did you give a thought to the alternative --

20 **A.** Yeah.

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

23 **A.** Yeah, of course we did.

24 **Q.** -- and the university network?

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

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

7 **A.** Yeah.

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

18 **A.** No, we didn't --

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

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

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

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1 doing, you know, a few hundred tests on a PCR machine,
 2 and you essentially requisition the PCR machine and you
 3 put it into a factory setting, then of course you get --
 4 that university can't do the test. I understand that.
 5 And we took the people with them in some cases, but the
 6 machine is there in the factory setting doing more
 7 tests.
 8 So this is --
 9 **Q.** That's the issue, Mr Hancock. It wasn't.
 10 **A.** No, but --
 11 **Q.** It was a time before it then scaled up.
 12 **A.** That's simply not reflected in the figures. The figures
 13 are that the number of tests increased during this
 14 period. There was -- it's absolutely true that it
 15 increased slowly during April as we built the system,
 16 and then exponentially towards the end of April, but,
 17 please, please, if this Inquiry concludes that what we
 18 need is a, next time round, is a -- that to use the
 19 disaggregated system because the voices who advocate it
 20 are eminent scientists, there is a totally different
 21 capacity between scientific inquiry and industrial-scale
 22 testing, and if we make the wrong conclusion for the
 23 nation on this, then we -- then whoever is in my shoes
 24 next time round will take exactly the same decision
 25 that I did, but instead of preparing for the mass
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1 segregation whilst awaiting result. This is obviously
 2 a good positive step & we must put into the [document]."
 3 So is this the new information that's being brought
 4 to you on 14 April that you've been telling us about?
 5 **A.** Yes. And I'm sorry that in my evidence before the break
 6 I was a bit emphatic.
 7 But in a way, this message sort of encompasses that,
 8 which is that we'd had this enormous frustration over
 9 the evidence and the formal evidence, and finally, after
 10 all of that, which I sort of slightly relived in the
 11 previous session unintentionally, finally, on 14 April,
 12 I get the formal evidence review from Chris Whitty that
 13 recommends testing of all going into care homes, and
 14 this is something that I had wanted, worried about from
 15 the start, but had not had formally advised to me, so
 16 you can see it here that there's a sort of sense of
 17 release and relief that, finally, what we had been, all
 18 of us had had worries about, and I, you know, it was now
 19 formally acknowledged, and we could now get on.
 20 **Q.** Thank you and we can see the questions asked:
 21 "These include all those asymptomatic too, right?"
 22 And if we just go, we get your answer "Yes".
 23 **A.** Yeah, and Allan saying, "Just checking -- this includes
 24 all asymptomatic", so he is sort of -- there's an
 25 element of surprise in that, that this is all
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1 scale-up, there will not have been the preparation done.
 2 **LADY HALLETT:** I have that well in mind --
 3 **A.** And that will be a mistake.
 4 **LADY HALLETT:** -- Mr Hancock.
 5 **MS CARTWRIGHT:** My Lady, is that a convenient moment?
 6 **LADY HALLETT:** It is. I shall return at 11.35.
 7 (11.17 am)
 8 (A short break)
 9 (11.35 am)
 10 **LADY HALLETT:** Ms Cartwright.
 11 **MS CARTWRIGHT:** Thank you.
 12 Now, Mr Hancock, we've got the exchanges relating to
 13 14 April now ready to go, and with great gratitude to
 14 the Relativity operator in the room.
 15 Can we start, then, please, by displaying
 16 INQ000093326, please.
 17 Thank you. And can we go to page 3 within this
 18 document, please, and if we can look at the entry timed
 19 at 8.16. Thank you. We can see there, Mr Hancock,
 20 you're the owner of the cellphone; is that correct?
 21 **A.** That is right, yes.
 22 **Q.** Thank you.
 23 We've got:
 24 "Chris Whitty has done an evidence review and now
 25 recommend testing of all going into care homes, and
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1 asymptomatic cases because of course until then tests
 2 have been regarded as not reliable on asymptomatic test
 3 cases.
 4 **Q.** I'm going to move across documents just to capture the
 5 timeline.
 6 Can we next, please, display INQ000292604, please.
 7 So that was 8.16. We can then see at 9.19 an email from
 8 Allan and that's the same Allan in the messages; is that
 9 correct?
 10 **A.** Correct, yes.
 11 **Q.** Where he says:
 12 "Hi all -- [Secretary of State] has just texted to
 13 say: Chris Whitty has done an evidence review and now
 14 recommend testing of all going into care homes, and
 15 segregation whilst awaiting result. This is obviously
 16 a good positive step & we must put into the doc.
 17 "Please can we action this asap?"
 18 So we're just going to follow these through, I don't
 19 think that needs any extra commentary, Mr Hancock,
 20 unless there's anything else you wish to say about that
 21 document?
 22 **A.** No.
 23 **Q.** Thank you.
 24 Can we now go to INQ000292606, so we move from 9.19,
 25 and at INQ000292606, we're now at 12.14. Thank you.
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1 We can see, an email from Ros. Can you just
 2 identify Ros's role, please.
 3 **A.** Yes, Ros Roughton was head of social care policy at the
 4 department.
 5 **Q.** Thank you, and we can see she details in this email:
 6 "Dear all, in light of the prevalence/transmission
 7 of Covid in care homes, the [Chief Medical Officer] has
 8 asked us to move to a policy of:
 9 " -- Testing all individuals before admission to a
 10 care home.
 11 " -- Testing all symptomatic residents in a care
 12 home.
 13 "This will be announced tomorrow as part of the
 14 social care action plan publication.
 15 "Hitherto, local [Public Health England] health
 16 protection teams have been undertaking some measure of
 17 testing in care homes. But it is clear that there is
 18 insufficient capacity to do this at the scale now asked,
 19 and we will need to develop a different operational
 20 model to deliver this new ask. I don't know
 21 realistically what that is, but I am copying you all as
 22 people who might be able to help generate ideas, and
 23 help us access, eg community health, [Care Quality
 24 Commission], the testing community."
 25 And then we can see a little further down:
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1 to give in respect of this email or is it simply to
 2 ensure we've captured the chronology?
 3 **A.** No, it makes sense. The key point of this is that the
 4 new CMO advice came in that morning. By lunchtime we
 5 were turning that clinical advice, operationalising that
 6 clinical advice, taking into account the constraints
 7 that Ros put in her previous email, the availability of
 8 testing for instance, and all in the context of them
 9 publishing the government policy the next day.
 10 **Q.** Thank you.
 11 And can we move, please, to INQ000093326. So we are
 12 now at 5.23 on 14 April.
 13 That's INQ000093326.
 14 I think in this exchange it's the update around what
 15 had happened in the meeting, and the change to the
 16 decision on testing.
 17 Mr Hancock, is there anything else in respect of
 18 this exchange you wish to highlight?
 19 **A.** No, so this is just merely a distinction between the
 20 advice was to test those going from hospitals into care
 21 homes, and there was a debate about whether to also say
 22 that in the future we would test those going from the
 23 community into care homes, and we decided only to say
 24 the former until we were confident that we could do
 25 the -- to do the latter, but it didn't make a policy
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1 "Please can you set up a meeting this afternoon, if
 2 possible, of people on the copy list, or people they
 3 recommend," and then we can see the suggested agenda,
 4 scope of new tests being asked.
 5 **A.** That's right.
 6 **Q.** Thank you.
 7 Can we move then from this email timed at 12.14 to
 8 INQ000292606, which is a readout of that meeting, which
 9 is at 13.44.
 10 So INQ000292606. Thank you.
 11 Sorry, I do apologise, I've been a rogue --
 12 INQ000292605. I do apologise. Sorry, this is the
 13 readout of the meeting at 1.44.
 14 If we just go down -- thank you -- we can see:
 15 "Ros updated that we have agreed with NHSE and local
 16 [government] wording on discharges in light of CMO
 17 testing wording. A lot of work to operationalise,
 18 looking at getting nursing staff to take swabs in care
 19 homes. [Secretary of State] said we need to ensure the
 20 nurses are in PPE or have been tested. MS(C) noted the
 21 wording on whether testing is on admission or discharge
 22 is a bit confusing."
 23 And then again:
 24 "Action: team to clarify wording on testing."
 25 Again, is there anything extra commentary you wish
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1 change; it was merely about whether we would forward
 2 indicate the testing of those from the community.
 3 **Q.** Thank you.
 4 Can we then move to INQ000292608, please.
 5 That's INQ000292608. Thank you.
 6 We can see this email is 6.49 in the evening. If we
 7 can scroll down, please, this another email from
 8 Ros Roughton, where again we can see she identifies:
 9 "I have just talked to Ed in [Secretary of State's]
 10 office about this, informed by a meeting with PHE, CQC,
 11 NHS E and others from testing world on how we
 12 operationalise this.
 13 "We agreed
 14 "- We can press ahead straight away with hospitals
 15 testing patients who are going to care homes."
 16 Then we can see the aspiration:
 17 "We think the numbers on this are under 8,000
 18 a month.
 19 "It's really important that we keep this aspiration
 20 in, as we need to build care home confidence that we are
 21 doing our best to help them keep their residents safe --
 22 and this will be an important part of it. This was also
 23 the advice earlier today via [the Chief Medical
 24 Officer]."
 25 **A.** Right.
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1 Q. Thank you. Then if we move, please, to the next
2 paragraph of the chronology.
3 INQ000292609. Thank you.
4 We're now at 8.12 in the evening, and we can see
5 essentially again a recording that:
6 "We agreed that on expanding of testing to all
7 residents of a care home where an outbreak is
8 suspected/confirmed the next steps by close tomorrow
9 are ..."
10 And then we can see, again, that through.
11 And again:
12 "We agreed that on the policy to test all hospital
13 patients ahead of discharge to a care home:
14 "Discharges are estimated to be c500 per week ..."
15 A. Yeah.
16 Q. So, Mr Hancock, is there any other context we need to
17 consider on this email as part of the chain that went to
18 the policy change on 14 April?
19 A. No. I guess what it shows is the -- simply the speed of
20 action from the policy change -- the advice change first
21 thing in the morning, through to here we are at
22 8 o'clock at night with the team putting together the
23 details of how this can then go into action.
24 Q. Thank you. And finally, then, just to complete the
25 point of the chronology, INQ000292611, please.

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1 And so, Mr Hancock, I said we'd go through the wider
2 exchange that you were anxious that was properly
3 considered when you had that change of advice from
4 Mr Whitty.
5 A. Yeah.
6 Q. Is there anything else before we move to the last number
7 of topics that I wish to consider with you, be ...
8 A. No, I think that takes us through the chronology on
9 that.
10 Q. Thank you.
11 Then can I ask, again on asymptomatic workers and
12 testing, one of the issues that's been explored with
13 a number of witnesses in this Inquiry is then the fact
14 that Wales then implemented the policy at a later time
15 to England, a couple of weeks later, but also there'd
16 been some reference or suggestion that there was no
17 value in asymptomatic testing. Can I ask you, having
18 gone on the journey you've told us about, particularly
19 through March and April, do you have any views about, at
20 a later time, sort of two weeks on, a position being
21 adopted at a different devolved nation that was still
22 saying there's no value in this?
23 A. Yes, well, I do remember the First Minister of Wales
24 saying that you shouldn't test people who are
25 asymptomatic, a bit later, and I remember thinking we

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1 Thank you.
2 So we're now at the following day at 10.07 in the
3 morning. Again, Ros to the various recipients, but
4 again we can see:
5 "Hi Natasha ..."
6 And then the detail, essentially detailing that:
7 "[They] want us to restrict the testing of patients
8 in hospitals going to care ..."
9 So let's just identify, "NHS England (Simon)" --
10 A. That'll be Simon Stevens.
11 Q. Thank you.
12 You say:
13 "[They] want us to restrict the testing of patients
14 in hospitals going to care homes, only to those patients
15 who are going to care homes for the FIRST TIME, not
16 those who are returning to their care home. They are
17 concerned about their operational capacity to do that as
18 they are trying to establish how many people are
19 admitted from a care home.
20 "I think in policy terms, we should be committing to
21 testing everyone going into a care home from hospital.
22 "Any" --
23 A. And that's what we did.
24 Q. "Any thoughts on handling?"
25 Thank you.

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1 need to make sure that he gets the updated advice that
2 I've seen and -- but I didn't -- I can't remember being
3 any more involved than that.
4 Q. Thank you.
5 Now, Mr Hancock, I'm going to deal with Lord Bethell
6 because he was essentially tasked with the scaling up
7 from 17 March --
8 A. Yeah.
9 Q. -- when the decision was made to move towards the mass
10 testing approach. So please know that that chronology
11 will be dealt with with Lord Bethell.
12 A. Yeah.
13 Q. But can I ask you, then, just if you can do it in
14 a compact way, we know that PHE was essentially
15 disbanded and it moved, then, into essentially what
16 became NHS Test and Trace and then UKHSA.
17 A. Yes.
18 Q. Is there anything else particularly that this Inquiry
19 should consider as to that decision for you to disband
20 Public Health England?
21 A. To disband them overall?
22 Q. Yes.
23 A. Well, that was a decision taken in August of 2020. The
24 reason to do it was to ensure that -- it was really
25 about preparedness. It was about making sure that there

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

7 **Q.** Thank you.

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

14 **Q.** Thank you.

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

18 **A.** No problem.

19 **Q.** -- to these topics.

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

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

8 So antibody tests were important.

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

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

23 **Q.** Thank you.

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

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

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

11 **Q.** Thank you.

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

15 **A.** Yeah.

16 **Q.** He also notes that:

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

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

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

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

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

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

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

11 **A.** Yeah.

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

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

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

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

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

11 Q. Thank you, now --

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

17 Q. Thank you.

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

22 A. Yeah.

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

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

3 Q. Thank you.

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

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

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

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

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

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1 that those meetings had not been properly recorded by
2 references?

3 A. No, not that I can recall.

4 Q. Thank you.

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

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

10 So paragraph 258, please. Thank you so much.

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

13 A. Oh yeah.

14 Q. You detail:

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

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

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

9 Q. Thank you, Mr Hancock.

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

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

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

19 You say this:

20 "I am concerned that at present our current capacity
21 is being dismantled and we will find it much harder to
22 scale again in the future as a result. It is a vital
23 weapon in the Government's armoury to combat any new
24 disease and, depending on the transmissibility and
25 virulence of that disease, may be sufficient alone to

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1 suppress and contain it without having to resort to
2 further social distancing measures. In my view, that
3 justifies the cost of building and maintaining testing
4 systems that are rapidly in the event of new variants or
5 an entirely new pandemic."

6 **A.** Yes.

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

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

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

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

3 Mr Thomas, who is over there as well.

4 **Questions from PROFESSOR THOMAS KC**

5 **PROFESSOR THOMAS:** Good afternoon, Mr Hancock.

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

7 **Q.** Thank you.

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

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

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

23 **A.** Yes.

24 **Q.** Can you explain how those decisions were made?

25 **A.** Ultimately, I relied on clinical advice on the

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

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

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

17 My Lady, there are Core Participants questions.

18 **LADY HALLETT:** Thank you.

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

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

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

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

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

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

16 So let me move on to my third question.

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

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

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1 things in a pandemic before we had better testing
2 available.
3 Once we had the various surveys up and running, the
4 ONS survey, the REACT survey, looking at the work of
5 Professor Tim Spector, the -- we had -- that gave us
6 better information to be able to make decisions which
7 were more led by the data.

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

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

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

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

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

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

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

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

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

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1 and reflecting the community that it's close to.

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

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

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

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

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

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

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

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

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

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1 example which came up quite regularly.
 2 I think it's really important that you look at it
 3 through the correct lens -- look through the telescope
 4 the right way, because otherwise you end up in an ivory
 5 tower in Whitehall thinking that people are disconnected
 6 and it's not -- and instead it's important to take
 7 responsibility for that disconnect and try to do
 8 something about it.

9 **Q.** Let me come to my last question, I'm going to roll it up
 10 because time is short, and it's that issue of structural
 11 racism that I just want to return to in this module.

12 **A.** Yeah.

13 **Q.** So I'll roll up my question in this way. Can you tell
 14 us, can you tell her Ladyship what consideration was
 15 given to the impact of existing structural racism within
 16 the NHS and wider health systems, when you were
 17 designing the -- and implementing the test, trace and
 18 isolate programme?

19 **A.** Well, I think the best way to answer this is to -- is
 20 that we were trying to understand and respond to the
 21 likelihood of somebody being infected and being very
 22 negatively affected by that. And one of the challenges
 23 we had in the data was to disaggregate how much of that
 24 was due to socioeconomic factors and how much of that
 25 was due to biological factors. And we put quite a lot

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1 context and in that light that any findings I make --
 2 I'm not somebody who believes in sitting in a hearing or
 3 a courtroom centre in the cold light of day who comes
 4 along and says, "Oh, I could have done it better".
 5 That's not my way. So please be reassured.

6 **THE WITNESS:** That's kind of you to say. Thank you.

7 **LADY HALLETT:** I believe we are going to call on you once
 8 more.

9 **THE WITNESS:** Yes.

10 **LADY HALLETT:** But I'm hopeful, pretty confident that will
 11 be the final time. So thank you very much for your help
 12 this time and I shall see you again, I hope, just the
 13 once more.

14 **THE WITNESS:** Thank you very much.

15 **LADY HALLETT:** Thank you.

16 Lord Bethell, I'm sorry to keep you waiting but
 17 I see you've been following proceedings anyway.

18 **MS CARTWRIGHT:** My Lady, could, please, Lord Bethell be
 19 sworn.

20 **LORD JAMES BETHELL (sworn)**

21 **Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 7**

22 **MS CARTWRIGHT:** Lord Bethell, could you give your full name,
 23 please.

24 **A.** Yes, James Nicholas Bethell.

25 **Q.** Thank you.

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1 of effort into trying to work that out.

2 And a large -- because if this is a structural
 3 problem that is because a virus affects people from
 4 a given ethnicity differently, then you need to respond
 5 to that. If it's because there are more people in, say,
 6 groups that are patient-facing, proportionately, then
 7 you need to address that. But getting to the root cause
 8 of why there is a disparity in impact of the virus by
 9 ethnicity, by gender, and by socioeconomic status, is
 10 important because you can then only address it if you
 11 can understand the root cause of it.

12 **Q.** What would you do differently, going forward?

13 **A.** Well --

14 **LADY HALLETT:** I think that's too broad a question,
 15 Mr Thomas, sorry. We've got a huge amount to get
 16 through today, I'm really sorry -- and this isn't also
 17 a thesis -- so I appreciate how important the point is,
 18 Mr Thomas, but I think we're going to have to leave it
 19 there.

20 **PROFESSOR THOMAS:** Thank you, my Lady.

21 **LADY HALLETT:** That completes the questions we have for you
 22 in this module, Mr Hancock. Please don't worry about
 23 your passionate responses earlier, I do understand, and
 24 I also understand the pressure that you and your
 25 colleagues at the DHSC were under and it's in that

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1 Lord Bethell, we thank you for the provision of your
 2 third witness statement to the Inquiry but the first to
 3 Module 7. Could we please turn to page 58 of that
 4 statement, please, where we see it's dated 16 April of
 5 2025. And can I ask you to confirm that the content of
 6 that statement is true to the best of your knowledge and
 7 belief?

8 **A.** Yes, it is true.

9 **Q.** Thank you. Now, Lord Bethell, you've given evidence
 10 already to the Inquiry twice, and you've already
 11 identified, but let's just deal with that now.

12 It's right, isn't it, that you were, during the
 13 pandemic, Minister for Technology, Innovation and Life
 14 Sciences, and you are going to help us with the
 15 development of that role relevant to test, trace and
 16 isolate from 1 January 2020?

17 **A.** That's right.

18 **Q.** Thank you. And can you just confirm when you ceased to
 19 act in that role, please?

20 **A.** September 2021.

21 **Q.** Thank you. Now, you have helpfully within your witness
 22 statement, at the very beginning, set out reflections,
 23 which I think are quite helpful to deal with at the
 24 outset to give some context to the evidence you wish to
 25 give by reference to test, trace and isolate.

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

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

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

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

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

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

21 A. Yeah.

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

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

4 Now, we have chosen in this country, quite
5 unusually, to put a huge amount of our resources, about
6 95% of the £220 billion into either primary care or
7 acute hospitals, and we put a huge amount into life
8 science research, billions of pounds in terms of
9 research funds. And we put a tiny amount, 2%, into
10 public health.

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

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

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

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

4 A. I understand.

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

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

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

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

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

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

16 So I think that coordination point is very
17 important.

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

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

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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 anecdotalism 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

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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

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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

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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%

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

12 **Q.** Thank you.

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

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

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1 people can actually isolate.

2 **Q.** Thank you.

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

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

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

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

8 **Q.** Thank you.

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

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

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

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

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1 treatments and test and trace as really the
 2 alternatives.

3 **Q.** Thank you.

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

7 **Q.** Thank you.

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

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

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

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

14 **A.** Oh, from his private office, yeah.

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

18 **A.** Yeah.

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

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

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

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

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

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

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

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

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1 So we're now at 18 March. And essentially that --
 2 **A.** Sorry, the "from" is the ...
 3 **Q.** Sorry.
 4 **A.** Do you know who that's from?
 5 **Q.** No, I'm --
 6 **A.** I'm presuming it's a private office.
 7 **Q.** We can clarify that certainly. If we look, essentially,
 8 following on from that meeting there was a creation,
 9 would you agree, Lord Bethell, of a testing working
 10 group that was now working almost, I think, until May of
 11 2020 --
 12 **A.** Yeah.
 13 **Q.** -- that really got the first four Lighthouse
 14 laboratories off the ground?
 15 **A.** That's right.
 16 **Q.** Thank you. If we go over the page, please, again we can
 17 see, essentially, the allocation of tasks and roles to
 18 individuals. Is there anything you want to say by
 19 reference to the actions, Lord Bethell --
 20 **A.** Well, I think one thing that was notable about that
 21 period, where there was just an enormous amount of
 22 goodwill, and I would pay tribute to the private sector
 23 companies that brought expertise, they leant in, they
 24 brought ambition, and sometimes they just did things off
 25 their own back without any remuneration at all, and this

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1 whole. It doesn't do well to employ large numbers of
 2 people. It is better at contracting out to the private
 3 sector. That's how a lot of government services are
 4 delivered. So it is no surprise.
 5 There is no way we could have done a formal
 6 recruitment process in order to get the right people in
 7 the right place. We needed agility, speed and
 8 expertise, and that can only be found through the
 9 private sector, and a firm like Deloitte, and it could
 10 have been any others of them, but they happened to be
 11 the ones that are good at that kind of lower-level
 12 public service, manual-style delivery, that they held
 13 the reins, and they also contracted to other parties in
 14 a way that, frankly, government procurement systems are
 15 not so good at.
 16 **MS CARTWRIGHT:** Thank you, Lord Bethell.
 17 My Lady, is that a convenient moment?
 18 **LADY HALLETT:** Yes, certainly, if that suits you.
 19 Lord Bethell, I'm sorry we're going to have to take
 20 you over lunch, but you appreciate we have to think of
 21 our poor stenographer, who copes so well. I shall
 22 return at 1.45.
 23 **(12.44 am)**
 24 **(The Short Adjournment)**
 25 **(1.45 pm)**

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1 **MS CARTWRIGHT:** Good afternoon, my Lady.
 2 Lord Bethell, I hope you'll indulge me just to
 3 continue using the documents to give an overview,
 4 chronology, around the scaling up of the National
 5 Testing Programme, please.
 6 Please could we display INQ000566069.
 7 That's INQ000566069, please.
 8 Thank you.
 9 Now, Lord Bethell, the date's not on the front of
 10 this, but the information we have is this is now
 11 22 March 2020 and we can see this was the briefing put
 12 together for the Prime Minister. And again, if we move
 13 through, I'm not intending to dwell on the pages but we
 14 really see the evolution as we move through the pages of
 15 the ambition, but also the practical things that were
 16 happening to get the laboratory test centres and
 17 distribution centres set up.
 18 **A.** Yeah, haha! This is how not to do a test lab, by the
 19 way.
 20 **Q.** But we also see, as well, there's plainly been
 21 forecasting, modelling, and projections as to the
 22 scale-up.
 23 **A.** Yeah.
 24 **Q.** Thank you.
 25 **A.** I mean, it's just an incredibly thoughtful and
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1 Now, Lord Bethell, this draft has got the June date
 2 on it but with the evidence of Mr Cook for Deloitte we
 3 had an earlier iteration of 25 March which follows on
 4 from the PM's briefing. This is how it develops
 5 a little bit more by the June, but did you see and have
 6 access to the Deloitte 168 plan to understand how they
 7 were bringing together the strands and the flow, as we
 8 can see on this, of Kingfisher, Roche, NHS, and digital
 9 Platforms to bring the project to fruition?
 10 **A.** Yes, well, I was very involved in, at this stage, all
 11 steps of it. Many of them were based on sixth floor,
 12 below my office, and I had daily engagement with the
 13 team on their progress.
 14 **Q.** Thank you. And I think, in fact, you tell us in your
 15 witness statement, was it from 19 March there was
 16 a Deloitte team located in Victoria?
 17 **A.** Yes, there was, downstairs. Absolutely.
 18 **Q.** Thank you.
 19 Now, pausing where we are on the chronology, I've
 20 a number of questions to contextualise the scale-up of
 21 the industry. So can I ask from your perspective,
 22 Lord Bethell, was there sufficient consideration given
 23 to working with universities as laboratories?
 24 **A.** Yes, I mean, I think we've been through this quite
 25 a lot. A huge amount of effort went into not just
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1 data-driven amount of work. I hope -- this sort of
 2 presentation I hope gives you an idea of what was
 3 involved.
 4 **Q.** Thank you. And we can keep going and just so -- I mean
 5 no disrespect to the project, Lord Bethell, with not
 6 going through the detail of it, but it gives an idea as
 7 to the evolution of, perhaps if we look at page 21, we
 8 keep going, I think what you've described as the battle
 9 plan.
 10 **A.** Yeah.
 11 **Q.** And I don't know whether this is in the context of what
 12 you've said already about scramble and the culture of
 13 scrambling?
 14 **A.** Yeah.
 15 **Q.** But can we then move to another document because we've
 16 then got what we've analysed in detail, and I promise
 17 I'm not going to take you through the 168 plan of
 18 Deloitte other than to identify it, please.
 19 I'm going to need my glasses for this one, I do
 20 apologise, INQ000581552.
 21 Now, can I ask -- sorry it's the 168 plan of
 22 Deloitte. INQ000581552. I hope that it's not a 6. It
 23 might be INQ000561552, I do apologise. Deloitte did
 24 recommend we use the hard copy.
 25 Sorry. Thank you for your patience, Lord Bethell.
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1 universities, but hospital pathology labs, animal
 2 pathology labs, all manner of private, public and
 3 university testing laboratories, in order to create, out
 4 of the battalion of small ships, some kind of network
 5 that could somehow utilise this expertise,
 6 infrastructure, and passion, because they were very
 7 enthusiastic, and I was lobbied on an hourly basis by
 8 just about everyone who had a PCR machine, about how
 9 they could play an important role.
 10 And I personally spent a huge amount of effort to
 11 try to figure out a way of creating an "Uber" for
 12 diagnostics, and that vision I thought was a very
 13 powerful one. Matthew Gould wrote a very thoughtful
 14 note on how we could apply modern insight from Silicon
 15 Valley on how to somehow harness this collective effort.
 16 It was a total disaster. It just didn't work. They
 17 were regularly late, they regularly lost tests. The
 18 turnaround times weren't quick enough. The data got in
 19 a mess. It was very, very expensive. And I would have
 20 loved for that effort to have worked. But the thought
 21 that it could in any way play a significant role is not
 22 just a distraction, it is, as I said in my opening
 23 remarks, promulgating this status quo mentality that we
 24 don't need to change anything in the way that this
 25 country does health, that backing acute care in the NHS
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1 and research in life sciences is enough, and we need to
2 focus on this thought that public health diagnostics is
3 a different beast and we need to think about how we
4 provide a platform for scaled-up industrial throughput
5 if we're going to be ready for the next pandemic.

6 **Q.** Thank you.

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

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

12 **A.** Yes.

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

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

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

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

12 Now, to try to be helpful --

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

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

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

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1 intervention to you. My biggest fear about where this
2 module is going is that you are looking for a sort of
3 list of micro-recommendations of around the sort of
4 10 million to 50 million ticket. And it would be great
5 if that was the answer, but genuinely, I don't think
6 it is.

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

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

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

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1 be cost effective for now.

2 **A.** Yes.

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

5 **A.** Yes.

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

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

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

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1 five pillars that I would recommend.

2 **LADY HALLETT:** Thank you very much.

3 **MS CARTWRIGHT:** Lord Bethell, just on the chronology, we

4 know that the UK Government moved from the 'contain' to

5 the 'delay' phase on 12 March and what that meant for

6 testing, but can I ask in terms of the small boats that

7 were offering assistance, and in particular the Crick

8 institute. I'm also going to ask you to deal with the

9 dealings you had with Sir Paul Nurse, because certainly

10 Mr Hancock has suggested you'd had some relevant

11 contact.

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

13 **Q.** We'll come to that in a moment. But can I ask, first of

14 all, in terms of, had -- whilst the Lighthouse

15 laboratories that were being set up, had the

16 United Kingdom Government utilised the offers from

17 laboratories, research institutes and universities,

18 could that have essentially impacted on the decision to

19 move from 'contain' to 'delay' so there was another

20 option to --

21 **A.** Oh, we used every single scrap of capacity we had.

22 I spent hours every day on the phone to just about

23 anyone who had anything like a testing kit available.

24 I spent a lot of time talking to the animal veterinary

25 industry, the racehorse industry in Newmarket, the very

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1 Compare that to the Rosalind Franklin, which is in

2 a massive white box, just off a motorway, where the

3 tests arrive at 6, 7 in the evening, are automatically

4 unzipped -- unzipping a test is a very dangerous thing

5 to be doing. You don't have to have teams of students

6 doing it, you have robots unpicking them.

7 They then get put into a massive conveyor belt,

8 which is about 100 yards long. It's banging them out

9 on strips -- no trays, strips -- and doing 30,000 on one

10 machine in an hour.

11 This a million miles from Paul Nurse and all the

12 others. But that's what you need.

13 **Q.** I don't mean to interrupt you, Lord Bethell, but we have

14 heard from Professor McNally, who set up part of the

15 Milton Keynes laboratory, so we understand something as

16 to the process, and equally I think there's quite a lot

17 of videos on YouTube if anyone wants to look at it in

18 action.

19 But because Mr Hancock giving evidence referenced

20 discussions you were having with Sir Paul Nurse, do you

21 want to just give some context to -- and anything you

22 want to tell us that's relevant to this discussion

23 around scaling up by reference to the conversations you

24 were having with Sir Paul Nurse?

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

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1 wonderful team at Cambridge University who, sponsored by

2 AstraZeneca, did stand up a laboratory. My goodness, we

3 looked at every single laboratory.

4 We also looked at every single test. We looked at

5 breath tests, cough tests, poo tests, water tests,

6 pee tests, sweat tests. We had a whole partnership

7 scheme run by the very able Lord O'Shaughnessy looking

8 at every single test and every single laboratory in the

9 country. We bust a gut to try to make the system that

10 you're describing work. And it didn't. It failed

11 completely. Because you cannot go to somewhere like

12 the Crick.

13 And I don't know if you've been to the Crick, but

14 it's an absolutely stunning building and it's won design

15 awards and it has one feature to it, which is incredibly

16 exciting, in order to encourage creativity: it has no

17 walls. No walls, a building without walls. Really

18 exciting.

19 This not a place where you want to base a laboratory

20 for a highly contagious disease. I mean, this is not --

21 doesn't make sense.

22 I went to the Cambridge University laboratory.

23 I nearly ran out in anxiety. There were piles of tests

24 in the corner, you had to climb over things in order to

25 get from one place to another.

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1 I think I've said in the last module that I had

2 a sense of: where is everyone? Why is there no one to

3 help?

4 Paul was there. He went above and beyond to try to

5 stand up a testing facility when the country needed it,

6 and deserves our praise and thanks. But Paul was

7 writing to everyone. He was writing to the CMO's office

8 about his scientific insight and he wasn't getting the

9 reply he needed.

10 If you're writing with scientific insight, you need

11 to write to the scientists, to the Chief Scientific

12 Adviser or to the CMO. And if you're not getting

13 a reply, you need to ring them up.

14 Phoning ministers because the CMO hasn't returned

15 your -- is a misreading of how government works. And if

16 you've got ideas about the NHS and nosocomial infection,

17 you need to write to the head of the NHS, because the

18 way our NHS works is that ministers do not tell the head

19 of the NHS how to run the NHS.

20 I had a lot of sympathy for what he was saying on

21 asymptomatic transmission and nosocomial infection.

22 I thought he was absolutely right. We had a large

23 number of conversations about it. And I was just

24 looking at my phone just now, there are dozens and

25 dozens of text messages and missed calls between us.

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

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

12 INQ000119438, please.

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

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

23 If we move over the page, please, we can see this
24 was really a thanks as he hadn't been one of the many
25 individuals that formed part of this testing scientific
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1 there that comprised the team, thank you -- if we could
2 scroll up -- thank you. You see we've heard from
3 Professor Molloy. Thank you.

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

7 **A.** No.

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

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

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

21 **A.** No. No way.

22 **Q.** Thank you.

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

25 This now 4 April. We know this is when the
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1 advisory panel that was working until the handover to
2 the test and trace in the May, and then ultimately to
3 set up UKHSA. But again, is this an example of
4 selflessness of a number of professionals to assist with
5 the national effort?

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

18 **Q.** Thank you.

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

22 That's INQ000497424, please. Thank you.

23 And it's the next page, really, where we have an
24 ability to identify, in a quick way, those that were
25 part of the taskforce. We can see the various names
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1 Lighthouse laboratories were starting to come online,
2 the scaling-up of the testing programme, and please if
3 we can move through this document.

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

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

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

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

24 **A.** Well, they did evolve a little bit but not really.

25 I mean, it remained pretty much the structure of things.
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1 I'd say that the Pillar 5 only really kicked in after
2 a few months when we started to try to build a local
3 industry and that was a struggle and has faded away.

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

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

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

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

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

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

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

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

15 A. Thank you.

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

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

25 I remember, as a brief anecdote, phoning up my

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

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

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

17 But please can we go to the INQ000088699, please,
18 which is the Covid Strategy Ministerial Group from
19 14 April -- that is INQ0088699, thank you -- and we can
20 see that you and Mr Hancock were present at that
21 meeting. If we go over the page again, we can see other
22 members of the testing. So we've got an official who
23 was the Director for Testing -- in fact she's named,
24 Kathy Hall, Director for Testing.

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

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1 in-laws and when my father was sent to the shops very
2 early on, when he came back he had to take all his
3 clothes off, put them in a black plastic bag and then my
4 mother-in-law would squirt him with Dettol and then he
5 was allowed to come in in order to have a shower. And
6 when they said that to me, I literally laughed out loud,
7 I thought how ridiculous. Boy, they had a point.

8 I mean, in other words other countries were on it
9 straight away, and when I brought this up amongst
10 colleagues at DHSC, they likewise had a good laugh and
11 said, well, you know, Asian culture is very different.

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

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

22 INQ000587456, please. Thank you.

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

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1 Alderley Park.

2 **A.** Yes.

3 **Q.** Thank you. Then can I ask from your perspective,

4 because obviously there was a great deal of effort to

5 get the four Lighthouse laboratories up and running.

6 **A.** Mm.

7 **Q.** But then there seems to be quite a delay between the

8 next set of Lighthouse laboratories coming online, and

9 can you offer any perspective or commentary about what

10 seems to be a really great start but then slight longer

11 delay with the rest of the Lighthouse laboratories

12 coming on?

13 **A.** Well, I think that Cambridge actually was stood down.

14 That wasn't really a mass throughput lab although --

15 I think scale counted for a huge amount. We didn't

16 necessarily need a lot of labs. We just needed really

17 big ones, because the insight we learned was moving the

18 samples around could be done quite quickly. It was more

19 important that they were accurate and quick.

20 The Leamington Spa lab that came in in June was

21 really the big mother ship and that one, for me, dealt,

22 you know, was a model of the kind that we should be

23 having in the future. The idea that there was going to

24 be a second wave was something that a lot of people

25 really struggled with. It was something that Chris

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1 how we should mothball this. I remember in -- I,

2 obviously, got sacked in September. One of my last

3 meetings was when DHSC colleagues had tabled an idea for

4 how we should have a phased retreat and how we should

5 try to preserve some of the infrastructure from the test

6 and trace, in order to create the kind of capability

7 that we're talking about. And when we met with NHS

8 colleagues, they had a completely different plan that I

9 was shocked and surprised to see, but I now understand

10 prevailed, which was to essentially dismember the entire

11 outfit, to ransack it for stuff that the NHS need, and

12 sell the rest on eBay.

13 How that decision was arrived at I think was

14 disappointing, and definitely did not include the kind

15 of strategic thinking that should have happened and that

16 this Inquiry should be calling for.

17 **Q.** Thank you.

18 I just have a few more documents now, please,

19 Lord Bethell, that I hope give some insight.

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

21 INQ000592613, please.

22 Just going back to the pillars, this is a document

23 you authored to give an update from Pillar 4 from

24 15 April. And again, if we move into the document,

25 I think you've described others as thoughtful, and if we

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1 Whitty said to us in January. When he first said it to

2 me, I couldn't get my head around it, but instinctively,

3 emotionally, culturally, I think that a lot of people in

4 senior leadership positions resisted the idea and that

5 did create a bit of a stall in progress.

6 **Q.** Can I then, obviously, reference the mother ship, the

7 Rosalind Franklin. Obviously there's been quite a lot

8 written about that in terms of the cost and expense, and

9 then obviously, again, all of this gone. Can I ask for

10 any views you have -- we heard yesterday from

11 Vaughan Gething that essentially they were part of the

12 investment in this structure --

13 **A.** Yes.

14 **Q.** -- and no one consulted them before they were all

15 mothballed.

16 **A.** I know.

17 **Q.** And I think that felt like, if they've contributed

18 financially as a nation, a government, that someone

19 should have at least done them the courtesy of speaking

20 to them about the plan before they were decommissioned.

21 Can I have your perspective on that, please,

22 Lord Bethell.

23 **A.** Well, he's got a point on courtesy, but that's not

24 really the serious point. There was no consultation

25 with the future pandemic thinking strategy team about

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1 move through again we can see the update in progress

2 that was being collated to speak to each of the pillars.

3 **A.** Yeah.

4 **Q.** And I think this is just one example, but is it right

5 that these were being prepared throughout the period of

6 time --

7 **A.** I can't speak -- all of the time, there was very

8 thoughtful data-driven analysis, very tricky questions

9 about what kind of posts to use, what kind of swab to

10 use, what kind of tube to use, which machines, which --

11 where we're going to get a biomedical workforce from,

12 hundreds of knotty little problems really analysed very

13 carefully. So there was a massive investment that went

14 into the creation of this system, and I hope very much

15 indeed it has been preserved, and would be disappointed

16 if it wasn't.

17 **Q.** Thank you.

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

19 please.

20 Again, on the timeline, although there's not an

21 immediately apparent date, this document is dated

22 21 April 2020. We can see contact tracing and testing.

23 We've already heard quite a lot of evidence the apps and

24 the development of the apps. I don't want to use the

25 precious time we've got to deal with that, but can we go

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

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

10 A. Yeah.

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

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

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

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

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

7 A. Yes.

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

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

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

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

7 We do not have the equivalent in public health.

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

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

16 Q. Thank you.

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

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

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

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

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

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

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

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

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

21 A. Yes.

22 Q. -- the need that something was missing?

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

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

7 Q. Thank you.

8 And then finally for the chronology --

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

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

13 A. Oh good.

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

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

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

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1 Lord Agnew has identified.

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

6 And asking you the question:

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

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

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

13 A. Yeah, sure, of course.

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

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

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

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

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

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

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

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

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

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

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

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

17 Q. Thank you.

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

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

23 A. Yeah.

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

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

8 Q. Thank you.

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

11 A. Yes, absolutely.

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

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

19 Q. Thank you.

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

25 A. Well, the only thing I'd say is -- that's right, you've
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1 additional symptoms before they were formally recognised
 2 on 18 May 2020?

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

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

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

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

21 Q. Thank you.

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

24 And can we please display INQ000279754, please.

25 That's INQ000279754.

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

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

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

15 Q. Thank you.

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

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

25 Were the test and trace taskforce aware of those
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1 And there's a number of questions I just want to ask
 2 around asymptomatic?

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

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

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

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

14 A. Yeah.

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

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

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1 today or triggering in myself any anxieties, I've got to
 2 be honest with you that the discussion around
 3 asymptomatic transmission was absolutely at the heart of
 4 everything we did from the very beginning.
 5 For me personally, I noted that in the chalet of
 6 superspreaders -- which you may remember began the Covid
 7 experience for Britain, when I think it was about ten
 8 doctors who had been on a skiing trip brought Covid and
 9 then spread it all around the country. A very notable
 10 feature of that story struck me, which was that, in
 11 their chalet, none of them had symptoms.
 12 So that's the question: how did these ten people all
 13 catch Covid off each other and none of them had
 14 a symptom?
 15 So that question of asymptomatic transmission was
 16 crystal clear to everyone, but it took until April 14 to
 17 get the clinical advice that we could put asymptomatic
 18 infection into our policy making.
 19 So, to answer your question directly, no, we were
 20 led by the science, and it was very much how we rolled,
 21 and we were respectful of the experts. But until the
 22 April 14th advice came through, no, asymptomatic
 23 infection wasn't in our official policies.
 24 I must admit, that I, like many other people,
 25 assumed that this day was going to come and therefore we
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1 hesitations about the idea of a total zero-Covid
 2 strategy in as much as that was part of Moonshot
 3 thinking at some parts.
 4 **Q.** Thank you.
 5 And can I ask, then, in terms of you referencing
 6 Slovakia, I think that's very different in any event
 7 because they have a population register; is that
 8 correct?
 9 **A.** Well, lots of countries -- yes, that's one aspect of it.
 10 They also have quite an autocratic regime which we
 11 don't.
 12 **Q.** Thank you. And before we deal with recommendations, can
 13 I ask you some questions about accessibility of testing,
 14 please.
 15 And can we display your paragraph 76(b), which is in
 16 your statement, which is INQ000587383, at page 35,
 17 please. Thank you.
 18 This is where you're telling us about meetings you'd
 19 had with the Minister for Equalities, Kemi Badenoch.
 20 Then if we look, please, at paragraph 76(d) you
 21 mention raising deep concerns about the government's
 22 communication with what you've referred to as
 23 "hard-to-reach" communities.
 24 **A.** Yes.
 25 **Q.** I think we've already qualified it's -- they should be
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1 did build it into our thinking.
 2 **Q.** Thank you.
 3 Can I take it from the screen.
 4 Can I ask you, we've heard some evidence about
 5 Operation Moonshot and how that then became part of the
 6 Community Testing Programme.
 7 Do you have any -- did you have any concerns when
 8 the Prime Minister announced his big Operation Moonshot
 9 as a policy or proposition before it then essentially
 10 used the tests that had been developed to move into the
 11 Universal Testing Offer?
 12 **A.** Yes -- well, yes and no. On the one hand, I was
 13 thrilled that mass community testing had such strong
 14 sponsorship from the Prime Minister and that he had
 15 become super engaged in the opportunity there. So I was
 16 absolutely delighted to ride the tide of his enthusiasm
 17 on this.
 18 There was a piece of Moonshot, which was the idea in
 19 Slovakia, that you could somehow eradicate the virus
 20 altogether from the community and have it open.
 21 Actually, I don't think that that was realistic. You
 22 can use test and trace to keep levels down, but if
 23 you're running red hot, if you've got a prevalence of 1,
 24 2, 3%, as I said earlier, testing can't really fight
 25 against that kind of tidal wave. So I did have
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1 referred to in a different way because it makes it look
 2 like the problem is them --
 3 **A.** Yes.
 4 **Q.** -- rather than they're seldom heard.
 5 **A.** Correct.
 6 **Q.** But could you outline the specific deep concerns you had
 7 regarding the communication strategy and what further
 8 work was undertaken to address these concerns and
 9 improve engagement with the relevant stakeholders,
 10 please?
 11 **A.** Yes. Well, I had done a lot of roundtables and
 12 engagement with communities because this was always
 13 a priority. We understood that the people who were
 14 going to be hardest hit by the pandemic were going to be
 15 the vulnerable and the dispossessed and the poor.
 16 The feedback that I got consistently was that these
 17 communities didn't trust the NHS, didn't trust
 18 government, and weren't really hearing the message.
 19 My own experience in the music industry, which
 20 I know seems very distant from this, is that I used to
 21 sell music to these communities, and I know that in
 22 order to talk to them you have to go about it in a very
 23 different way. And when I was in the room with our
 24 communications team I couldn't see the people or the
 25 strategies or the tactics that were going to be
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1 successful in getting these messages across, and
 2 I raised these with Kemi, who agreed with the point.
 3 And actually, I pay tribute to the communications
 4 team at both Cabinet Office and DHSC, because they moved
 5 very quickly. They were very creative. They brought
 6 new people onboard, new staff, and at the end of the
 7 day, they proved to be very effective and testing rates
 8 in these communities did go up and ultimately vaccine
 9 rates in these communities were a great success.
 10 **Q.** Thank you. Still on the same page, and in fact if we
 11 look up to paragraph (b), please, of your 76(b) you
 12 mention that the data indicated it was less to do with
 13 ethnicity so much as cultural and socioeconomic factors,
 14 and the need to understand how groups were behaving to
 15 understand how to target NHS Test and Trace
 16 communication.
 17 **A.** Yes, so it was a story of --
 18 **Q.** Sorry. So the specific question, please, Lord Bethell,
 19 is: could you provide any insights on the understanding
 20 gained about cultural attitudes towards testing within
 21 these communities, and how this was incorporated into
 22 the design of the testing strategy?
 23 **A.** Sure. If I may give, by anecdote, I remember some
 24 testing team turned up amongst a caravan park of
 25 Herefordshire apple pickers, and when they arrived,
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1 Can I ask, were the locations of the testing sites
 2 informed by impact assessments and the needs of the
 3 general community, including age, disability, and
 4 socioeconomic factors?
 5 **A.** Yes. So to begin with, we were just trying to stand
 6 them up wherever we could, and so they correlated to
 7 where B&Q was, more or less. But we were conscious from
 8 the beginning that, by definition, having a drive-in
 9 testing site was essentially middle-class, because you
 10 needed a car to attend, and so we were -- we prioritised
 11 from the beginning other ways of trying to get tests
 12 into communities that maybe wouldn't have a car, and
 13 that's why things like door-knocking and driving to
 14 caravan sites became more of a priority.
 15 There was a sequence to that. Without doubt, early
 16 on, we went for the most convenient template possible,
 17 which was the drive-through. But I think that we went
 18 a very long way, and I would very much commend Baroness
 19 Harding for the huge amount of work that she and her
 20 team did on that.
 21 **Q.** Thank you. Can I ask, would you agree, then, that the
 22 location of test sites was in some instances a barrier
 23 to testing?
 24 **A.** Early on, the lack of tests was the barrier to testing.
 25 **Q.** Can I ask you, there's information that suggests there
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1 everyone climbed out of the windows of their caravans
 2 and ran off into the trees because they were terrified
 3 that it was some kind of police raid because they were
 4 from eastern Europe and weren't used to public health
 5 officials being trustworthy.
 6 I remember in streets in Tooting where -- which
 7 I know well from having fought an election there, where
 8 many women aren't registered in the NHS, and you would
 9 have to have people from the same group and often
 10 speaking the same village language, knocking on the door
 11 in order to build the kind of trust necessary in order
 12 to reach very, very important groups who were very
 13 vulnerable to the disease.
 14 Those are two examples of, I'd say, 100 different
 15 local patterns that aren't really to do with ethnicity,
 16 they're to do with pockets of culture, and also,
 17 broadly, poverty. And it is a -- I'm not saying that
 18 everyone who is poor is disconnected with government, or
 19 everyone that's disconnected with government is poor,
 20 but there is a big correlation between them.
 21 **Q.** Thank you. Can I then ask you about location of test
 22 sites, please. The location of testing sites in the
 23 first five months of availability of tests to the
 24 public, saw many people travelling large distances to
 25 have tests undertaken at the regional testing locations.
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1 was a shortage of tests in the September of 2020; do you
 2 have any views on whether that was foreseeable and the
 3 result of poor planning in response?
 4 **A.** Ugh. I had evangelized for being better prepared for
 5 the second wave. I think that plenty of colleagues in
 6 Treasury/Cabinet Office had reservations about whether
 7 that was necessary. It was, in part, to protect the
 8 taxpayer and in part to protect the society from
 9 unnecessary lockdowns. It was an argument that I
 10 thought was unfortunate, but it was well intended.
 11 I think that understanding how pandemics play out
 12 and that they take a long time is something that we've
 13 all grown more accustomed to.
 14 **Q.** Thank you. And then Lord Bethell, finally, you've
 15 already touched throughout your evidence, you've told us
 16 about the scramble and the rethink to approach. You
 17 detail within the statement your reflections and lessons
 18 learning, but is there any other recommendation, I'm not
 19 going to go through each, your statement will be
 20 published, but is there any particular lessons learning
 21 or view you wish to provide to her Ladyship to inform
 22 her thoughts in respect of Module 7 that you've not
 23 spoken about that you'd like to end your questioning
 24 with me, to just make clear?
 25 **A.** Thank you. I think that the science around testing and
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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.

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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.

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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

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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

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

3 **PROFESSOR THOMAS:** Thank you, my Lady.

4 **LADY HALLETT:** Thank you, Mr Thomas.

5 Ms Munroe, she's just there.

6 **Questions from MS MUNROE KC**

7 **MS MUNROE:** Good afternoon, my Lady.

8 Good afternoon, Lord Bethell.

9 **A.** Good afternoon.

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

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

23 **A.** Yeah.

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

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

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

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

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

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1 you refer to dated 8 July 2020 --

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

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

5 **A.** Sure. Yes, thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

23 **A.** I understand.

24 **Q.** -- 2021?

25 **A.** So, in terms of the process, I'm afraid I can't answer
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1 Lord Bethell. I think it probably completes the burden
2 we've placed on you in helping us, and if there's
3 something that you haven't mentioned but it's in the
4 written material, please don't forget that when I reach
5 my findings and make my recommendations, I take into
6 account all the witness statements as well.

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

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

15 **LADY HALLETT:** Thank you very much for your help.

16 I gather you still need to see the next witness,

17 Ms Cartwright, so I shall come back at 3.15.

18 **MS CARTWRIGHT:** Thank you, my Lady.

19 (2.57 pm)

(A short break)

21 (3.19 pm)

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

24 **THE RIGHT HONOURABLE LORD PATRICK VALLANCE (affirmed)**

25 **LADY HALLETT:** Thank you for your continuing help,
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1 your question off the top of my head, but I would like
2 to reassure you that the principles of equality and the
3 understanding and the insight that vulnerable groups
4 were going to be hardest hit was absolutely baked into
5 test and trace from the very beginning.

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

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

22 **MS MUNROE:** Thank you very much, Lord Bethell.

23 Thank you, my Lady.

24 **LADY HALLETT:** Thank you, Ms Munroe.

25 That completes the questions we have for you,
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1 Lord Vallance. I hope the last slot of the week was
2 suitable for your diary.

3 **THE WITNESS:** Thank you.

4 **Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 7**

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

7 **A.** Yes. Patrick John Thompson Vallance.

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

11 Can we then, please, turn to your fifth witness
12 statement, please, and if we could move to internal
13 page 31, please, we can see that it's dated
14 13 March 2025, and can I ask you to confirm that the
15 contents of that statement are true to the best of your
16 knowledge and belief.

17 **A.** Yes, I can confirm that.

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

22 **A.** Yes, I was.

23 **Q.** And I know you have a huge CV and expertise and
24 background, but -- it's been spoken about before so
25 I hope you don't see any disrespect by dealing with your
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1 background -- (overspeaking) --
 2 A. I'm delighted not to have to go through it again.
 3 Q. And can I just say, for my purposes, I'm delighted that
 4 as part of your Module 7 statement you provided all of
 5 the other witness statements of relevance to TTI to
 6 assist our work and, in fact, the earlier Module 2
 7 statement is particularly relevant now to a topic I'd
 8 like to deal with you first, please, which is the
 9 question of asymptomatic transmission and testing, and
 10 I think the best way to deal with that issue, please, is
 11 to move to your statement, please, INQ000238826.

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

14 That's INQ000238826. Page 170. Thank you.

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

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1 weeks, we were clear that the likelihood of asymptomatic
 2 or pauci-symptomatic, so few symptoms, transmission was
 3 highly likely.

4 Q. Thank you. Can we then, please, have highlighted your
 5 next paragraph, 512, and rather than me read what's
 6 detailed about sensitivity and specificity, could you
 7 please, just again, in the straightforward explanation
 8 explain what the issue is and what you were advising in
 9 relation to being able to test, on a PCR, someone that
 10 was asymptomatic or pauci-symptomatic.

11 A. Well, the first thing we wanted to know was that the
 12 test picked up Covid and didn't pick up other things, so
 13 you weren't getting so-called false positives, people
 14 who had other diseases who were appearing to have Covid.
 15 And the second thing, which is the ability to pick up
 16 everybody who's got it, in other words, there's
 17 a threshold of virus below which it might not work, so
 18 that's the sensitivity. Were there a number of people
 19 who might have had the infection but they had very low
 20 viral amounts which meant you didn't pick it up? And
 21 those were the things that needed to be sorted out in
 22 order to be sure when the test was giving you a reliable
 23 negative result, ie, you didn't have the disease for
 24 sure.

25 Q. Thank you.

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1 Can we then, please, start with your paragraph 511.

2 You say this:

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

16 Now, can I ask you in terms of that position, can
 17 you just confirm whether that SAGE advice and position,
 18 and particularly what that means for testing, from your
 19 perspective, was understood to have been passed on to
 20 Mr Hancock?

21 A. Oh, yes, I'm sure he would have seen this. We had --
 22 I think he was chairing COBR meetings at the time and,
 23 indeed, I think chaired a COBR meeting where
 24 asymptomatic transmission was discussed. So I think
 25 there is no doubt that then, and over the subsequent

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

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

11 And you say this:

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

15 And again, are you clear about that?

16 A. Yes.

17 Q. Now, you then also referenced I think the emerging
 18 literature that was supporting asymptomatic transmission
 19 and given one example there from 30 January of a journal
 20 (sic) published in The New England Journal of Medicine?

21 A. Yes.

22 Q. Thank you.

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

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

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

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

10 And you then say that:

11 "The revised [reasonable worst-case scenario] ..."
12 Is that what RWCS --

13 A. Yes.

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

19 Is that correct?

20 A. Yes.

21 Q. And again, we've heard some evidence about PCRs, but can
22 you just explain, when you talk about virus shredding
23 and the levels at one to two days, can we just, again,
24 have that in complete layman's terms, that would assist
25 a layperson at a SAGE meeting, to explain complex
169

1 that time. It's very, very sensitive and, as you say,
2 it will continue to pick up the shedding of virus even
3 when you may no longer be infectious.

4 Q. Thank you.

5 And in terms of the way you are helpfully describing
6 it and explaining it within the Inquiry, would you be
7 explaining it in the same way to the relevant ministers,
8 civil servants, and officials that were in the meeting,
9 where they had come to SAGE and the experts and yourself
10 for advice to inform their policy and decision making?

11 A. Yes, but also, in any department, and particularly the
12 Department of Health, of course, there were many medical
13 experts and many scientists who would be there to advise
14 people on what this meant. And of course Public Health
15 England experts as well. So there would be many places
16 in which this can be explained.

17 Q. Thank you.

18 Now, continuing, please, with paragraph 514 on
19 page 170, please, you tell us that on 13 March, in your
20 interview with the Today programme on Radio 4, you said
21 that:

22 "It looks quite likely that there is some degree of
23 asymptomatic transmission. There's definitely quite
24 a lot of transmission very early on in the disease when
25 there are very mild symptoms."
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1 medical concepts to someone that does not have
2 a scientific or medical background?

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

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

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

25 A. Yes. So that was the only test that was available at
170

1 A. Yes.

2 Q. And so, again, this is you making a public statement to
3 assist the general public, and is there any doubt that
4 you would have been saying the same things in the SAGE
5 meetings and the advice provided to officials?

6 A. Well, there was no doubt what we were saying in the SAGE
7 meetings. The previous minutes from 6 February make
8 that clear, and this is what would have been said in all
9 of the meetings that we had.

10 Q. Thank you.

11 Now can we go to the next paragraph, please, 515,
12 you tell us then about SAGE 16, from 16 March:

13 "... it was noted that: 'Antibody testing is
14 particularly vital to address the central unknown
15 question of the ratio of asymptomatic to symptomatic
16 cases'."

17 And you tell us that:

18 "This was in the context of a discussion on the
19 importance of scaling up diagnostic testing to manage
20 the epidemic."

21 You say:

22 "I made a similar point the following day in
23 evidence to the Parliamentary Select Committee on Health
24 and Social Care."

25 A. So the point here is, if you've been infected, the
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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

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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

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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.

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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:

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1 "Following this exchange, I sent a message to the
2 [Chief Medical Officer] asking if he could draft
3 something on testing".
4 And in quotes again you've got:
5 "It's not true to say it doesn't work. It can
6 detect cases but would miss a lot and so isn't
7 recommended".
8 You say:
9 "Again this refers to using a negative test result
10 to assert that someone is definitely not infected. The
11 [Chief Medical Officer] expressed his agreement and
12 commented that this was 'A classic example of why
13 government by WhatsApp is not the way to deal with these
14 kinds of things.'"
15 Is there any expansion you wish to say about that
16 paragraph, please, Lord Vallance?
17 **A.** Well, I think it was clear that Chris Whitty would then
18 make sure that within the Department of Health this
19 position was clearly understood and that fact that the
20 tests did pick up people who were asymptomatic, but not
21 necessarily everybody who was positive who's
22 asymptomatic, and could take that into account with
23 their planning on what their policy should be.
24 **Q.** Now, can I ask you from your perspective where you have
25 the Health Minister having, I think, some confusion or
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1 **A.** I can't remember exactly but I think I was in a meeting
2 where I heard this said again, and I think I again
3 raised, "That's not correct", and I got the impression
4 that then this was being promulgated as an idea in the
5 Department of Health. So I wanted to speak to Chris
6 Whitty just to be absolutely clear that we were on the
7 same page as to what the situation was, and we obviously
8 were.
9 But as a result of this, I decided that I needed to
10 get something, again, written down so that there could
11 be no ambiguity about what the position was. And
12 I asked somebody within the Government Office for
13 Science to do a piece of work to quickly document what
14 the situation was. She did that that very day and the
15 next day I sent the paper across to say: this is the
16 position, can we please just make sure everybody is
17 clear as to what this means?
18 **Q.** Thank you. Perhaps if I give some wider context to this
19 timeframe that we're looking at, would you agree that it
20 was a significant timeframe because decisions were made
21 on 12 March 2020 by the government to move from
22 'contain' to 'delay', and so, if there was
23 a misunderstanding about the virus and the testing, that
24 could have been affecting policy decisions that were
25 being made? I appreciate there's capacity, but would
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1 needing clarity, when we looked at 11 March, can you
2 help us in terms of on the range of whether that's
3 concern or understandable depending on where the advice
4 is coming from, your views, bearing in mind particularly
5 that this is the relevant minister that's making policy
6 and strategy decisions?
7 **A.** Well, I was obviously worried that he was getting advice
8 that, or thought that he was getting advice that it
9 didn't work, because that's incorrect. I was perfectly
10 happy with the idea that he was getting advice that says
11 it may not be reliable. That is correct. It may not
12 pick up everybody. And those were important
13 distinctions. So once that was clear, I was happy that
14 he'd understood the position and that the people in the
15 department were then reinforcing that.
16 **Q.** Thank you.
17 Then if we pick up the chronology, please, at
18 paragraph 521, you say this:
19 "The issue arose again in April 2020, when I became
20 aware that Mr Hancock had been saying that PCR testing
21 did not work on asymptomatic individuals and that policy
22 was being based on this."
23 Just pausing there, where had you been getting the
24 information that Mr Hancock was repeating the similar
25 position that had been expressed earlier in March?
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1 you agree that that is a significant factor?
2 **A.** Well, I think it's a significant factor that I thought
3 we'd put the issue to bed in March. I thought it was
4 actually clear before that, but I thought we'd put it to
5 bed in March and it obviously wasn't sorted out in some
6 people's minds by mid-April.
7 I think the decision around stopping community
8 testing was a very, very different decision. It was
9 based, as I understand it, within the department on
10 a very simple problem, which is there weren't enough
11 tests to test people coming into hospital.
12 **Q.** Thank you.
13 **A.** And that therefore there were people coming into
14 hospital with doctors unable to ascertain whether they
15 had the disease. That was a pragmatic decision to use
16 the tests quite rightly, in my view, for people who were
17 ill with Covid.
18 **Q.** Thank you. Now, you've just detailed what is set out in
19 paragraph 521. You exchanged those messages with the
20 Chief Medical Officer on 13 April, and again, you
21 confirmed that while the test was likely to be less
22 sensitive in asymptomatic people, it was not correct to
23 say that it did not work. And you added:
24 "... while it was not known whether it was helpful
25 or not to test asymptomatic people, South Korea was
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1 doing so."

2 And you detailed that:

3 "The [Chief Medical Officer] expressed agreement and

4 said that he had changed a document to reflect this."

5 Can you give us any more detail? What was the

6 document that he had changed to reflect this? Does that

7 suggest --

8 **A.** I think it was probably their testing strategy document.

9 I can't remember exactly which document it was.

10 **Q.** And again, we've looked, in the Inquiry, I'm not going

11 to take you to testing strategies, we know there's a lot

12 of documentation as to testing strategies as it evolved

13 to the strategy of NHS Test and Trace were evolving over

14 April.

15 You then go on to tell us and say you think that the

16 paper that was produced, if we could just briefly

17 display that, it's INQ000871777. That's INQ000871777.

18 Apologies for the delay. Thank you.

19 So is this the paper, if we scroll down, where it

20 was the clarity as to what you've said around that you

21 could be -- there was a value to PCR-testing even

22 individuals who were asymptomatic because it would pick

23 up those that had the virus?

24 **A.** Yes.

25 **Q.** Thank you.

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1 "The CMO took the matter forward and I understood

2 that the relevant policy, the social care plan, was

3 changed as a result so that everybody leaving hospital

4 for a care home would be tested."

5 **A.** Yes.

6 **Q.** So, in terms of your expression or view, or what your

7 account is, because, again, Mr Hancock was at pains to

8 say about his views about confusion and advice, can we

9 be absolutely clear about what your position is about

10 Mr Hancock's knowledge and understanding around the

11 value of testing of asymptomatic or pauci-symptomatic

12 individuals on 14 April before this note was shared?

13 **A.** Well, I think all of this is backed up with documentary

14 evidence. This is the advice that was given.

15 What I can't comment on is what advice he might have

16 been getting from within the department, and therefore

17 I don't know what else he may have heard. And he

18 certainly had a lot of people from Public Health England

19 and elsewhere who would be advising him on a day-to-day

20 basis and feeding in the scientific advice. But this

21 was the very clear position and it was the one that SAGE

22 had discussed as well.

23 **Q.** Thank you.

24 Can I ask you, the document we looked at very

25 briefly that had been drafted by the member of the

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1 Now, if we go back to your statement, please, at

2 paragraph 522, at page 172, you say this:

3 "The following day, 14 April, I sent an email to

4 others in [the Government Office for Science] asking for

5 some work to be done on this topic. I was unsure where

6 Mr Hancock was getting his advice from ... and I wanted

7 a definitive position documented. This led to an

8 academic secondee to the SAGE Secretariat producing

9 a rapid review paper ..."

10 Which we've just looked at together.

11 "... which laid out the evidence. It concluded that

12 'PCR screening of asymptomatic individuals is not only

13 possible, but useful and being employed elsewhere'.

14 I subsequently provided the paper to the [Chief Medical

15 Officer], saying that I thought it was important that

16 Mr Hancock see it as 'He is firmly under the impression

17 that tests don't work in asymptomatic people and this is

18 clearly wrong'."

19 You go on to say:

20 "In a later email I added that I thought there was

21 a 'pretty high rate' of asymptomatic in infection in

22 older people, and that this meant that 'testing was

23 important and that isolation on return from hospital

24 should probably be for all, not just the symptomatic'."

25 You say:

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1 secretariat of SAGE, did Mr Whitty have any input into

2 that document or was that a separate document that was

3 then provided to Mr Whitty?

4 **A.** It was provided to him.

5 **Q.** Thank you.

6 **A.** I mean, I had just got frustrated by the fact that this

7 kept getting repeated and just wanted something that was

8 absolutely clear that everyone can have one version of,

9 and that's why this paper was produced.

10 **Q.** Thank you.

11 I'll just complete the topic with your 523 before

12 briefly taking you to an email exchange that Mr Hancock

13 dealt with this morning.

14 You say this at 523:

15 "I am asked about the extent to which concerns about

16 the reliability of testing of asymptomatic people

17 affected the response to Covid-19. What was evident

18 from an early stage, and was made apparent in the

19 science advice to ministers, was that asymptomatic

20 infection and transmission were possible and even likely

21 but we did not know the proportion of asymptomatic

22 infection. As described above, I sought to correct

23 a misapprehension on Mr Hancock's part that the PCR test

24 'did not work' on asymptomatic patients. I do not know

25 where this incorrect advice came from or why it was so

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1 firmly adhered to."

2 **A.** That's correct.

3 **Q.** Now, can we display next, please, briefly there's

4 a whole number of emails and documents that I went

5 through with Mr Hancock this morning, but can we display

6 INQ00093326.

7 That's INQ00093326. And if we can move to page 3,

8 please, of this document. Thank you.

9 Now, the owner of the cellphone -- this is

10 Mr Hancock's messages, and we can see at 8.16 he

11 details:

12 "Chris Whitty has done an evidence review and now

13 recommend testing of all going into care homes, and

14 segregation whilst awaiting result. This is obviously

15 a good positive step & we must put into the doc."

16 Then the clarification:

17 "Just checking -- this includes all the asymptomatic

18 too, right?"

19 Obviously you're not on copy to these, but it seems

20 to be -- it evidences the debate you've already told us

21 about and what led you to provide the note from the SAGE

22 secretariat to inform and give the absolutely clarity as

23 to your position; is that correct?

24 **A.** Well, it looks like it. I don't know what these are.

25 This is a policy discussion, and they're taking

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1 was dealt with.

2 **Q.** Thank you. Just excuse me, there's one document I need

3 to go through with you and I've just mislaid it, so I do

4 apologise, Lord Vallance, for keeping you waiting.

5 Thank you very much indeed.

6 Lord Vallance, the next topic I want to deal with,

7 please, is -- it's using some entries from your evening

8 notes. And can I apologise that we're revisiting your

9 evening notes, and perhaps if I give some context to

10 these, Mr O'Connor King's Counsel went through some of

11 these evening notes in an earlier module, and perhaps if

12 we clarify the context to them.

13 I think, first of all, you had never intended anyone

14 to see these evening notes. They were personal

15 reflections at the end of the day; is that correct?

16 **A.** Yes. I'm not even sure that they were really

17 reflections; they were sort of spontaneous ways to

18 decompress at the end of the day.

19 **Q.** I think Mr O'Connor described them as late-night

20 musings.

21 **A.** Yes, that's probably accurate.

22 **Q.** So I apologise that we're going to go through some very

23 brief entries that are selective from wider entries of

24 those late-night musings, but can we please just work

25 through the few brief entries that we have and then

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1 into account the advice that's been given.

2 **Q.** Thank you. I'm not going to take you through all of the

3 exchanges that Mr Hancock produced and we went through

4 this morning, as to emails, to evidence, how that

5 informed the change in policy, but can I ask you,

6 because there was a suggestion that on 11 March, the

7 exchange that we looked at, the WhatsApp, off the back

8 of -- Nadine Dorries exchange, if we call it that, that

9 Mr Hancock was saying that he had expected a paper from

10 yourself and Mr Whitty and that the next he heard

11 anything in reality was 14 April.

12 So some suggestion that had there been any ambiguity

13 about confusion or what he needed to know, he would have

14 expected a paper sooner than 14 April.

15 Lord Vallance, is there anything you wish to say to

16 respond to the evidence we heard this morning on that

17 topic?

18 **A.** Well, I think we've just seen it: that I had an exchange

19 with Chris Whitty saying: Is it now clear that

20 asymptomatic people can test positive; it's just that

21 not all of them test positive?

22 To which he said: Yes, we just looked at it.

23 And I said: Will you now deal with that in the

24 department?"

25 Or words to that effect. So I think -- I think that

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1 there's a number of them that I just want to ask some

2 questions, because they do identify a little of the

3 timeline.

4 Now, this is the first one to be displayed on the

5 screen but, just to give some context, the day before,

6 on 1 April, there was an entry:

7 [As read] "Testing, testing. Testing still not in

8 a good place. PM right getting tetchy about it."

9 Then if we move -- now, the following day we've got:

10 "Crick offered 300 scientists and got no response

11 from [Public Health England] -- crazy! & letter came

12 from Peter Ratcliffe."

13 We have helpfully had clarified, or I have, that

14 Sir Peter Ratcliffe is a Nobel Laureate and perhaps one

15 of the eminent experts in this area.

16 Can you give a little bit more context that might

17 assist some insight into this late-night musing, please,

18 Lord Vallance.

19 **A.** Yes, on 10 March I got a message from Sir Paul Nurse

20 which outlined some of the science they were doing in

21 the Crick that might be useful to Covid. I think I had

22 a conversation with him at the time -- it was quite

23 detailed -- about the types of science they were doing.

24 And we also talked, I think, about testing.

25 Seven days later, Peter Ratcliffe sent a message

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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

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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,

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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,

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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."

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1 Is there any information or context you would wish
2 to give that assists in any way with this entry in the
3 evening notes?
4 **A.** Well, I'd become extremely worried during March that the
5 capacity and capability of PHE to do the testing that
6 was required was lacking. And there may be all sorts
7 reasons for that that you would need to ask them and
8 their chief executive at the time, Duncan Selbie, about.
9 But I was worried about it and there had been a push
10 from Number 10 to have a much more determined approach
11 to trying to get this scaled up.

12 I don't know how Dido Harding was appointed to this
13 and I don't know how the actual structure was decided,
14 but obviously at this moment I thought: thank goodness
15 somebody is taking this seriously and trying to get on
16 top of what we need to do to get testing scaled up and
17 active.

18 **Q.** Thank you.

19 Can we then move, please, to the next entry of
20 18 May. We can see:

21 "TTI now talking about 500,000 tests/day.

22 "Must record that the reason that ONS is doing the
23 study is that when I asked PHE to do it they said NO
24 (April) and the issue of testing asymptomatic (or not
25 testing) that was a pure DHSC refusal until I wrote the
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1 notes and it's not said that all of these entries
2 represent everything you were making notes about
3 relating to test, trace and isolate, but can I ask you
4 about 27 May entry, sorry.

5 "TTI -- lots of 'lock them in filing cabinets' type
6 approach to isolation. I said clearly that SPI-B said
7 incentives more important than punishment to those who
8 don't.

9 "PM agrees but DC"--

10 Pausing there, is that Dominic Cummings?

11 **A.** I should think so, yes.

12 **Q.** "... and Cx" -- is that the Chancellor?

13 **A.** Yes.

14 **Q.** "... very against regards 'fairness' is a big issue and
15 the [Dominic Cummings] position undermines it. The
16 meeting on TTI was a shambles only saved by Dido."

17 Again, is there any further context, if there is
18 any, to provide -- (overspeaking) --

19 **A.** Well, I think it's clear from other entrants in my
20 witness statement that behavioural science was very,
21 very clear that incentives were more likely to work than
22 punishment, and gave several examples of the types of
23 incentives which can be practical help with isolation,
24 it can be monetary help, it can be sick leave pay.
25 There are a number of things that the behavioural
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1 email. Remember DHSC tried to stop."

2 And if you're able, Lord Vallance, is there any
3 additional context you'd wish to give to this?

4 **A.** Well, there are two different things here. There was
5 the issue of community testing, and community testing
6 was about trying to get on a regular way an assessment
7 of what was going on across the country, so it wasn't
8 diagnostic testing, it wasn't test, trace and isolate,
9 it was to try to work out where the infection was, how
10 many people had it, how it was changing over time. And
11 it was something that SAGE had asked for very early on.

12 In fact, if you go back to Exercise Alice from 2016,
13 one of the exercises around this, that said that sort of
14 thing needed to happen.

15 And we had said repeatedly that we need this
16 information, and there was a very important meeting in
17 April, I can't remember the date, when the person from
18 PHS said, "We can't do it." And at that point we asked
19 the Office for National Statistics and said, "Can you do
20 it?" And they said, "Yes", so they took it on. That
21 was an important part of it.

22 **Q.** Thank you.

23 Can we then move on to the next entry, please, from
24 27 May and again, Lord Vallance, we've already caveated
25 that these are out of context, there are plenty of other
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1 science indicated would help. But clearly in this
2 meeting, it was one where people were going in another
3 direction.

4 **Q.** Thank you.

5 Can we move, then, next to 6 July, please, where
6 it's recorded:

7 "NHS T&T has now done what we said and set up
8 a central team ('the Feds') to assist local responding
9 (exactly what Germany did)."

10 Can I ask for clarity around this, and I don't know
11 whether you can give further context, we've heard some
12 evidence that in Germany they operate a system where,
13 essentially, universities are on stand down but have an
14 ability to agilely assist, which is part of the German
15 federation system to scale up testing. Is that any
16 relevance to the reference to the "Germany did" and "the
17 Feds"?

18 **A.** Yes, well, it is partially, I mean, they have a Länder
19 system, anyway, of government which is very
20 decentralised, it is very different from the UK, and
21 they had a system which brought together academia,
22 industry, so they have a lot of diagnostic capability in
23 industry in Germany, and they brought that together, but
24 they then had a central team that could supplement that
25 if needed, and that is what this is referring to, the
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1 idea that you have local application, whatever that is.
 2 It could be government laboratories, it could be
 3 industry laboratories, it could be academic
 4 laboratories, and then supplement that with --
 5 I've called them "the Feds" here -- to send people in
 6 when you have a need for more help.

7 **Q.** Can I just ask you, Lord Vallance, we've heard some
 8 evidence last week and touched upon it this week about
 9 the value of universities being utilised, and their
 10 laboratories, as a potential source for scaling up in
 11 future pandemics. Is there any view, perspective, input
 12 you'd like to provide on what was one view from
 13 Professor McNally indicated as a potential area where
 14 her Ladyship might wish to consider, bearing in mind the
 15 financial sums that would be needed to retain or
 16 supplement the universities that could provide that
 17 scaling-up role?

18 **A.** Yes. So one of the principles in the 100 Days Mission
 19 that we said was make the exceptional routine, in other
 20 words use things that are used routinely so you can
 21 scale them during an exceptional time.
 22 And obviously we do have laboratories right the way
 23 around the country that could be used. I don't think we
 24 can assume that they would be able to do that in an
 25 emergency. That would need to be tested, and I think

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1 control again.
 2 "PM Dido was very robust.
 3 "For Rishi, it is all about personal responsible and
 4 get the state out."
 5 Again, quite a lot covered there, but can you
 6 summarise or break down anything else additionally to
 7 help us understand --

8 **A.** Given these are my ramblings, it's a bit difficult to
 9 know exactly what was going on, but I think the point --
 10 if I remember correctly, the point that I think the
 11 Chancellor was making was that if you reduce social
 12 interactions and allowed people to go back to work and
 13 tested them at work, you might have a positive effect.
 14 I think that's what he was pushing for.

15 **Q.** Thank you. Can we then move, please, to 3 August.
 16 **A.** Sorry?
 17 **Q.** Sorry, I was asking if we can move on -- thank you.
 18 The next note, please:
 19 "[It was] pointed out that I pushed very early on to
 20 decentralise testing and be more like Germany. I put
 21 Crick in touch with PHE several times."
 22 I think we have perhaps touched upon and dealt with
 23 this issue. Is there anything else, Lord Vallance you
 24 wish to say?
 25 **A.** I don't think I have anything else to add to that.

199

1 Paul Nurse said that in his evidence, as well. The
 2 Crick, clearly, was able to do something. It wasn't
 3 contact tracing; it was doing testing and that part of
 4 it, but you'd need to test the ability of that.

5 I think it would be quite difficult to assume that
 6 all of that could be stood up. And it goes back to one
 7 of the points I made in Module 1, which is that
 8 exercises should really test the practical application
 9 of these things and the operationalisation, not just the
 10 theory.

11 **Q.** Thank you.
 12 Can we move then, please, Lord Vallance to an entry
 13 from 27 July 2020, please. Thank you. It records:
 14 "Dido pushed to get financial support for people to
 15 get tested in low socioeconomic groups.
 16 "Rishi reacted strongly against that and said just
 17 basically ... 'just stop the social interactions'.
 18 "My paper on how quickly this can take off should be
 19 listened to. Hancock came in and said delay the August
 20 1st additional measures opening up.
 21 "But the PM says that he wanted to stick with
 22 August 1st measures.
 23 "Rishi is getting very excited about it all and
 24 suggested everyone gets tested at work.
 25 "It's perfectly obvious to me this could get out of

198

1 **Q.** Thank you.
 2 Moving on then, please, 6 August:
 3 "People changing all the time -- eg no one knows who
 4 actually is in charge of Lighthouse labs: 'Like wading
 5 through treacle to see process from start to end of
 6 testing process.' Continues the operational mess
 7 confirmed that PHE has had its science stripped over
 8 past decade."
 9 Sorry, "confirmed". I do apologise.
 10 Anything to add clarification to --

11 **A.** I think, the Lighthouse labs are obviously set up under
 12 the TTI framework. There was advice being given into
 13 the Department of Health at the time, including
 14 scientific advice from others, I think John Bell and
 15 others were involved in this. I wasn't involved in this
 16 operational side of it and obviously in that meeting it
 17 was quite difficult to see who was actually leading this
 18 on a practical day-to-day basis.

19 **Q.** Thank you. Can we move then to the next day --
 20 **A.** Which may be my fault, by the way. I mean, it may just
 21 be I just couldn't see it.

22 **Q.** And if it assists, Lord Vallance, we've heard evidence
 23 about the system and who was involved.
 24 Thank you. 7 August:
 25 "OMG, discussion with testing lead Emma Stanton.

200

1 She has no scientists on her team. Why oh why is DHSC
2 at this stage at this point in the pandemic, spoke to
3 Chris".

4 Again, is that Chris Whitty?

5 A. Yes.

6 Q. "... and have a plan to help her, but what a mess."

7 A. Well, I was obviously surprised that Emma Stanton, who
8 I think actually was very good, didn't have the science
9 support from within the department that I thought she
10 required.

11 Q. Thank you.

12 We move on to 12 August, please, and in fact there's
13 two entries for 12 August. We see:

14 "PM very agitated about getting new higher
15 throughput tests going. Freaked out because apparently
16 [the Chancellor] told him this morning there is no money
17 for an SR."

18 Pausing there, what's an SR?

19 A. Spending review.

20 Q. Thank you.

21 "They have finally clicked on the issue of clock
22 speed. Backward contact tracing only started yesterday
23 but Dido is trying really hard."

24 Again, can you give any further --

25 A. I think maybe the only point I would -- I mean, because
201

1 A. Well, it sounds like it was a meeting where -- trying to
2 look at what we knew in those areas and what was
3 actually being operationalised and people were being
4 asked to say whether we were, you know, green, all good,
5 or red, not good at all.

6 Q. Thank you.

7 And then you say:

8 "Instincts of this crew is to go for more
9 enforcement and punitive measures. We suggested more
10 carrot ..."

11 Pausing there, who is the "we"?

12 A. That would be a SAGE recommendation.

13 Q. "We suggested more carrot and incentives required to
14 make people take a test, self-isolate, etc but they
15 always want to go for stick, not carrot."

16 Who is the "they" that preferred the stick to the
17 carrot?

18 A. Well, I think in this case it would have been the
19 decision makers for policy.

20 Q. Thank you.

21 Can we then move, please, to the next entry,
22 25 August.

23 "Interesting email exchange with Sue Hill ..."

24 Is that Dame Sue Hill?

25 A. Yes.

203

1 some of this is about money but the point that would
2 make is that backward contact tracing is something that
3 is really important to pick up clusters and to stop
4 clusters spreading, and was a repeated advice from SAGE
5 right from February onwards that that is an important
6 part of the system. So it was disappointing, to say the
7 least, that backward tracing took quite so long to get
8 started.

9 Q. Thank you. Then moving to the next entry for 12 August,
10 please:

11 "Then 2 hours with PM, [Dominic Cummings], CMO,
12 Case, Mirza and a couple of others in next 8/12".

13 A. I don't know what that means.

14 Q. "And Imran" -- and is that Imran Mirza?

15 A. No, Imran Shafi.

16 Q. Thank you -- "set us up well with some facts and figures
17 and built from the what we know, what we don't know
18 paper.

19 "Then did 4 big areas -- Behaviours, tracing the
20 virus, outbreak management and is the NHS ready? We
21 voted -- red, amber yellow.

22 "1st 2 got lots of reds and ambers."

23 Pausing there, what's the red/amber vote that's
24 relevant here? Can you give any extra context to that,
25 please?

202

1 Q. "... and others that clearly says that the reason NHS
2 labs weren't used for testing was that they were too
3 expensive. You couldn't make it up."

4 So Lord Vallance, is that relaying some information
5 you were provided with that had come from Dame Hill?

6 A. Well, I asked why we weren't using more regional labs,
7 and the answer I got in an email from the same date is:

8 [As read] "One of the reasons that the NHS labs had
9 not increased capacity was the cost of the testing
10 needing further funding, et cetera. The recent approval
11 by DHSC of the business case for the NHS to increase
12 delivery to 100,000 is predicated on improvements in the
13 cost/efficiency etc".

14 Q. Thank you. Can we move then, please, to 7 September.

15 "Chief constables have said current rules too
16 complex and difficult to police.

17 "[Chancellor] blocking all notion of paying to get
18 people to isolate, despite all the evidence that this
19 will be needed."

20 Lord Vallance, is there any extra context --

21 A. I don't think there's any -- I mean, presumably that was
22 in a meeting that I was at.

23 Q. Thank you, and Lord Vallance, we have also heard from
24 the National Police Chiefs' Council and Mr Hewitt's
25 views on the rules that the police had to enforce.

204

1 Thank you.
 2 Can we move then to 10 September, please?
 3 "Moonshot with PM."
 4 Is this a reference to project Moonshot or Operation
 5 Moonshot, sorry?
 6 A. Sorry, well I think this was rather alarming that the PM
 7 wanted to know what the figure of 265,000 was that he
 8 was being presented with as a success story. Was it the
 9 number of tests actually taken? The number of people
 10 tested, or both, or something else? And he didn't get
 11 a very clear answer from the TTI team and I must say
 12 found that slightly surprising.
 13 Q. Thank you and we can see:
 14 "Started off with what is happening with existing
 15 testing and why it is so constrained and people having
 16 to travel miles. A complete car crash. PM wanted to
 17 know whether figure of 265,000 was tests, people tested
 18 or both ... They just couldn't answer questions. It was
 19 alarming.[I/S] [Chief Medical Officer] and
 20 I agreed that this is a mess and his concentration on
 21 moonshot has caused the whole story to be about that
 22 rather than the cautious message about sticking to the
 23 rules."
 24 Lord Vallance, is there anything else you can assist
 25 with by reference to this entry?

205

1 Lord Vallance, I have just four more entries and
 2 then I suspect I have utilised all of my time with you.
 3 If we can move to the next page, please, 25 September:
 4 "PM, 'Punish people who won't self-isolate.'
 5 "'Punish people who aren't doing the right thing.'
 6 "'Close some pubs and bars.'
 7 "We need a lot more punishments and a lot more
 8 closing down. **I put a message in chat that support an
 9 engagement very important to get adherence up.
 10 "... PM ends with 'Massive fines massive fines'.
 11 A. Well, I said in an earlier one that the PM was on the
 12 side of doing incentives. I mean, I think he would
 13 change quite a lot between meetings.
 14 Q. Thank you.
 15 And again, against the timeframe, we know the
 16 decisions that were being made around isolation
 17 payments, and also the enforceability of isolation that
 18 came in place in England first of all and then later in
 19 Wales.
 20 We can move to the next entry, please, 25 September:
 21 "PM obsessed with testing again. Wants to know why
 22 not ramped up and why is turn around slow?
 23 "PM asks, 'Why is the orange line in the graph so
 24 wonky?' Dido explains that things happen that mean their
 25 performance is not linear ..."

207

1 A. I don't think I have anything else to say on that.
 2 Q. Thank you. If we can move then to 14 September, please:
 3 "(Re PM) We got him to understand the need to
 4 separate the TTI and the moonshot. Have clear
 5 accountability for the latter. Stop talking about it
 6 and get TTI sorted out with priorities published."
 7 Is there any --
 8 A. Again, I think that's pretty clear.
 9 Q. Thank you. Two days later, please, 16 September:
 10 "Testing has the 'loo roll panic phenomenon' Where
 11 it is overwhelmed because people perceive shortage.
 12 Simon Stevens says NHS labs are at 100% capacity."
 13 And is the "loo roll panic phenomenon" a reference
 14 to the public and how they stopped buying --
 15 A. Yes, I mean, it was, just, I think, something --
 16 somebody must have said that in the meeting, that --
 17 obviously at the beginning of the pandemic everyone went
 18 and bought loo rolls and suddenly there weren't any loo
 19 rolls anywhere, and that's a sort of behaviour
 20 phenomenon and there's a worry that because the message
 21 was that testing was in short supply, people may go and
 22 get tested and use up all the short supply and we would
 23 end up with a problem. I think that's what this refers
 24 to.
 25 Q. Thank you.

206

1 Is that essentially just someone like myself that
 2 would struggle with interpreting the graphs when they
 3 are -- (overspeaking) --
 4 A. Possibly, I can't remember the specific example here.
 5 Q. "Are people actually doing isolation.
 6 "I argued that low levels of isolation is the key.
 7 "They of course go straight to enforcement.
 8 "... PM says 'We must have known that this wasn't
 9 working -- we have been pretending it has been whereas
 10 secretly we know it hasn't been.' Hancock lets out
 11 a big sigh. Hancock says other countries are asking him
 12 'How have you managed to do this'.
 13 Is there any other context you can give --
 14 A. Well, this was a very fraught time, when the prevalence
 15 was going up pretty fast, and it looked like things were
 16 getting out of control and would get out of control to
 17 the extent that further very serious restrictions would
 18 need to be placed, and I think this reflects some of the
 19 anxieties at that time.
 20 Q. Thank you.
 21 And finally on the evening notes, 28 October,
 22 please -- sorry, there's two more, I do apologise,
 23 I bring false hope. 28th October:
 24 "Dido gave a rather upbeat assessment of where T&T
 25 is. How correct is this? They now have a support

208

1 package in place for isolation & are calling people
2 (they say 15-50% adherence). PM completely obsessed
3 with testing as the solution even as numbers so bad that
4 is obvious more action is needed"?

5 **A.** Well, there's two things to say here, it's really
6 important, as we talk about testing, to remember testing
7 was only done for a purpose, and the purpose in this
8 case is to isolate and try to make sure that the
9 isolation occurs. If the isolation isn't happening,
10 then the testing isn't really doing what it's supposed
11 to be doing.

12 And again, this is at a time when the prevalence was
13 going up very fast, and I've made the point in previous
14 modules that test, trace and isolate doesn't work when
15 the prevalence gets so high that it's stamped. It stops
16 being effective.

17 **Q.** Finally, just the last entry, please -- in fact it's
18 7 January 2021, I'll just read this:

19 [As read] "PM meeting. Testing. Testing
20 performance looks much better. Now the challenge is
21 self-isolation. Dido is saying we need to get better
22 schemes in place to help people isolate. PM says 'We
23 haven't been ruthless enough, we need to force more
24 isolation, I favour a more authoritarian approach'.
25 Rather late in the day, the PM isn't understanding that
209

1 **LADY HALLETT:** I hope people get a decent weekend.

2 **MS CARTWRIGHT:** Thank you.

3 (4.17 pm)

4 (The hearing adjourned until 10.30 am on Tuesday, 27 May)

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1 incentives (or removal of disincentives) need to be in
2 place to help people. Those instincts are punishment,
3 not help. Sounds like a good testing system is
4 gradually coming together and will be ready when
5 lockdown released."

6 Is there anything --

7 **A.** I think that was the position.

8 **Q.** And perhaps, Lord Vallance, that's our time together up
9 and an appropriate place to end. Can I thank you for
10 answering my questions.

11 My Lady, there are no Core Participant questions.

12 **LADY HALLETT:** There are no more questions for you,
13 Lord Vallance. I think it's probably the last time
14 we've going to place the burden on you. I'm truly
15 sorry, because I do understand how difficult it must be.
16 I appreciate you are now in a different role but thank
17 you so much for all the help that you and your
18 colleagues have given to the Inquiry. And maybe as
19 a minister, you may be able to be in a position to help
20 implement any recommendations I make.

21 **THE WITNESS:** I hope I will be. Thank you.

22 **LADY HALLETT:** Thank you so much for your help.

23 Very well. I shall finish now and I shall return
24 for a 10.30 start on Tuesday, 27 May.

25 **MS CARTWRIGHT:** Thank you, my Lady.
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