Tuesday, 27 May 2025

(10.30 am)

LADY HALLETT: Ms Cartwright.

MS CARTWRIGHT: My Lady, the gentleman by the witness box is Ben Dyson, could I ask for him, please, to be sworn.

MR BEN DYSON (affirmed)

Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 7

MS CARTWRIGHT: Good morning, could you please tell the Inquiry your full name.

A. Benjamin Paul Oakley Dyson.

Q. Mr Dyson, you have provided four witness statements for Module 7 providing, essentially, the corporate position of the Department of Health and Social Care. Can we, firstly, identify each of those four statements, please.

If we can turn, first of all, to what we are going to call statement A, INQ000587292. Could I ask for us, please, to go to page 42. Thank you.

It's the first statement, dated 27 March 2025, and can I ask you to confirm, are the contents of that statement true to the best of your knowledge and belief?

A. Yes.

Q. And is it right to say that essentially this statement gives context as to the structures, the key individuals, and gives an overview chronology?

A. That's correct.

Q. Thank you. Can we then, please, move to the second witness statement, which is INQ000587347. Can we please turn to page 85. It's dated 4 April of 2025, and are the contents of that statement true to the best of your knowledge and belief?

A. Yes, they are.

Q. Thank you. And I think this statement principally deals with the scaling up of testing?

A. That's correct.

Q. Thank you. If we can then move to witness statement C, please, INQ000587346. Could I ask you to turn to page 106, please, in that witness statement. It's dated 11 April 2025 and again, is this statement true to the best of your knowledge and belief?

A. It is.

Q. And I think this statement essentially gives full details as to the scaling up of the contact tracing by the department?

A. And it deals with self-isolation and other matters.

Q. Thank you. So adjunct matters dealing with tracing and isolation and support for isolation?

A. Yes.

Q. Thank you. Finally then, please, if we can turn to witness statement D, INQ000587345. Can we turn to page 70, please, where we there see your statement of

truth. It's dated 11 April 2025. And can I ask you to confirm, are the contents of that statement true to the best of your knowledge and belief?

A. Yes, they are.

Q. Thank you. Now I think although you're the signatory to these witness statements, it's right, isn't it, that essentially a large volume of individuals have assisted in the preparation of these four statements, but you are the person to speak to them?

A. That's correct.

Q. Thank you. Can we then, please, deal with you and your background, please. It's right, isn't it, that you personally held four roles in relation to the pandemic response. Is it right that you were first director of the reasonable worst-case scenario team from March to April of 2020?

A. Yes.

Q. You then were director of policy for NHS Test and Trace from May of 2020 to June of 2021?

A. That's correct.

Q. You then were director of cross-cutting policy for NHS Test and Trace from June of 2021 to October of 2021?

A. Correct.

Q. And then you were director of cross-cutting policy and public and parliamentary accountability at the UKHSA

from October of 2021, when UKHSA was established, to the March of 2022?

A. Yes.

Q. Thank you. And I think it's right, isn't it, that since then, you returned to the Department of Health and Social Care on 14 March of 2022 to take up the post of director of prevention services?

A. Mm-hm.

Q. And you're currently a director for the Better Care Fund and Hospital Discharge, a role you've held since December of 2022?

A. That's all correct, yes.

Q. Thank you. And you're still in that position as at the present day?

A. Yes.

Q. Thank you. And Mr Dyson, can we thank you for the obvious care that's gone into these four comprehensive statements, but also you being the person to speak to them.

Can we then start, please, with providing some context in respect of what you say relating to development of testing, please. I want to go, please, into your statement B, which is then, please, at paragraph 4 so that's INQ000587347, and go to paragraph 12 on page 4, please.

That's INQ000587347, page 4., paragraph 12.
Now, I'm just going to move through these paragraphs, because it's right, isn't it, that you deal with testing for pathogens prior to the pandemic and if we move, then, to paragraph 13, but essentially the role of the Department of Health and Social Care, is it correct, pre-pandemic, was mainly limited to its oversight of Public Health England?
A. Yes, the department didn't have a direct role in testing at that point.
Q. And I think -- throughout the statement I think you similarly make the observation that the Department of Health and Social Care didn't pre-pandemic either have rule for contact tracing; is that correct?
A. Not an operational role.
Q. Again, I think you identify that sat with Public Health England?
A. Mm-hm.
Q. But also the involvement of Directors of Public Health; is that correct?
A. Yes.
Q. Can I then seek your assistance, please, and necessarily our time together today will be focused on specific areas and specific topics -- by reference to scaling up of testing, please. And linked to an earlier operation,

the Operation Alice.
And can I ask, please, to be displayed INQ000090431. Thank you.
And I think you've had an opportunity to consider this document as part of your preparations.
And if we move through the report, please -- we can see it's a Public Health England report but if we move, please, through to page 10, thank you, we can see that action 4 was that -- the requirement for the development of a MERS-CoV serology assay procedure to include a plan for a process to scale up capacity.
And if we can, please, just continue to move through to appendix A, I think -- on page 16, we see that summary of lessons and actions identified. Thank you.
And also, just to identify the involvement of the Department of Health, please, can we turn to page 18, appendix C, which is the list of participants, but there's a large number of Department of Health individuals that were part of that exercise. Thank you.
And so can we then move back, please, to the recommendation, please, which is on page 10. Thank you.
As we can see there, one of the actions from Exercise Alice was to develop a MERS-CoV serology assay to include a plan for a process to scale up capacity. Can you assist, despite this, no plan was put in place

to scale up testing, and according to other evidence we have, PHE had never been resourced to scale up testing.
Do you accept or does the department accept that they were aware that there would be need for both planning and capacity to scale up testings as one of the lessons learning from Operation Alice?
A. Yes, that is clearly one of the lessons, as we see here. I think it's worth bearing in mind that this was an exercise about MERS, which is a -- doesn't have the same level of infectiousness as Covid-19. So I think it's important not to see this as a blueprint for the scale of testing that it -- that we went on to need during the Covid-19 pandemic. So yes, this is about scaling up capacity, but I don't think there's anything in the report that really envisages the industrial-scale level of testing that we did during Covid-19.
LADY HALLETT: Can I just interrupt there. I understand the level that was needed, because of Covid-19, but if MERS is not as infectious, yet still Exercise Alice said you needed to scale up testing, surely there's all the more reason that capacity to scale up should have been increased?
A. I agree. I agree. The recommendation was to include a plan for a process to scale up capacity, as it says here, and as has been reflected in my Lady's report on

Module 1, we didn't have a plan in place for the industrial-scale expansion of capacity that we went on to adopt during the Covid-19 pandemic.
MS CARTWRIGHT: Can I ask you, then, leaving aside the industrial-scale capacity that was needed, bearing in mind that MERS-CoV was a coronavirus, and Exercise Alice had identified the need for a process to scale up capacity using an assay, was there any planning done by the Department of Health and Social Care to essentially plan to scale up capacity informed by this exercise?
A. I don't have any direct knowledge of the work done at the time. So I'm afraid I can't answer the question very directly. What I would say is that, at the start of the pandemic, PHE, having developed a coronavirus test, did then expand capacity to some extent, but what was clear, and certainly became clear later on, was that it didn't have the capacity to go beyond that.
Q. Thank you.
Can I then ask, then, in terms of asking about the learning or the action from Operation Alice, were the department aware that there would need to be planning and capacity to scale up testing, but they failed to ensure these were in place by the time of January 2020?
A. As we've seen, the exercise report has a clear set of actions and recommendations. I can't say -- again,

because I wasn't involved at the time, I can't say how far there was awareness within the department, but certainly I would imagine that the Emergency Preparedness Team would have been more than aware of all these recommendations.

And I come back to the fact that there were clearly some systems in place to allow what I would call a moderate scaling of capacity and that's the work that we saw PHE did in the early stage of the pandemic. I would say that there weren't the plans in place to move beyond that.

Q. Thank you.

Can I then ask questions again in the context of lack of scale-up of capacity.

Could we please display -- it's paragraph 104 of a statement of Mr Hancock. It's INQ000587294. That's INQ000587294, please. And it's paragraph 104, please, at page 31. Thank you.

Now, within this paragraph, we can see that Mr Hancock is detailing his frustration by the lack of scale-up capacity, given Public Health England's early assurances that they had the best system in the world.

Now can you assist, had the Department of Health and Social Care allocated the development of -- had they allocated resources to the development of such a system

for scaling up testing? Or at this stage, in February, was it still that it had been left as the responsibility of Public Health England?

A. May I just clarify, that's a question about testing or tracing?

Q. Well, this is obviously the context of testing, but also, and we'll come on to deal with it separately, through the prism of tracing, please.

A. So, to the best of my knowledge, the department hadn't provided additional resources to allow scaling up of testing, certainly not to the extent that we saw during the pandemic, no.

Q. Thank you.

Then in terms of, again, in the context of the scale-up needed of contact tracing, which we'll come on to look at a little bit more together, what was the position of the department in terms of what was there to assist with scaling up on contact tracing?

A. Again, I can't speak to exactly what the department would have done prior to the pandemic. I think what this statement is telling us is that the PHE had -- it certainly had the protocols in place for contact tracing. As it says here, it didn't have the -- it didn't have the ability to scale up beyond a certain point.

Obviously at the start of the pandemic, the department made clear that -- or the government made clear that resources were not to be an obstacle to further scale-up. So, as soon as it became clear that more contact tracing would be needed, resources became available.

Q. Thank you.

Can I then, please, building on the scaling up of contact tracing, please, can we move into your statement C, so INQ000587346, please, and it's paragraph 40 at page 12, please.

Thank you.

You detail, and now we're just after the January in the paragraph before:

"... contact tracing was considered likely to be more effective in the early stage of the pandemic, when the focus was on preventing wider community transmission."

And we can see the paper reference there.

It noted that:

"... contact tracing ... would no longer be effective and should cease where there was sustained community transmission."

Can I ask you, was that the position? Was it linked to the sustained community transmission or was the

reality that there simply wasn't the capacity available for doing the contact tracing? Can we just be clear as to why the contact tracing stopped?

A. It's worse -- well, I'll come on to the answer to that question, it's just worth emphasising that contact tracing didn't stop entirely; it continued in high-risk settings, most obviously. But as this indicates, the view, of I think both SAGE and Public Health England at the time, was that neither contact tracing nor testing would be effective in -- when it came to the point of widespread community transmission. But as I say, notwithstanding that, it continued in high-risk settings.

You ask whether this was because there weren't the resources for it. That's not my understanding. My understanding is that the position was that, other than in those high-risk settings, it wouldn't be effective in controlling widespread transmission once it's covering the whole population.

Q. Thank you. And obviously you've sought clarification that contact tracing did continue --

A. Mm-hm.

Q. -- in high-risk settings. So can I perhaps use the decision of 12 March when the government move from the 'contain' -- sorry, from the 'delay' to the 'contain'

phase, and so can you just be clear because I think you wanted to make some clarification about the fact that contact tracing did still continue in those high-risk settings and can we just be clear, then, where you say contact tracing continued after the move from -- into the 'contain' phase, please.

A. Yes, that's the case. So Public Health England managed contact tracing largely through its regional health protection teams who often worked in conjunction with local authority public health teams, and throughout the pandemic, including this early phase, they would have used contact tracing as a way of looking to control and manage outbreaks in settings such as care homes or prisons.

Q. Thank you. Can we then ask a question through the prism of scaling up of testing, please. And can I have displayed, please, the statement of Professor McNally, which is INQ000587245, please. And it's paragraph 11, please.

Now, Mr Dyson, the Inquiry has heard some evidence that -- I know you've identified about the scaling up of testing, perhaps the context I want to give to this is before we move to the Lighthouse Project there is evidence that the Inquiry has heard that other resources were available, including through academic institutions,

universities, and other research facilities, that were offering their laboratories to assist with the scaling up of testing.

Now, this is one example of the context and, in fact, we've heard from Professor McNally, where he was essentially detailing that the UK universities had the equipment and expertise to help but it fell on deaf ears, and he's given some evidence about what would have been possible through the University of Birmingham by way of scaling up of testing and, similarly, the Inquiry has heard from some others, such as the Crick, as to what was feasible in the early stages of scaling up, also.

Can you provide any view from the department as to why these offers were not taken up of smaller institutes that could have assisted with the scaling up of testing in the January, February, March and onwards?

A. Again, I don't have any direct knowledge of this, because I wasn't involved at the time. My understanding is that from -- well, throughout March, Public Health England was very much looking to expand testing, and I think the phrase here about "the scrapping of testing for patients" is misleading, that there was a decision taken to prioritise testing for hospital patients and, indeed, for outbreaks in residential settings like care

homes, but the aim throughout March, and this intensified from mid-March onwards, but the aim throughout March was to grow testing as quickly as possible.

And my understanding, I can't comment on individual offers of help, but my understanding was that at this point, Public Health England was working with both commercial and academic partners to do that.

So yeah, I appreciate there is frustration here and in other evidence from people who clearly felt they could have helped more. It is entirely possible that if things had been done slightly differently, then there could have been some more testing at that point.

The other -- but the other thing I'd just emphasise is that this was at a time when it wasn't just laboratory capacity that was the issue; it was also the supplies needed for testing, particularly reagents. So we could easily have been in a position, and I think this was the case throughout March and April, where even if we'd had more diagnostic laboratory capacity available, we wouldn't necessarily have been able to source all the supplies, including reagents, needed to use that capacity.

Q. Thank you. Can we then give some context to some questions I want to ask you, please, by reference to the

devolved nations. Can we, first of all, deal with the context, please, and can we display your statement A, INQ000587292, please, and it's paragraph 83, please, at 22.

I think it's a point you make across the four statements. You say:

"Whilst health and social care policy is largely devolved to the Welsh and Scottish Governments and the Northern Ireland Executive, the Department has some reserved policy areas with UK-wide responsibility, including international relations. Public health is a devolved matter and each of the Devolved Administrations was responsible for its own testing, contact tracing, and self-isolation strategies and operations. This meant that certain arrangements to respond to the pandemic could be and indeed were made separately by the Devolved Administrations."

And I think you go on to deal with the work that took place for collaboration.

Could I ask you just to give an overview and a summary about what steps had been taken, particularly when there were differences in strategies, to try and ensure that there was an understanding of what each of the devolved nations was doing by reference to testing, contact tracing, but also then support for

self-isolation?
A. Certainly. If I may, I'll take those in turn. And then make a general point about collaboration.
Q. Thank you.
A. So on testing, although, as the statement says, policy on testing and, indeed, responsibility for operations was a devolved matter, in practice, the -- all four countries chose to have a UK-wide testing programme that provided essentially the infrastructure, the laboratory capacity, the procurement of tests and so forth.

So in practice, although Wales, Scotland and Northern Ireland could have chosen to go a different way, in practice the infrastructure was organised on a UK-wide basis, and that obviously required constant close collaboration across all four countries.

On contact tracing, the operations were largely separate, with the exception of the app, which I suspect we may come on to, but the app was, as we know, shared between England and Wales. The other issue on which there was close collaboration was arrangements for cross-border tracing, where you have somebody who has tested positive one side of the border with contacts the other side. So there were protocols in place for that.

Then on self-isolation, although again this was a devolved matter, in practice through most of the

pandemic -- there were some exceptions, but through most of the pandemic the self-isolation rules were the same because they were based on the consistent advice of the four UK chief medical officers. And if I could just add the Joint Biosecurity Centre, which is possible we may come on to, provided advice across all four nations.

And just the final point I'd make is that, in addition to what I've described, there were, from memory, if not daily, then, I mean, at least weekly and -- very frequent calls between us and the devolved administrations to share insights on everything to do with testing, tracing, self-isolation, and other aspects of the pandemic response.

I remember, I think it was in June when there were outbreaks in both Leicester and Wrexham, people came together to compare notes and understand how best to respond.
Q. Thank you.

Now, you've just referenced the role of the Chief Medical Officer. Can we move to your paragraph 87, please, which is on the next page. Thank you. Obviously you detail there the role of the chief medical officers, chief scientific advisers and the deputy chief medical officers, but also the collaboration that took place.

Can I ask you, obviously that statement recognises that, as public health is devolved, and information -- if we look at paragraph 83, information and experience was widely shared, can you help, certain aspects of the different policies across the devolved nations diverged markedly in timing and decisions, and one example that's been explored with a number of witnesses is the Welsh Government's response in respect of -- testing in respect of asymptomatic.

And perhaps -- obviously the UK Government announced on 28 April 2020 that there would be testing of those that -- in care -- expansion of testing to all staff and residents in care homes in England whether exhibiting symptoms or not. However, the testing of asymptomatic workers and residents was not adopted in Wales until 16 May 2020. And obviously you identify in your statement that testing for infectious disease is particularly important, where infection has non-specific symptoms.

So are you able to assist? And there are also other examples of people's views on how this developed and also the thinking linked to testing of those with no symptoms. Are you able to assist as to whether the scientific advice in relation to asymptomatic testing was captured to ensure it was the same across the four

nations in April 2020 and for the remainder of the pandemic? So if something was identified of a significant scientific matter, to ensure, then, that it was cascaded and dealt with in the same approach across the four nations.
A. Particularly for that early stage of the pandemic, I'm afraid I don't have any direct insights into the exact nature of how scientific advice was shared across the four nations. Although, as it says here, I'm confident it's saying that there was collaboration and coordination. And certainly in all the time that I was involved in test and trace, not only was scientific advice being shared, but we were having regular conversations with colleagues in the devolved administrations to understand how you then marry up that scientific advice with the practicalities of different interventions and the policy implications.

And the other thing I'd just say briefly is that it's worth bearing in mind that understanding -- or scientific understanding of asymptomatic transmission, and I think Chris Wormald touches on this in one of his earlier statements, scientific understanding of both asymptomatic transmission and the role that testing could play in relation to asymptomatic transmission evolved gradually over the -- certainly over the first

few months and beyond of the pandemic.

Q. Thank you.

Can we, please, then move -- there are some questions, please, based on your statement B, INQ000587347.

Can we start, please, at page 22, just with displaying the table which is a different way we've looked at the five pillars but I think where you've identified what each of the pillars were, and also the organisations responsible for the five pillars of the testing strategy from April of 2020.

But then, having looked at that, because it is going to be relevant to questions I ask you now, please, linked to Pillar 1 and 2, can we move, please, to your paragraph 126 at page 27, please.

This is is under the subheading of "Testing NHS and Social Care Workers". And you detail within the statement:

"... that there were 71,961,000 Covid-related absences in hospital trusts on 25 March 2020 ..."

And that:

"... the submission recommended that the initial priority needed to be the testing of NHS staff and social care workers, given the importance of health and social care services, particularly for older and

vulnerable people."

And in fact there's a submission that's been provided, please, which was a submission from Julia Dudley and Kathy Hall, "Approach to Keyworker Prioritisation for Covid-19 Testing", which is one of the documents in your pack, dated 28 March 2020. Can we turn to that, please, for a moment, which is INQ000546879. That's INQ000546879. Thank you.

Can we move forward, please, in respect of this submission, to paragraph 8. Go back, sorry. It's paragraph 6. Sorry, paragraph 6. Thank you. Thank you.

We can see that this paper from 28 March identified:

"Once we reach more than 1,000-2,000 tests per day, we will move into a new mode. The legal position is that Devolved Administrations ... have autonomy over testing decisions. As tests are being purchased on a UK-wide basis, the Chief Medical Officers will agree an overall allocation for each nation based on the current disease profile and activity profile. The DAs will then prioritise key worker testing as best meets their needs. In some cases and for some groups, 2 or more of the 4 nations may choose to align their prioritisation approaches."

Can I ask then, you've obviously identified, if we

go back to your witness statement, please, so it's the INQ000587347, and it's, please, paragraph 135. Thank you. So paragraph 135, please. Page 29.

Thank you for your patience, Mr Dyson, as we move across these documents. You identify that:

"Thanks to the successes of implementing Pillars 1 and 2 of the testing strategy, eligibility for testing was expanded again on 20 April ... to include anyone over the age of 65 with symptoms, anyone with symptoms whose work could not be done from home and all social care workers and residents in care homes (with or without symptoms)."

Can I ask you, then, with that having been identified and also, then, allocation of testing, having regard to allocation of testing between the four nations, was test capacity then increased to the four nations in light of the fact that there would then be testing of those without symptoms? So to ensure, essentially, each of the four nations had the appropriate test to do this testing of those without symptoms?

A. That is a good question. And the first thing to say is that I don't know for sure what the precise arrangements are. As we've seen in one of the other exhibits that you've shown, the agreement was that the chief medical

officers across the four countries would allocate testing based on both population size and relative need, but I'm afraid I can't say exactly what arrangements were made to factor in asymptomatic testing.

Q. But are you able to help, was there someone within the department that had a role for looking at issues such as that?

A. To look at issues vis à vis the -- well, certainly the testing team, from all the time I worked in Test and Trace, our testing team had a dedicated team responsible for working with the devolved administrations. So they would have looked both at the operational aspects of testing and any associated policy issues.

Q. Thank you. I thank you for your assistance, Mr Dyson, because certainly the Inquiry has heard evidence from the Covid bereaved that this was a concern particularly where there was not the standard testing of care home workers, and even in the second wave, for example we've hearing from Hazel Gray of that being an issue linked to her parents and, similarly, it's an issue that a number of the Covid bereaved statements addressed their concerns. So I wonder whether you could assist with ensuring that, essentially, the Barnett consequentials to ensure the appropriate testing were increased in line with an identified need for testing of those without

symptoms.
A. As I say, I'm afraid I can't offer more on the detail. I can reaffirm the principle that, as you say, under the Barnett principles, the firm intention was to make sure that there was a fair allocation of testing capacity across the four nations based on both population size and the relative needs of the four countries.
Q. Thank you. Can we then, please, staying in your statement B, please, move to paragraph 305, please. And that's at page 67, please -- in fact, before we go to paragraph 305, can we start, please, at paragraph 297, page 66. And I think perhaps this is an important distinction to make.
You tell us by reference to adult social care testing:
"The Department's role in testing for the adult social care sector is referred to at various points in the statement ..."
But essentially you identify that there's a difference by reference to adult social care and the department.
And can you, perhaps, give the clarity, and I think it's linked to where the responsibility for adult social care sits within local authorities; can you just clarify the position, please?

A. To clarify the position as regards the department's relationship with the social care sector?
Q. Please. Thank you.
A. Yeah, so the department has overall responsibility for policy in relation to adult social care, but funding for adult social care is a combination, broadly speaking -- there are some exceptions to this, but broadly speaking, of funding allocated by what at the time was the Department for Levelling Up, Housing and Communities, and also locally-raised revenue. So local authorities have -- also have much greater flexibility, if you like, to decide how to deploy funding and what policies to follow. Notwithstanding that, we may come on to this, the department did play a very active role in working with the adult social care sector throughout the pandemic to support testing, amongst other interventions.
Q. Thank you. Can I then, please, having identified that, can we move to paragraph [306], which is the creation of a digital portal. Thank you.
You refer to the creation of this digital portal to facilitate the rollout of the testing programme in adult social care from 13 May 2020 and to allow care home workers to access tests.
And I think the -- can you assist, please, whether

there was any particular discussion with the devolved nations about how this rollout and testing priorities would operate across the four nations, or was that solely for the devolved administrations?
A. That would have been a matter for the devolved administrations.
Q. Thank you. Thank you. Can we then, please, move back to another topic, please, on international cooperation, please, and can we move back into your first statement, please, INQ000587292.
It's at page 28, please, at paragraph 113. Thank you.
Now, you tell us that:
"Throughout the pandemic, the Department interacted with other countries and international partners to identify best practice with regard to testing and contact tracing."
And if we can move to the next paragraph, please, you identify that:
"The Department [also] established the Testing and Contact Tracing International Forum to share insight and learning from other countries' testing and contact tracing programmes ..."
And you detail the attendees there.
Can I ask, because it's identified as

representatives from the United Kingdom; would that also include representatives from the devolved administrations?
A. I don't know whether the devolved administrations did attend some or all of these meetings. What I can say is that, at the same time as these international forum meetings were taking place, we were meeting, I suspect, on almost a daily basis with the devolved administrations. So if they were not at these meetings, and if significant issues had arisen in them, I have no doubt that we would have discussed them with the devolved administrations.
Q. And that's the follow-on. What was the way to cascade knowledge and learning? Is that from what you've just said in the meetings that followed?
A. Yes. There were multiple forums through which we worked with the devolved nations. My team, which was a policy team, had a, we had dedicated leads for liaising with counterparts in the devolved administrations, so we were regularly discussing policy issues in relation to testing and contact tracing, but there were complementary arrangements for operational cooperation through the testing programme, and as I've mentioned, the Joint Biosecurity Centre was providing advice, on the epidemiology and understanding how Covid was

spreading, to all four nations.
Q. Thank you. Can I then ask you some questions, please, around the development of the app, and perhaps before doing that, can we just contextualise. We know that there's reference to the contact tracing app in the May strategy that it was hoped that it would be available "in a few weeks' time", but as it happened, the Inquiry has heard quite a lot of evidence about the development of app 1 and app 2, so I don't want to spend time going over that chronology we've heard, but we know, as it happened, it wasn't until the September time that the app was available, and I think utilised in England and then Wales.
A. Mm-hm.
Q. That was not until the end of September. So can you assist when it was anticipated that there would be a contact tracing, an app that would have a contact tracing function, what impact that delay in it being operational had on the scaling up of contact tracing, please?
A. To the best of my recollection, it didn't alter the plans we were making for scaling up of what's sometimes called manual contact tracing, although I think "manual" is a slightly misleading term because even standard contact tracing does rely to some extent on digital

support. So essentially during April and May, PHE, together with the department, the business services and authority -- the Businesses Services Authority and others, were working to make sure that we had sufficient standard contact tracing capacity, if I can call it that, to deal with the projected number of positive cases and contacts there would be.

So from the best of my recollection, I don't think that was affected by the timing of the introduction of the app.

And although you're absolutely right that -- I think at that point in the pandemic, there was perhaps greater emphasis being placed upon the importance of the app, sometimes, I think, to the exclusion of people thinking about the benefit of standard contact tracing, certainly we geared up to make sure that we had a standard contact tracing service able to deal with all positive cases and their contacts.
Q. Can we then just deal with it as a topic, please, using your third statement, please, INQ587346. If we start really with the purpose of contact tracing, paragraph 10, please, on page 4. You tell us that:

"Contact tracing is a longstanding public health measure used to identify individuals at risk of having been infected with -- and manage the spread of -- a

pathogen. This includes both forward and backward contact tracing, with forward tracing forming the primary approach during the pandemic."

We can see that principally, I think, a forward contact tracing approach was taken rather than backward contact tracing. Can you assist as to the consideration of that, as to the effectiveness, please, of contact tracing by the department?
A. It's worth saying there was some backward contact tracing undertaken, particularly from, I think, the summer of 2020 onwards. So one of the changes we made within the contact tracing service was to ask people who'd tested positive not just about who they'd been in contact with in the previous two days, but to ask them to think back, I think it was, seven or ten days, about who they'd come into contact with, and provide some clues or indications as to where they may have become infected. And that enabled Public Health England and local authorities to start to identify where there might have been outbreaks associated. So essentially where you have multiple people testing positive in the same setting or in the same area, that can then lead you back to how you manage outbreaks.

But it's certainly correct to say that at the start, the big focus was on forward contact tracing as a way of

essentially identifying people who -- individuals who had come into contact or were thought to have come into contact with a person who had just tested positive and then to advise them to self-isolate.
Q. Can I ask you, you detail within the witness statement essentially the process of the scale-up --
A. Mm-hm.
Q. -- and how then the Public Health England teams and then the involvement, latterly, of the local authority Directors of Public Health, but certainly one of the issues and themes in the Inquiry is the under-utilisation of the local contact tracing and the skills of the Directors of Public Health. I think you just identified how there was some backward contact tracing that started in the summer of 2020. Do you identify that link as to when the contain framework was established in the July of 2020 and essentially looking to use more of those local resources by the Directors of Public Health?
A. So there are a number of issues here. I mean, first off, can I say I think it's a critical piece of learning from the pandemic that we understand, as far as we can, the -- how you get the best balance between local and national. And certainly in hindsight there are things which I think a number of us wish we'd done slightly

sooner, to strengthen the local element of that relationship.

It's also worth saying that -- and we've touched a bit on this already, that from the start, there was certainly local authority involvement in the more complex cases. So even before the introduction of test and trace, where there was an outbreak in a care home or a prison, it would very often be the public health protection team, that's a regional team, working with local authorities to take appropriate action in that setting.

So there had been an element of local contact tracing from the start, and indeed, when we established the test and trace service on 28 May, it was built into the model from the start that you have essentially a three-tier system and the first tier is where the person who's tested positive is from -- say, somebody who works in a care home or a school or a prison, and straight away those cases would be referred to health protection teams who would then often work with local authorities.

So that is context in terms of what was done from the start.

The big change in from around June/July onwards, was to start to look at people who'd tested positive and

whose details had therefore come into the contact tracing system, and where the central tracing teams were unable to reach them. So the central tracing teams would have routinely emailed, texted, and then, where they didn't get a response, they would seek to phone them. But we were finding that some people with either not engaging or were engaging later than was ideal. And so the approach taken at that time was to start to ask local authorities to do the tracing of positive cases for those who the central service had been unable to reach.

And I think that was an important step in, if you like, harnessing the -- what local authorities could bring to contact tracing with the greater efficiency that you could get from doing more straightforward contact tracing on a national basis.

Q. And can I ask you, in terms of the central service and the building up of that from scratch, I've described it as call centre contact tracers, albeit they may have been operating virtually as a call centre, but who in the department had an input into the numbers or that centralised model initially before the skills of the local authorities and local contact tracing was identified as really being the preeminent skill? Can you help as to who identified the numbers that were

needed for that central contact tracing, or who thought a centralised approach was the best way to go initially?

A. The -- so, again, I think there are a number of questions caught up in that.

In terms of who thought the centralised system was the way to go, ultimately that was a ministerial decision, but it was based on the -- as I recall, the firm recommendations of both Public Health England and the team within the department that was responsible for what became test and trace, it was called I think the Test, Trace and Certify programme at the time.

So the team in the department and Public Health England, supported by the NHS Businesses Services Authority, had identified that the most efficient and effective way of scaling up contact tracing at the start would be through that three-tier model. The first being the local for the high-risk cases and the more complex contact tracing; the second element being health professionals -- doctors, nurses and other health professionals that were brought in to act as people who interviewed the person who had tested positive. And then finally the third tier was the contact tracers who essentially phoned people who were identified as contracts.

Q. Can I ask you, would you agree that if the local level

infrastructure of contact tracing was utilised from the outset, it would have increased test and trace capacity?

A. Um, so certainly it would have been advantageous. There is no doubt about this. It would have been advantageous if, early on, it had been possible to adopt the blended tracing model that we did.

I think it's still the department's view that where you have what I'm going to call straightforward cases -- and essentially by that, I mean somebody who has tested positive who is ready to engage, ready to share information about their contacts, and then it's relatively straightforward to get in touch with those contacts and pass on advice. For those more straightforward forms of contact tracing, I think the department's view still is that there are obvious efficiencies in doing that on a national basis. But yes, I agree that particularly where there are people who are perhaps either more reluctant to engage with the national service or are taking time to engage with the national service, it would have been beneficial to have the local tracing element in place sooner.

Q. Thank you.

Then can I ask you, why did it take until July for this to be established and only then, I think initially, on a pilot level in certain local authorities?

A. Partly for the -- I mean, for the obvious reason, and this is, I think, another key lesson, that we didn't have plans in place before the pandemic, and certainly I, you know, my personal view -- yeah, my personal view is that that should be a key learning for the future: that you plan in advance for the type of local, national blend that you're likely to need.

I think the other thing I'd draw out is that there may have been a degree of optimism bias, if I can call it that, in terms of how successfully the national service would be able to get in touch with people and get in touch with them quickly. It did do that for the majority, indeed the great majority, for most of the pandemic of people who tested positive, but I don't think anybody had quite anticipated that there would be a sizeable minority of people who were either not engaging or really taking time to come back and engage with the National Tracing Service.

Q. Thank you.

Now, I'm not going to go through the aspect of your statement that deals with the local outbreak management plans and essentially the allocation in June of 2020 of the 300 million to local authorities to develop local outbreak management plans, but can I ask you, was lack of resources also an inhibiting factor to the

establishment of a localised system of contact tracing?

A. As I say, the -- I don't think it was ever considered, and I think it's still the department's view that it would be unwise to consider a system where you put all of contact tracing responsibility with local authorities. So that model would certainly not have been possible, but nor do I think would it have been desirable.

It is certainly the case that as we started to roll out local tracing partnerships, there were times when local authorities were unable to deal with the volume of cases that were being referred to them, and we had to adopt a very flexible model whereby we could adjust the thresholds that you use to determine which cases a local authority takes on, and which cases the national service continues to operate.

So yes, it's possible that certainly at the margins, additional resources would have been helpful.

It's worth emphasising, though, that the money allocated to local authorities under the Contain Outbreak Management Fund, which you've referred to, was definitely intended to give them as much flexibility as they needed in deciding how to -- how best to use that resource to tailor testing, tracing and support for self-isolation to the needs of local communities.

Q. Thank you. Can I then ask you, on the app, please, in your statement, please, at paragraph 127.

So this is in the INQ000587346 statement, please. That's INQ000587346, statement C. It's paragraph 127.

It's just a question on the use of the contact tracing app.

A. Mm-hm.

Q. And obviously you give the detail within the statement about that development and rollout.

If we could go though, please, to INQ000587346 at paragraph 127. Thank you.

You deal there with:

"Interoperability with the devolved administrations was discussed at an early stage. Wales chose to join with England in adopting the NHS COVID-19 app, while Scotland chose to develop its own contact tracing app. Northern Ireland joined with the Republic of Ireland in adopting a test and trace application. The NHS COVID-19 app was interoperable with the Northern Irish StopCOVIDNI app because it was also based on the Google/Apple system and became interoperable with the Protect Scotland app in November 2020."

Are you able to assist as to liaison that took place with the Welsh Government as to why they stuck with the NHS Covid-19 App and didn't develop their own contact

tracing app?

A. I didn't have any direct involvement on this particular issue so I can't, I'm not sure I can add much in terms of the specific conversations that took place with devolved administrations, but I -- I'd reiterate what, I think, both Matthew Gould and Simon Thompson have said in previous sessions about the regular contact we had with all four nations throughout the development of the -- of the app 1 and app 2.

Q. Thank you.

And if we could go back a page to your paragraph 125, thank you, you deal there with the analysis from the NHS Covid app by reference to the Nature article of May 2021 and so, essentially, you identify the positive things that the UK -- sorry, the app that was rolled out and used in England and Wales had by reference to preventing a million cases, of 44,000 hospitalisations, and saved 9,600 lives.

But can I ask as to whether you can assist in identifying the analysis of the data from the app, whether you can help with the trend that was also picked up in at Nature article which is -- please can we go to that very briefly, INQ000475153 and it's internal page 27, please, INQ000475153 -- thank you. And could the map be expanded.

So obviously there's been some review of the article but, obviously, no reference to this universal trend of low uptake across Wales. Had that -- has that been spotted at any point by the department and can you cast any light on why there appears to be the low uptake of 16-20% or even lower in one area, almost universally across Wales, please?

A. So on the first question I'm afraid I can't be absolutely sure. I do know that as a -- well, as a test and trace service within the department, we were very alert to what we knew to be the risks of different levels of uptake in different communities, but I'm afraid I don't recall any specific discussions about this strikingly low uptake in Wales.

And sorry, the second part of the question was?

Q. Whether there had been any analysis of it.

A. Whether there'd been any analysis. Um, I don't know, I'm afraid.

Q. Okay, thank you.

LADY HALLETT: I should just say I think -- was it Mr Drakeford or somebody questioned the accuracy of the map.

A. Mm-hm.

MS CARTWRIGHT: Can I ask you bearing in mind the department has relied upon the data to identify those positive

things that the app had identified, has the department identified any issue with the data that fed into this Nature article?

A. Not that I'm aware of, but I am not familiar with any work that's been conducted since the pandemic which could have touched on that.

Q. Thank you. Can I then move on to a separate topic, please, which is support for isolation and then the enforcement of isolation.

And to contextualise the question, can I ask you, if we look in your statement D, please, INQ000587345, and can we go to paragraph 109 at page 35 of statement D, please. Thank you. Thank you.

You deal with the rollout of the contact tracing and also, at paragraph 110, that the department recognised that, for some people, self-isolation was likely to have an impact in respect of loss of income, concerned about job security, loneliness.

And I think if we look at paragraph 108 also, please, I think it had already been identified by the department in May of 2020 the inequalities that self-isolation would cause to individuals.

Can I first of all capture when the department had identified that there was going to be a disproportionate impact of isolation on many?

A. I -- my recollection is that this would have been considered throughout April and May. Certainly when I was involved in both April and May we were thinking about the impact of -- that would arise once we are -- once we are testing on a much more widespread basis and contact tracing on a widespread basis, and therefore asking thousands of people to self-isolate.

Q. Thank you.

And then can we move forward, it's a paragraph that's within reflections and lessons learning. It's paragraph 203, please, at page 65, and just on this theme of isolation, support for isolation and enforcement, you say this:

"Some of the individuals culled in the development of this statement reflected that, for any future health threat, it will be important to consider carefully the balance of potential benefits and risks in making rules on self-isolation and other public health measures legally enforceable, taking account on the one hand the value of reinforcing the critical importance of these rules and on the other hand the potential impact on uptake of testing and engagement with contact tracing and the challenges of enforceability. Some individuals consulted in the development of this statement also reflected on the potential advantages, subject to public

health advice, and behaviour insights, of encouraging and enabling individuals to take a greater personal role in giving information to their close contacts (to complement the role of contact tracing teams) and of exploring how to strike the right balance in terms of the detail and specificity of self-isolation rules (bearing in mind the possibility that what are perceived as overly restrictive rules could limit adherence). This requires understanding both the science behind how any future pandemics operate and behavioural insights into how people are likely to respond to rules or guidance and applying that knowledge to implement tailored measures specific to the threat. These reflections are not Departmental policy but have been included in this statement so that lessons learned by individuals who worked on testing, contact tracing and self-isolation policy during the pandemic can be documented."

And so obviously -- that's obviously a clear view that is not attributed to any one individual, but did you have an input in that particular paragraph, and is that expressing your own personal views, Mr Dyson?

A. It expresses a number of views and it's probably worth saying that these reflect views of people who were involved in the Department of Health and in Test and

Trace. I suspect you would get somewhat different views if you spoke to people in other parts of government, but certainly the -- this reflects I think both my views and a number of my colleagues' views at the time.

Q. Now, you deal with the history around the development of the self-isolation payment that came in at the end of September alongside the legal enforcement of isolation. And we -- I think in fact you led on the policy for isolation support payments?

A. Mm.

Q. And we're going to hear some evidence I think from Baroness Harding on Thursday that identifies a pitch that was made to make the scheme equivalent to the jury service payment, where essentially you could claim £64.95 per day for the ten days.

Can I ask you, just by way of overview, can you help as to why it took, when it was identified that people need financial support to isolate, and that certainly seemed to have been identified as early as May, if not earlier, why it took to almost the end of September before there was a scheme, leaving aside the Statutory Sick Pay, that provided a scheme for financial support for isolation?

A. Yeah. You have said leave aside Statutory Sick Pay, so I'll only touch on that --

Q. It is -- and it's more this specific fund that gave support to individuals to isolate.

A. The reason why I think both Statutory Sick Pay and other benefits is relevant in this context, because certainly the view of Treasury at the time was that the combination of Statutory Sick Pay and the eligibility that some people on low incomes would have through other benefits, income support, housing benefit, and so forth, coupled with the furlough scheme, provided, in their view, a reasonable and proportionate response.

That was not our view within the department and with Test and Trace, and throughout June, July and August we worked with Treasury colleagues and others to seek to identify some different possible ways of specifically opening up financial support to, or more generous financial support to people on low incomes, and the reason those weren't initially successful was, I think, primarily, primarily a view within Treasury, amongst Treasury ministers, that first off, they were unconvinced that this would have the impact we claimed it would. We felt this was very important, particularly in getting people to come forward for testing in the first place, where we knew that the financial disadvantages they would face if they tested positive and were then asked to self-isolate were a barrier.

So it's partly they felt we weren't providing firm enough evidence that it would have a positive impact, and second, they were concerned, from memory, that there are difficulties in providing financial support when you can't verify that people are then self-isolating, people could be paid but not self-isolate.

Q. Thank you. And can I ask you, having looked at what you say about the May of 2020, the Inquiry has also heard evidence from Professor McKee that detailed that isolation is a key element of a pandemic control strategy and was a weak link in the United Kingdom, with a key element being financial vulnerability due to comparatively low Statutory Sick Pay, at 29%, and inadequate emergency payments, leaving many without adequate financial protection?

Would you agree that by May of 2020 there was a recognition within the Department that there was lack of adherence to self-isolation advice which undermined the efficacy of the Test and Trace Programme?

A. This is an important point, and I haven't got the -- I haven't got Professor McKee's statement in front of me but, from memory, he refers to reported evidence that only 20% of people were self-isolating, and the point I just want to emphasise is that that was a statistic based on people who had symptoms of Covid, and sadly,

through most of the pandemic, and certainly at this time, I think fewer than 30% of people with symptoms were getting tested.

The surveys that we were doing within Test and Trace, and these were borne out later by studies done by the Office for National Statistics, showed that if you did come forward for a test and you tested positive or if you were identified by Test and Trace as a contact, you were likely to self-isolate. So very, very different results for people with symptoms versus confirmed cases and their contacts.

And what we also found from our surveys and from the ONS surveys was that even if some people said that they weren't following the strict letter of the rules, the great, great majority reported that they avoided contact with other people. So they might leave the house to go for a walk, but they were not going to work, they were not going to bars or restaurants. So I think there's a crucial distinction between self-isolation for people with symptoms and self-isolation for people who tested positive.

But I think that reinforces what was then our view that, given one of the critical elements of the successful testing and tracing service is people's willingness to come forward for testing in the first

place, if you know that the financial consequences of testing positive and then self-isolating might be a deterrent, then that is certainly something we felt we needed to test, and that was borne out by pretty much all our conversations with local authority, Directors of Public Health.

Again, they couldn't provide the hard and fast evidence that Treasury colleagues were looking for but I think it's fair to say that every local authority Director of Public Health we spoke to said this is a big issue, particularly in more disadvantaged communities.

Q. Now, having asked you to put aside Statutory Sick Pay, can I ask you, do you agree that the lack of Statutory Sick Pay infrastructure around the Test and Trace system, and inadequate emergency payments compared to other countries undermined the Test And trace system's efficacy?

A. We don't have, I think it's important to emphasise we still don't have good hard and fast evidence on this. I still don't think we know how far -- how far either the level of SSP, which I think was -- is about 90, 94, £95 at the time per week, we don't know how far the level of SSP or eligibility for SSP was a factor, so we can't quantify if it, but certainly, as I say, our concern and that of local authorities and Directors of

Public Health, were, first off, that the level of Statutory Sick Pay was unlikely to be enough to encourage everybody who needed to, to self-isolate. And second, that there were key groups, like people on lower incomes, the self-employed, people on zero-hours contracts and so forth, who wouldn't benefit from it.

Q. Thank you.

Can I then, please, still in your statement D, please, INQ000587435, turn to your page 112 please -- sorry paragraph 112, page 36.

And it details the self-isolation equality issues identified by the Department in its May and September 2020 equality impact assessments and the mitigations which were put in place to address them, and also references then the equality impact statements -- impact assessments shared with ministers on 21 May 2020. Thank you.

Can I ask you, because the Inquiry has an expert report of Professor Machin, and the view taken by Professor Machin is that the equality impact assessment completed in England was inadequate and the evidence it presents is inconsistent with established knowledge on the disproportionate impact of self-isolation on certain groups in society, and the report continues: a clear rationale has not been provided for why there is no

specific impact on any group in society, and I think you've had an opportunity just to review that paragraph of Professor Machin's report.

Can you assist, what steps were taken by the Department to ensure that vulnerable communities, including ethnic minority groups, were properly informed of and supported in accessing support for self-isolation?

A. So, again, I agree, this is a critical issue. And from the start, the -- and I'm not saying we always got this right by the way, but from the start the department and the test and trace service were looking to understand how we could make sure that you have a combination essentially of three things. One is good comms and engagement to make sure that people understand not just what the rules or guidance say, but also why it's important to self-isolate, so to provide the motivation to do so when you're asked.

The second is the practical, social and emotional support.

And the third, which we've touched on already, is the financial support.

And throughout the work we did, we were trying to strike a -- we were trying to get a balanced package across all those three elements. That's reflected in

part in the work that we did with local authorities, starting with the contain framework which you've mentioned, and the funding given to local authorities under the Contain Outbreak Management Fund, which was designed in part to enable then to communicate and engage with different communities working with voluntary organisations, faith groups, Community Champions and so forth, but was also designed to enable them to offer or partner with the voluntary sector and others to either offer or signpost people towards support.

What we found when we were looking at this in the autumn of 2020 was that although there were some excellent examples of what local authorities had done, there was also some inconsistency, and that led to the decision to develop a framework governing practical, social, and emotional support, and to give additional funding, which I think began in January of 2021, to local authorities to enable them to go further in either offering or mobilising offers of practical support for people self-isolating.

But I -- having said all that, I think the main point I would make is that I think lots of us working on Test and Trace at the time would, with hindsight, say that we wish it had been possible to do more, sooner, and I think this is a critical element of preparedness

for future pandemics: that however technically good your testing and tracing systems, they're only as good as the willingness of people to -- the willingness and ability of people across different communities to use them.

Q. Thank you.

LADY HALLETT: Sorry to interrupt, what would you have done sooner? You've been through one or two things. Do you have a list of what you and your colleagues to feel could have been done sooner?

A. I can give some examples of that. The -- I've mentioned the framework that we developed, which was -- you know, it was just a framework, but all the local authorities we've worked with said that they found it a helpful framework for understanding the different elements of practical, social and emotional support you should offer, and being given additional targeted funding to help with mobilising that support. We did that in January 2021, I think. I wish we'd done it sooner.

Similarly, it was about that time that we introduced the medicines delivery scheme for people self-isolating which had already been in place for people who were shielding but it wasn't until 2021 that we extended that to people self-isolating, and again, with the benefit of hindsight, I wish we'd done that sooner.

But more broadly -- I think the broader thing

I would say is -- and I believe there's some evidence from the UKHSA on this, and this is work that UKHSA have done since the pandemic, but what they found, and I hope this is a fair characterisation of their work, is that some of the things we did to communicate and engage better worked, some worked less well. So it was quite mixed. And the things that work best is where you are working through local groups. It may seem a very obvious point but having local authority Directors of Public Health and their team, able to work with those voluntary organisations, faith groups, Community Champions and so forth, is probably the most important thing when it comes to cutting through and making sure that people not only have got the support they need, but also that they understand the importance of engaging with testing and self-isolation, and so forth.

And I think a critical part of future preparedness for pandemics is having the protocols in place from the start to understand how you -- essentially how -- at the same time within the first hundred days that you are building up your testing and contact tracing capacity, within those first hundred days, how are you working with local communities to build trust and willingness to be part of the response?

Q. Thank you.

And finally on lessons learned and recommendations, please, Mr Dyson, a good part of witness statement D, at pages 50-69, deals with lessons learned and reflections and recommendations. But can I ask you, in respect of data, if we can just display page 64, please -- sorry, 62, "Diagnostics and Data Are Crucial in a Pandemic Response", but can I ask you specifically first of all, and if there's time a follow-up question: how did the department's shortcomings in respect of the collection and evaluation of data exacerbate the inequalities faced by ethnic minority healthcare workers and communities in relation to test, trace and isolate policies, please?

A. The -- so -- first to say that, again, data sharing is important, and was recognised as such from a very early stage. So I -- there were some features of the way that we had to establish initial services at huge pace and at scale, that meant that the right data sharing arrangements weren't in place at the start, but from, I think, May onwards it was an explicit role of the Joint Biosecurity Centre within Test and Trace to work with local authorities to improve data sharing. But I'm very aware that there have been a number of criticisms about the speed at which that happened, and the scale at which it happened.

What I can't do is -- I think it would be -- I'm not

sure that anybody could do this -- is to pinpoint the quantitative difference that that made, to ask the "what if?" What if this data had been available sooner, can we quantify the impact that would have? I suspect that would be very difficult and I certainly can't provide an answer on that.

MS CARTWRIGHT: Thank you.

My Lady, that's my time up, and so there are Core Participant questions from Covid Bereaved Families for Justice Cymru.

LADY HALLETT: Thank you.

Ms Parsons, I don't know whether Ms Cartwright has left you ... I think she may have pinched at least one of your questions.

MS PARSONS: She has, my Lady. In fact, both our permitted questions have been covered by this witness but I wonder whether I might be able to follow up, just briefly, on the first of those topics, that's scientific advice on asymptomatic transmission?

LADY HALLETT: Certainly.

Questions from MS PARSONS

MS PARSONS: Thank you.

Good morning, Mr Dyson. I ask questions on behalf of the Covid-19 Bereaved Families for Justice Cymru.

Your statement describes good levels of coordination

and collaboration between the scientific communities of the four nations. I want to ask you about scientific advice on asymptomatic transmission.

A. Mm-hm.

Q. And I do appreciate the limitations that you've given in your evidence this morning on what you can help us with, but the Inquiry heard last week from Mr Hancock that he received advice, scientific advice, on 14 April 2020, and that advice marked a major change of approach. In short, it meant that asymptomatic transmission became a baseline assumption for policy making and decision making.

Can you help at all with whether that scientific advice would have been shared among the four nations?

A. I'm afraid I can't. I'd only refer back to what I said before, that certainly the principle throughout the pandemic, I've no reason to suppose it was different at the time, the principle was to work very closely across the four countries in relation to both scientific advice and public health advice, but I'm afraid I can't shed further light on what specific information was shared at that point in relation to asymptomatic testing.

LADY HALLETT: It seems likely, doesn't it?

MS PARSONS: It does.

Thank you.

Thank you, Mr Dyson.

LADY HALLETT: Well, given how much the CMOs were working closely together.

A. Yes, I'm perhaps being over cautious in not speculating about things that I don't know. I would find it very surprising, but I've been warned not to speculate too much about things. I can't be sure.

LADY HALLETT: Right. Thank you very much indeed for your help, Mr Dyson, and for providing the reflections from you and some of your colleagues. It has been extremely helpful. And I repeat what I've said many times to other people from government departments, particularly the DHSC: I am so acutely aware of the burden that we've been placing on you and your colleagues, so thank you very much for what you've done and your colleagues have done to help us.

THE WITNESS: Thank you.

LADY HALLETT: Very well, I shall take the break now and return at 12.10.

MS CARTWRIGHT: Thank you.

(11.54 am)

(A short break)

(12.11 pm)

MS MALHOTRA: The next witness, my Lady, is Dame Raine, CBE.

DAME JUNE RAINE (sworn)

LADY HALLETT: Dame June, thank you for coming back to help us.

Questions from COUNSEL TO THE INQUIRY

MS MALHOTRA: Could you state your full name, please.

A. June Munro Raine --

Q. Now, Dame Raine, you've --

LADY HALLETT: Dame June, I think.

MS MALHOTRA: Dame June, you have provided a witness statement dated 2 April 2025. We can see the date there in the top right and on the final page as well.

Have you had an opportunity to familiarise yourself with your witness statement recently?

A. Yes, I have.

Q. I am very grateful.

Can you confirm that the contents of that statement are true?

A. I can confirm that.

Q. Now, this is a corporate witness statement on behalf of the Medicines and Healthcare products Regulatory Agency, I'm going to refer to it as "the agency", meaning, effectively, that you've had the input and the benefit of a number of other individuals in preparing this witness statement; is that right?

A. I have, very much so.

Q. And this is your Module 7 witness statement, I believe

your fourth to the Inquiry. You've previously provided written evidence in Module 3, Module 4, and Module 5 and you've also given evidence in Module 4, so you'll be certainly familiar with the process. Could I just invite and remind you to keep your voice up and to speak into the microphone, please.

Now, you were the chief executive of the agency until 31 March of this year; is that right?

A. I was.

Q. Now, at paragraphs 5 to 10 of your statement you give details of your professional background and your statement will be published, as you know, on the website so that the public will have the full context of your witness statement and your professional background. So I hope you will forgive me for not repeating it now.

With regard to your roles and responsibilities as chief executive of the agency, you say at paragraph 5 of your statement, page 2, that you were accountable to health ministers for ensuring that the agency took all possible steps to ensure that medicines, medical devices and blood products for transfusion meet appropriate standards of safety, quality, effectiveness and performance; is that correct?

A. That's correct.

Q. And the -- just in terms of the regulator, the agency,

it's an executive agency of the Department of Health and Social Care; is that correct?
A. It is.
Q. And it takes decisions on behalf of the Secretary of State; is that so?
A. It does.
Q. And the function of the agency is wide and your statement touches upon various aspects of it. For the purposes of why you're here today to give evidence with regards to Module 7, it's with respect to Test, Trace and Isolate. As succinctly as possible, could you please summarise for us the role that the agency played with regard to testing of Covid-19?
A. Well, thank you. The agency played the role as it does with all medical devices, from clinical investigations, these are proposals to undertake studies, right through to looking at surveillance. The important point the agency undertook during the pandemic was to be flexible and adaptable, and one of the key tools is the exceptional use authorisation when there is no available product and a medical need arises.
Part of the flexibility and adaptability was also to use the very extensive scientific resource the agency has to produce target product profiles to drive up industry, scientific endeavour to produce the best

possible products to benefit the public's health.
And it's very good to know that those target product profiles, including for self-testing of asymptomatic people, had benefits worldwide, so a flexible and adaptable agency focusing on the access safely to innovative diagnostics.
Q. And so with regard to diagnostics, that were used during the course of the pandemic that we're concerned with, LFD tests and PCR tests, what was the role of the agency with regard to those two tests?
A. The lateral flow device tests and the PCR, the polymerase chain reaction tests, are both medical devices, and as just mentioned, we would be concerned with any clinical investigations that were to be conducted and we would also conduct surveillance. And in respect of our tool that we used extensively in the pandemic, exceptional use authorisations, we used that for those particular types of diagnostics.
Q. Now, in your witness statement -- I needn't take you to it -- you say that the agency didn't approve testing kits, but it regulated them. Could you perhaps explain the distinction, please?
A. The generality is that a medical device, and that includes a diagnostic like a lateral flow test, receives a conformity assessment mark, either from a European

notified body or from an approved body, as now we can issue a UK CA mark. But as I have tressed, during the pandemic, we were able to use the power to exempt companies from meeting those standards and requirements by issuing an exceptional use authorisation.
So I hope I've helped with the distinction there that the generality is that we do not approve, but in this case, we were capable of making judgements about the circumstances and the data needed to exempt a product from CA mark -- CE marking, or UK CA marking.
Q. And, in fact, there were 17 occasions when the use of exceptional authorisations was made; is that right?
A. That's right.
Q. Now, there are three topics, time permitting, that I'd like to explore with you. The first is wastewater testing; the second is issues with those diagnostic tests that we've outlined; and thirdly, recommendations for the future.
So starting with wastewater testing, please. The agency played a role in wastewater testing; is that right?
A. That's correct, but building on experience as a WHO collaborating centre for polio, where there's a long-established monitoring role looking for any fragments of the polio virus that might hint that this

was coming back, which is clearly something our immunisation policy colleagues would wish to prevent. There was evidence in the pandemic that the SARS-CoV-2 virus particles, the ribonucleic acid, could be picked up in a similar way. So what our scientists did was to look back to ask the question: did what we might pick up in the wastewater, the sewage, mirror clinical infections?
Q. Just coming to that, then, you set it out in your witness statement page 26, paragraph 82, that, by testing waste water samples from a North London sewage site serving 4 million people retrospectively, the agency was able to ascertain that on 11 February 2020, so three days before the first case of Covid-19 was reported in the sewage plant catchment area, low levels of SARS-CoV-2 viral ribonucleic acid was present, so RNA was present; is that right?
A. That's correct. And further samples showed an increase in concentration as Covid took hold in that area.
And more importantly, my Lady, is we were able to -- the agency scientists were able to pick up variants when the genetic sequence changes. So, overall, an important piece of work, although, as counsel is saying, retrospective at that stage.
Q. Can you help us with whether it was possible to

undertake the testing of wastewater samples prior to July 2020?

A. It would have been possible, particularly as the technology and the research team had already used that methodology, that kind of research, for polio, and it was important that that continued. The discovery that SARS-CoV-2 fragments had been detected in other countries was what triggered the piece of research we're talking about.

Q. So do I understand it then that the reason why it was done in July 2020 as opposed to earlier was because of what the agency was viewing happening overseas?

A. Yes.

Q. And that prompted then -- for the retrospective investigation.

Can you help us, then, if that information had been known in realtime, sort of, say, for example, in March 2020, how could that have been used in responding to the threat posed by the virus in those early stages?

A. From what we know now, it could have been an early warning, and it could have been systematically used to look for variants as they appeared well before -- appreciably before clinical cases then were tested. And it's a matter of thinking that this could be done UK-wide and even internationally to help us be on the

front foot and look for these early warnings.

So if I continue a little bit, this is a subject we're looking at carefully at the moment. You find what you look for. Should we be expanding the range of kinds of viruses that wastewater testing could look for?

Q. And just on that point, then, can you help us understand, what are the limitations to wastewater testing?

A. At the moment we have a small team, our polio team, whose names are on the paper, together with Public Health England. The reliance on grant funding; the funding from the Coalition for Epidemic Preparedness Innovations has been invaluable. And the need for the kind of international network -- we might come to this, considering the World Health Organization is now looking to build alignment internationally. So there are several things, the science, capability, and capacity, the funding, and the design of a system which could be switched on and scaled up as needed.

LADY HALLETT: So basically are you talking about a surveillance going on the whole time?

A. In a --

LADY HALLETT: As well as --

A. -- defined set of viruses or other pathogenic organisms.

LADY HALLETT: So, given that viruses change in their

nature -- forgive me, I'm no scientist -- given they change their nature, how might you detect a novel virus like Covid-19 was, if you were doing this kind of -- or would you only start it once you knew something more about the new virus?

A. The Covid-19 was actually one of the viruses that the scientists in our laboratories had actually been ready to look for, because of the experience with SARS and MERS. As you say, my Lady the challenge is to expect the unexpected, but I think it's quite clear that there could be a hit list or a panel of multiple pathogens that, perhaps with an international agreement, would be what was systematically looked for.

LADY HALLETT: And if you're talking about -- as ever, everything comes back to resources -- what size of cost are we talking? Are we talking a huge amount of money to give the agency the kind of resources it needs? Are we talking about a reasonable amount of money? What's reasonable depends -- (overspeaking) --

A. I think I would build from the funding which CEPI has already used, and look at this study to see what a business case would look like. I'm sure that's very much in the thoughts of the scientists who are currently looking at what an international or a local system might mean.

LADY HALLETT: Thank you.

MS MALHOTRA: Just -- you said there, in response to my Lady's question, that coronavirus was something that the scientists were already looking into.

If it was something they were already aware about, it was already on the horizon and were looking into, can you help us with why it was then only in July that there was this retrospective review?

A. I would say that the priority was to create the standards and reference materials that our laboratory scientists are expert at. They supply over 90% of the standards worldwide. And these are the materials that enabled testing, diagnostics, to be accurate and reproducible and consistent. So that really was the first priority in mind. And as I mentioned a moment ago, only when it was clear that we could adapt the environmental surveillance was that piece of work done.

Q. We've -- I've asked you about the limitations and you've given us some practical limitations to wastewater testing with regards to grant and funding and resourcing. Can you help us -- and obviously you need to know what you're looking for in order for there to be value with regards to wastewater testing, can you help us with what the real benefits of wastewater testing can be?

A. It would, I think, enable early warning and monitoring variants. Those are the clear benefits, if scaled up and adequately resourced.

I think it's worth, perhaps if we do touch on the World Health Organization agreement of last week, thinking about the pathogen access and benefit sharing group that would, I think, now need to be the basis for the design of a system, and let's look forward to countries involved putting their scientists into this work.

Q. You've mentioned the WHO agreement that has been recently reached. I think it was last week it was signed. We've got that available.

I wonder if we could bring up INQ000587665, please. This is the WHO report. And if we go to page 13, a number of articles -- it says there at the bottom of the page -- I'm not sure why it's highlighted green but that's how it's been provided:

"Each Party shall strengthen its national and, where appropriate, regional regulatory authority responsible for the authorisation and approval of pandemic-related health products, including through technical assistance from, and cooperation with the World Health Organization ..."

And I think, if it goes over to the next page:

"... and other international organisations upon request and other Parties as appropriate, with the aim of ensuring the quality, safety and efficacy of such products."

So, in essence, what article 8 is dealing with here is to make available and to update information on regulatory processes for authorising the use of pandemic-related health products and to promote strong regulatory systems with international alignment where possible.

And can you help us whether the agency is ready for this or taking steps to be ready towards this?

A. Well, absolutely. It happens to come at a time point when the agency, as in the statement, is already looking at changing, reforming the law on medical devices, and that includes diagnostics. But what we see here, and it's, I think, right through the agreement, is a focus on equitable access, which I think is part and parcel, as was said before, no one is safe until everyone is safe, and for that reason, the coming together to look at what an expedited pathway, like the emergency exceptional use authorisation might look like, what effective vigilance is like on an international scale, and reliance on decisions made by other regulators. So all about this -- about being better prepared but more

agile in response, including equitable access.

Q. That can be removed.

I'd like to move on to ask you about DHSC self-test. Now, the Inquiry has heard evidence the test already and I'd like to focus on the agency's role with regard to this test. Now, for context, the agency provided DHSC with support to become a legal manufacturer of self-tests, also known as the lateral flow device tests; is that right?

A. That's correct.

Q. And Innova was the manufacturer of the test; is that correct?

A. Yes.

Q. And DHSC subcontracted the provision of the supply of the kits to Innova; is that so?

A. Yes.

Q. And the agency seconded a member of staff to DHSC to support the efforts including ensuring that instructions for those self-tests were fit for purpose; is that right?

A. Yes, the goal was to integrate a good understanding of regulatory requirements and to be able to look at an application from the DHSC in the shortest time possible. There was very great care taken to ensure that the staff, the teams of scientists and clinicians who would

look at the data were not involved in close advice to the department. So that separation was very fundamental.

Q. Now, the agency granted an exceptional use authorisation on 22 December 2020; is that correct?

A. Yes.

Q. And that was because there was no CE marking, the CE marking you've already referred to that signifies the medical advice complies with EU legislation; is that right?

A. Yes, and there was no alternative product available, CE marked.

Q. And on 10 June 2021, the US Food and Drug Administration, the FDA, issued a safety notice and a recall letter with regard to those Innova LFD antigen tests; is that right?

A. That's correct.

Q. And if we can have up INQ000496261, we can see here, and I'll perhaps deal with it as briefly as possible, there were three reasons cited here that we can see: firstly, the tests had been distributed in the US without the food and drug administration approval; secondly, the labelling included a clinical performance section which claimed a level of sensitivity and specificity that was not matched by the evidence that the FDA had seen at the

time of the inspection; thirdly, that there were significant failures in the quality management system in the company; and fourthly, it's dealt with in the section below, that Innova did not notify DHSC of the FDA audit and findings.

So I would like to ask you about the second and third of those matters, please, if we could turn to page 2. We can see here that the false negative results which may lead to delayed diagnosis or inappropriate treatment and false positive results that could lead to a delay in both the correct diagnosis and the initiation of an appropriate treatment, can you help us understand whether the agency was satisfied with the information it received about the efficacy of these tests, in particular their sensitivity and specificity?

A. Yes, I can. And I think the first thing to say in this context is that the use in the UK for asymptomatic people, people feeling okay, at home, was different from the use in the US. And what data were provided at the time of the application back in December 2020, assured us on the laboratory analytical accuracy, and on field studies and thirdly, usability. The question, of course, is always in a regulator's mind overall benefit and risk, and I'm sure even with the prism of reflection back we can all see what a change it meant to allow

people, enable people to test at home rather than driving to a testing centre. And to have a result within 15 minutes or half an hour. So a benefit in enabling that change, big change to happen.

Of course the sensitivity of the test was very much in mind, and the fact that we've already heard, I think, from some witnesses about the debate about how infectiousness and being asymptomatic relates to amount of virus, the viral load in the body. So there were some uncertainties but the judgment that resulted in the issue of the authorisation was that about two-thirds of cases would be identified and prevented and chains of transmission could be broken, such that there would be benefit at that time.

So the reasons for the agency's decision, I think, were clear.

Having said that, absolutely inherent in that decision was very clear mitigations, and a very clear message to self-testers, to people using this test, is that a negative does not guarantee or mean that you do not have Covid. And that was always very clear. This was what we call a red light test not a green light test.

Q. Now, the Inquiry has received evidence from Professor Jon Deeks, a medical statistician at the

University of Birmingham. And he explains in his statement, I don't think we need to pull it up for time, but he had an official role within the agency between the March '21 and July '21 as a member of the In Vitro Diagnostics Expert Advisory Group. And he gives reference to a letter that the group wrote on 8 July 2021 to the Director of Devices at the agency, and we can see that and I will ask that that is pulled up, INQ000531145, please.

Thank you.

We can see this was the letter that was sent, and if we go to page 2, for example, he sets out, the letter sets out a number of concerns and issues. So for example, it says there at paragraph 1:

"We would advise that prior to any further extension of the Authorisation of Specialist Use [the agency] should seek independent evidence and not just rely on evidence submitted by the manufacturer."

Was this a concern that you recognised?

A. The agency always takes into account all available evidence at the time of reaching a position but what's important about Professor Deeks' letter and the In Vitro Diagnostic Expert Advisory Group is that we also have access to independent experts to, if you like, challenge our decisions. I think I could explain that at the time

of the FDA letter and recall, we paused an extension and carefully considered at that time, which was mid-'21, whether it was still justified, knowing that the company were preparing for a CE mark, and we were eagerly anticipating that they had done the work for that. We had also, the agency had also audited the company and was aware of areas that needed attention in their systems, which we may come to.

So this, I think, accords with the view of the agency. Of course, the question then later in the letter is that the changed terms of the EUA did include one off testing prior to an activity which the expert advisory group had concerns about.

Q. And that CE marking is dealt with at paragraph 4. And at paragraph 3 the letter raises the independent scrutiny of the claim that the test has 95% sensitivity for infectious people. Can you help us with whether the Innova test achieved the lower limit of the 95% confidence interval above 60%?

A. I would have to check data available at that time to assure you on that, although clearly we were monitoring, this is mid-June, work ongoing, for example, the Liverpool study.

Q. And there were a number of reports -- I needn't take you to any more -- but a number of reports and concerns

about the efficacy of the tests, false positives, false negatives. Should the agency have been more robust in its scrutiny of the Innova and other test kits once approved, given the significant risk from inaccurate results?

A. I'd like to be clear that the issuance of an exceptional use authorisation is really just a milestone. There is a very rigorous ongoing monitoring and a set of requirements, particularly around post-market performance follow-up, that, if you like, we're sitting on the company's tail or the legal responsible body's tail all the time, fortnightly updates in this case. So I would like to assure you that the approach of the agency is very rigorous and ongoing.

Q. Can you help us, the agency was involved in assessing the swabs, for example, and can you help us with what consideration was given to those who were, for example, neurodivergent or healthcare workers with regard to using that method of testing? Was that within the regulator or the agency's thinking?

A. Yes, it was and I know that our test team had a lot of ongoing interactions, to make sure that the instructions for use were as helpful as possible, available in 11 languages, and also a video. So multiple modalities for people to understand really quite an important and very

clearly defined set of requirements there.

Q. Did the agency have any role in regulating the Lighthouse laboratories?

A. The agency doesn't have a role in regulating laboratory practice, this is the UK assessment service, UKAS, that does this. And will leap in, though, if products are being used that are non-compliant, they don't meet the standards that would be expected under the legislation.

And we didn't have any reports. Otherwise we would have, as I say, jumped in.

Q. Now, the Inquiry has received some evidence in April of 2020, correspondence between the Catapult Medicines Discovery (sic) and Deloitte, with regard to voiding of test results caused by the use of supermarket sandwich bags, and we can see that at INQ000511040 at page 2.

Can you help us with the agency's role with regard to collection of those samples?

A. Requirements in terms of the function of the medical device, in this case I think it is the PCR test, are clearly described. These laboratories were working under enormous pressure and, as I say, it isn't the MHRA's role to step in and regulate how their processes work. I'm assuming that the processes would have been evolving rather rapidly and I think we've hearing about Rosalind Franklin, for example, being state-of-the-art,

you know, that digitalisation of these end-to-end processes has made a very big difference. I hope the comments are helpful but in a nutshell, we wouldn't have had a responsibility for this.

Q. And similarly on 13 May 2020, if we can pull up INQ000511161, page 1, here there were concerns that were raised, voiding of samples because of faulty kit, so split tubes, two samples in the same tube, labels covering lids of tubes, samples with no liquid and sample tubes not being sealed correctly.

And then if we go to INQ000511111, page 1, there's reference here to unvalidated tubes. Can you help us with regard to the agency's role in swabs and sample collection tubes?

A. These are as individual consumables, subject to the requirements of the medical device legislation, and the regulations that we oversee and give guidance on, and depending on any signals we get, any harm that results, as I say, we would distinguish our role to ensure that products perform as appropriate and are safe. However, the issues around what happens in a laboratory, the standards that apply there need to be looked at through the accreditation role.

Q. Just finally, I'd like to ask you about the Randox tests, so sticking with that theme. The Randox tests --

at paragraph [146] of your statement, you explain that the National Testing Programme flagged them to the agency. Can you explain what the issue was that was raised with you?

A. The issue was that the regulation of this kind of product is a matter for the categorisation that allows for self-certification, unless any part needs to be sterile and in the case of these kits, the swabs needed to be sterile, as you can imagine. The worry about a contaminant, either making the test invalid or causing patient harm. So the agency was very clear that there had to be microbiological or cultures done to test if there was contamination.

The understanding, shortly after that alert was given to the agency, was that there had been communication to stop use. I believe that was on 15 July. And that had gone out on gov.uk. The reason for the recall later was that it became clear that the kits were still being used and therefore they had to be removed until such times the swabs were sterile.

MS MALHOTRA: Thank you. That completes my time with you, Dame June, thank you.

I believe there are some Core Participant questions.

LADY HALLETT: Certainly, I think Mr Thomas is first.

Mr Thomas is over there.

Questions from PROFESSOR THOMAS KC

PROFESSOR THOMAS: Good afternoon, Dame June, just a few questions. My name is Leslie Thomas and I'm representing FEMHO, that's the Federation of Ethnic Minority Healthcare Organisations.

A. Good afternoon.

Q. Between 3 March 2020 and 30 June 2022, the Medicines and Healthcare products Regulatory Agency received 3,400 adverse incident reports through the Yellow Card Scheme relating to devices using Covid-19 testing. These included reports of missing or defective kit components and possible incorrect results, and we note that all reports were triaged and assessed under normal safety surveillance processes. We would like to explore how this monitoring system functioned for healthcare workers, particularly those from ethnic minority backgrounds. So with that in mind, let me turn to my questions.

Firstly, Dame June, can you assist us with what steps were taken to ensure that healthcare workers, including those from ethnic minority backgrounds, were aware that the Yellow Card Scheme could be used to report concerns about Covid-19 diagnostic tests such as the lateral flow and the PCR tests?

A. Well, thank you, it's a really good question. Many of

the healthcare workers will have received messages about reporting for medicines, but in fact the Yellow Card Scheme took reports on medical devices, including diagnostics, since 2014, I believe. So they would have known that they could report. But the important point is that a Covid portal was set up by the May, and that was particularly to invite reports, not just about medicines or vaccines, but about medical devices.

Q. Were any of the 3,430 reports linked to patterns of concern raised by frontline health or care staff, and did the MHRA analyse this data in a way that captured occupational or demographic context, including ethnicity?

A. We do capture the reporter's specialty or profession, and -- that's really part of the analysis that's done. I'm not aware that the scheme actually looks into the demographics, ethnicity, and so forth, of the reporter. We do that for the patient.

So I think that's a gap you've highlighted, and would like to look further into it.

Q. Okay.

What engagement took place with NHS bodies, professional associations or community health networks, to promote participation in the scheme among healthcare workers from minority ethnic backgrounds?

A. I participated, as someone from an executive agency of the Department of Health, in multiple interactions, largely led, I believe, through NHS England, and my laser focus was on ensuring outreach on reporting. I mentioned, I think in Module 4, as an example, working with Vaughan Gething in Wales for this. But I did also stress that more can be done, and I think for the future a planned approach will be really important.

Q. Finally this: in light of feedback that the scheme lacked transparency, or trust among some groups, what changes would the MHRA now recommend to ensure that future safety reporting systems are inclusive, responsive and actively used by those most at risk?

A. Thank you. This is a really important question and an important priority, I believe. My legacy for the agency is a yellow card strategy that does include this kind of much more facilitated interaction. The ability for our what we call interactive drug or device analysis prints to be able to search out relevant information for the health professional who is interested in a particular safety issue is at the heart of that.

And I think there will be a lot more that you will see as that important strategy moves forward.

I think that a key development and a key milestone in our reform of legislation for medical technology is

coming into force of post-market surveillance requirements, which is the middle of June. So a lot is happening, and more will be done.

PROFESSOR THOMAS: Dame June, thank you.

LADY HALLETT: Thank you, Mr Thomas.

Ms Maragh is just there.

Questions from MS MARAGH

MS MARAGH: Thank you, my Lady.

Good afternoon, Dame June. I am Thalia Maragh and I ask questions on behalf of the Covid Bereaved Families for Justice UK.

Two topics, if I may, starting with the Yellow Card reporting and online system of surveillance to which you were taken just now.

And, my Lady, with your leave, if I could just tailor my question in light of the matters explored with Dame June with Mr Thomas.

And it's this: you mentioned moving towards equitable access. And bearing in mind that the online reporting system, it was digital, it was online, would you agree that the exclusive use of online platforms for reporting lost, late or incorrect test results potentially excluded sections of the populations such as those -- the elderly and the digitally excluded?

A. Thank you for your question. It's really important.

The agency has kept alive different ways of reporting and it's quite clear that someone can report on your behalf, so you just need to tell someone that you've got a concern or a worry, and your health professional or a member of the family can do that for you. But it's still possible to phone or to use a paper report, a card. So I hope that is of some reassurance, but digital exclusion we do understand is a very important issue.

MS MARAGH: And I think, my Lady, that deals with the second question in terms of forward planning.

Dame June, may I move to my next topic briefly, which is NHS Digital, which you touch on at paragraph 63 of your statement.

In short, the MHRA software team worked with NHS Digital in the Covid-19 app in relation to the development of contact tracing and the lateral flow device reader.

Knowing, as we now know, that there were -- by the time the NHS app was rolled out, there were more than three symptoms which were known to detect Covid-positive symptoms, however the app only captured fever, cough and shortness of breath.

Firstly, was the NHS app subject to the MHRA regulatory oversight and scrutiny?

A. The app needed to conform to the requirements as a medical device, yes.

Q. So in light of the limitation at the start of the rollout of just the three symptoms, was there regulatory oversight over the period of the life of the app, in terms of data updates?

A. I'm very confident there will have been. I can't give you a date as of today as to when a change in taste or smell might have been added in there as a symptom, but the coherence of the different sources of information is a really important one, and the app was clearly very well used, as we heard earlier from the previous witness.

Q. Right. It's just that during the life of the app, there were known to be more than the three symptoms, however, it was not updated. And so the question and the issue for you, if you can assist us, is whether the failure to pick up on the additional symptoms could be considered as a gap in the regulatory framework?

A. Well, those additional symptoms -- as we know, Covid had a different manifestations in different people, really important point. I would be surprised if the app wasn't updated, but I stand corrected if you're able to speak with confidence on that one. It's something consistency between information sources, really important, otherwise

trust in experts, including government, isn't a taken as read.

MS MARAGH: Thank you.

My Lady, that's as far as I will take that point in light of Dame June's answer.

LADY HALLETT: Thank you very much indeed.

Dame June, that completes the questions. I think it probably completes your assistance to the Inquiry, so thank you very much indeed for all that you've done to help the Inquiry and, of course, your colleagues, who have helped prepare the statement.

THE WITNESS: And the agency as a whole, my Lady, has made an immense and outstanding effort in this time of crisis -- with results.

LADY HALLETT: I'm really grateful to everybody, and may I wish you luck in your so-called retirement. I suspect it won't be retirement if you're anything like me, but thank you very much for your help.

THE WITNESS: I'm very grateful to you, my Lady.

LADY HALLETT: I shall return at 1.55.

(12.57 pm)

(The Short Adjournment)

(1.55 pm)

LADY HALLETT: Ms Nagesh.

MS NAGESH: My Lady, the next witness is Dr Robin Howe.

Could the witness please be affirmed or sworn.

DR ROBIN HOWE (sworn)

Questions from COUNSEL TO THE INQUIRY

MS NAGESH: Dr Howe, thank you for coming to give evidence to the Inquiry. May I ask you, please, when you're answering questions just to keep your voice up and to direct the answers towards my Lady.

Now, Dr Howe, you have produced, helpfully, two witness statements for the Module 7 of the Inquiry. The first you'll see on screen is a corporate witness statement, and we can see in the first line two names: Dr Giri Shankar and yourself, Dr Robin Howe. That's because this statement is jointly signed by both of you; isn't that right?

A. That's correct.

Q. And just to put things into context, you were both professional lead consultants for Public Health Wales during the pandemic, and Dr Shankar was the professional lead consultant in health protection and you were the professional lead consultant in microbiology.

A. Correct.

Q. Now, but as this is a corporate witness statement, not only have yourself and Dr Shankar contributed to the statement, but where matters you've been asked about fall outside your or Dr Shankar's personal knowledge or

experience, is it right that you've sought input from others within the organisation?
A. Yes, correct.
Q. If we could turn, please, to the last page, which is page 132 of the statement. Can you see at the top of the page there's what's headed as "Statement of Truth" attesting to the facts in the witness statement being true to the best of your knowledge or belief. Does that remain the case today?
A. Yes, that's correct.
Q. And is it the case that although only you attend to give evidence today, you are able to speak to all matters in this statement?
A. Yes.
Q. Thank you. And the second statement is a statement you've produced individually on behalf of yourself, dated 2 May 2025, and that's on screen as well. And again at page 24, do we see a statement of truth which you've signed attesting to the facts in the witness statement being true to the best of your knowledge and belief?
A. Yes, correct.
Q. And again, does that remain the case today?
A. Yes.
Q. Thank you. Now, both statements and their exhibits are

with the Inquiry and the statements will be published, but -- so please rest assured that the Inquiry will be taking everything in those very full witness statements into account. But for today's purposes, if I may, I want to just focus on some specific topics and ask for further clarification or assistance with those as far as you're able.

So let's start, please, with your professional background. You qualified in medicine in 1989 having trained in Cambridge and Newcastle upon Tyne; is that right?
A. Correct.
Q. You then trained in microbiology at Sheffield and Bristol and became a consultant senior lecturer at Bristol University and North Bristol NHS Trust in 2002?
A. Correct.
Q. In 2025 you moved to Cardiff to undertake the role of consultant microbiologist and head of the Welsh Antimicrobial Resistance Programme for the National Health Protection Service which was the predecessor to Public Health Wales?
A. Yes.
Q. And your particular area of professional interest has always been -- or has been, all aspects of the antimicrobial resistance?

A. Yes.
Q. So following that interest you were chair of the British Society for Antimicrobial Chemotherapy Standing Committee for antimicrobial susceptibility testing since 2012?
A. Yes.
Q. And then from 2014, you were working within Public Health Wales as the national clinical lead for the microbiology division, which meant that you were providing overall clinical leadership for the Public Health Wales microbiology service?
A. Yes, that is correct.
Q. And then in February 2020 you, alongside Dr Giri Shankar, became an incident director for the Public Health Wales Covid response?
A. Yes.
Q. And outside your role as incident director, your main role during the pandemic was focused on Covid testing and you were the lead for the team delivering laboratory testing across Wales and also advising on operational and scientific matters.
A. [No audible answer].
Q. Then, finally, in April 2022, you were appointed to the new role of director of Infection Services in Public Health Wales; is that correct?

A. Correct, yes.
Q. And so if we can just then go through a broad overview of Public Health Wales, it was established in 2009, wasn't it, as an independent NHS body in Wales, is that --
A. Yes, correct, yeah.
Q. And is it right that its overarching function is to provide professionally independent public health advice and services?
A. Yes, correct.
Q. One of those services is public health related specialist advice to the Welsh Government and its ministers?
A. Yes.
Q. And in order to provide those services there is, within Public Health Wales, a health protection division?
A. Correct, yeah.
Q. And that encompasses within itself several teams including, for example, the Communicable Disease Inclusion Health Programme and the All Wales Acute Response team?
A. Yes, correct.
Q. And as we've touched upon so far as your role during the pandemic is concerned, in relation to the Inquiry and this module in particular, you provided advice in

relation to Test, Trace and Protect services in Wales?
A. Yes.
Q. But importantly, you weren't the decision maker in relation to any test, trace or protect services. I use the word "advice" because you provided advice to the Welsh Government and they were the ultimate decision maker?
A. Yes, because Public Health Wales is part of the NHS and not part of Welsh Government.
Q. Thank you. So that's an overview of your role. If we can move, then, on to one specific task which you had relatively early on during the period in which we're looking, which was the development of a health protection response plan.
And just so we can see what it is can we have up, please, INQ00056350, page 1, thank you.
So is this the "Public Health Protection Response Plan", which you led the development of, and we see a publication date of 5 May 2020?
A. Yes, that's correct.
Q. If we can turn to page 3 of that same document, please. There's an introduction, and going down the page we can see the heading "What needs to happen", and it says:
"The Plan outlines three major activities for concerted public health action at scale. These are:

"1. Preventing the spread of disease through contact tracing and case management ...
"2. Population surveillance ..."
And then over the page, please:
"3. Sampling and Testing different people in Wales ..."
So the language sounds relatively familiar to us now here at Module 7 of the Inquiry, and is that because this Public Health Protection Plan formed the basis of Test, Trace, Protect strategy in Wales?
A. Yes.
Q. Now we'll return to its contents a little later but if we could just take it off the screen, please, I want to ask you a few questions first, if I may, about the development to that plan.
You were instructed, I believe, to create the plan on 22 April 2020?
A. Yes, that's when we had a formal instruction from the CMO Wales.
Q. Thank you. And then on 4 May, so I think less than two weeks later, you submitted a final version of that plan to the CMO?
A. Yes, correct.
Q. Then the Welsh Government published its final Test, Trace, Protect strategy on 13 May 2020 following,

I believe, a seven working day consultation with its stakeholders?
A. Yes, that's correct.
Q. What I wanted to ask you about that timeframe is this: with just under two weeks for the development of the plan and then something like 11 days before the publication of the Welsh Government Test, Trace, Protect strategy, do you consider that gave adequate time for the development of, and consultation on, the plan?
A. It was a very challenging timetable, although Public Health Wales had already been in discussion with colleagues in Welsh Government and also been doing some work in the background on thinking about, you know, the TTP programme that would be required.
But nevertheless, those -- I think it was ten working days, were very challenging, both to pull together the breadth of the document and then have some consultation. And in fact, the consultation that we were able to have with colleagues, stakeholders across Wales was really only 24 to 48 hours. But we did get helpful feedback that then -- that did play into the response plan.
Q. Thank you. Now, we know, of course, you developed the plan but the Welsh Government were responsible for delivery of the plan. During the development process,

to what extent, if at all, was there any involvement of the Welsh Government in the development, or was it purely Public Health Wales developing the plan and handing it over effectively?
A. As I said, there was at this point a lot of informal discussion between colleagues in Public Health Wales and in Welsh Government so it was not -- there wasn't a formal working together on this, but informally, we knew from, you know, what we had shared with them, and vice versa, that this was -- the direction was going to be appropriate.
Q. Now, we mentioned, of course, that the plan -- you were given the instruction by the CMO to develop it on 22 April. Are you able to help us with why -- the -- why 22 April, why there was no Test, Trace, Protect strategy or plan before 22 April or even before the pandemic?
A. I'm not -- I don't recall why particularly there was a question raised on 22 April. Prior to that time, we had already started working on a TTP plan, and colleagues in Health Protection had drafted the, you know, the outline plan a couple of weeks earlier than that.
Prior to that, and prior to the pandemic, the emergency response plans that we had worked through more

usual health protection response levels, and didn't have -- didn't take account of the extent of a pandemic response such as this. They had been appropriate for previous pandemics, such as the 2009 pandemic, but needed a different approach.

Q. I see. Thank you.

Now, we've touched upon the fact that you, obviously your main role was to give guidance to the Welsh Government, and you helpfully mentioned that during the development of the plan there was some informal discussions. In relation to the guidance and advice that you provided to the Welsh Government, did it largely take the form of informal or formal discussions? How did you provide the advice?

A. At this point and during these -- the development of the plans, they were informal discussions with colleagues within, predominantly, the CMO's office.

Q. And generally speaking, when you would provide advice to the Welsh Government, what form would that take in the early stages of the pandemic?

A. Well, there were a lot of meetings, and I think you've heard previously, in previous modules, about meetings between colleagues in Public Health Wales, the CMO, and other colleagues in Welsh Government. And at lower levels in the organisation, people such as myself would

be meeting with colleagues in the CMOs office.

Q. And then I think, am I right that from about October 2020, you set up a system which you called the CMO advice notes?

A. Yes.

Q. And what was that?

A. So prior to October 2020, there were a lot of informal and sometimes more formal interactions, but coming into Public Health Wales were a number of queries from different parts of Welsh Government and other organisations, and there was clearly a challenge in ensuring that the Public Health Wales response was collated in Public Health Wales and also directed into a single point in Welsh Government, because there was a danger of disparity in advice, or, you know, where it landed in Welsh Government.

So we set up the system of advice notes whereby the questions should come from CMO and the advice would be given to CMO.

Q. Thank you. I'd like to just ask you, if I may, about instances when the guidance you provided to Welsh Government wasn't followed. First of all, paragraph 585 of your statement, oh thank you.

If we're looking at the second line, and the bracketed line, you say:

"Note: Public Health Wales had advocated contact tracing to commence on the basis of symptom onset rather than test results, but this was assessed as being not practicable."

So is that one example of a time when you had provided guidance and it wasn't followed by the Welsh Government?

A. Yes, I think so. I mean, we felt that contact tracing on the basis of symptom onset meant that it could occur -- it could commence two days, on average, earlier rather than waiting for a positive test. That meant that contacts could be advised two days earlier to modify their actions and that we felt it would have a bigger impact. There was a contrary issue that, without a test result, it was possible that we would be contact tracing and isolating people who actually didn't have Covid but had symptoms due to something else, and so there was that concern about the -- that system being more sensitive but less specific. And at this point in the pandemic, we were looking to come out of lockdown, and it was felt that putting a lot of people into contact isolation potentially, when wasn't justified, was not the direction we want to go.

Q. If we just turn to another piece of advice that you gave to the Welsh Government at INQ000056323, page 3, please.

Thank you.

You've said at the top here:

"The Public Health Wales IMT has discussed the changes from 14 days quarantine of contacts to 10 days."

Then in the third paragraph you explain that:

"Reducing the quarantine period from 14 days to 10 days will mean that an increased number of contacts will be mixing when they are infectious ..."

And you finish by saying:

"However, we are concerned that the increased risk of COVID-19 transmission is significantly greater risk for individuals who work with vulnerable people, specifically care home workers and healthcare workers."

So were you there advocating for self-isolation for healthcare workers especially to stay at 14 days rather than be reduced to ten days?

A. Yes, for health and social care workers to continue contact isolation for 14 days.

Q. Thank you. And then if we just turn to page 1 of that same document, please. And just going down to the email:

"Robin, CMO has responded to say that we need to be careful not to divert from agreed 4 nations approach on this. If [Public Health Wales] have a different view, they should discuss with [Public Health England]

colleagues ..."

So again, is that another example of there being pushback on your guidance, if I can put it that way?

A. Yes, I mean, there was an important principle of trying not to divert from agreed four nations approaches, and really, this was a situation where it was a risk balance, and we felt the risk was in favour of maintaining 14 days. There were a number of colleagues in England who had similar reservations, particularly in the world of infection control, and a paper -- following this exchange, a paper was put together by colleagues in England and taken to the Senior Clinicians Group. That then led to an agreement that contacts would have reduced isolation to ten days if they were healthcare or social care workers, but that residents and patients would maintain contact isolation for 14 days and we accepted that view.

Q. Thank you. We can take that off the screen, thank you.

I just want to understand, using those two documents as a touchpoint, how common was it for Welsh Government not to follow your advice? Can you think of any other key instances?

A. I can't recall other key instances. In general, Welsh Government followed our advice. There were -- I mean, we were trying to, you know, follow advice coming from

the CMO group as well.

Q. Thank you. I just want to ask you just a couple of questions about your case management system, because at the time the pandemic started, you operated using a case management system called Tarian, T-A-R-I-A-N.

A. Correct.

Q. Which you'd had, I think, since 2017. Now, did there come a point around the preparation of your report that you consider that Tarian was not fit for purpose for the test, trace and protect scheme?

A. Yes, when we were mapping out the likely demand and workload within the system, and predicting that, we could see that Tarian would not be able to cope. It was server-based rather than cloud-based, and it was designed to be able to have a maximum of 500 concurrent users, and we mapped that we were going to need more like 3,000 concurrent users. So, for those and other reasons, we felt we needed to develop a new system.

Q. Was there a reason that Tarian was not tested or -- in advance of the pandemic or at least an earlier 2020?

A. So Tarian was used up to the point at which we developed the CRM, so it was used in the first tranche of contact tracing that happened in February and March, but it had -- you know, it had not been designed to fulfil what was required.

Q. Thank you. Now, you mentioned in your answer about the self-isolation periods, about liaison with Public Health England, and I think that brings me to my next topic, which is I wanted to ask you about your work with the other nations, England, Scotland and Northern Ireland.

One of the contributors -- to place this in context, one of the contributors to the Inquiry's Every Story Matters public engagement exercise said this:

[As read] "I think you have to have a standard over the UK. You can't have something different in each UK country. When you live so close to a border, you could be working in England and living in Wales or vice versa, and you've got two different guidelines."

So, bearing that in mind, what was the extent to which Public Health Wales engaged with Public Health England, and/or either of the public health agencies in Scotland and Northern Ireland to try to aim for consistency?

A. So we very regularly engaged, initially on a less formal basis, but later on more formally, with colleagues in England, Scotland and Northern Ireland, and, you know, there was an effort to try to keep key elements consistent between their four nations, but health is a devolved matter and it is the responsibility of the Welsh Government and Public Health Wales's advisers to

try to do the best for the Welsh population.

So, you know, we did take different approaches to our contact tracing, for example, but at the level of, you know, trying to, you know, have the same guidance around 14 days or ten days, we did try to work together.

Q. You've said in your statement -- we don't need to bring it up, but for your reference it's paragraph 155 -- that Wales had limit ability to influence UK Government decisions and that the largest porous border between England and Wales was pretty much impossible to close.

Do you consider there ought to have been greater account taken of Wales in decisions taken in UK Government?

A. Well, I think it's an issue for the Inquiry around the decision making at UK England level, and how the four nations can be or should have been more closely involved in that decision making, because there were clearly issues with central decisions made that then, in Wales -- that I can speak for, you know -- we then had to process those and assess whether they were appropriate for the Welsh population.

Q. Thank you.

Now just moving even further outside the borders of the UK, you've mentioned again, we don't need to bring it up, I think, but for your reference it's

paragraph 576 of your statement, you've referenced that in April 2020, following a request from the Chief Medical Officer for Wales, you established an international horizon scanning and learning workstream, so a workstream looking specifically at international comparators.

My question about that is this: prior to the pandemic, or indeed earlier on at the start of the pandemic, had Public Health Wales undertaken any exercises to learn from comparative international examples in relation to Test, Trace, Protect?

A. So prior to the pandemic, Wales had -- Public Health Wales had engaged with IANPHI, the International Association of National Public Health Institutes, and in fact, you know, was a full member of IANPHI and the purpose of that was to share public health knowledge and understanding.

I'm not aware that TTP arrangements were discussed in that forum.

Q. Thank you. Now, can we move on then, please, to discuss testing. First, you may or may not have heard the evidence of Vaughan Gething last week, but he gave some evidence to the Inquiry about the decision to stop community testing on the 17 March 2020. He linked it to capacity and he said:

"... if you're going to have sustained community transmission and community testing is going to come back, you need a much bigger testing infrastructure ..."

So he said it was about scale-up, the decision to stop community testing. And he said that scale-up didn't happen in the timeframe expected and that was partly due to the issues with Roche.

So I appreciate there's a bit to unpack there but can I invite you, please, to comment on that evidence of Vaughan Gething?

A. Yes, so at this point we had moved into the delay phase of response, and we were rapidly moving towards the first lockdown, people had already been enjoined to isolate if they had symptoms, so that actions were being taken in order to try to limit the spread and with lockdown, the most draconian of actions, to try to limit the spread was going to happen in the next week or so.

The issue of capacity was both an issue of testing capacity within the laboratories, but also sampling capacity in the community, in the health boards, and neither was in a position to be able to upscale at that point, and there was also an issue with capacity in terms of contact tracing. So if we had positive individuals, we didn't have the contact tracing symptom into place.

So it was all of those three things that impacted, you know, what was available.

Q. Thank you. I actually do want to now move on to ask about asymptomatic testing, if I may. It may be helpful to anchor that, or these questions, in the timeline of the Welsh Government's testing strategies throughout the pandemic.

The first strategy, I believe, was developed in March 2020 and published in April 2020. Is it right that Public Health Wales had no formal input into that strategy but did have informal input?

A. Correct.

Q. And then 15 July 2020 was a refreshed Welsh testing strategy, and is it right that at that point, whilst the main focus was still on testing of symptomatic individuals, there was acknowledgement that testing of asymptomatic individuals may be appropriate in certain settings such as care homes?

A. Correct, yes. And in fact, a national framework for leading the NHS out of lockdown and into potentially more normal operations that Welsh Government published in 2020 also touched on asymptomatic testing in healthcare workers as well, and suggested that it -- excess capacity could be deployed to routinely test asymptomatic healthcare workers.

Q. Thank you.

And then it may assist to look at INQ000227202, please. And page 1, thank you.

This is a written statement by the Welsh Government and in fact, more specifically, by Mr Gething. And this was a statement, as you can see from the second paragraph, is it right, to accompany the release of the Welsh testing strategy on 15 July?

A. Yes. Sorry.

Q. And then if we just turn to page 2, then. And if we look under the heading "Testing in Care Homes", we can see five bullet points. We can see there:

"All residents in care homes [at the first bullet point] were offered testing in May and June, whether they were symptomatic or asymptomatic."

Then again:

"Following the testing programme for all care home staff and residents, all staff in care homes have been tested on a weekly basis since 15 June, whether they were symptomatic or asymptomatic."

So do we see there a focus on asymptomatic testing as well?

A. Yes.

Q. So I just want to pause on that data of 15 July -- and we can take that off screen, thank you -- and just ask

you about the advice that you at Public Health Wales had given to the Welsh Government in relation to asymptomatic testing.

So, first of all, when was it first appreciated by Public Health Wales that asymptomatic transmission was a possibility?

A. I think, and I speak personally, that I rather assumed that there would be asymptomatic infection and some level of asymptomatic transmission from the outset, from translation from other respiratory viral illnesses.

It, however, became clearer during March, April, May, that -- the extent of asymptomatic transmission. I should say that, you know, asymptomatic transmission was a little bit difficult to define, because it was defined to an extent due to the definition of symptoms. So that clearly there were -- and others have touched on this, including Lord Vallance -- clearly there was a small proportion of people who were without any symptoms, but then a larger number of people who were -- who had -- who were pauci- or oligosymptomatic, so had some symptoms but were not the typical symptoms.

And that confusion made it slightly difficult to unpick some of the studies and the science as to exactly what was asymptomatic or paucisymptomatic and how we should use that information to determine our testing

policies.

Q. Thank you.

Did you give any guidance to the Welsh Government, either for the March 2020 testing strategy document or for the July one, in relation to asymptomatic testing or indeed, as you say, paucisymptomatic people?

A. So there was informal discussions around asymptomatic testing that -- where we wanted to balance whether we would be better concentrating on testing, or alteration of the symptomatology, because we could increase the number of healthcare workers who might be infected with Covid. We could increase the detection of them by either performing testing or by moderating the symptoms.

So there was that -- that was discussed, yeah.

Q. Now, just on that point, you've referred in your statement to having conversations with other countries, and in fact am I right that you -- for example, you had conversations with contacts in South Korea and in Germany?

A. [No audible answer]

Q. Now, just considering Germany in particular, could we please have up on the screen INQ000338265, page 1.

Now, these are -- it says "TAC Notes", so that's the technical advisory committee, dated 15 April 2020. Just first of all briefly, what was the technical advisory

committee?

A. Well, so there was the technical advisory committee or the Technical Advisory Group and I'm not -- sometimes their names were used interchangeably. I think this was the Technical Advisory Group, which fed into TAC, which was the committee that was actually a Welsh Government internal group that took the information from the Technical Advisory Group.

Q. That's helpful, thank you.

So would Public Health Wales have been part of, do you think, this meeting?

A. Public Health Wales, I think, were part of this discussion.

Q. Thank you.

So if we then turn, please, to page 3 of this document, if we look at the penultimate paragraph about four lines from the bottom, thank you. And it's -- if you can see, there's a line that starts "reconsidered?" With a question mark. About four lines from the bottom.

A. Yes.

Q. Then -- it's being highlighted now, thank you -- it says:

"TC suggested looking at the German approach, which consisted the daily testing of all healthcare staff regardless of symptoms."

So at this stage, 15 April, it was known in the group that Germany was testing healthcare staff regardless of whether they were asymptomatic or what their symptoms were. Was this something that would have come from your discussions with your German contact?

A. Yes. So I wasn't part of the specific discussions with our German colleagues, so I'm afraid I don't know exactly what was discussed with them.

Q. Thank you. You've said that this is more likely the Technical Advisory Group which was -- which involved Public Health Wales. Do you know whether this information was provided by way of advice to the Welsh Government in relation to asymptomatic testing?

A. I don't know, and I'm not sure whether Germany, at this point, which was April 2020, was actually able to do daily testing of all healthcare staff regardless of symptoms.

Q. You're not sure whether Germany --

A. I'm not sure. I just don't know whether that was actually the case. That was quite early in the pandemic and would have required a huge resource in terms of testing.

Q. Thank you. If you can take that off the screen. Thank you.

Now, just linked to that, the Inquiry has heard, you

may be aware, has heard in earlier modules about a so-called "precautionary approach" that could be taken in a pandemic. So effectively an approach to treat risks such as asymptomatic transmission as a possibility until they can be excluded.

Now, keeping in mind what you've said about the fact that you always assumed asymptomatic transmission would be a possibility and, on the face of it, the fact that Germany seemed to be implementing asymptomatic testing, did you consider that the Welsh Government were taking a precautionary approach or not?

A. I think they were taking a precautionary approach within the resources that were available at that time.

So, you know, in order to test all healthcare staff with the PCR test -- you know, the simple testing process takes some time, but the sampling process would have taken a very significant amount of staff resource, which would have been a challenge for the healthcare institutions, which were really stretched in delivering other elements of the pandemic response.

Q. Thank you. That answers my question, I think.

If we can move on, then, from asymptomatic testing to the range of symptoms, and I'd just like to read out an extract from a witness statement from Anna-Louise Marsh-Rees of Covid Bereaved Families for

Justice Cymru, it's paragraph 36, page 13. I think you've seen the statement.

A. Yes.

Q. Thank you. And she says:

"CBFFJ Cymru are aware that testing criteria in Wales was limited to three cardinal symptoms -- fever, cough and anosmia. The families and friends of many of our members experienced a range of symptoms outside these three symptoms, such as headaches, sore throat, fatigue, nausea, and diarrhoea, amongst others."

And she goes on to say:

"The Welsh Government's failure to acknowledge this broader range of symptoms in testing criteria, even as late as March 2021, would have led to a very high number of instances of symptomatic people continuing to spread the virus."

Now, just pausing there and moving on to another document that's linked to it, if we can have up on screen, please, INQ000116616, first of all at page 1 to place the document in context.

This was ministerial advice dated 23 March 2021, for a decision by the Minister for Health and Social Services.

If we can please turn to page 11 which might be page 11, which might be a page you recognise. Ah,

apologies. I think page 12 is the ... oh no, sorry, back to page 11. My fault there.

If we see at the top, there's a title "Expanded Criteria for COVID Testing" and it says, "Author" -- your name, Robin Howe.

A. Yeah.

Q. And the date is 15 March. So this is advice from you that's included in that ministerial advice.

A. Yeah.

Q. If we can turn to page 12 then, please. And in the bottom half of that page, we see a line starting "If symptom criteria are broadened there are a few issues to resolve", and then you talk about issues to resolve in relation to broadening the spectrum of symptoms, and then over to page 13, please. "Recommendations", we see:

"It is recommended that:

"Symptom criteria for public access to testing should be broadened to include new and unexplained sore throat, runny nose, sputum production, fatigue ..."

And you go on to list a number of symptoms.

So do you recognise this advice as being from yourself?

A. Yes, yes.

Q. And then if we please go back to page 1 of this

document, we see again a heading "Recommendation" and can you see there that it says:

"The Minister is asked to agree:

"That all LHBs can recommend [local health boards] can recommend testing for a wider range of symptoms

"[But] that our national messaging should remain focused on the 3 primary symptoms until there is 4 nations agreement on widening the case definition."

So just a few questions arising from all of that information.

First of all, can you help us at all -- you may not be able to and if you can't, please say, but can you help us with why the advice was to persist with national messaging based on three symptoms?

A. So I think this was written at a time where, you know, we understood that there was a wider range of symptoms for people with Covid, and that if we wanted to optimise the pick up of cases, that we should widen the definition. And a number of health boards had already started, because we were embedded with the health boards, they had already started to do this locally. And so we brought this to Welsh Government colleagues to reach a more standardised national approach, and as you can see from the Ministerial Advice Note, there was agreement with broadening the symptomology for testing,

but a wish, going back to our earlier discussion, to, you know, await a four nations agreement on this before pushing that at the national level.

Q. Did you or do you now have concerns that the delay, perhaps I should say, to expand the range of symptoms in public messaging could have resulted in individuals who did suffer from Covid-19 not taking a test because they didn't realise that they had Covid-19?

A. It's possible, yes.

Q. Thank you.

Now we'll move on, if we can, to tracing, please. I wanted to ask you few questions about contact tracing, and firstly about the digital element of contact tracing. Is it right, first of all, that in relation to contact tracing, much as with the rest of the Test, Trace, Protect scheme, you sought to align with Public Health England in your approach?

A. We did as much as possible, yes.

Q. Now, one specific question that has arisen time and again, which you may well be able to help us with, is in relation to the Welsh adoption of the NHS England app, or NHSX app. We know that Wales, unlike Scotland and Northern Ireland, did adopt the English app in late 2020.

Now, first of all, did you have any concerns in

Public Health Wales about adopting the English app?

A. Well, I think from fairly early on, we felt that the app was going to be an adjunct rather than a major, major part of our response. Our model for contact tracing was personal, someone speaking to another person, delivered by local teams who understood the local geography and culture.

And as the NHS app was being developed, there were concerns about, you know, it needed Welsh translation and basic Welsh-ifying, but also that it didn't follow exactly the same contact tracing guidance that we had. So we always recommended contact isolation, whereas there were some categories in England from the NHS app where people would be just asked to perform strict social distancing rather than isolation.

So we had that concern.

And then we were concerned that the data from the NHS app didn't then come into our contact tracing system. So the individuals would get some advice, but they weren't within our system, either for us to, you know, just know about them from the surveillance perspective but also from the perspective of the support that we would wish to give them.

Q. Thank you. Given those concerns, why did Wales or the Welsh Government ultimately decide to adopt the app?

A. I think it was really just because we thought that, you know, for certain sections of the community, it may be a helpful adjunct. But, you know, not a main plank of the response.

Q. Now, you've mentioned that contact tracing in Wales was delivered by local teams, and that's something, I think, that -- in fact if we can put up the plan again, your initial plan, INQ000056350, at page 3. And underneath "What needs to happen", we can see under the contact tracing heading:

"Contact tracing identifies individuals who have come into contact with an individual with COVID-19 ..."

You go on to say:

"The Plan proposes a three-tiered approach across Wales at a national, regional and local level. It will require very large numbers of people to be involved as local contact tracing teams. They will be managed locally and coordinated regionally ... [and that] Local authorities, health boards and other partners will be pivotal in leading and supporting local action."

Now, it's right that, as we've heard from other witnesses as well, that this differed from the approach in England.

Now, why was it? Why was it that Wales decided to choose a local contact tracing system?

A. Well, we -- you know, we felt that there was a clear advantage in having a local system where people would understand the geology, geography, and the culture within their local areas, and it was really growing out of the pre-existing arrangements. We had always worked very closely in terms of communicable disease management in the community with our local authorities, and they were very keen to be involved, and so something that was based on the local authority level supported by our health boards seemed to be a, you know, the best solution.

Q. Thank you. We can take that document off screen. Thank you.

In terms of, effectively, feedback of, if I can say it that way, or monitoring of how local health boards implemented tracing, is it right that they produced operational plans for the --

A. Yes.

Q. -- for Public Health Wales? And is it right that the lead strategic director and his deputy reviewed the plans in August 2020 and concluded that they didn't provide complete assurance of a whole of Wales system response for the next phase of the pandemic at that time?

A. Yes, that's correct. And feedback was given, and then

acted upon. Yeah.
Q. And when you say "acted upon", how were the problems addressed?
A. So the challenges in the different -- in the seven different responses were different. One was more -- was giving more of a sitrep of what the situation was and wasn't forward looking, and then others had had various gaps. And all those elements were fed back to the health boards who were the regional unit for them to address.
Q. Were the problems addressed, as far as you're aware?
A. Yes, yes.
Q. And just finally on tracing, I just want to ask you a question about backwards contact tracing. Because am I right that in October 2020, you provided advice to the Welsh Government's Test, Trace, Protect programme board which advised on the use of backward contact tracing?
A. Yes.
Q. And am I also right that the advice was effectively that full backward contact tracing was the best way to maximise the potential for effective contact tracing?
A. Yes.
Q. Do you recall what the response was to this advice?
A. So we put forward the advice around backward contact tracing because at that time, only 10% of cases had been

identified as a contact already. So we were aware that there was a lot of transmission going on that we were not picking up.

We were also aware that for most cases, actually led to less than one secondary case, but a few cases led to many secondary cases, and it was felt that those were driving the community spread, so-called superspreader events. And so backward contact tracing is going further back, as the name suggests, to try and identify the source of infection, and with a view to being able to identify the superspreader events and try and get on top of those.

Unfortunately, that requires very significantly more resource, because it identifies many more contacts, and I think the outcome was that backward contact tracing was felt not possible as a blanket approach but was definitely used in areas of, you know, high prevalence or to investigate particular situations.
Q. So it was implemented but only in specific situations?
A. Yes.
Q. Thank you. Now, then, if I can just move on to, as you may have gathered, isolation, and your role in relation to isolation.

Now, am I right that Public Health Wales advised on numerous occasions about changes to self-isolation

periods?
A. Yes, yeah.
Q. And I think you say in your statement, but we don't need to bring it up unless it would particularly help you, on 10 December 2020, 31 December 2021, and 28 January 2022, those were three changes to self-isolation periods.

Now, is it right that you didn't provide any specific advice on the first change in December 2020?
A. I don't recall such, no.
Q. You did provide advice on 31 December 2021 --
A. Yeah.
Q. -- in relation to allowing individuals to be released from isolation after day 7 if they had a negative test, and you provided advice again in relation to the third change.

Now did you also undertake, I believe, or commission research in relation to the impact of isolation?
A. Yes. Yes.
Q. If we can please get up on the screen INQ000056337.

Is this is an example of some research that was commissioned on 10 March 2021?
A. Yes.
Q. If we can turn then, please, to page 4 of that same document, and the third heading down, "Challenges of self-isolation", and the third bullet point, we see

there:

"The top 5 challenges contacts thought they would face during self-isolation were: Suffering from anxiety or mental health problems ... looking after children ... being concerned about the impact isolation will have on work or business ... experiencing financial problems ... and caring for vulnerable people who cannot stay with friends or family ..."

Then if we could then, please, go to page 6. Thank you.

And under the bottom heading, 1.4.2, we see "Developing and targeting support for those experiencing challenges whilst self-isolating", and there's -- if I can call it a recommendation, "[Providing] mental wellbeing and social support".

Then over the page to page 7, please.

We see three more recommendations in light blue -- sorry, just the second paragraph there. The second paragraph is:

"[Increasing] financial support and access to food and medications for those with precarious incomes."

So does it follow from this document that it was within -- first of all, it was within your remit to advise on the impact of self-isolation?
A. Yes.

Q. Does it then also follow that it was within your remit to advise on the necessity for, or indeed consequences of, support for those isolating?
A. I think throughout we were highlighting the issues and stresses the self-isolation caused for different groups, and giving a range of options to be able to mitigate some of those, to be able to make it easier for people to isolate. So within that comes a suggestion that increased financial support would help.
Q. Now, we know in fact that the Welsh Government did offer financial payments for those isolating, initially £500 and then it was increased to £750. Given in particular your recommendations and your findings in relation to people's concerns about their finances when isolating, were you asked to provide any specific advice as to the financial packages or support offered by the Welsh Government?
A. I'm not aware of whether we had a specific query about, you know, how much it should be or whatever like that.
Q. Would you consider that you ought to have been involved in those discussions?
A. I'm not sure that we should. I'm not sure that I can answer that question.
Q. Thank you.
Then if we can move on, please, to my final small

topic before we get on to lessons learned and recommendations, I just want to ask you about equalities and inequalities.
What steps, if any, did Public Health Wales take to ensure that Test, Trace, Protect, and indeed isolation support, was effective in relation to protected groups or those with vulnerable characteristics?
A. So, as we noted the -- with one of our studies -- we did a number of studies that looked at the impacts of various parts of the pandemic on different groups, including black, Asian, minority ethnic and people in lower socioeconomic groups, et cetera, and all of this was fed into the TTP programme in terms of -- to the local teams as well as to Welsh Government to try to make improvements as to how they operated and could reach all the different -- different sections of the community.
Q. And did you get any feedback from the local groups as to steps they'd taken, or was your role done at that stage?
A. We did -- I think we did get feedback, but I don't have that.
Q. Thank you.
Then just finally, if I can turn, please, to lessons learned and recommendations, you've very helpfully provided us in both of your witness statements with

a list of recommendations and lessons that you have taken from the pandemic and your experience. The Inquiry has those, and we will be taking those into account and using them going forward.
Having had some time to reflect since those witness statements, is there anything that you wish to add today?
A. I don't think there's anything that I want to add to the -- what's written down in the two statements, thank you.
Q. Thank you.
LADY HALLETT: Is there anything in particular you wish to highlight?
A. I'm not sure to what extent it is documented explicitly, but I would highlight the need for digital interoperability in the future, and also, as we have touched on this afternoon, the involvement in the four nations in UK decision making, as well.
LADY HALLETT: And when you say digital inoperability, between which different systems are we talking about? Systems around the UK or systems within Wales?
A. Um --
LADY HALLETT: Or all of them?
A. All of them, but specifically systems around the UK.
MS NAGESH: Thank you, my Lady. Those are my questions.

I understand that there are some questions from others.
LADY HALLETT: Thank you, Ms Nagesh.
Yes, I think Ms Parsons, who is -- if you look that way, there you are. You've probably got direct sight.

Questions from MS PARSONS

MS PARSONS: Thank you very much, my Lady.
Good afternoon, Dr Howe, I ask questions on behalf of the Covid-19 Bereaved Families for Justice Cymru. My questions are about delays in testing of healthcare workers, care workers and patients. That's the overall topic.
Firstly in relation to testing of care home residents and care home staff in Wales, Mr Drakeford recognised in the Senedd as early as 3 March 2020 that older people, especially those in care homes, were particularly vulnerable to Covid-19. That view that routine testing in care homes may therefore need to be prioritised was held by experts and, indeed, it was a view highlighted in a paper produced by the Welsh Government Office for Science on 29 April 2020.
On that date, the 29th, Mr Drakeford said this in the Senedd:
[As read] "The reason we don't offer tests to everybody in care homes, symptomatic and asymptomatic, is because the clinical evidence tells us there is no

value in doing so and that such testing would divert capacity."

He made a similar statement the following week, 6 May.

Firstly, Dr Howe, what is your view, from a clinical perspective, on Mr Drakeford's statement in the Senedd that there was no clinical value in asymptomatic testing in care homes?

A. So I think what he said was at the end of the sentence was "in care homes where there's no evidence of Covid", and I think that this was in a situation that the majority of patients would have had symptoms, and if there were no symptoms within the care home, it was felt that the likelihood, given the prevalence within the community, was very much that there would be no benefit from asymptomatic testing when there was no signs of symptoms.

Q. So it's confined, then, to if there is no symptoms in the care homes?

A. Yes, I think that -- the expectation, I think, was at that point that Covid being present within a care home would be identified through the presence of symptoms.

Q. Right, but what was your view, from a clinical perspective, on that statement that there was no value?

A. I think there was limited -- there would have been

limited value at that point for testing if there was no signs of infection within that care home, and it was at around this time that there was whole home testing, including asymptomatic individuals, if there was signs of Covid within the care home, but if there wasn't any sign, routine testing of all residents and staff was not being performed.

That started, you know, the routine staff testing started on 15 June.

Q. I won't dwell on this point for much longer because we have other points to cover, Dr Howe, but as to the chronology of routine testing for care workers in Wales, asymptomatic testing or routine testing was announced on 16 May, as I'm sure you know, implemented on a weekly basis on 15 June, and then on 4 December 2020, twice weekly routine testing. And given what we know about the particular vulnerability of people in care homes, do you think it should have been introduced earlier and more regularly?

A. At the time, there were challenges in terms of capacity, not just testing capacity, but also sampling capacity and the ability to deal with the results appropriately. If all those symptoms had been in place, then there would potentially have been benefit in testing earlier, most benefit significantly earlier during the earlier in

the first wave, lesser benefit as the community levels of Covid were falling.

We referenced the routine testing that was done from 15 June. In the week of 22 June, 9,700 asymptomatic staff were tested through the Lighthouse labs, and of those 9,700, only four were positive. And from a purely statistical perspective, you would expect, with the specificity of the test, if you tested 10,000 individuals, that you would get around about four false positives. And so statistically it was possible at that point that, you know, those four people who were identified were actually false positives, and that -- and this is just to give an idea of the fact that the -- you know, at a low prevalence, the number of cases to be picked up was relatively modest, but that --

Q. Dr Howe, I apologise for cutting in, but I've got other topics that I've been permitted to ask you about. That was June, the example you give, and obviously as we go further in 2020 we get to wave 2, and then a much greater prevalence of the virus.

I'm going to ask you now, please, about delays to routine testing of healthcare workers, which you have touched upon already in your evidence.

A. Yeah.

Q. And it was recognised very early on that asymptomatic

testing was of benefit, and the Inquiry heard evidence last week from experts that by April 2020, it was clear that asymptomatic testing of healthcare workers was absolutely essential, and you've referenced healthcare testing in Germany in April 2020.

The chronology as we understand it is this: 4 December 2020 the Welsh Government announce routine testing of healthcare workers; implementation begins on 14 December 2020, and in many cases, Dr Howe, it isn't in fact implemented until March 2021.

Now, given what we know about the value of testing healthcare workers, in particular in relation to preventing nosocomial infection, do you think routine testing of healthcare workers should have been introduced sooner?

A. So I think that the big change that happened in November was the availability of lateral flow tests, and that meant that the testing could be delivered at much greater volume and much more effectively in November. And, you know, we were able to take advantage of that and introduce the healthcare worker testing.

Q. So you don't think it should have been introduced sooner or you do?

A. If we had the resource, and particularly lateral flow tests that could effectively test for whether people

were infectious, then I think there was -- there would have been benefit in testing earlier.

Q. I want to ask you about resourcing and testing capacity in particular, please, because in the evidence that the Inquiry has, and indeed in your statement, you talk about Wales's underutilising of its testing capacity.

I'll give you two quick examples before turning to the question: 6 May 2020, utilisation of 35% Public Health Wales laboratories, and January 2021, 24% of capacity.

So does that not suggest, Dr Howe, that, actually, there was a huge amount of capacity that was under-utilised, and indeed testing could have been brought about or introduced much sooner?

A. So this was purely testing capacity that I was talking about, and you referenced, and that doesn't necessarily reflect sampling capacity or the capacity across the whole system to be able to support not only the sampling but dealing with the results. So there was not the capacity across the board to deal with what would have been a very significant increase in resource requirement.

So if we were to have, using PCR tests, introduced healthcare worker testing for 80,000 healthcare workers, just the processing prior to the laboratory would have

required something like 160 whole-time equivalent weeks of resource behind it.

You know, that's -- in the pandemic, that might have been possible, but that was -- sampling was being -- at the responsibility of the health boards.

Q. Dr Howe, just before we move on to the last topic, I think the answer to my question is you don't think there was the scope or the capacity to test routinely sooner, but did you in fact advise the Welsh Government to do so?

A. I don't recall formal advice to test healthcare workers, although we were involved in the advice that I referenced earlier in June 2020 to use excess capacity to test asymptomatic healthcare workers, and the health boards responded to the extent that we were in July testing 400 healthcare workers a week, and that increased up to 2,000 a week in October 2020. And they were focusing on areas either where there were outbreaks or areas where staff were looking after particularly vulnerable patients, such as bone marrow transplant units, et cetera.

Q. Thank you, Dr Howe. So I think the answer is that you provided advice, informal advice, and you used the word in your evidence "informal discussion", about asymptomatic testing; is that correct?

A. Yes, and --

Q. And was it advised to not test asymptomatically?

A. I don't think we advised to not test asymptomatically. We did raise the question of, you know, why would we be testing and what was the best way of achieving the necessary outcomes from testing.

MS PARSONS: Thank you.

My Lady, I'm very conscious of the time, may I touch briefly on the final topic and I'll be quick.

LADY HALLETT: Yes, if you can shorten it -- (overspeaking) --

MS PARSONS: Yes, I'll shorten it, my Lady. I'm most grateful.

LADY HALLETT: Thank you.

MS PARSONS: The last topic, Dr Howe, is routine testing of patients in hospitals, and we know from an Audit Wales report in March 2021 that that needed to be strengthened further, "Once tested on admission", I quote, "there has been no regular testing during a patient's hospital stay unless patients have developed symptoms", and then the report concludes that more should be done -- that more effective testing should be done, including more frequent testing during a patient's hospital stay.

And I think a Public Health Wales report of 23 September 2020 said that there is evidence to suggest

transfer of patients between wards and hospitals resulted in spread of Covid-19 to new areas in the hospital.

Just quickly then, please, Dr Howe, the question is this: given the high levels of nosocomial infections in Wales, are you able to help with why the Welsh Government didn't implement more frequent testing sooner of patients during a patient's stay in hospital? And is this something Public Health Wales advised or not?

A. I think the recommendation was from fairly on to test people who were symptomatic, and then -- when they presented to hospital, and then there was advice to test, asymptomatically, people who were coming in electively. It did appear from the Welsh Audit Office report that that was not -- that that had not been implemented by colleagues in the health boards, and then there was later advice on routine testing of hospital inpatients, which was initially at day 5 following admission, and then subsequently to every five days, and the update -- uptake of that by health boards was variable and we reviewed that in fact in 2022, and found that it was variable across the health boards as to how they had implemented that.

MS PARSONS: Thank you, Dr Howe.

Thank you, my Lady, I am most grateful for the time.

LADY HALLETT: Thank you, Ms Parsons.
Mr Thomas.
Mr Thomas is around there.

Questions from PROFESSOR THOMAS KC

PROFESSOR THOMAS: Good afternoon, Dr Howe. I represent FEMHO, that's the Federation of Ethnic Minority Healthcare Organisations.

In paragraph 546 of your witness statement, you note that data from sources such as passenger locator forms and other UK nations was not integrated into the contact relationship management system, and had to be manually inputted.

What efforts, if any, were made to integrate these data sources and what operational impacts did the lack of integration have on the delivery of Test, Trace, Protect programme?

A. So I think that it was difficult during the pandemic to make much progress with the data, automated data integration, which was the challenge. And so we had to rely on manual data entry, which was obviously time consuming. The impact was on the time and, at times, us having an incomplete picture of the situation.

Q. At paragraph 547, you state that the epidemiological reports, based on the CRM data, were used to guide strategies and advice.

A. Mm-hm.

Q. How regularly were these reports reviewed and adapted to reflect realtime changes in infection patterns or risk among different population groups?

A. So the situation evolved during the pandemic. I mean, epidemiological reports were given on a daily basis, and then more thorough reports on a twice-weekly and later weekly basis.

Q. Paragraph 549, you refer to SAGE's recommendations for essential data fields for test and trace systems. How did Public Health Wales assess its readiness in relation to the recommended data fields, and were there any gaps identified that required urgent remedy?

A. As stated in the statement, we went through the data fields as required by SAGE, and we were able to show that most of the data was already captured in Wales at that time.

There were one or two elements that were not captured --

Q. Gaps?

A. Sorry?

Q. Gaps. When you say one or two elements, there were one or two gaps?

A. Gaps, yes, there were one or two gaps that we then sought to remedy.

Q. How urgently?

A. I think as soon as we could.

Q. At paragraph 555, you highlight the poor completeness of occupation, place of work and ethnicity data in the CRM system. Given these gaps, how did they affect Public Health Wales's ability to evaluate adherence to or to assess the equity impacts of Test, Trace and Protect programme, particularly among ethnic minority or low-paid workers?

A. Yes, this was a particular challenge, and as your question implies, it did mean that we had some gaps in the information. We felt that we had a, you know, reasonable overall appreciation. However, as you say, we didn't have this information filled in as much as we would wish. And we fed this back to the local teams, because, you know, the reason that it was not filled in was because the contact tracers were very focused on speaking to contacts and telling them to isolate, and were not always collecting some of the important metadata that we were relying on.

So we fed that back to them, the importance of filling that in.

Q. At paragraph 558, you refer to efforts to improve the recording of ethnicity data in NHS systems. What concrete steps have Public Health Wales and its partners

taken since the pandemic to improve the recording and use of ethnicity data, and are these measures now embedded in routine surveillance or emergency planning?

A. Yes, so in our IT systems that we're now using, and as -- and we're also seeking to procure a new system, a replacement to the Tarian, of which we've spoken earlier, in that, and our current systems, a number of these fields have been made mandatory, so that staff have to, you know, record a response.

Q. I now want to move on to another theme, which is lessons learned.

What lessons were learned from the data reliability issues with postcodes, addresses, ethnicity and international travel in the CRM system, and the lack of integration of certain data sources?

A. So I think that the lesson that isn't necessarily learnt but is to be learnt, as I said earlier, is, you know, that data interoperability is key. We have made some steps in terms of what I've said earlier around mandatory fields, to try to improve some of the information that we collect, but being able to move it between different systems I think will be key in the future.

Q. Let me move on. I want to do these last three questions very swiftly, if I may.

What changes would you recommend to improve data accuracy and completeness in future public health programmes and ensure better integration of data in future contact and tracing of healthcare systems, surveillance systems?

A. So I'm not sure if I am misunderstanding the question, because I'm not sure that I've got anything to add over what I've said --

Q. All right.

A. -- around interoperability and, you know, ensuring the data capture in the first instance.

Q. Given the operational challenges caused by the lack of integration that we looked at of certain data sources, passenger locator forms et cetera, what improvements would you recommend to ensure better integration?

A. And again, it's similar, but it needs a review of all the different systems, because it potentially might not be recognised which systems do need to be integrated, but across the board, integration or interoperability more, I think is the answer to the question.

Q. Okay. Any specific recommendations you would make to improve the consistency and accuracy of ethnicity data recording in the NHS public health systems to ensure more equitable and inclusive pandemic responses in the future?

A. I'm sorry, I don't have anything to add. I think it's key information because it enables us to understand the impact on different parts of society, and it really should be a priority for the future.

Q. Finally this: in the light of the challenges faced with aligning data fields with SAGE recommendations, are there any steps that could be taken to ensure that future public health systems are better prepared and more adaptable in terms of data collection and analysis that you can suggest?

A. Well, as I referenced, you know, we are looking at a refreshed system in Wales and all these issues are well acknowledged, that, you know, for the future.

PROFESSOR THOMAS: Dr Howe, thank you.

My Lady, sorry for racing through them.

LADY HALLETT: No, don't worry. Thank you very much, Mr Thomas. I'm very grateful.

Dr Howe, that completes the questions that we have for you. You have spoken about the time during the pandemic very calmly, but that's probably your professional training. It must have been enormously pressurised for you and your colleagues, so thank you very much for all that you did and your colleagues did to try and keep the people of Wales safe. I'm very grateful to you for that work and of course for helping

the Inquiry.

THE WITNESS: Thank you.

LADY HALLETT: Very well, I shall return at 3.35.

(3.21 pm)

(A short break)

(3.35 pm

MS CARTWRIGHT: Good afternoon.

My Lady, please could Oliver Munn be affirmed.

MR OLIVER MUNN (affirmed)

LADY HALLETT: I hope you were warned that you were last on today, Mr Munn.

THE WITNESS: Yes, my Lady.

Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 7

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

A. My name is Oliver Munn.

Q. Mr Munn, quite unique in this Inquiry, you have provided a one-page witness statement to the Inquiry dated 30 April 2025. Can I ask you, first of all, to confirm that the content of that statement is true to the best of your knowledge and belief?

A. It is.

Q. And in reality you are, by this statement, confirming that the statement of Jessie Owens dated 15 April 2025, who was the corporate witness for the Cabinet Office,

was true to the best of your knowledge, as well, and belief.

Perhaps if we just briefly identify, at page 108, please, the signature and date of the statement of Jessie Owen, please. Thank you.

But essentially, you've adopted this statement now as your own and so, for all practical purposes, you are the corporate witness.

A. That's right.

Q. Thank you. So can we then start with identifying yourself, please. You tell us that you're a former senior civil servant who had the role of director, testing and tracing delivery, in the Covid taskforce within the Cabinet Office from 28 April 2020 to 25 February 2022.

A. That's right.

Q. And I think it's right that prior to joining the taskforce in the Cabinet Office you were not -- you were in the private sector; is that correct?

A. That's right.

Q. So we need to bear in mind that you only arrived 28 April 2020.

A. **(Witness nodded)**

Q. Thank you. And you tell us that essentially you were in that role for the two years to the February of 2022, but

thereafter, you were part of the UK Health Security Agency's director general Health Protection operations from 2022 to 2024?
A. [No audible answer]
Q. And can you help us identify, because I think you're back in the private sector now, when in 2024 did you leave UKHSA?
A. On 31 March 2024.
Q. Thank you. So can we thank you for, notwithstanding that background, agreeing to speak to the corporate witness statement on behalf of the Cabinet Office.
But perhaps before we identify the role of the Cabinet Office, can we just understand, then, as the director of Testing and Tracing Delivery in the Covid taskforce and the Cabinet Office, can you give us an idea what that practically that meant day-to-day when you first joined in April of 2020, please?
A. Well, in April of 2020, NHS Test and Trace had not been set up. It was still a period where things were moving very quickly and, indeed, I didn't join on 28 April with the title director of Testing and Tracing Delivery because at the time things were so fluid that portfolios would change day-to-day and so in my first week I remember I did something on transport and something on test and trace and something on businesses, and it was

only really over the course of May that my portfolio became defined as everything relating to testing, tracing and isolation.
Q. So taking that date, then, of around May when you then became the director for testing and tracing, can you just give us some idea, bearing in mind we're going to look at the roles of different departments they had in supporting the work of, particularly, the Test and Trace system, what were you actually doing day-to-day, just to give an idea practically of the involvement of the Cabinet Office and you in particular?
A. So the Cabinet Office corporate statement refers to three roles that the Cabinet Office played, one of which was the critical friend role, and, my Lady, I spoke to test and trace colleagues pretty much every day for two years, and ensured that I was aware of exactly what they were doing, where they were going, fed into their strategy, updated them on the government's broader Covid strategy so that everything test, trace and isolate related fully tied into where the government was and was going on non-pharmaceutical interventions, vaccination, et cetera.
The Covid taskforce also played an important role in relation to collective agreement and the process of ensuring that decisions were properly taken by

ministers, and so the taskforce was the secretariat for the Covid-O, Covid Operations Committee, that ministers used throughout the pandemic to make decisions. And in that regard, I and my team would sometimes draft papers for Covid O to consider on testing, tracing and isolation matters, or at least draft the chair's briefs for the chair of Covid-O and the CTL.
Q. Thank you. Can we then, please, turn into the statement INQ000587352 at paragraph 2.5, please, just to make sure we are clear before we get into the detail of the role of the Cabinet Office, please.
So it's paragraph 2.5 on page 7 of the statement of Jessie Owen INQ000587352, please. Thank you.
At paragraph 2.5 you detail that:
"Throughout the pandemic, including in the context of work relating to TTI, many decisions rightly continued to be taken within individual departments. Where collective decisions were not required, the role of the Cabinet Office was, as is typical for the centre of government, focused around strategic coordination, ensuring collaboration between the relevant parts of government, assuring progress and providing challenge to help strengthen policy making and ensure alignment with the Government's overarching strategic objectives."
And then if we move down, please, to paragraph 2.7,

you detail that:
"The Cabinet Office also had 'responsibility for coordinating the Government's response to crises', working closely with the lead government departments."
Just pausing there, it's right, I think, you identify that the Lead Government Department for test, trace and isolate was the Department of Health and Social Care; is that correct?
A. Correct.
Q. So can you then help, when you describe that the Cabinet Office has that lead in respect of crises, how that operated in practice in respect of test, trace and isolate, please.
A. The Cabinet Office, and through the Civil Contingencies Secretariat, that I think you heard about in Module 2, my Lady, plays an important role in planning for crises, and in the early stages of the crisis in the coordinating the central response, but, as I think Lord Sedwill in his evidence in Module 2 made clear, the aim is then to hand over to the Lead Government Department as quickly as possible, and so responsibility for testing, tracing and isolation was obviously the responsibility of DHSC, and it was rightly for DHSC to lead the planning and operationalisation of TTI.
Q. Thank you. Can we just highlight another number of

paragraphs that perhaps help understand the dynamic that operate between the Cabinet Office and the Department of Health and Social Care.

Paragraph 2.18, please, at page 9, you detail that:

"The Cabinet Office was not and would not have been expected to be routinely involved in the detailed TTI work led by [the Department of Health and Social Care] and its agencies, for example, establishing, maintaining or monitoring infrastructure, laboratory capacity, testing technologies or other associated capabilities, nor would the Cabinet Office be expected to assess overall UK preparedness to develop and scale diagnostics for a given disease. This more detailed preparedness work would fall under the responsibility of [the Department of Health and Social Care] as the [Lead Government Department]. DHSC and its executive agencies, notably the UKHSA [which we know came on latterly and was operational from October 2021], would therefore be best placed to summarise and comment on the adequacy of the TTI policies and strategies in place prior to the onset of the COVID-19 pandemic."

A. I think this paragraph relates specifically to preparedness, and so what it's saying is that the Cabinet Office would not and would not have been expected to be routinely involved in detailed TTI work

by DHSC before the pandemic came along, hence why there are several references to preparedness within the paragraph.

Once the pandemic had come along and that TTI was a big part of the government's response, and -- the Cabinet Office was very close to TTI work being led by the department, obviously not in the lead role, but as I mentioned we were having daily conversations with them and ensuring that what they were doing was fully coordinated with the rest of the work of government.

Q. Thank you.

Then perhaps just to highlight some additional paragraphs, paragraph 2.37, please, at page 14. Thank you. The statement details:

"As was the case throughout the COVID-19 response, one unique role of the Cabinet Office was its work to consider and provide advice to ministers on the trade-offs of different TTI approaches. Whereas the focus of other government departments centred around, for example, the impacts of TTI policies on health (for DHSC), the economy (for [Her Majesty's Treasury]) [at that time] or specific sector-based impacts (for other government departments), the Cabinet Office's role at the centre of government was to look across the board and support decision-makers to understand and balance

where possible the trade-offs of different response options."

Is there anything you want to add in respect of that?

A. No.

Q. Thank you.

And then significantly you then identify at paragraph 2.38 that:

"The Prime Minister, [Mr] Johnson, remained close to this work throughout the pandemic, including through regular, often weekly, meetings with Baroness Harding, as Chair of NHS [Test and Trace], and others closely involved in TTI work including the Health Secretary, the Chief Scientific and Medical Advisors and other officials, which focused on a range of issues from the ambition to roll out a mass population testing programme ... to community testing and surge testing in specific settings and geographical areas."

And you also detail:

"In addition, Baroness Harding on occasion provided updates on the progress NHS [Test and Trace] to the Prime Minister and the Cabinet Office."

Pausing there, can you assist us, because we know that when Baroness Harding was the chief executive of NHS Test and Trace there was a unique reporting

structure initially until the December of 2020, where essentially she reported directly to the Prime Minister, and so can you help us understand that structure set against the lead department being the Department of Health and Social Care, please.

A. Yeah, absolutely.

And Ms Cartwright, you mentioned the word "unique", I actually don't think it's unique because the chief executive of NHS England had exactly the same arrangement reporting directly in to the Prime Minister rather than the Health Secretary, and so actually, I think it was quite a parallel arrangement to that with NHSE before its recent abolition.

I wasn't involved in the decision to appoint Baroness Harding or to make her report in to the Prime Minister rather than the Health Secretary, but I can only speculate that the Prime Minister was trying to make clear that he was very personally invested in this work and that that would send a message across Whitehall that Test and Trace was a foremost government priority and that other government departments should do all they could to assist it in its work.

Q. Thank you. And so, in correcting me in describing it as a unique reporting restriction, we know that that reporting directly to the Prime Minister came to an end

in December of 2020, so can you help us understand, then, why that shifted after December 2020 and then it went back to reporting essentially to the Health Minister in the Department of Health and Social Care?

A. So that was a decision made by the Cabinet Secretary, and I can't pretend to know exactly what was going through his mind in determining that, but by way of context, I can tell you that the Secretary of State for Health had been very, very closely involved in all of the work of Test and Trace since the very beginning, and that Baroness Harding, who you'll be hearing from tomorrow, was speaking to the Health Secretary all the time on everything and that submissions that Test and Trace was preparing were going through the Health Secretary for his approval. So I think, although the formal reporting line may not have changed until December 2020, in practice, the Secretary of State for Health was all over every aspect of NHS Test and Trace's work from the very beginning.

Q. Thank you. Can we, then, please, look together at paragraph 3.2 on page 28, please.

Thank you.

Now, you detail there under the "Development of Test and Trace":

"As explained in Section 2, in line with the [Lead

Government Department] model, the [Department of Health and Social Care] is responsible for public health protection and responding to emerging infectious diseases. At the outbreak of the pandemic, therefore, the Cabinet Office ordinarily had limited involvement in policy and strategy work relating to TTI."

Can you assist, then, we've already looked together that the Cabinet Office was responsible for coordination across government departments in response to crises, working closely with lead government departments, and this would have included with regard to Test, Trace and Isolate; would you agree?

A. Yeah.

Q. Thank you. And if we look at paragraph 3.5, please, it details:

"In this early stage, the Cabinet Office worked to understand the progress of test and trace work across government in order to update and provide advice to the Prime Minister, and to understand where further support from central government may be needed. The Cabinet Office was not, however, closely involved in [Public Health England [or the] Department of Health and Social Care's] detailed work in this initial period to test, trace and isolate contacts, nor is the department able to comment on how any existing capacity, infrastructure

and policies and capabilities were used to respond to the initial cases of the novel coronavirus."

And so can I ask you then, why is the Cabinet Office not able to comment on how existing infrastructure and capacity was utilised in the early stage, especially given its central coordination role in times of crises?

A. The central coordination role that you describe, led by the Civil Contingencies Secretariat, involves assigning actions and being clear on owners and assessing progress across a waterfront of the crisis response, but those actions, those owners, sit in nine departments in the nine -- in the Lead Government Department for each of those activities, and the Civil Contingencies Secretariat is not staffed to man mark, for want of a better phrase, each of those workstreams being led by departments.

As we might get on to, it became clear in the spring of 2020 that the centre of government needed to grip a wide range of department-led initiatives, and so a Covid taskforce was created within the Cabinet Office over the spring of 2020, precisely to provide the kind of close involvement that the Cabinet Office had not been resourced to provide in January, February of 2020.

Q. Thank you. Now, that may partially answer the next question, please, Mr Munn. Do you accept that as part

of the Cabinet Office role in advising the Prime Minister, it would have needed an understanding of what infrastructure actually existed at the outset of the pandemic? So I think you've dealt with the spring, but would you agree that it would have been far better if there was that information known about the infrastructure in the January of 2020?

A. The Cabinet Office would be reliant on the relevant government department to provide it with information on the state of preparedness in its area or the actions that it was taking. And so in those early days before the Covid taskforce was created, the Civil Contingencies Secretariat would have been commissioning the Department of Health and Social Care for updates on the testing and tracing infrastructure that they had in place, how it was expanding, et cetera. It would have been receiving updates from DHSC, but would not have been in a position to do much more than pass on those updates to the Prime Minister and certainly wasn't in a position, as was the case later when the Covid taskforce was established, to have real subject-matter experts who knew all about testing, tracing and isolation sitting within the Cabinet Office and who understood, you know, the various nuances and complications of operationalising a TTI system.

Q. Thank you.

I'll take you in a moment to a passage in Mr Johnson's statement by reference to the Civil Contingencies Secretariat just for reference, but briefly before doing that, do you accept that the United Kingdom's lack of infrastructure for testing at scale would have been obvious to the Cabinet Office from January 2020 had comprehensive enquiries been made in that early stage?

A. As we covered a few moments ago, I joined the Cabinet Office at the end of April 2020 and so it's difficult for me to state with any certainty what the Cabinet Office should or shouldn't have known in January. What I do know is that from the documents I've reviewed in preparing for this meeting, that the Cabinet Office did ask DHSC for various updates in January and February of 2020 as to what testing capacity was in place and could be put in place, and received those updates. I can't tell you to what extent they had the resources or the knowledge to really scrutinise the responses they got back.

Q. Thank you; can we then briefly look at a passage in Mr Johnson's witness statement that he's provided, please.

Which is INQ000587378. It's page 9, paragraph 22.

Thank you.

We can see that he details in this statement:

"I remember that I was told that we had an excellent system for testing and tracing contacts although I cannot now recall who said this -- I think I was told it many times by many people."

Then it goes on, effectively:

"As an example of a document that gave me this reassuring message about our preparedness ... on 28 February 2020, the Director of the Civil Contingencies Secretariat sent me a briefing note prepared in consultation with the CMO and GCSA on the UK's preparedness ... The note said that our '[p]reparations are well underway' and '[w]e continue to be ready with to deal with ...many more if the outbreak escalates' ... '[o]ur NHS has tried-and-tested systems to quickly identify and isolate those who may have Covid-19'."

Thank you. Can you assist, why did the director of the Civil Contingencies Secretariat send Mr Johnson this reassuring message about the state of preparedness, rather than inform him that there was, in fact, a lack of infrastructure and capability? Can you assist with that, please?

A. I can assist by providing context. As I mentioned,

I was not an employee of the Cabinet Office at the time, nor even a civil servant, and I have never worked in the Civil Contingencies Secretariat, so my knowledge of that process is secondhand, but I can only assume that the director of the Civil Contingencies Secretariat had received from DHSC a reassuring update endorsed, as is mentioned, by the CMO and the Government Chief Scientific Advisor, and had passed that on to the Prime Minister. I'm afraid there's not much more I can add.

Q. No, thank you.

Perhaps, then, if we can go back into the witness statement, please, at paragraph 1.8, so it's the INQ000587352, page 2, paragraph 1.8, we can see that in fact the position that is now detailed is:

"At the outset of the pandemic, the UK had very limited capability and infrastructure to test for cases of the novel coronavirus and trace their contacts. Setting up a test and trace system on the scale and at the speed demanded by the virus posed an unprecedented challenge. The UK Government worked to meet that challenge in collaboration with the wider public sector, [including] industry, academia, local government and others."

And so identifying that unprecedented challenge,

when did it become clear to the Cabinet Office that there was very limited capability and infrastructure? Can you assist?

A. All I can tell you is that when I arrived on 28 April, I think that was the feeling within the Cabinet Office. I suppose what you're asking is at some point between the notes to the Prime Minister at the end of February, where the message from CCS was there's infrastructure in place, and my arrival at the end of April, the message changed, but I am afraid I can't tell you within that two-month window exactly when that feeling changed. And obviously the Cabinet Office is a big organisation and different people would have had different views at different times.

Q. Thank you. But would you agree with the principle that the role of the Cabinet Office should have been to advise the Prime Minister of this lack of infrastructure and capability as early as possible?

A. Absolutely.

Q. But you can only really speak to that that plainly had been identified when you came along near to the end of April?

A. Correct.

Q. Thank you.

Can we then, please, move forward again to

paragraph 3.8 at page 29, please.

And perhaps before doing that we'll start at 3.7, please. The statement details:

"By mid-March 2020, at the time the World Health Organization (WHO) was encouraging countries to 'test, test, test', concern was being raised within No.10 about the UK's ability to scale testing to the levels required to respond to COVID-19, particularly in relation to limitations in PHE's capacity for operational delivery of testing and contact tracing on a large scale."

Then if we move then to 3.8 you detail that:

"On 14 March 2020, CDL" -- is that the Chancellor of the Duchy of Lancaster?

A. That's right, Michael Gove at the time.

Q. Thank you. Obviously as a member of the cabinet:

"... chaired a meeting to explore ways that the Cabinet Office could Help DHSC to increase testing capacity ..."

Can I ask you, do you accept that there was no attempt by the Cabinet Office to have a high-level meeting with the Department of Health and Social Care on the subject of test and trace specifically to understand the UK's readiness and detail until this meeting of 14 March 2020?

A. Whilst I'm not aware of any other attempts, I cannot

categorically state that there were none.

Q. Can you assist, then, if the Cabinet Office did not undertake sufficient detailed work to understand the progress of test and trace until March, but is it -- does it look more like that the Cabinet Office was accepting the assurances at face value from the Department of Health and Social Care without examining or scrutinising capability and infrastructure?

A. The processes of the Civil Contingencies Secretariat, as I've mentioned, are not a process I'm familiar with. They obviously go out to the department asking them for their plans and their preparedness and they receive them. I imagine that they do more than just, you know, passing them on to the Prime Minister and saying, "We've received this and here it is", but I'm afraid I don't know the level of scrutiny that they apply, or the extent to which they dive into the responses they receive from departments.

Q. Thank you.

Can I then, please, briefly ask you about some evidence that we're going to hear from on Friday from Professor Pillay, and it's one of the documents in the pack, it's INQ000475152.

That's INQ000475152 and it's page 4, paragraph 15, please.

This is on capability.

A. Mm.

Q. Thank you.

We can see detailed there that Professor Pillay details:

"... there remained considerable expertise through local Directors of Public Health and outbreak control teams. Despite this, the immediate COVID response involved very significant investment in a series of outsourced functions, rather than using such resource to rebuild existing [infrastructure]."

And similarly, the Inquiry has a statement from Lord Bethell that similarly comments upon the preference to use Directors of Public Health's knowledge.

So can I ask you, do you agree that the UK's lack of sufficient localised infrastructure for test and trace hampered its ability to deliver a Test and Trace Programme despite Directors of Public Health, expertise and local teams?

A. Let me say that Directors of Public Health have a huge amount of expertise and often are extremely accomplished and talented people. They lead public health teams within local authorities that have faced consistent resourcing and budgetary challenges, and it is not the case, in England today, and it certainly wasn't in 2020,

that we have a well-resourced local public health layer that, you know, can be deployed at short notice to do all sorts of extremely ambitious things. There are extremely talented people in public health departments in local authorities across the country but they are operating on very limited budgets and they often have considerably smaller headcounts than they had historically and so, unlike some other countries where contact tracing in particular was sent to a subnational level, and I'm thinking particularly of federal countries like Germany or the US which had well-resourced, high-budget public health departments at a regional level, England does not have that. It has 152 public health teams at local authority level, some of which cover really very small areas, all of which face massive budgetary challenges in the context of local authority finances.

And so whilst there are some exceptionally talented and hard-working people working for Director of Public Health and as a Director of Public Health, they are not a well-resourced function that can easily be activated to deliver huge, very ambitious contact tracing as was required -- (overspeaking) --

Q. Can you assist, considering the United Kingdom's Civil Contingencies Act framework which emphasises the role of

local responders as the building block to response, did the Cabinet Office liaise across departments to identify and build up the localised infrastructure early on in the pandemic?

A. When NHS Test and Trace was launched on 28 May, it was a very national operation, and fairly quickly transitioned into a mix of national and local and indeed, by August 2020, local tracing partnerships were announced, I believe on 10 August 2020, and the Cabinet Office was certainly supportive of that move to better involve Directors of Public Health and local public health expertise to ensure that contact tracing was more effective and made better use of local knowledge.

Q. Thank you. But obviously that seems slightly later on in the chronology. I wondered if you could assist, before we get to what was announced in the May, whether you're able to assist from the April when you were in -- sort of arriving in the Cabinet Office, was there consideration being given about this existing local resource with the expertise that existed in Directors of Public Health?

A. I think there was knowledge in the Cabinet Office that Directors of Public Health were in place across the country and often brought tremendous talent, energy and enthusiasm to their roles. What DHSC was tasked with

assembling over the course of May 2020 before its announcement on 28 May, was a large-scale contact tracing operation that could handle the many, many thousands, tens of thousands of tests -- of cases a day that were forecast, and so they put their focus on building a large, scalable central operation at first, before then transitioning fairly quickly in the following months to a mix of national and local, to ensure that they were making best use of the expertise that was held at local level.

Q. Thank you. Then can I ask with referencing obviously the large-scale testing and therefore the large-scale central contact tracing, was any thought given about the fact that this was outsourcing to companies with no experience or relevant expertise or local knowledge, in terms of whether that was the best way to go for this centralised contact tracing, rather than utilising the local contact tracing?

A. The first thing to say from a Cabinet Office perspective is that that was a decision for the Lead Government Department, the Department of Health and Social Care. And so the Cabinet Office would not that have had a direct role in that. But I would add by way of context, we were looking at tens of thousands of contact tracers that needed onboarding, and local public health

teams who already have a large number of existing and ongoing responsibilities, did not have tens of thousands of people sitting around waiting to be -- to have new responsibilities given to them.

Q. Thank you. Can we then, please, just look on the chronology, and I appreciate we're just picking issues and themes out of the full chronology context that your witness statement provides, but can we please look at paragraph 3.22 where you detail, at paragraph -- sorry, page 39, paragraph 3.22.

You detail there the announcement of the 2 April 2020, when Mr Hancock the Health Secretary announced the 100,000 testing target across the UK by the end of the month. And can you assist, did the Cabinet Office play any role in the identification of the need to increase testing to be 100,000?

A. Well, later in that paragraph it says:

"... Dominic Cummings notes that he and the Prime Minister had told the Health Secretary to aim for 100,000 tests per day."

So from that I conclude that the Cabinet Office, or Number 10 as part of the Cabinet Office, was very supportive of a stretching testing target.

Q. So can I ask with obviously identifying that Mr Cummings and Mr Johnson had been involved in that, do you accept

that the Cabinet Office was under a duty to clearly advise that the target was wholly unrealistic rather than simply encouraging rapid extension of -- expansion of testing capacity?

A. It would have been for DHSC to judge whether it was realistic or not. The role of the Cabinet Office and, I think, the role of the Prime Minister as he'd have seen it, would be to challenge departments to aim high, and that's what he did with that 100,000 target. And to the point that it was wildly unrealistic, it was met, which suggests that it was not wildly unrealistic.

Q. Thank you. Now I'm going to move on now to the creation and establishment of NHS Test and Trace. Can we briefly look, please, at the terms of reference which is INQ000198082. INQ000198082. Thank you.

We can see there the Test, Track and Trace Ministerial Taskforce terms of reference and I think at this point we can see the membership included Dido Harding as the chair. And if we move through, we can see that, as required, please, a little further down, we only have "As required" that Number 10 would be involved.

And then over the page, I think it identifies as what you've already told us -- we can keep moving down -- that the Cabinet Office had the secretariat role

of those meetings.

And so without a standing member in the taskforce can you assist us as to why the Cabinet Office was only the secretariat on those meetings, please?

A. I think it's important to give some context on this taskforce. It was announced on 7 May, and by 28 May had been superseded by the creation of Test and Trace, so it existed for no more than three weeks.

Q. Yes.

A. And I've asked the Cabinet Office which, as you say here, was the secretariat to look through records and they have confirmed that they have no evidence that this taskforce ever met in its form. So I think this taskforce is a bit of an irrelevance, if I'm honest.

Now, it's true that, you know, these stakeholders remained involved, but the notion of the taskforce as described in these terms of reference I think was quickly overtaken by events.

Q. Thank you.

Well, then can we look at an email that I think -- looking, from the appointment of Baroness Harding on 7 May, at an email of 18 May, just to try to understand something that you were involved in.

It's INQ000195932, please. That's INQ000195932. Thank you.

And so this is an email of 18 May 2020. So almost -- just over a week before the announcement of the NHS Test and Trace strategy which was then going to be implemented on 28 May. And we can see that you're one of the recipients of this e-mail.

A. Mm-hm.

Q. And essentially we just move through the policy. If we look at the punchline:

"Punchline is that most of the big design questions remain unresolved -- with some pretty fundamental differences of view as to what this programme is trying to achieve, and by when."

And then we can obviously see reference to the app. And:

"It won't involve the app ..."

So this is 18 May suggesting that the app wouldn't be involved.

"... it won't be very good, but she [Dido Harding] thinks she has agreed with Chris and Patrick that it will be 'good enough' to begin with, if coupled with the JBC being able to implement effective ... measures."

And again, if we go over the page -- the time doesn't allow to go through the detail of this, but if we go over the page, please, we see "Questions outstanding", and they include relating to strategy,

speed and scale, fundamental questions about isolation, about -- then over the page -- asymptomatic contacts and testing, enforcement. And again in respect of the app on page 3. Questions about what was the hurdle to the app to make comfortable enough to launch it. And again over the page, questions around sort of further issues of testing and capacity.

And so can you help us, we know that this is 18 May with some fairly fundamental concerns being expressed about the strategy of test, trace and isolate, can you help us understand this in the context of then what happened at the announcement on 27 May? Was test, trace and isolate at this stage in a very poor state?

A. Let me first say that I think this -- you were asking earlier about the role of the Cabinet Office vis-à-vis DHSC.

Q. Yes.

A. This is a wonderful example of the role of the Cabinet Office versus DHSC, which is to say the Cabinet Office asking difficult questions, including big-picture difficult questions, and tasking them to the DHSC.

And you'll see in this email it's -- Tom Shinner writes:

"I've agreed with Dido that if we give her ... seven days, they'll come back with that they think the answers

are."

Which is exactly the role that the Cabinet Office should and did play. I mean, it's clear from this email on 18 May that Tom Shinner, as well as others who he references, and I am among them, still had some concerns over whether Test and Trace was going to be ready to launch promptly. But to give full credit to Baroness Harding and her team, they engaged with these questions promptly and came back with answers, and there were a series of discussions over the following week which got us into a place collectively where we were happy to go ahead with the launch of the Test and Trace service on 28 May, just ten days later.

Q. Thank you.

Now, there's two references to the app, and essentially this seems to be identifying that it was not going to be ready, but can you assist, then: when the announcement was made of NHS Test and Trace, and the public announcement on 27 May, it indicated that to complement the rollout there would be the NHS Covid-19 app that was predicted to follow in a couple of weeks or in the coming weeks, and we know in fact that it wasn't rolled out until 24 September 2020, so four months later.

This email seems to suggest that the significant

issues with the app were still not dealt with. Can you help as to why, then, it was expressly referenced as being almost imminent on 27 May?

A. I think by 27 May, apps had already been rolled out in various European countries, and the Prime Minister and the Health Secretary felt the need to say something about an app. But you're right: on 27 May, the app was not ready to go and it would -- as we know, it would take several more months for it to be ready to go, but I think ministers wanted to signal that that was the desired direction of travel and that we weren't ignoring what others were doing in other comparable countries and that we wished to make use of all the technology available to ensure an effective testing, tracing and isolation system.

Q. Can I ask you, was there not an issue, though, of public trust then in suggesting that the app was about to be rolled out in the next couple of weeks? Would it not have been better to be more open about the stage that the Covid-19 app was at, rather than, in the rollout of NHS Test and Trace, almost heralding that the app would be with us in a couple of weeks?

A. It's a good question and a question that comms professionals within Number 10 would have doubtless considered. I mean, I don't -- my memory is not good

enough to know whether, on 27 May, we were clear how far away the app was. I think we all thought the app was going to come sooner than it did.

There had been a successful trial on the Isle of Wight in April or May 2020, and so I think that, you know, if you'd have asked the average person within the Cabinet Office or Number 10 "When is the app going to come?", they wouldn't have said as late as 24 September, but I would say the Cabinet Office was -- broadly supported the principle of getting the app right before rolling it out, and you will see emails from Tom Shinner, from Ben Warne and others saying there was a very real risk of going live with an app that wasn't ready, that would lose public confidence, and you only really got one opportunity to launch it and drive take-up, and that if an app was rolled out prematurely that was unstable or not functional, that would destroy public confidence in the app.

And just one thing I'll say is that the effectiveness of the Bluetooth app is proportionate to the square of the number of users. So you double the number of users, you have an app that's four times more effective. Hence it's incredibly important that you get high take-up. And that's why there was a real desire from the centre to ensure that the app was not launched

until it was ready to go.

Q. Thank you. Can I briefly, then, ask you about just two paragraphs. There are others where Baroness Harding in her witness statement comments upon the role of the Cabinet Office.

But please can we display INQ000587322, at page 21, please. That's INQ000587322, and it's paragraph 5.10.

We're going to hear from Baroness Harding tomorrow, but because the Cabinet Office are referenced, I wonder if you can assist at all. We can see at 5.10, its detail, for example:

"... NHS [Test and Trace] faced various difficulties in obtaining HMT and [Cabinet Office] approval for Lighthouse laboratories in the summer of 2020 ... and this meant that the approvals process for the expansion of the Lighthouse network took far longer than it should have in the circumstances. Had [NHS Test and Trace] had greater delegated procurement authority during this time, this would likely have reduced the capacity issues we experienced in the autumn."

So can you assist, the criticism of the delay, then, in the later rollout of the Lighthouse laboratories, seems to be referencing difficulties in the Cabinet Office approval. Can you give us some context to whether that's accurate as to the assessment made by

Baroness Harding, please?

A. Of course. In Module 2, Lord Sedwill, the former Cabinet Secretary gave evidence to the Inquiry, and I think he very aptly described the dual roles of the Cabinet Office. The first is to coordinate cross-government action on the Prime Minister's top priorities, such as Covid, and the second is to act as a shared service provider across government on things like digital, legal, commercial, HR, et cetera. And I think what you see here is the second of those.

So I was in the Covid taskforce which was very much in the first of those, but there is a Government Commercial Function as part of the Cabinet Office that is charged with ensuring that departments follow commercial best practices and commercial rules in order to deliver the best possible value for money to the taxpayer.

And I think what Baroness Harding is referring to here is that Test and Trace had to get approval from the Government Commercial Function and from the minister, who was Lord Agnew, for various spends, and that at times that process took longer than they'd have liked.

What I will say is that the Government Commercial Function moved very quickly compared to its usual pace, very much took on board the exceptional circumstances in

which we were operating, and was, broadly, very expeditious in getting approvals to Test and Trace but I think on these particular occasions there are some emails that suggest that Lord Agnew as the minister had some concerns and some questions that he wanted answering before he was willing to approve the sign-off.

My Lady, I believe you've heard from Lord Agnew in a previous module and you'll know that he had strong opinions on these topics.

Q. Thank you. And then briefly can I take you to the next paragraph of Baroness Harding's statement, please. 5.11. It's detailed:

"These challenges were further exacerbated by the inherently unpredictable nature of the pandemic. In December 2020, [NHS Test and Trace] was encouraged to move towards a more 'business-as-usual' environment and increase focus on value for money across the organisation (including in relation to procurement). Shortly afterwards, a new variant of the virus emerged which led to the standing up of new use cases such as the testing of hauliers at the border and of secondary school staff and pupils at very short notice and the need for a third lockdown. This meant that simultaneously [NHS Test and Trace] was being challenged by the Prime Minister to scale faster, and the [Cabinet

Office] to slow down."

Can you assist to identify in this time period, in particular, the Cabinet Office is seeking to slow down matters?

A. I think, per my previous answer, this is a reference to commercial approvals, and I think the exhibits that are attached to that, relate to some emails that Lord Agnew sent laying out his concerns about approving certain spend.

Q. Thank you. Can we then briefly, just to make sure there's absolute clarity about the ultimate responsibility for the development of testing, can we look at 3.47, please, in the INQ000587352 statement to which you're speaking at page 47. That's paragraph 3.47, thank you.

Sorry, it's INQ000587352. Sorry, we're back into Jessie Owens's statement now, please. INQ000587352, at page 47, paragraph 3.47. Thank you. And we can move into page 47, please. Thank you.

So just so there's absolute clarity as to responsibilities, we can see at paragraph 3.47 you detail that:

"Under the leadership of the Executive Chair, [NHS Test and Trace] had the Prime Minister's full authority to deliver. Ministerial accountability to Parliament

remained with the Health Secretary. Considerable freedoms and independence were afforded to [NHS Test and Trace] to expedite the delivery of testing and tracing. Baroness Harding was given permission to draw upon resources and expertise across government, to bring in external experts as required ... and all government departments were instructed by the Cabinet Secretary to provide any necessary support that [NHS Test and Trace] requested."

And then the next paragraph, please. 3.48:

"At the same time, it was important for the Cabinet Office to maintain a proportionate level of central oversight of work undertaken by [NHS Test and Trace] given its centrality both to the understanding the virus and the government's overarching strategy for managing the pandemic and easing restrictions."

And so can we just have complete understanding of who ultimately was responsible for the development of an effective large-scale mass testing and tracing system?

A. Baroness Harding.

Q. Baroness Harding, from NHS Test and Trace?

A. Mm-hm.

Q. And can you assist, then, in terms of that sitting within the Department of Health and Social Care, as the Lead Government Department, how did that work?

A. Baroness Harding and all of the officials working within NHS Test and Trace were members of the Department of Health and Social Care. Indeed, they worked out of the DHSC building, they had DHSC email addresses. And in practice, they sent submissions to the Health Secretary and health ministers before making important decisions, but I think Baroness Harding will be able to describe the inner workings of Test and Trace to you better than I can.

Q. Thank you.

Can I briefly touch upon Operation Moonshot, which was then the Prime Minister who made the announcement on 9 September 2020 about his desire for Operation Moonshot. It's your paragraph 3.91. I don't think we need to turn to it. But can you assist, then, as to why the Prime Minister was getting involved again in testing strategy, which ultimately had quite a number of people criticise the Operation Moonshot philosophy, and I think ultimately, from that announcement on 9 September, I think the tests that were identified that would have been part of Operation Moonshot effectively were used as part of the Community Testing Programme that came in in November of 2020, but do you have any observations from the Cabinet Office's perspective of the Prime Minister essentially making that Operation Moonshot announcement?

A. I think by way of context it's worth remembering that until vaccines came along very late in 2020, testing, tracing and isolation was one of the largest tools at the government's disposal, and it's absolutely natural and right that the Prime Minister should take a personal interest in it.

I think the PM was very excited by the possibilities that large-scale testing using lateral flow devices offered. These would -- a technology that had been around for years but was only really proven to work for Covid at scale from autumn 2020 onwards, and he saw in that a huge tool in the government's arsenal for combatting Covid, particularly before vaccines arrived. So I think it's no surprise that he was keen to push NHS Test and Trace to move fast on the rollout of lateral flow tests.

Q. Thank you.

Can we then, please, move to the topic of financial support briefly, please, and can we move to paragraph 5.18 at page 85.

You detail at paragraph 5.18:

"By mid-September 2020, with infections rising and evidence suggesting only a very low percentage (circa 20%) of those with COVID-19 symptoms in England fully complied with self-isolation guidance, and that

rates of self-isolation by other household members and contacts were likely to be even lower, the [Covid-19 Taskforce] prepared advice for the Prime Minister recommending a carrot-and-stick approach to increasing compliance."

We obviously know that the figure that was then arrived at subsequently was £500. Can you assist, did the Cabinet Office have a view on the -- whether £500 was an adequate amount of --

A. I think there's an important context to provide here. Ministers, including the Prime Minister, had been arguing for some time that they were keen to increase support for self-isolating people, both financial and non-financial support, that there had been a range of views across ministers on this topic I think it's fair to say, and it took some months of conversations at official level and at a political level, in -- to get alignment across government on what that would look like. And, eventually, a package that was acceptable to the Chancellor, the Health Secretary, and the Prime Minister emerged, and that was the package that is described in paragraph 5.18.

Q. Thank you. And are you able to assist how the needs of those from ethnic minority backgrounds were considered in decision-making respect to the provision of financial

support for isolation?

A. Absolutely. Test and Trace, by the summer of 2020, was doing a lot of work to understand the barriers to self-isolation among groups of all types, with polling data, with follow-up calls to people self-isolating, asking them whether they fully complied, et cetera. And although NHS Test and Trace is best placed to answer this question, from my personal recollection I know that they really, you know, went into the data on what was keeping people from self-isolating, people of all ethnicities, people in different professions, different income levels, and so they built up a data picture that was able to move ministers towards alignment.

Q. Thank you.

Then can we pick up, then, perhaps on that theme on inequalities and disproportionately impacted groups.

Can we move, please, to paragraph 6.5 at page 93, where you detail:

"The Cabinet Office's involvement in work to address inequalities in relation to TTI began early in the pandemic, prior to the establishment of [the Covid-19 Taskforce] and [NHS Test and Trace]."

And so can you assist, the Cabinet Office provided guidance to the Department of Health and Social Care on the public sector of -- PHE as well as equalities

insights regarding the potential impacts of TTI policies. How were the needs and concerns of those from ethnic minority backgrounds, including healthcare workers, factored into this?

A. The Cabinet Office was home to the Government Equalities Office that eventually emerged with some other teams to become the Equalities Hub, and I'd also add that on the establishment of the Covid taskforce, a team was established within that taskforce focused on disproportionately impacted groups. So there was a real focus at the Cabinet Office that then saw the appointment of Emran Mian as the senior responsible owner for disproportionately impacted groups. I know that you heard from him, my Lady, recently.

So the Cabinet Office was very keen to share with DHSC and with NHS Test and Trace the expertise that the Department had on equalities questions, and to ensure that NHS Test and Trace took full advantage of the knowledge that was at the central government.

Q. Thank you.

Now, if we just move forward, please, to paragraph 6.15 on page 98, please. And throughout 6.15 through to 6.20, you refer to the recommendations in the quarterly reports on inequalities, including to improve participation in the TTI system.

Can you assist, were the recommendations from those reports implemented?

A. So I can't speak to those exact reports. What I do know, though, is that, following the pandemic, the government launched an Inclusive Britain action plan with 74 actions that I think incorporated many of these actions that had come from the quarterly reports during the pandemic. That action plan the government has been providing periodic updates against. The most recent of those updates was in May 2024 when it was reported that 62 of the 74 actions had been completed.

I don't have an update since May 2024, but I can tell you that at that date the vast majority of the actions in the Inclusive Britain action plan were complete.

Q. Thank you.

And then can I move, then, to lessons learned and recommendations for the future. The Cabinet Office has provided seven pages looking at lessons learning and recommendations.

Can we please briefly look at paragraph 7.6, please, at page 103. Thank you.

It details there:

"A number of recommendations were made by [the Covid-19 Taskforce] strand of the project."

And I think this is a project that followed following the spring of 2022.

"One recommendation was to ensure equalities considerations were central to decision making from the start, and to identify those who may be disproportionately impacted as early as possible (eg multi-generational households), whilst recognising that disproportionately impacted groups will not always be the same cohort of people. Another recommendation was to create and maintain an overview of all pressures on local authorities and key delivery agencies related to the policies and decisions in question to ensure effective allocation of resources."

Are you able to assist as to what specific action the Cabinet Office has taken since the review to implement this recommendation, and to ensure that equity is embedded in its decision-making processes?

A. Yes. I have three updates. Firstly, the National Security Risk Assessment methodology now includes a specific impact category on vulnerable people with the Cabinet Office having issued new guidance to departments in October 2024 to improve consideration of the disproportionate impacts that risks may have on different groups across a full spectrum of vulnerability.

Second, supported by the ONS, the National Situation Centre has created a risk vulnerability tool to estimate the number of people who are vulnerable to negative impacts of national security assessment risks. It will be made available across government, including to the devolved administrations.

And thirdly, lessons management best practice guidance, published last year on gov.co.uk, now advocates for a participatory approach to emergency management which considers the impacts of emergencies on individuals and builds community resilience.

Q. Thank you. And then finally can I take you back to 7.4, please, which deals with data and analyses at page 102. Obviously, data analyses was one thematic area reviewed as part of the Innovation and Lessons Learned Project. It goes on to detail that:

"The report acknowledged that 'more interoperability between digital systems across government would improve the ability of the state to rapidly introduce new digital services."

The Inquiry has heard quite a lot of evidence about issues of data blockages and with number of criticisms levied as against how data was managed within the Department of Health and Social Care and how that operated across departments. Are you able to provide

any update of any work that's been done to improve data sharing or interoperability?

A. I'm afraid I'm not, but I do know that this remains an area that the government is focused on and that recent public statements have focused on the need to share data better across government, particularly in an age where AI and others tools are emerging.

MS CARTWRIGHT: Thank you, Mr Munn.

Those are my questions, my Lady. There are no Core Participant questions that have been permitted.

LADY HALLETT: Thank you very much indeed, Mr Munn, and thank you, particularly having left the Civil Service, to return to the private sector to volunteer -- I assume it was volunteering, rather than anything else, to come along and help the Inquiry. I'm really grateful to you.

THE WITNESS: Very well.

LADY HALLETT: Very well, it is 10.00 tomorrow.

MS CARTWRIGHT: Thank you, my Lady.

(4.36 pm)

(The hearing adjourned until 10.00 am the followed day)

I N D E X