Friday, 30 May 2025

(10.01 am)

MS CARTWRIGHT: Good morning.

Please could Professor Machin be sworn.

PROFESSOR RICHARD MACHIN (sworn)

Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 7

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

A. It's Richard Machin.

Q. Professor Machin, you have helpfully provided an expert report for the purposes of Module 7 -- thank you, we can see it displayed there -- a report, namely "An analysis of the effectiveness of COVID-19 financial support and the impact on adherence with the Test, Trace and Isolate system". We can see you signed the relevant declaration, expert declaration, on 26 March of 2025, and can I ask you to confirm, are the contents of the expert report we see true to the best of your knowledge and belief?

A. That's correct.

Q. Thank you.

Professor Machin, your report will be published with all the finer analysis and detail that we have within it, but I wonder if you could assist us, then, first of all, with some detail, first of all, about you and your

background, please.

And we see that at page 4. Thank you.

It's right, isn't it, that you are an associate professor in social policy in the Social Work, Care and Community Department at Nottingham Trent University?

A. That's correct.

Q. You specialise in research on the UK social security system, poverty, and financial wellbeing?

A. Yes, that's correct.

Q. Then you've given us some detail of your recent research, but significantly, your Covid-19 research explores financial support available to vulnerable groups and local government experience of managing the pandemic, and you then give detail of the other matters to which you're a co-editor.

Is there anything else by way of your background and experience that you'd wish to detail before we deal with --

A. No, that's comprehensive. Thank you.

Q. Thank you.

Professor Machin, can we then look at the executive summary of your report, please. You detail that the report evaluates the effectiveness of financial assistance that was available to support and encourage self-isolation during the Covid-19 pandemic, and you

tell us that the main focus is on self-isolation payments that were introduced in 2020 in all four nations of the United Kingdom, and you tell us that these payments provide a financial support to people on low incomes who were required to self-isolate but who would lose income as a result of not being able to work from home. Is that --

A. That's correct.

Q. Now we probably won't get into the finer details of how each of the schemes operated across the four nations but it's right, isn't it, that within the report you do a detailed analysis as to how the schemes operated in each of the four nations?

A. That's correct, and there is some significant differences between the schemes in those four nations, the details of which are in the report.

Q. Thank you. And I think you've also -- perhaps if we go to one of those now -- you've helpfully provided tables within the report. If we go first of all to page 6, you've provided essentially a summary of the schemes themselves within the report there; is that correct?

A. That's correct.

Q. Thank you. If we then briefly -- if we go to the next page, please, page 7, thank you -- we see Northern Ireland's scheme.

Then can we go to, please, page 87. Thank you. And just go to 88 as well.

It's right, isn't it, that you've also stripped down the overview of the strengths/limitations of the four self-isolation schemes in the UK also to try to assist with the headlines, but the more detailed analysis we see in your report?

A. That's correct.

Q. Thank you.

Can we then, please, turn to your key findings, please, which are on page 8. And, Professor Machin, I want to use this as the foundation to give context to the overview of your findings and recommendations, appreciating that in the latter part of the report you give a huge amount of detail to support the recommendations that we'll look at together in summary, and then we'll work together to some particular areas where we would ask for your assistance.

So let's start with the key findings, please, first of all at paragraph 4. You detail that you have found that:

"... there is clear evidence that the ability and willingness to self-isolate is linked to financial status."

You detail that:

"The UK Government acknowledged the risk that people would not self-isolate because of their financial circumstances."

And:

"[Your] report recommends that self-isolation payments should sit alongside other forms of non-financial and practical support (such as food parcels, delivery of medication, referrals to voluntary sector organisations for wellbeing/practical support)."

A. Yes, so I think there's two clear points there. The research undertaken shows very strong links between financial status and ability to self-isolate, but alongside that, non-financial support is absolutely critical.

Q. Thank you.

If we then look at paragraph 5, please. You detail that:

"The self-isolation payment schemes were developed and implemented at speed and evolved over time to reflect the changing dynamics of the pandemic."

You tell us that:

"While changes were implemented to enhance the schemes, these changes also caused administrative complications and contributed to a low public understanding of the payments."

A. That's correct, so the timeliness of self-isolation payments is absolutely key, and there were challenges around the schemes being rolled out quickly, and which were understandable, given the size of the task and the unexpected pandemic.

I think what is important from the research is that when schemes are launched, it needs to be really clear systems and communications that support effective administration of the payments. And sometimes that was lacking. We could sometimes see inconsistent information on central government and local government websites, the systems weren't always in place that the NHS Covid app could make a referral for Test and Trace Support Payments. So certainly the timeliness was an issue, which was understandable. But I think the systems that underpin the self-isolation schemes could certainly have been more effective.

Q. Thank you.

Now if we turn, then, to paragraph 6, please, you detail:

"There is an important relationship between self-isolation payments and the broader social security system. Self-isolation payments were introduced alongside a significant range of temporary COVID-19 amendments to the social security system. For some

people, the temporarily enhanced levels of social security payments provided protection from the need to claim self-isolation support payments. For others, a newly established entitlement to social security benefits acted as a passport to eligibility for self-isolation support."

Can you, perhaps, just be absolutely clear what you mean by that paragraph.

A. Yes. So the government, during the pandemic, did introduce a significant range of enhancements to the social security system, most notably an increase in the rate of Universal Credit by £20. For some people, those enhancements to the social security system would have contributed to a lessening in financial hardship and would perhaps have meant that they didn't need to rely on self-isolation payments, but across all four nations of the UK, self-isolation payments, the eligibility, was linked to entitlement to a means-tested benefit.

So, for example, we saw a leap in the number of Universal Credit claimants during the pandemic from just under three million to six million people, so those newly entitled Universal Credit claimants would have potentially had that passport to be able to claim self-isolation support.

Q. Thank you.

Now, you make findings at paragraphs 7 and 8 which I think are perhaps self-explanatory as to the impact on mental health and psychological distress. Is there anything you want to add in respect of those paragraphs, please, Professor Machin?

A. So the overwhelming evidence, both pre-pandemic and during the pandemic, is that there's very clear links between financial hardship and mental health issues, and so a period of self-isolation, if that is associated with financial difficulties, for many people that would have also led to some emotional challenges, to issues around mental health.

So really the emphasis on these paragraphs is that comprehensive financial support is not just a matter of pounds and pence in the pocket that has a really significant impact on overall wellbeing.

Q. Thank you.

Can we then move please through what -- a, necessarily, summary of your key recommendations that are expanded in the report but can we work through those together now, please. You detail at paragraph 9:

"Future self-isolation payments should be delivered via an employer-delivered earnings replacement model. This model was used to deliver the Coronavirus Job Retention Scheme and Self-Employed Income Support Scheme

... and could be adapted to delivery self-isolation payments. The adoption of this model would create parity between those compelled to be at home for self-isolation purposes and those required to be at home because their normal employment was suspended. To ensure scheme recognition, self-isolation payments should have a distinct branding, for example, 'Self-isolation earnings replacement grant'. Entitlement to a self-isolation payment should automatically trigger referral to a local authority for holistic, wraparound support."

Could I just ask you to expand on that key recommendation, please?

A. Yes, in many ways this is the most important recommendation in the report and it's a matter of policy, priority, and quite a difficult decision to come to, to make that recommendation. So to provide some context, the self-isolation payments that were delivered in the four nations were administered by local authorities and there was some merits to those schemes in terms of local authorities having systems in place and knowledge of local communities.

However, there were many inefficiencies and challenges that local authorities had with those payments and so overall, that certainly led me to

recommend that self-isolation payments would have been much more efficiently administered if they were done on a central basis rather than on a local basis.

This would have created parity between people who were satisfied to self-isolate and those whose employment was interrupted because their jobs were no longer available for a period.

Much greater recognition by the public of the Coronavirus Job Retention Scheme, commonly referred to as "furlough", and also within those schemes, some flexibility to change the earnings replacement levels for people who were self-isolating.

So I really concluded that there would be much greater efficiencies in a centralised scheme such as those.

Also, though, absolutely key, that a centralised scheme potentially would lose some of that local knowledge and so, alongside that delivery model, people who apply for a self-isolation support payment, there's a recommendation that there should be automatic referral to a local authority for additional support, non-financial support, practical help.

Q. Thank you.

Can we then look, please, at paragraph 10 --

LADY HALLETT: Sorry, just before you move on, it may be

you're about to go to it, forgive me, Ms Cartwright, but while it's in my head, how do you cater for the self-employed under this recommendation?

A. So the self-employed, it would be the eligibility rules for self-employed people would be reflected in some of the rules for a self-employed income support scheme and to use the criteria from that scheme as a model for self-isolation payments.

MS CARTWRIGHT: Thank you.

Perhaps, then, with you arriving at a centralised scheme as the way forward, have you given thought about who the relevant stakeholders and departments are, that need to have the discussion to essentially look at what would be necessary to implement a centralised scheme?

A. Yes, so certainly that would need to be employers groups, Treasury, HMRC, and there would be some important conversations around data sharing and protocols.

Q. Thank you. Can I ask you additionally, we've heard some evidence from the Treasury that also it would require the involvement of the Department for Work and Pensions; is that similarly a stakeholder you think that would be necessary for these discussions?

A. Yes, yes certainly.

Q. Thank you.

So at paragraph 10 you tell us:

"Self-isolation payment schemes should have a rapid review process."

Can you give us some context for that recommendation, please?

A. Yes, there were a very high number of refusals of self-isolation payments during the pandemic. In England and Wales there was no capacity for applicants to review those decisions. In Scotland and Northern Ireland they did have review processes. And that really is just good practice around a social welfare system to allow people to challenge that, why there might be quick and obvious errors that have been made.

There are some challenges around a review process that creates an additional administrative step, but that has been suggested as an element of best practice for delivering welfare payments to people on low incomes.

Q. Thank you.

Can we then move to your next recommendation and perhaps to give some context to this, certainly the Every Story Matters record that the Inquiry has obtained indicates that there was wide-scale either lack of knowledge or lack of understanding of the schemes, and perhaps then having given context to some wider evidence the Inquiry has received, you tell us that:

"Central government and local government websites should include a self-isolation payment eligibility checker."

A. Yes, so certainly in the initial stages of the pandemic there was a -- an inconsistency between information on central and local government websites. There is some evidence to suggest that when the self-isolation payments were launched in England, there was a complete lack of information whatsoever on the English Government website. So I think that would be a really quick and easy win, for people to be able to check in an online way whether they were entitled, and might also create some efficiencies in terms of claims not being made where it's clear that that's not going to -- someone doesn't meet the eligibility criteria.

Q. Thank you. You then next tell us, at paragraph 12:

"Self-isolation payment guidance should include timescales for the issuing of a payment, and monthly reporting data should be published."

A. Yes. So this is really about the timeliness of payments, self-isolation payments. So experience shows, both during the pandemic and generally in terms of the administration of crisis support for people on low incomes, it's absolutely critical that payments and that financial support is made at the point at which crisis

or hardship is experienced. We saw with the administration during the pandemic of self-isolation payments, when there was a high demand on the schemes, the timescales slipped for the issuing of payments. Sometimes went beyond four weeks. And clearly there the risk is that people will make alternative arrangements. They might carry on working or not feel they can comply with self-isolation regulations.

Q. Thank you.

You then tell us that:

"A communications strategy should be published which clearly indicates eligibility criteria and payment processes. Accessibility and language issues should be fully considered."

I think that probably follows on from what you've already said around a self-isolation payment eligibility checker, but do you want to add anything to that recommendation?

A. I believe that the evidence shows, particularly in England, there was a lack of consideration of equalities issues, and this, then, feeds into communication plans. So I think there needed to be a much clearer recognition of the marginalised groups who were most likely to qualify for self-isolation support payments.

There then needed to be (a) a clear communication

strategy that had some consistent messaging, but also then some more bespoke and tailored communications for certain groups. And this needs to -- needed to take into account issues of digital exclusion, around language, about pushing messages out through employers and through community groups.

Q. Thank you.

And so, with referencing employers and community groups, are you indicating that they have the role for the bespoke communications?

A. Yes, absolutely.

Q. Thank you.

You then tell us at paragraph 14 that:

"Careful consideration needs to be given to the scheme name for future self-isolation payments as there was confusion around this and how self-isolation support payments interact with other support."

A. Yes. So scheme names for social welfare payments is not easy. So, in my experience previously working in local government advice services, recipients of social security and social welfare payments often find it really difficult to accurately label the payments that they're receiving. However, there are, I think -- there is good practice and poorer practice with that.

So, for example, in England, test, trace and support

payments I think had a very low recognition. Often people would just refer to it as "the £500 payment". I think something that actually includes the phrase "self-isolation" would certainly be -- would be preferable to that. And also the scheme name is important because, although I've suggested that the self-isolation support payments should be part of a centralised scheme, they do need that distinct branding within that scheme.

Q. Thank you.

LADY HALLETT: Sorry, I'm not following what was wrong. "Self-isolation" did feature, "support"; what's wrong with "self-isolation support scheme"? Why doesn't that do what it says on the tin?

A. So it's a good question. So there were four different names across the four nations. So in England, "Test [and] Trace Support Payment[s]", I think. I feel that was less clear than in some of the devolved administrations. So, for example, in Scotland we had the "Self-Isolation Support Grant". That, to me, is much clearer. So I would use that as an example from Scotland as being much more efficient than the title we had in England.

LADY HALLETT: I follow. Thank you.

MS CARTWRIGHT: And I think on that note, each of the

devolved nations referenced self-isolation support. You've referenced Scotland, Wales was the "Self-Isolation Support Scheme", and Northern Ireland that the "Discretionary Support self-isolation grant". So I think perhaps you're just highlighting the fact that England chose not to reference self-isolation; would that perhaps be fair?

A. That's correct, yes.

Q. Thank you. You tell us in paragraph 15 that:

"In a future pandemic, software applications (central government and/or healthcare systems) should include clear information about self-isolation payments and include clear links to claim a payment."

A. Yes, and that was the case, as the pandemic progressed, and self-isolation payments became more established. But there were particular issues at the launch of Test, Trace and Support payments in England, where there was question marks about the efficiency of central government information and also about whether the official Covid app had clear referrals to Test, Trace and Support payments. So I think it's about getting those communications right at the initial launch of the schemes.

Q. Thank you. You've just referenced the Covid app that operated in England and Wales, so what's the issue

you're saying about how that linked with the ability to make a claim under the scheme?

A. So, initially, there wasn't a link to make an application for a self-isolation payment, and in the early stages of the pandemic, it then relied on human contact tracers to issue a code to allow people to proceed with a claim for self-isolation payment. So that automation was missing in the initial stages.

Q. So in terms of development of an app, should that have really been at the heart of one of the things that the app enabled, bearing in mind, I think, they operated almost in time, I think the app came online on 24 September of 2020, the scheme in the United Kingdom, I think, was also at the end of September. Was it quite a failure, then, that the app rolled out alongside the requirement to isolate that was enforceable should have had a clear link to make an application for an isolation payment?

A. Absolutely. I think that was a failure, and there were a number of changes to communications and even to the scheme rules, and I think in a future pandemic there needs to be a much clearer communications process, and application process, right from the launch of schemes.

Q. Thank you. You next tell us at paragraph 16:

"In a future pandemic contact tracers should provide

clear signposting to self-isolation payments and other local support for financial hardship ..."

I think that's perhaps self-explanatory, that recommendation.

And you then go on:

"In a future pandemic full self-isolation payment equality impact assessments should be published in all four nations of the [United Kingdom]. Assessments should consider the impact on claimants with protected characteristics, as stipulated in the Equality Act 2010."

Why do you particularly draw this out? Because I know in the report you referenced, I think, some of the difficulties you had in identifying the impact assessments; is that correct?

A. Yes, that's partly correct. So equality impact assessments which directly related to self-isolation schemes were completed in England and Scotland. In Wales and Northern Ireland, there were a series of equality impact assessments that were conducted, some of which did look at the issue of self-isolation but not specifically around self-isolation support payments.

It's really important that equality impact assessments are carried out in a comprehensive and robust way in order to identify equalities issues for

the rollout of policy, and then to be able to make modifications to policy to ensure that's fair and equitable.

The Scottish equality impact assessment is an example of best practice in that that drew on a really wide range of evidence, and specifically identified equalities issues for certain groups, for example people with disabilities, women, children and young people. And then clearly the Scottish Government could point to how their scheme catered for those groups.

In England, the equality impact assessment, when it went through the protected characteristics of the Equality Act, simply made an assessment that there were no issues with any of those protected characteristics, which I think was a very incomplete assessment of equalities issues that were at play during the pandemic and risks the assumption that there aren't any equality issues.

Q. Thank you.

Now next, you recommend:

"A consultation exercise should be delivered as soon as is practicable (with central and local government stakeholders, the voluntary and third sector and academics) so an agreement in principle/working framework can be provided for the level of

self-isolation payments in a future pandemic."
A. Yes, so this is connected to the opportunity we now have for future pandemic preparedness to be in a much better position, should there be a future pandemic, and that a scheme such as self-isolation payments can be launched in a much more efficient and timely manner.
So a consultation exercise would require central and local government stakeholders, Department for Work and Pensions, Treasury, public health, academic, experts, think tanks, the voluntary sector, and some of the things that it could look at in the non-pandemic period is about the level of payment, different modelling, the level of earnings replacement that self-isolation payments could be set at and what the implications of those different earnings replacements levels might be.
So, for example, should it be set at the real living wage? Should it be set at Universal Credit levels or Universal Credit levels plus 25%? Should it be aligned with a future furlough or Coronavirus Job Retention Scheme?
Q. So really what you're saying is those discussions informed by what happened in the pandemic can be taking place now to essentially get the model ready to roll out in the event of a future pandemic?
A. Yes, absolutely, and I think some of those principles

can certainly be identified, different options can be identified. Of course, the detail of the policy would be affected by political and fiscal decisions at the time of any future -- a future pandemic, but I think certainly that framework and principles can be established now.
Q. So exactly that: a framework in principle.
A. Yes.
Q. Thank you. Then finally before we get into some particular detail, please, you say that:
"In a future pandemic central and devolved governments should publish the policy rationale for the payment level of self-isolation payments and funding to local authorities for wraparound support."
And I think we've touched on those issues in the answers you've given already.
A. Yes, I guess what I would add is that it was striking during the research and completion of the report that it was difficult to penetrate the policy rationale beyond a very headline couple of sentences justifying the development of self-isolation schemes. So certainly very little information around the groups that self-isolation payments were catered for, or around the level of payment.
Q. Thank you.

Can we then move to some particular questions and then -- before we look again at your ultimate conclusion.
Can we move, please, to page 11 and paragraph 30. Thank you.
And this is under the section where you were dealing with the scheme that operated in England. And you say this:
"Pressure had been building on the [United Kingdom] government to provide financial support to individuals who were required to self-isolate. A number of local authorities and directors of public health expressed concern that for some residents, financial hardship was having an impact on the ability to self-isolate."
Can you assist, is that a fair interpretation also of your position as expressed in the report?
A. Yes, so the report details that there was certainly a growing awareness and concern about the lack of financial support during the self-isolation period, as stated there in the report, from local authorities and directors of public health, and also community groups, advice agencies, social welfare agencies.
So this was, I think, a growing concern in those early months of the pandemic.
Q. Thank you.

Can we then next, please, move to paragraph 82 at page 25. And again, we can see this falls under the topic of "Self-isolation support payments as part of a broader range of support". You detail that analysis of the role -- sorry. You deal with the details of the financial support available to those self-isolating, and obviously set out the various arguments, and can I ask you: the indication is that there's strong evidence that self-isolation payments should sit alongside other forms of non-financial and practical support, as we've touched on in your recommendations; are there any other examples of non-financial and practical support that you think should sit alongside financial support?
A. Yes. And some of this draws on my research based in Nottingham where local authorities provided support with medicine delivery, the delivery of food, with supporting families with educational resources such as textbooks and support around online learning. It can also include wellbeing checks. So there's examples of local authorities using helplines for wellbeing checks, as well as referrals to voluntary and community groups that have got specific functions, perhaps around mental health or community engagement.
Q. Thank you. And I think it perhaps fits with some of the observation and detail you provide in the report,

particularly about the schemes as operated in New York, for example?
A. Yes, that's right. And particularly interesting you mention New York. There was the provision of accommodation there, which wasn't part of the schemes in the UK. That hasn't come through as a key issue, but that certainly would be something that could be considered during this period, around principles and frameworks, whether that wraparound support perhaps needs to look at accommodation needs.
Q. Thank you. I think I was thinking in particular -- I think the schemes in New York included dog walking services and the like?
A. Yes.
Q. Thank you.
Can I then ask you, building on that earlier question, do you consider that the policies implemented, funding allocated for forms of non-financial and practical support were sufficient during the pandemic? And I appreciate you need to look at this through a four nations perspective.
A. Yes, so the research indicates that there was a high level of refusals of self-isolation support payments, and that some local authorities, quite a high percentage, around 25, 30% of local authorities, in the

early stages of the pandemic exhausted funding for self-isolation support payments.
There is also, I think, an interesting comparison between England and Wales. So, overall, the expenditure on self-isolation support payments in England was around 285 million and in Wales it was around 70 million. So we can see that the scheme in Wales was funded to a high level, and the indications are that that was a much more efficient scheme as well.
So, trying to draw out some of those financial issues has been quite difficult from the publicly available data, but I would be comfortable in concluding that there was a lack of financial support for local authorities to meet the needs of communities who were self-isolating.
Q. Thank you.
Can we then move forward, please, to page 27 and your paragraph 87, under the topic of "Self-Isolation and Financial Status". You detail that:
"In the early stages of the pandemic the [United Kingdom] Government made it clear that they wanted to avoid 'a situation where people [didn't] feel they were financially able to self-isolate' ..."
You then detail that:
"Similarly SAGE ... stated that providing

appropriate financial support was key in encouraging people to self-isolate, and that financial assistance should be provided alongside emotional and practical support."
Having identified those early statements of intent, are you able to assist as to what, in your opinion, accounted for the late introduction of payment support in the United Kingdom, namely being in September 2020, Scotland being October 2020, Wales similarly October 2020, and obviously Northern Ireland introduced their discretionary scheme in March 2020?
A. I think there was a number of factors that contributed to delays in scheme launches. I think, firstly, it is not straightforward to deliver this sort of social welfare payment at speed, and there are challenges with that. I think also there was a connection between the developing regulations, legal obligations to self-isolate, and for financial payment, which perhaps didn't start right at the beginning of the payment, so there was some alignment between financial support and those legal obligations.
But I think overall there was this growing sense of pressure that the government felt, and growing evidence, that people on low incomes, one of the factors in non-adherence to self-isolation was financial hardship.

Q. Thank you. And can I ask you, I appreciate that you had information provided to you by the Inquiry, have you been able to follow any of the evidence in the Inquiry, particularly Baroness Harding's evidence about the efforts that she was making to try to get a self-isolation scheme and payments there? Have you --
A. Yes, so I'm aware that there were certainly those high-level conversations at an early stage that financial support was seen as absolutely critical. So certainly arguments that that should have fed into policy at an earlier stage.
Q. Thank you.
Can we then, please, move to your paragraph 111 at page 31, please, and this is under your heading of "Covid-19 Experiences for excluded groups".
You specifically reference:
"A study in Wales by Isherwood et al ... [that] found that financial challenges associated with self-isolation were particularly severe for people with high income precarity, women and younger people ..."
Can you comment on the ability of these groups to self-isolate, given the severe financial challenges?
A. So this piece of research has identified those particular groups as having additional challenges. So it's often related through those three groups -- high

income precarity, women, and young people -- around the employment type. So being in care work, hospitality, leisure, where they were typically in low-paid jobs that might have stayed open during the pandemic.

For women, particular issues around, often, low wages, part-time work, and combining employment with caring roles. And for younger people, often again over-represented in those employment types where there is low pay. For younger people often have a higher percentage of their income spent on accommodation and rely on a lower level, often, of wages and social security support.

And also, for all of those groups, there is a relationship with Statutory Sick Pay. So two million of the lowest-paid workers in the UK are not entitled to Statutory Sick Pay, clearly creating pressures during the self-isolation period and those groups would be over-represented in those statistics of people not entitled to Statutory Sick Pay.

Q. Thank you, and I think an observation has been made, similarly, for those categories, that would apply principally also to a large proportion of social care workers who often are women on low incomes; would you agree?

A. Absolutely, yes.

person needed to self-isolate, and then in February 2021 there was an extension to the eligibility criteria to include people whose income went up to the real living wage.

So there was those changes in the eligibility criteria that created a more generous scheme, more comprehensive scheme that accounted for some of those spikes.

Then we can also see in September '01 (sic) and then in January 2022 those really clear links between transmission rates through the Delta and Omicron variants, and number of claims for self-isolation payments.

Q. Thank you. And then can we go over the page again, just --

LADY HALLETT: Sorry, just before you move on. Remembering, as you may not know, that I'm not that good with graphs, you say changing the eligibility criteria in early 2021 and February 2021 led to spikes, but in fact the graphs seem to show that the claimants went down until June '21?

A. So I think maybe that's linked to perhaps time lags, in terms of public awareness. The Scottish Government did disseminate quite a lot of information around the grants, so I think that what -- we can perhaps see that

Q. Can I next ask your assistance, please, with some of the graphs you've provided.

If we start at page 38, please, under the heading of the "Adequacy and scope of the self-isolation support grant in Scotland". So it's page 38, just to orientate ourselves.

And if we go on to the next page, please, can you just, just in simple terms, assist us, first of all, with what you're showing us on this figure at page 39, please, in respect of the operation of the scheme in Scotland.

A. Yes, so this indicates the number of applications over time for the Self-Isolation Support Grant in Scotland. So really, the commentary that goes along with this, is that we can see in the early phases of the rollout of the grant, so it actually was rolled out from October 2020. There was a fairly low number of claims in that initial period, and that is thought to be around low public awareness of the scheme. We can then see there's a number of spikes or increases in the number of claims to the scheme. This is in part that the Scottish Government made some changes to widen the eligibility criteria for the grant.

So in December 2020, extended eligibility criteria to include people isolating where a child or young

time lag in terms of change in eligibility and then claims following from that.

MS CARTWRIGHT: Thank you.

Can we then go over the page, please, and you've again, on the table at figure 3 given some detail about the applications process. Could you, again, just summarise what this position helps us understand relating to the scheme as it operated in Scotland?

A. Yes. So we've already discussed the importance of the timeliness of payments, and what this is indicating -- it hasn't got the dates here, but the commentary to go with that, is that during the periods of peak demand for the scheme in Scotland, the processing times became longer. So in that peak that we saw in the previous graph in January 2022, for example, we've got over half of the claims at that point in time were taking more than 28 days to process. So there's those clear links between the pressures on the scheme and the number of applications, and an increase in the processing timescales.

Q. Thank you.

And can we then go to the paragraph that sits below that, paragraph 150, please. You say that:

"In a future pandemic, it is important that self-isolation payment schemes are robust enough to cope

with changing/increased demands and that appropriately trained staff are available to process claims."

Could you assist, please, as to what measures should be adopted to improve robustness of the self-isolation payment schemes.

A. This, I think, links to the earlier question about sufficient funding. So the evidence from Scotland indicates that during those peak pressures on the Self-Isolation Support Grant, there were capacity issues in the local authority. There were -- of course, that was combined with staff absence in the local authority. So I think this is an opportunity, again, in this period, to do some modelling around the extent of the number of claims, and capacity requirements to actually deliver those, both in terms of IT systems but particularly in terms of workforce and personnel.

Q. Thank you. Can we next move, please, to page 42, just to orientate ourselves with where we are in the report. So we are now under the heading of "Adequacy and scope of the self-isolation is it a scheme in Wales", and having located ourselves, can we then move to your paragraph 168 which is on page 44.

Thank you.

Now, you note that:

"The value to qualitative research from Wales ..."

but then go on to state that:

"... detailed, quantitative analysis based on local authority data not available ..."

Then in the following-on paragraph you highlight the limitations to the research, given the small scale and reliance on self-reported information.

Can you assist, please, as to why quantitative data from Welsh local authorities was not available for consideration, and assist at all on what research should have been undertaken to avoid the limitations you've identified?

A. Yes. So I think there are two elements to this. During the completion of the report across all four nations, there was a lack of quantitative data relating to the number of claims over a month-on-month period, the number of refusals, the expenditure on a month-by-month basis, and how that was linked to Covid transmission rates.

So I think that's the first element, that in a future pandemic there needs to be much clearer and robust monthly quantitative reporting on the administration of the scheme.

The second element about the qualitative data, some of the qualitative research, actually, in Wales is clearer and more detailed than in the other nations of

the UK. However, it still was small in scale and so I would suggest, in a future pandemic we would need to have much more rapid qualitative analysis of the experience of people claiming self-isolation support payments, particularly around seldom heard groups and also around research for local authority decision makers, and people who chose not to self-isolate for financial reasons.

So I think it's a combination both of certainly lack of official quantitative monitoring and data, and a more comprehensive range of qualitative research.

Q. Thank you. Now can we go back a page, please, to paragraph 163 -- thank you -- which again just gives some context, again in Wales because we know it was -- Wales was the only of the four nations that, for a short period, increased the payment schemes to £750. But you detail that:

"More than 50% of respondents who received the initial £500 payment stated that they had lost income as a result of self-isolation".

And then go on to say that:

"For respondents who received the £750 payment [which was increased obviously from 9 August 2021], just under 25% reported that they had lost income as a result of self-isolation."

Now then, can I just seek your comments then on the figures that were arrived at and if you just bear with me while I give you some context to this question. First of all, we can see that in the report, when there were the pilot schemes initially, I think it operated in Blackburn and Pendle, there were schemes that had a £13 per day allocation of support initially, and then we know latterly that the Westminster government arrived at the figure of £500 for financial support, and plainly that applied whether the isolation period was 14, 10 days, or latterly, seven days.

Are you able to assist as to how the Westminster Government arrived at that £500 figure?

A. There isn't a clear policy statement or intent on how the Westminster Government did conclude the £500 payment was appropriate.

Q. Now, we've looked at the figure in Wales, where the increased payment threshold was introduced, but then can you assist, because you've had provided in your pack, and we'll briefly look at it, please, the statement of Mr York-Smith, on behalf of the Treasury, please.

And can we briefly go to INQ000587305 at paragraph 148, where we see the analysis there as to the Treasury officials in November 2020:

"... [noting] in advice that when it was first

introduced, the £500 payment was intended to support isolators for a 14-day period, equating to £35.71 per day, or 82% of the National Living Wage rate at that time."

Noting as we have, as the lead-up to this question, the actions of the Welsh Government, you've also detailed the fact that SAGE and other organisations criticised the level of financial support payment in England.

Are you able to assist as to whether the Westminster government ever reviewed the level of financial support and considered increasing it?

A. So we can see from the evidence on screen that there was consideration of that initial £500 payment. I've not reviewed any evidence that suggested that that was reviewed on an ongoing basis.

Interestingly, in Wales, when the payment was increased to £750 in August of 2021, that was -- there was a consultation exercise in order to make that policy decision, and that also considered the fact that, at that point in time, it was the ending of the Coronavirus Job Retention Scheme the following month and also in the following month, in September '21, was -- the upgrading of Universal Credit was finishing.

So there's a clear example from Wales there of

consideration of overall societal circumstances, which I haven't been able to find from the Westminster government.

Q. Thank you. And then can we briefly then go back to page 43 in your report, at paragraph 163, where you have detailed the statistics as to what effect the £750 payment had. Thank you.

You conclude that paragraph by saying:

"... increased payment[s] were amongst the recommendations from participants for scheme improvement."

A. I think the level of payment is clearly a political and fiscal decision, and there is actually a lack of clear research around -- an investigation around the level of payment. You mentioned earlier in the context of the question that in pilot areas in Lancashire there was a £13 a day payment. That has been analysed, and there is some quite clear conclusions that that level of payment was inadequate and led to a really low take-up. I believe only 12 or 13 people actually claimed during that pilot period.

Overall, what I think is absolutely clear is that people are more likely to self-isolate where there's a higher level of earnings replacement. So if we wanted a gold-plated system, then self-isolation payments which

replaced earnings like for like I think would be the most successful, but clearly that's got massive budgetary implications.

This research that's on screen now is interesting, that this does indicate that for people on low incomes, the self-isolation payments in Wales weren't covering the full costs incurred by self-isolation. So again, there are -- we have to think: to what extent does that create a risk that some people will choose not to self-isolate, and maybe continue to work?

LADY HALLETT: I appreciate the logic of increase the financial support and you're more likely to get adherence to self-isolation policies. Wales increased it to 750. Do we have the hard evidence that that improved adherence?

A. Not that I've seen, no, no. So -- and I think that's part of the challenge I've had with the report, is, drawing on lots of different sources of information, some of that is speculative. So certainly my recommendations, and we discussed this a few moments ago, about the need for that robust information, quantitative monitoring on a monthly basis, and those links to transmission rates, that doesn't exist. So.

MS CARTWRIGHT: Thank you.

Can I then -- just building on those general topics,

have you any views as to whether the policy of England, Wales, Scotland or Northern Ireland was most effective as financial support for those isolating? Is there a view as to which of the schemes was better?

A. So you mentioned at the beginning of the questions, within the report there is a detailed analysis of some of the merits and limitations of the schemes. As an indicator of that, the scheme in Wales supported around 111,000 people at a cost of 70 million. And if we just take those headline figures, that was a more comprehensive scheme than we saw certainly in England, where we'd got around 285 million for 570,000 claimants, or in Scotland, where the overall expenditure was 70 million.

And certainly the evidence indicates that, in Wales, that did create scheme efficiencies. There was a lower level of refusals of the payment, and we had a huge postcode lottery in England based on local authority administration that was largely avoided in Wales.

So we have talked a lot about scheme roles, about communication, about wraparound support, but the effectiveness and efficiency of the schemes is really connected to the budget that supports that, both for staffing and then issuing of payments, and of those schemes, the indications are that Wales had

efficiencies.
Q. Thank you. And then can I ask you as a general proposition, we know the discretionary scheme was introduced in March 2020 in Northern Ireland, and the policies in England and Wales came on later, and Scotland also. Does that reflect an issue of inadequate preparation, in your view?
A. Yes. So interesting, Northern Ireland had quite a different scheme which the grants available in Northern Ireland were available not only for people who were self-isolating, but effectively as a cost of living payment for people who were affected by Covid-19 and suffered financial hardship.
Northern Ireland made a decision to go very early with that scheme, and to use the existing discretionary support scheme that they had, which was a scheme that provides emergency payments. So there were some merits in using those existing systems, and that allowed Northern Ireland to roll that out more quickly. But I think, thinking about a future pandemic preparedness, there is enough evidence and learning from the Covid-19 pandemic that these schemes could be rolled out at a much earlier stage.
Q. Thank you. Can we then briefly touch upon an issue of accessibility. Your paragraph 193, please, on page 50.

You, in the context of Wales, talk about accessibility issues, and a common concern within Wales has been written communications provided by the Welsh Government being interchangeable to either Welsh or English language that made comprehension difficult.
Are you able to assist as to whether similar issues were experienced with the information provided about the scheme as operated in Wales?
A. So some of the qualitative research indicates that participants did find that the online information was difficult to understand. That sometimes was connected to the requirements to provide evidence for claims, and that people weren't clear about what the eligibility criteria for the scheme was, and the evidence that they would need to provide in order to support a claim.
And I think in terms of broader accessibility issues, there is a lack of consistency between central and local government information, but I think also sometimes a lack of tailored communications for people maybe who have communication issues or perhaps aren't digitally literate and wouldn't be able to access online information.
Q. Thank you.
Now, can we move next to a brief topic, please, on international comparators. Can we turn to page 70,

first, to orientate ourselves, where we can see this paragraph I'm about to take you to falls under the topic of provision of Statutory Sick Pay compared to sick leave payments in other countries.
Can we then move to paragraphs 274 and 275, please. You detail that:
"TUC Cymru ... argue that there is a correlation between countries with the best track records in self-isolation adherence and high levels of statutory sick pay payment schemes, [citing] New Zealand, Taiwan, Singapore and South Korea as indicative examples."
And you go on to say that:
"There appears to be merit to these claims, but a higher level of analysis (ideally by an economic think-tank or academic institution of any future pandemic) would be required to establish a firm link between sick leave payments and self-isolation adherence in the countries referenced above. A broader range of factors beyond provision of sick pay (eg cultural norms, pandemic legislation, and surveillance measures) would need to be considered, alongside analysis of sick pay provision."
Are you able to assist, or are you aware, of whether any further comparative analysis work on this topic has been undertaken?

A. At the time of writing the report, I don't believe so. My summary of those two paragraphs would be there is a logic and merit to what's stated in paragraph 274 about those correlations.
I think a comparative exercise between the UK and other countries is really difficult. I think overall, it's fair to say that in the UK the provision of Statutory Sick Pay is less comprehensive than in many other comparative countries, certainly European countries. So I think that the restrictions on Statutory Sick Pay created financial hardship in the pandemic that was more pronounced in the UK than many other countries.
To then try and tease out some of these particular comparisons, I think is difficult because of those factors that are indicated on screen and we would have to know about wage levels in those countries or other social protection schemes.
One of the really key findings from the section of the report that deals with international comparison is, in countries which have a more comprehensive and adequate social protection system, the reliance on bespoke self-isolation payments is much lower.
So for example in Germany and Sweden, effectively the governments there didn't need to bolt on

self-isolation payments in the way that we needed to in the UK, because the existing protections were considered adequate to compensate people during self-isolation period.

Q. Thank you. And then finally, please, can we move to your overall conclusion at page 93. And, Professor Machin, this overall conclusion comes after where you've given a much more detailed analysis of the recommendations at pages 83 to 94 that essentially build on what we've already dealt with in the first portion of our discussion this morning. But you say this as to your overall conclusion:

"This report has demonstrated that there are clear links between the ability to self-isolate and financial status. The self-isolation schemes analysed in this report were introduced in recognition of the risks that people will not self-isolate because of financial hardship.

"This report finds that self-isolation schemes with high levels of earning replacement are more likely to encourage self-isolation compliance. Where a substantial financial loss is incurred because of the need to self-isolate there is a real risk of non-adherence without comprehensive financial support from the government."

So can I ask you, in light of that particular finding, would you agree that resilience planning should have included financial payment support to be rolled out as part of the early pandemic response when isolation measures were imposed?

A. So certainly the research and conclusions of the report are that self-isolation and adherence to self-isolation is intrinsically linked to people's financial circumstances. And so although it's really clear that financial support needs to be provided as an overall package of support that we've discussed, I believe it should have been -- people's financial status should have been given a high level of prominence and earlier recognition in the pandemic response.

Q. Thank you. And then, again building on that, looking forward, do you consider that there is evidence of sufficient commitment from government and those in authority that this must now form a central part of resilience planning?

A. So the evidence presented is overwhelming, in terms of the links between self-isolation and financial support. What we have now is an opportunity to take this learning -- for central government stakeholders, Department for Work and Pensions, HMRC, the Treasury, to actually reflect on the learning from Covid-19 and, in

a future pandemic, to have in place systems which are ready to be delivered right from the start of a pandemic, communication plans that are very clear, that have clear equalities issues running through them, and that we now have the opportunity for a reflective exercise to look at some of those issues, particularly around level of payment.

Q. Thank you. Can we then go over the page, please, to your paragraph 339.

You also conclude that:

"[Your] report has demonstrated that the pandemic created particular financial and self-isolation challenges for certain groups, including women, young people, those in precarious work and people from ethnic minority backgrounds."

And you say this:

"Despite this, equalities monitoring of self-isolation schemes was inadequate, particularly in England."

A. Yes. So this relates to the completion of the equalities impact assessment in England that concluded there was no specific impact on any protected characteristic, and that simply isn't the findings of my report, and that isn't my experience in the sector and isn't the evidence -- isn't supported by the evidence

that I've drawn on for this report.

Q. Thank you. If we then briefly look at the next paragraph, you also detail that there was a lack of transparency, particularly in England, about the policy rationale to determine the payment level of self-isolation support?

A. Yes. So, certainly from the publicly available documents, there was a lack of a clear rationale for the £500 payment, and this wasn't something that was monitored or reviewed as the pandemic endured.

Q. Thank you. Can I ask you, would you agree, it would be of considerable value to share your conclusions with government bodies?

A. Yes, absolutely.

Q. And then just finally, perhaps just building on the question asked by her Ladyship, you answered the question that there's no firm evidence that increased payments in Wales supported adherence to self-isolation. Are you able to assist us as to what evidence there is?

A. So the qualitative report that specifically deals with different experience of a £500 payment in Wales and £750 payment in Wales does indicate that people felt more able and equipped to deal with a reduced loss of income.

So I think the evidence is not clear as more anecdotal, but I think the anecdotal evidence is there.

Q. And then can I ask you, are you able to, beyond the anecdotal evidence, assist as to why there is no firm evidence?

A. So I think that relates back to our earlier discussion around a lack of robust monitoring and it's really been difficult to interrogate the administration of the schemes in a very detailed way. So that month-on-month reporting, links to transmission rates, looking at local communities, number of claims, number of refusals, expenditure. That's been really difficult to interrogate on that granular level.

MS CARTWRIGHT: Thank you. Professor Machin, those are my questions.

LADY HALLETT: I have no further questions, Professor. Thank you very much indeed for your help. I'm very grateful for your very thoughtful analysis of the problem. Thank you so much.

THE WITNESS: Thank you, my Lady.

LADY HALLETT: Very well. I shall return at 11.25.

MS CARTWRIGHT: Thank you.

(11.11 am)

(A short break)

(11.25 am)

LADY HALLETT: Ms Cartwright.

MS CARTWRIGHT: Thank you, my Lady. Please could

Professor Pillay be sworn.

PROFESSOR DEENAN PILLAY (affirmed)

LADY HALLETT: Professor Pillay, our final witness for these hearings. I gather it wasn't deliberately chosen you would be last, it was because you've been away, I gather.

THE WITNESS: Thanks.

Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 7

MS CARTWRIGHT: Thank you.

Could you please give your full name to the Inquiry.

A. Yes, Deenan Pillay, Professor Deenan Pillay.

Q. Thank you.

Professor Pillay, could we please display your witness statement first of all, and then move to page 11. It's a statement dated 25 February of this year. Can I ask you to confirm that the contents of that statement are true to the best of your knowledge and belief?

A. Indeed, yes.

Q. Thank you. Can we, then, first of all, briefly introduce you and you are expertise.

It's right, isn't it, that you, whilst retired now, are a medical virologist?

A. That's right.

Q. And can you give us some idea as to your career as

a medical virologist and how long you practised before your retirement?

A. Of course. I trained post-graduately after medical school in virology. I took up my first consultant post in the early nineties, in Birmingham, working for the Public Health Laboratory Service at that time, and then I ran a reference laboratory for anti-viral drug resistance, a national laboratory. I then moved to University College London, where I took on an academic position as well as working as a consultant at University College Hospital, and I became a professor there in the mid-2000s, 2007 or so.

And I've carried on my research as well as clinical activities. My research has been predominantly on HIV, therapies of HIV. And latterly I then was seconded to run a Wellcome Trust-funded research centre in rural South Africa, which is an HIV and TB research centre, from which I returned in 2019, just before the Covid pandemic. And I've been working more in the context of involvement in Independent SAGE and within the Clinical Virology Network from that time until my retirement in 2022.

Q. Thank you.

Now, in addition to your role as a clinical virologist and an academic, it's right, isn't it, that

you're a member of the Clinical Virology Network?

A. That's right.

Q. We'll come on to deal with that in a moment. Between 2020 and 2022 you were a member of the MHRA expert working group on COVID therapeutics?

A. That's right.

Q. You're also a member of the Department of Health and Social Care's horizon scanning group for new Covid diagnostics, in 2020.

A. That's right.

Q. And can you just give a brief summary about that horizon scanning group, please.

A. Certainly. There was a complex set of structures developed, I think under the Cabinet Office, with regard to new diagnostics, both identifying new diagnostics, sourcing new diagnostics, and the role that I had was chairing a horizon scanning group to look at the data on both suppliers as well as their -- obviously the diagnostics they were supplying, the quality of those, and indeed to identify what the best way was to evaluate them and then moving through the MHRA process for approval.

Q. Thank you.

Now, in addition, it's right, isn't it, that you were a member of the serology diagnostic taskforce which

was the scientific advisory committee in 2020?
A. That's right.
Q. And you also sat on the governance committee of [COVID-19] Genomics UK from 2020 to 2022?
A. That's right.
Q. And you've already identified that you were a member of Independent SAGE, and you give us some detail about your involvement in the work of Independent SAGE --
A. Yes.
Q. -- in the pandemic.

So can I start, first of all -- I think you're the first virologist that we've heard evidence from in this Inquiry. It may be a pretty basic and obvious thing, but can you, first of all, describe why a virologist, that expertise is so important in a pandemic but also what a virologist does and why it was so important to what was needed in the pandemic.
A. Of course, I'll be as brief as I can. Consultant virologists are, in the main, medically qualified but can also be scientifically qualified to become consultant clinical scientists responsible for leading and running diagnostic laboratories.

The responsibilities of a consultant clinical virologist are -- include testing, treatment of, and prevention of viral infections of clinical consequence.

Increasingly, they work within larger teams, if in hospitals, for instance, with infectious diseases, consultants, microbiologists, infection control.

They can be employed by the NHS, therefore by UKHSA and its predecessors, Public Health England, as well as universities, and work, there are something like 49, what we call, specialist virology units around the United Kingdom and Ireland, all of those are consultant led, and that represents the Clinical Virology Network.

Just briefly, a key component, almost a given for clinical virologists, is to evaluate new tests for viruses that emerge or existing viruses that need diagnosis to identify when tests should be done, how best to advise others on management of patients with those, or see patients ourselves with those, and liaise with other hospital consultants, GPs, and directors of public health and their teams, and therefore implicit in all the work we do is all the components of that, of that cascade, as it were, of getting samples in, making sure the right samples are taken, through to the data linkages and advice.

And just finally to put it in context, since I went into university, on average there's been one new virus affecting humans identified per year. So there's always new viruses coming up, and with each of those viruses,

whether they cause chronic infection or lifelong infection or acute infection, such as Covid, these same challenges exist. What best tests? How do we evaluate tests? How do we develop tests? Through to treatment and vaccination, prevention, and dealing with the consequences.

And I should say that since I was first in medical school, HIV and hepatitis C have been identified, and we've just had another public inquiry dealing with the consequences of them 50 years or 40 years later, so how we deal with these viruses now also has consequences for the long term.
Q. Thank you. Now in answering that question you've identified the importance of virology to a pandemic response, and you've set out that there was, in the Clinical Virology Network, essentially 49 centres that existed in the United Kingdom; is that correct?
A. That's correct.
Q. We're going to be looking, in due course, at some letters that were sent, or evidence, which has, along with you as a signatory, 69 other consultant virologists that were raising concerns about the lack of use of the Clinical Virology Network -- that's my summary -- would you agree that's what the letters reflect?
A. Yes, that's correct.

Q. Now, in terms of what you've said clinical virologists do day in, day out, it is essentially to deal with viruses, but also the public health response; would you agree?
A. That's right.
Q. And that the Clinical Virology Network is connected to health protection teams?
A. Yes.
Q. Public health and the associate directors of public health?
A. Yes.
Q. And then you've raised about your role with data. Can you assist, those laboratories, the 49 that are part of the Clinical Virology Network, is there a linkage that existed at the time of the pandemic for, having got the test, to then get the results onto the patient record and to the GP?
A. Of course there's been, obviously, much development of data systems linking different components of the health service, but implicit in what we do and our laboratories do is direct electronic transfer of data. We don't do that by paper, and now the systems are very well developed for getting data to where it needs to be.

Obviously within hospital systems, that's a given, because we'd all be part of the hospital network, but

with primary care, that's now the case, as well as public health consultants, directors of public health and their teams, particularly, of course, where the testing we do relates to outbreaks of whatever virus is going on and needs that input from those public health officials.

Q. Thank you. So from your perspective, the Clinical Virology Network, if scaled up in the pandemic, could have got the test results directly into the patient and GP records?

A. Yes.

Q. Now, can I ask you additionally then, just because you're an individual that's visited these labs throughout your career, the letters that you have sent that we'll look at, that were sent to the relevant individuals in government, did not have a response, you tell us in the witness statement. And certainly was identifying this capacity that existed in the Clinical Virology Network. We heard some evidence from Mr Hancock that effectively they'd looked everywhere, they'd looked at the laboratories, and they were not fit for the purpose that was needed in the pandemic.

Are you able to assist as to whether, to the best of your knowledge, the laboratories that Mr Hancock visited included the Clinical Virology Network?

A. No, and I listened with interest to his answers to your questions in this module. I think it's a given that these 70 clinical virologists representing 49 laboratories across the UK, including the devolved nations and Ireland, the fact that they've written letters both in July, I think one of them, and the other is in October 2020, the fact that they've written these letters, it's self-evident that they felt that they were not involved and their advice had not been sought with regard to scaling up capacity for Covid testing.

Q. Perhaps we'll just briefly look at these letters together now and then go through your statement, please.

A. Yes.

Q. Can we, first of all, go to a letter that was sent on 10 July 2020, which is INQ000551844. Thank you.

We can see this is the letter sent on behalf of the Clinical Virology Network of 10 July 2020 to Professor Whitty, Sir Patrick Vallance and Professor Jo Martin.

If we go over the page, please, to page 2, we see the start of the list of the names of the consultant virologists and their locations. And again, go to page 3, thank you, and again identifying location and specialty. And I think it numbers, as you said, the 70 consultants that were located at the various -- the 49

laboratories.

So can we go back to page 1, please, and we can see the letter detailed the concern of the clinical virologists over the lack of engagement by policymakers with clinical virology expertise in the United Kingdom in the management of the Covid-19 pandemic.

You detail this:

"Our skills have been underused and under-represented (albeit to differing extents within the devolved nations of the [United Kingdom]) resulting in lost opportunities to establish a coordinated, robust, and durable testing framework for SARS-CoV-2".

Then it details what the professionals have offered expertise in, and then go on to make recommendations that -- what should be facilitated in terms of the emergency discussion with specialist virology centres, over the page, rollout of validated RNA PCR assays, a testing strategy to be coordinated, and then again in the next paragraph, please, detailing:

"We work as a network, and offer to help with planning for, and dealing with any subsequent waves of infection. We can enable better communication and collaboration between major institutions (PHE, NHS, [the Royal College of Pathology]) provided there is increased representation of clinical virology expertise on

appropriate policy making bodies. We are ideally placed to understand what is achievable with current infrastructure and staffing, and to advise on the investments in people and facilities needed now to prepare for the upcoming challenges of this and future pandemics. In addition, we are well placed to promote and disseminate advice and guidance, using our established professional networks to facilitate rapid adoption."

Then in the next paragraph essentially reference the work that had been done in 2009 on the influenza pandemic.

And so again, we've explored with a number of witnesses what would have or could have been possible by way of scale-up of differing laboratories that existed, and are you able to give some assistance, that letter referenced the existing infrastructure that did exist, what's your views and opinion as to how the Virology Network could have been scaled up for the testing that was needed?

A. So I've outlined earlier what our sort of bread and butter function is, which includes all aspects of, from sampling through to data transfer, including, of course, testing. And it struck me, listening to actually others in this module, the degree to which almost people

involved in testing early on at government level were discovering for the first time that you needed to consider how samples were transferred, how tests could be undertaken, how data could be transferred, and indeed, what was needed in order to make sure that the impact of those tests on the person at the end of the line was enacted.

So first of all, was that experience and that understanding could have, I think, bypassed many of the problems there were early on.

Secondly, and of course I accept that with the scale of tests needed, there would always have had to be new infrastructure built and developed, but had that been done on the back of those systems with the same ownership of those systems, then I think we would have been far more effective far earlier in maximising the utility of testing for the benefit of both those who had Covid, but also to prevent further infections.

Q. And so in terms of the scale-up of testing that the Inquiry has heard evidence that was needed, are you saying first of all, in the existing capacity as was, the testing could have been substantially increased across the network?

A. I think that would need to be on a case-by-case basis but a question early on could have been put to these

specialist laboratories: what other facilities are needed? What partnerships do you have? As an example, Paul Nurse talking about the link between my hospital and the Crick in terms of upscaling testing. There were many -- and we've heard from Professor McNally as well, similarly. So there would have been lots of opportunities and that would then be a place for further investment where that could actually dramatically increase the capacity. So number one.

And number two, I think even existing capacity was not utilised fully.

Q. Thank you. And so is it really you're saying that there was a lost opportunity to build on the existing infrastructure in the Clinical Virology Network?

A. Well, I think it's not only a lost opportunity, but what I've said in my statement, which I have to say is shameful, is that the huge investment that went into the new structures means that we've been left with nothing. You know, there literally is no legacy of that. Whereas had investment been made into existing partnerships, then of course we would still have that capacity for now and for future.

Q. Thank you. Can we then just briefly look at, I think an expansion on this earlier letter that was sent by way of the written evidence from November 2020, please, and can

we go to INQ000474853. Thank you.

So again, this is a submission broadly by the same consultant clinical virologists, and we're in November now, and is it right that the significance of November 2020 is that this is at a time after the national -- the new NIHP had been introduced in the August of 2020, and I think it was the frustration again, if we look at the document, the fact that, again, a new health protection body had been created which was then scrapped and became UKHSA where again, the virologists network had not been consulted about that new health protection body; is that correct?

A. That's correct.

Q. So if we go through again, you summarise essentially, if we go through the first couple of pages, what was said in the earlier letter, and then on the next page at page 3, please, you recommend, again, what's necessary. Thank you.

If we can move to page 4, you say, at the bottom of that paragraph:

"The letter outlined our view that the establishment phase of the NIHP was the ideal opportunity to build a new relationship with the clinical virology community of the UK. We work as a network, and offered to help with planning for and dealing with, any subsequent waves

of infection. Moreover, the NHS and academic associated laboratories include most of our members and our membership of the Royal College of Pathologists enables rapid and functional communication and collaboration between these institutions."

Over the page, please. You then also highlight that:

"Focusing testing in the Lighthouse laboratories rather than funding expansion of those existing and experienced NHS laboratories would have been able to [assist with the] large scale testing."

So can I ask you, this is November of 2020, we know that there were then subsequent waves of the coronavirus, the second wave that came in the autumn of 2020, do you have a view as to whether, if there had been consultation with the Clinical Virology Network earlier on, that that was an opportunity also for the network to have essentially put plans in place that could have prevented the second wave of the coronavirus?

A. I certainly think that a more coordinated testing environment would have mitigated some of that growth of the -- of that wave. Of course it would be foolish for me to say prevented that at all. But I think the convening power of this network, and as we've learnt during, again, this module, as I've learnt listening to

witnesses, is the silos that exist between NHS and with UKHSA have meant that there's not been the ability, I think, to maximise the potential of this network.

Q. Thank you.

Then can we go to page 6, please, which gives the conclusion, again supported by the names -- over the page -- as well as of those consultant virologists, you say this:

"We feel that if the [Clinical Virology Network] and the associated NHS and university laboratories had been involved from March, the capacity for testing and tracing would have been increased and improved from a regional perspective. This would have been augmented by liaising, collaborating and sharing experience with both validating tests and equipment with the Lighthouse laboratories. This would have offered local mass testing as well as regional and national mass testing in a standardised way involving professional networks in the NHS, PHE and public health. The opportunity to notify infections and act on those results locally, regionally and nationally together with the public health teams would have helped the test and trace strategy."

A. That's completely correct, yes.

Q. Thank you.

Can we then work through your statement together, please.

If we can please go to INQ000475152. And if we could go to paragraph 9, please, on page 3.

You deal with the purpose of testing and say this:

"A diagnostic test only has value if there is a clear reason for undertaking it, and an action which will follow on from the result. It is this purpose which is key, and will define the effectiveness of a testing strategy."

I think that's perhaps self-explanatory.

A. Yes.

Q. But I think you produced a document today, I think, again to address some of the evidence we've heard, for example, from Sir Paul Nurse that gave an example of it's not just about numbers and the fascination of getting to that 100,000 tests figure. Are you able to assist as to any views you have about that as an approach to the strategy that was implemented?

A. Yes, I'm pleased to. The purpose of mass testing -- I mean, let's put -- three reasons for testing for Covid. First of all, if someone is ill and there needs to be a diagnosis so that that individual can be managed appropriately with their illness. Secondly, for someone to themselves isolate in order to stop spreading that

virus to others. And thirdly, for contacts of those individuals to identify whether they themselves have been infected and therefore can isolate.

So, for that mass testing part, the second part of what I've said, the aim is to reduce transmission of infection. That should be -- that's the aim. And any strategy should be measured as an outcome measure of how many infections have been averted.

In the same way, for instance, that imaging for, and scans for cancer diagnosis, one wouldn't -- one wouldn't say the target is X number of scans. The target is how many cases of cancer have been caught early, therefore treated effectively, or averted. And that -- and that should have been the purpose here.

So focusing on a number of tests in that context is pretty meaningless unless there's a well-thought-out way in which that's come up.

I suspect, and as we've heard, that this was more of a political statement to garner activity within those who were setting up laboratories, but I don't think it engendered the sort of trust of the population that is required and, as we've learnt, has been central to willingness to be tested and willingness to isolate and therefore limit infection transmission.

Q. Thank you.

I think you've alerted the Inquiry today to a response letter from Sir David Norgrove to Mr Hancock from May 2020. Can we briefly look at that.

It's INQ000237412.

And it's right, isn't it, that Sir David Norgrove, you've identified his role within the UK Statistics Authority.

A. Chair of the UK Statistics Authority.

Q. Thank you.

If we go over the page, please, I think essentially this is really commenting upon the figure of the amount of tests that's been put in the public domain, including:

"The data around COVID-19 are inevitably complex, which makes it the more important that publications should meets the standards set by the Code of Practice for Statistics. We urge Government to update the COVID-19 national testing strategy to show more clearly how targets are being defined, measured and reported. Measurements will no doubt need to change and develop as we move into new phases for tackling the pandemic."

So can you assist as to why in particular you wanted to bring this document to the attention of the Inquiry today?

A. Well, if you don't mind me saying, I listened earlier to

the module where you asked Mr Hancock precisely this, and you quoted my report in asking him that question about the rationale for 100,000 tests. Mr Hancock responded robustly about why it was appropriate. So I wanted just to illustrate that it's not just my opinion; this is the UK Statistics Authority also bringing doubt into that logic.

Q. Thank you.

Can we then go to your paragraph 11, please, at INQ000475152. You essentially detail that a testing strategy needs to be assimilated into a pathway to effect an appropriate outcome, and talk about data capture, linkage and accessibility, but also why, then, Independent SAGE in particular says, you know, it needed to be a find, test, trace, isolate and support system.

Can I then ask you, in the context of the importance of data capture, linkage and accessibility for a successful testing strategy, and I think noting what you do in the statement and other documents about the poor degree of linkage of tests undertaken in private laboratories to NHS records and reporting back being identified by you as a problem in the pandemic, are you able to assist as to whether, to your knowledge, the problem resolved satisfactorily during the course of the pandemic?

A. That's correct. What this report, which is a modelling report, a modelling paper, but did suggest that by reducing the time, this is the time from someone donating a sample and that result getting back to them, if that was reduced from five days to three days, that could increase the effectiveness of the isolation strategy by 60%.

So clearly, days matters in this. And then any data problems, data linkage problems, will contribute to a delay.

Q. Thank you. And can I ask you then in terms of what we've already discussed around the Clinical Virology Network, are those essentially the knowledge and the speed of from testing to results, something that was part of the functioning of a Clinical Virology Network?

A. That's quite right, because we are embedded within those data linkages.

Now, even if there needed to be new data links developed in respect of the developments of further infection control structures in the midst of a pandemic, the framework would have been there to develop that. All the agreements in terms of data sharing and compatibility of data systems would have been there. So the development work would be far less than I think was required in setting up the Lighthouse laboratories as

A. I think it took a long time for data, particularly from Lighthouse laboratories, to make its way into those that needed it, and I think what's well recognised is -- and I think I referred to it in the document -- is an outbreak in Leicester where local public health officials found it difficult to access those data, even though the data existed and others within the system could see what was happening in Leicester, the people who actually needed it were not able to obtain it.

I should also say, and it's another, if you don't -- if I can relate to another document, the DELVE document, which is a Royal Society report quite early on in the process which did identify that the speed with which from the time of swab through to result coming back was central to the effectiveness of an isolation approach.

Q. Can we then briefly look at that DELVE report, please, which is INQ000194035. That's INQ000194035. Thank you.

And is what you're referencing here this second paragraph we see, that:

"Based on our modelling work, we find that adding TTI to a broader package of interventions can generate a reduction of 5-15% in the number of new infections".

And then talking about the need to, essentially, reduce, and I think the reduction is from five days to three days, saying it would be necessary.

independent structures.

Q. Thank you. Can we then move to your witness statement again, please, and paragraph 18, which is at page 5 of INQ000475152.

You provide there a summary of the test and trace response, and you characterise it as:

"... a confused, uncoordinated approach which lacked strategy and clear leadership, and quickly focused on test number rather than ensuring that testing could lead to the goal of reducing disease and ongoing transmission. Further, the urgent need to scale up testing within this framework was severely compromised by not taking advanced of existing laboratories, expertise and well-developed systems."

Can you assist, to what extent did the emphasis on scale rather than targeted strategic testing obscure the specific needs of those most exposed to infection risk?

A. Well, I think it was a confused approach. There was lacking of strategy, and when I'm talking about strategy, it's not number of tests, but I'm thinking rather the overall goal of the pandemic response. I don't doubt that there needed to be increased, a dramatic increase in capacity for testing, but I say again, that if that had been developed on the back of existing structures and expertise and understanding,

then the effectiveness of that upscaling would have been much more.

Q. Thank you. Can you assist in terms of a strategic focus. Have you any views as to whether the testing system designed recognised and responded to occupational and structural inequalities faced by ethnic minority healthcare workers?

A. Well, it is pretty much a given in the NHS, and I say this now I've retired, I'm a non-executive director on a couple of NHS trusts, and any new service that is developed first goes through the lens of how is this addressing the inequality of access to healthcare that exists? And so that would be a prerequisite for development of any, particularly, sampling strategy, how best to access people, how best to convince and enable the population to be tested, and that goes without saying, really, for an NHS service.

The fact that this had to be learned afresh, really, by those setting up these new structures just, I think, added to delay and would have contributed, unfortunately, to the inequality that exists in our health service, and indeed as we've seen, Covid has contributed to further inequality in outcomes.

Q. Thank you.

Can we then move and have displayed your

paragraphs 22 and 23, because you detail within that, essentially, contact made by you with Deloitte, a meeting you attended with Deloitte, and then observations about that experience.

Can I ask you, you detail that when you attended that meeting, it became clear that they had "no relevant expertise and were urgently seeking answers to some basic questions".

Despite already being engaged to lead the aspects of the national testing rollout, are you able to assist as to your views of what the implications were of this approach for the delivery of safe, equitable testing services?

A. Well, we were all -- remember, at this stage of the pandemic, everyone wanted to help out. So when this meeting was called, many of us attended. And as in my witness statement, the questions being asked by the individual representing Deloitte, and she was working for Deloitte, it's not an individual problem -- you know, I don't have antagonism or any comments on her, she's doing her job -- but it was clear that she didn't have and the team, the Deloitte team, didn't have an understanding of some basic aspects of how you package up samples, how you put them in the post, et cetera, things that are pretty much standard for those of us in

diagnostic virology and infection control.

So it seemed to me, sitting on a call with a large number of experts working in the NHS and universities, advising someone like that on these basic processes, it didn't make me feel that this was going to be as effective as it could have been from those sitting around the table or on that virtual call being asked to develop a system.

Q. Thank you. You also detail in your report, which I'm not going to deal with because it's self-explanatory, the concerns you had about the testing issues in these laboratories.

But can we move to your paragraph 28, please, where you reference chairing that horizon scanning group, from the end of March to May of 2020, in the Department of Health and Social Care.

If we go over the page to page 8, you specifically reference that, during that meeting, a spreadsheet was provided including potential suppliers:

"Some of these ... listed separately on a 'VIP' tab; these were the companies which had approached ministers directly ..."

And you were:

"... asked to consider them for fast tracking, as in through the Cabinet Office Commercial Team."

And you say this:

"I refused because this undermined my wish for an objective expert-led assessment."

You say this:

"This experience gave me an insight into the contractual mayhem in play. Indeed, there were many criticisms from the Consultant Virology community of national purchases of testing systems which were not evaluated or were being imposed on their laboratories at the expense of well-established systems."

A. Yes, that's correct, it was surprising to me that there was something such as a VIP tab. Even if there had been approaches directly to ministers or others in government, why was there need to identify that specifically? And I do recall being asked to consider those because of those personal approaches being made.

Q. Thank you. And so, Professor Pillay, would you ask, when we consider your evidence, we see it through the lens and the context of your expertise, but also you had direct liaison with the consultants that were assisting in setting up the strategy and the testing plan, but also you were directly involved with the Department of Health and Social Care in those early stages, horizon planning on what was needed?

A. Yes.

Q. Can we then, please, move to your paragraph 31 on page 8. You detail, and going over the page on to page 9:

"Nevertheless, it seemed obvious that local public health structures were ideally placed to receive further investment to grow contact tracing and isolation support for the population ..."

And you go on.

Was it foreseeable pre-Covid that existing health inequalities would be exacerbated by both the pandemic and interventions implemented to address it, and should these have been central to the planning and implementation of any test, trace, isolate programme?

A. Indeed. The period from 2009 to 2019, there was shockingly a reduction in life expectancy in the UK. I mean, that's an amazing thing for those of us brought up with ever-improving health. And that reduction and increased morbidity was particularly the case for those in lower socioeconomic positions and disenfranchised. And therefore it's clear to many of us that any new intervention or any new health structure needed to focus specifically on how to prevent that inequity being replicated.

Q. Thank you. And are you able to assist us as to your views: was there any benefit of taking a national

approach to Test, Trace and Isolate rather than basing it on existing local public health resources?

A. Well, I do think there needed to be a national strategy, and clearly, there needed to be collaboration and assimilation of local efforts to national -- to the national goal, and of course, there would need to be strengthening of local facilities as well. We, again, have heard, I've heard from others in this module of the reduction in resource in local authorities, in particular, since 2012, when public health was put into responsibility of local authorities and we're all aware of how little money and how financially stressed they are, and therefore, it was essential that more resource was able to go to those structures, just to support local responses.

Q. Thank you.

Now, Professor Pillay, I think you give some observations as to international comparators and how they support isolation, in particular with adequate financial support.

And if we briefly look at page 10, please, which is a summary of the blueprint for an effective Test, Trace, Isolate system that Independent SAGE proposed, which included the £800 isolation payment.

So can I ask you, in your view, was the UK's failure

to provide adequate support for isolation both harmful for individuals, harmful to immediate efforts to limit the spread of infection, and detrimental to the country's ability to recover from the pandemic?

A. Yes, I preface this by saying this is the precise nature of support for those asked to isolate. It's not my own area, and we've just heard from an expert, Professor Machin, on this, but in answer to your question, yes.

Q. Thank you. Then can we then turn, finally, for my questions, please, to legacy. You say this:

"One of the most disappointing -- indeed in my view disgraceful -- outcomes of the Test and Trace programme is the lack of any meaningful legacy or strategy for the next pandemic threat. Many of us in the field recognised that a significant increase in testing capacity would be needed early during the COVID pandemic. And further, the manner in which this was undertaken would be core to developing a sustainable system for further threats, incorporating surge capacity. By contrast, we witnessed a one-dimensional approach to testing developed through the outsourced model, with the establishment of the Lighthouse laboratories. As early as February 2021, concerns were expressed regarding the mothballing of some of the

expensive Lighthouse laboratories, at a time when testing would be essential to monitor relaxation of some non-pharmaceutical interventions, such as school reopening and people returning from holidays ..."

Professor Pillay, it's strong language you've used, including the word "disgraceful", is there anything else you would wish to add to your views as to legacy expressed in the statement?

A. Yes. So firstly, the reason that has been given for the effectiveness of testing, as well as the infection control in those countries such as China, Taiwan, South Korea, is that they had previously gone through SARS-1 and had learnt from that experience, and therefore they had an infrastructure able to rapidly respond.

The fact that we have been through Covid, yet do not have that, and not been -- not taken advantage of that, I think that is disgraceful, that, you know, as a country that has, going back many years, has led globally on infection control, laboratory testing, for infectious agents, the fact that we're now in this position, I have to say, with the investment that has gone in, is, I think, a disgrace.

Q. And I think you deal with that finally in your paragraph 38 where you say:

"By contrast, despite a reported of £37 million

spent on the Test and Trace programme ... the UK has been left with minimal capacity for the next pandemic."

A. Yes.

MS CARTWRIGHT: Thank you. Professor Pillay, those are my questions. There are some questions --

LADY HALLETT: Thank you.

Mr Weatherby has some questions. He sits there.

Questions from MR WEATHERBY KC

MR WEATHERBY: Yes, Professor. I've just got two short points on behalf of the Covid Bereaved Families for Justice UK group. I want to first of all just pick up important evidence that you've already touched upon in terms of the failure to take advantage of the expertise of clinical virologists and the outsourcing that you referred to. And I want to put to you part of the statement of Dr Cotgreave.

And just for the record I'll give the reference, INQ000147814, paragraphs 17 and 20.

And Dr Cotgreave says this, and I quote:

"... more time was spent by some of our members 'educating' management consultants within government in the basics of infectious diseases, obtaining samples from people, diagnostics, and serology rather than the same members of the Microbiology Society with expertise given authority to establish at speed and scale what

they already knew worked from past experience."

And that genuine offers of support were "turned down or ignored", and:

"The overall impression of official responses to offers of help from genuine experts with real potential to be of potentially life-saving value to the nation was not that they were not needed but that they were not wanted."

Does that resonate with the evidence that you've already given in terms of the effect of the failure to take up the existing expertise?

A. It does resonate. That -- the Society for General Microbiology that's represented by that statement will overlap somewhat with the Clinical Virology Network but would also include particularly university academics, and so, yes, that does resonate.

Q. Now you'd already been asked about a couple of letters that you and others sent to Professor Whitty and others, and you've talked about the issue of outsourcing. Did you raise the issue of outsourcing during this time? And if so, what explanation, if any, were you given about the engagement of companies such as Deloittes, who had no history or expertise in these areas?

A. The key way in which I, as an individual, undertook that was through my involvement with Independent SAGE, which

produced many documents which related to that process of testing and outsourcing. And so in that way -- and all of those documents were passed on to senior government ministers.

Q. And were you given any explanation as to the engagement of companies without any history or experience?

A. No.

Q. Finally this: the last point you were asked about by Ms Cartwright. Is there any reason why the UK should not now develop the infrastructure and testing protocols and planning for a future pandemic, as countries such as South Korea, Taiwan did in response to SARS and MERS 20 years before the Covid outbreak? Is there any reason that that can't be done now?

A. There's no reason that that can't be done now. I'm sure my Lady will -- any recommendations have to be put in the context of finance, but nevertheless, if we are to avoid the same amount of money being spent the next pandemic, then I think it could be done much cheaper with infrastructure.

As to, very briefly, the organisation for that, I still think the opportunity is there to have a much more upgraded public health/infectious disease/communicable disease structure. UKHSA is a shadow of what the Public Health Laboratory Service

was when I joined it in 1993, which was the envy of the world, and I still think that that is the sort of framework within which that sort of cooperation amongst different parts of our health service can -- and diagnostic testing, can happen.

MR WEATHERBY: Thank you very much, Professor.

LADY HALLETT: Thank you, Mr Weatherby.

That completes the questions we have for you, Professor. Thank you very much indeed for your assistance, and please don't think that because we had a relatively short time with you, that I won't bear very much in mind all that you've put into your very helpful witness statement.

THE WITNESS: Thank you very much.

LADY HALLETT: So thank you for coming to help us.

MS CARTWRIGHT: My Lady, that concludes the evidence in Module 7 and I think we'll move now to the Core Participants' closing statements. Thank you.

LADY HALLETT: Thank you, Ms Cartwright.

Ms Munroe, I'm told you're hiding behind a pillar. Ah, you were.

Closing statement on behalf of Covid Bereaved Families for Justice by MS MUNROE KC

MS MUNROE: My Lady, thank you, and good afternoon.

I, of course, act on behalf of Covid Bereaved

Families for Justice and in these closing submissions, my Lady, I will highlight perhaps six themes, but by dint of the time allocated, will be brief.

In our closing written submissions, these themes and more will be expanded upon.

Where our position aligns with other Core Participants, I will also, and do, endorse those submissions to come. And of course, those submissions made on behalf of Covid Bereaved Families for Justice Northern Ireland.

My Lady, in our written opening we stated that the failings in Test, Trace and Isolate were not merely a case of limited capacity or systems under pressure, but a pattern of missed opportunities, avoidable delays, and a persistent failure to act with urgency, even when expert advice was being offered, when support was available, and when international models of success were there to be drawn upon.

Nothing in the three weeks of this module has caused us to alter that analysis of TTI and the system in the UK during the pandemic. Rather, the evidence from a raft of witnesses, many of whom were there at the time, others were experts instructed by the Inquiry, have confirmed and expanded upon that analysis.

Theme 1: broken promises. Boris Johnson promised

"a world beating system". Sadly, it was anything but that. We've heard at length in other modules about the lack of infrastructure and under-resourcing.

Well, it will come as no surprise to anyone that those factors again reared their head in TTI. The UK entered the pandemic from a position of structural fragility.

My Lady, we are now six modules completed and we're still hearing the same song, and we all know the lyrics by heart. As your Ladyship said to Sir Paul Nurse: "In this Inquiry, everything comes back to planning."

And I think his answer was simply "Yes".

The lack of planning, poor foresight, wasted opportunities, and a continued, almost obdurate, inability to learn, adapt and prepare, were all hallmarks of the government's TTI. The losers, as ever, were the public. We, who were left to deal with the fallout, the dangers, and the deaths. As Professor McNally succinctly put it: "We were fighting Covid blind."

Theme 2: reinventing the wheel. There are many things that people complain about, in this country. My Lady, one thing that we can perhaps all agree with and that we should rightly be proud of are our universities, their research departments, and particularly the

scientific research that can stand against anything in the world. Those departments are brimming with talent, knowledge, and expertise.

One of the slogans repeatedly said from the broadcasts by the government during the pandemic was that the politicians were following the science. Yet when it came to Test, Trace, Isolate and Support, the advice and expertise of some of the foremost scientists in this country, nay the world, was ignored. Politicians no longer followed the science but followed the men and women in business suits. The new reality was following the consultants.

Professor McNally again: "I do believe the university to research institutes and industry labs could have been stood up in February and March 2020 to increase capacity whilst Lighthouse labs were established."

Professor Pillay emphasised that point as well, and we've just heard from him and, my Lady, we would commend his evidence to you, both written and oral, which has been both powerful and very compelling.

At a time when clear bold political leadership was needed, infused with a sense of public duty and responsibility, the government made political choices that flew in the face of that. Our families and the

wider public ask a simple question: why?

Perhaps an answer to that can be gleaned, to some extent, by comparing two witnesses, one who was new to the Inquiry and one whom we've heard from on a number of occasions, those individuals being Sir Paul Nurse and Mr Hancock, the then Health Secretary.

Dealing first with Sir Paul. My Lady, military and particularly wartime analogies have been made in Module 7. Sir Paul spoke of the university institutes who offered their services as analogous to the small boats, of course referencing Operation Dynamo and Dunkirk, which exemplified courage and solidarity and adversity.

Sadly, far from embracing our modern little ships and the unique role they could play, the government ignored them, stopping them from even leaving their home ports before they could make any real difference.

Sir Paul said:

"... We had the machines and we had the expertise ... We had about 50 PCR machines operating in the building [the Crick]. We also needed containment facilities and we had good containment facilities, I mean, the sort you would find in a local hospital ... we had ... 20 of them. And those were critical ..."

He wrote, of course, that letter on 14 April to

Matt Hancock. The response from a civil servant, which Sir Paul described as anodyne, came in July. He said it took three months to get this letter. Peter Ratcliffe is a renowned individual.

"... to ignore a letter from two Nobel Laureates ... for three months is a little surprising ..."

My Lady, you may feel, certainly some of our families did, that Sir Paul was being a little humble, a little too humble in his response there.

In his view, the government didn't put in place what was necessary at the time because of testing capacity, and they wouldn't acknowledge that they couldn't do it as that would have exposed their strategy.

He goes on to say:

"What we were doing was ... public duty ...

"People wanted to help ..."

To volunteer.

"... all that was being thought about were commercial solutions ..."

Finally, Sir Paul added that there was too often empty sloganeering and non-existent successes that took the place of actual purposeful leadership.

Mr Hancock, by contrast, is no stranger to the Inquiry and he continues to be a controversial figure for many of our families. Many were watching online,

others travelled, some at some distance and at difficulties to themselves, to listen to him in person that day.

My Lady, suffice to say they left the hearing room after his evidence significantly more perturbed, some upset, some angry, and some simply bemused, than they had been when they arrived that morning.

Mr Hancock, if nothing else, has always been consistent in his inability to read the room. His responses to questions from Ms Cartwright King's Counsel about support and Professor Ratcliffe and the failure to utilise the existing talent on the ground within the scientific community was not to listen or to engage or to consider or to self-reflect. Mr Hancock's initial response was, at best, rather disappointing, at worst, somewhat churlish. Almost literally dismissing the question with a wave of his hand, and the response -- and characterising the response of these preeminent scientists as "bruised egos".

Our families can only sadly conclude, and it gives me no pleasure to say this, my Lady, that this is yet another example of the hubris of Mr Hancock.

Theme 3: ignoring international lessons. Some people maybe old enough to remember the phrase "Think globally, act locally", it was a phrase popularised in

the seventies and eighties, its actual origin is somewhat unclear but it's widely attributed to the environmentalist David Brower who adopted it as a slogan for his organisation that he founded, Friends of the Earth.

It means, and I think this is right, my Lady, it's about considering the interconnectedness of global problems whilst taking concrete steps within your own locality to address the larger issues that you are thinking about globally.

Perhaps, if there was one slogan that the government should have adopted and seen a resurgent during the pandemic, it was that slogan, because other countries were facing the same virus but they responded with greater urgency, adaptability, clarity of purpose.

South Korea and Germany are two examples, in particular, that took early and effective steps that demonstrated what a timely, trusted and decentralised response could look like. These were not just case studies; these strategies were widely reported, discussed by health experts, and praised by international bodies. They were comparable nations in terms of wealth and public health systems. Some of them had learnt through previous pandemics.

Our families, sadly, have heard nothing from those

ministers, those government -- those from Whitehall who have given evidence in this module to explain why our government was unable at the time to learn from other countries.

Theme 4: the local-central dichotomy. Myriad witnesses spoke about the misguided policy which concentrated on a centralised system thus bypassing local skills and resources.

Professor McKee in his witness statement noted: "We emphasise for a system rooted in local communities, integrated with the NHS, and led by local directors of public health. We argued that the current private sector on NHS Test and Trace systems should be replaced with a more effective model. That leverage is local knowledge and the resources we were aware of and the actions taken by the directors of public health, for example in Leicester, and subsequently emulated by the counterparts in Sandwell and other places."

And Greg Fell, my Lady, who gave evidence this week, spoke of the local public health system being undervalued by successive governments, demonstrated particularly by a lack of real term increases in England to the public health grant.

Now, of course, the evidence that we've heard suggests, very properly, that larger labs were needed as

well. It wasn't a question of one or the other, but an integrated policy involving both. But where are we now? Well, the elephant graveyard of the Lighthouse labs are another shocking outcome of the pandemic. The Lighthouse labs no longer exist. All equipment has been sold off. All expertise gone. The subsequent closure or scaling back of such infrastructure raises important questions about long-term planning, value for money, and the legacy of pandemic investment.

Theme 5: asymptomatic testing. There was not effective asymptomatic testing within the TTI programme. By late January 2020, credible evidence of asymptomatic transmission of the virus had emerged and by February 2020 there was very much a growing body of evidence that Covid-19 could be transmitted by individuals who showed no symptoms, whether truly asymptomatic or not. But the UK was slow to adapt.

There was and there should have been a precautionary approach to routine asymptomatic testing. That did not begin until November 2020.

Theme number 6: support. My Lady, we've heard a lot about the issue of support, and again this morning, from Professor Machin. The two points about the success of TTI and support are inextricably linked. Self-isolation is an altruistic act and most people are actually very

altruistic and they want to help. It makes you feel better. You want to be part of that community. But they cannot always do this.

Underpinning the ability to be altruistic, the ability to self-isolate, there has to be a proper programme of support, be it financial or otherwise. And yesterday, Professor Arden emphasised and underscored the importance of behavioural science to planning. How people act and how people behave is something that needs to be part and parcel of the planning. There needs to be trust. They need to understand and adhere to certain restrictions and how is that developed? And how is that message and guidance given?

Lady Harding, from her statement, said as follows:

"The UK spent proportionally much less than any other developed country, enabling disadvantaged people to self-isolate. If we had allocated more of the NHS Test and Trace budget to Isolate and Support, I strongly suspect that fewer would have died, and infection rates would have been lower, with all the benefits that would have brought. We had the money in the budget, you know. We didn't spend all of our budget. But I wasn't the decision maker. The decision maker was the Chancellor, and at every opportunity from June onwards, the Chancellor rejected the proposals."

Where support was lacking, the vulnerable, the dispossessed, those who were digitally deprived, those most in need felt it most. These shortcomings within the TTI system, in terms of support, were compounded by the failure to combat structural and institutional discrimination, in particular around race and disability.

My Lady, Mr Gething gave particularly trenchant evidence, you may think, in regards to that.

Turning then finally to our conclusions. The reality is that the failure to plan and the lack of capacity for TTI and support meant that the UK had far greater mortality and morbidity rates, deaths and serious illness and Long Covid.

My Lady, you will recall the evidence of Professor Naomi Fulop who gave evidence on behalf of Covid Bereaved Families for Justice. She gave moving testimony initially about her own mother and her journey, and then she spoke about the themes that she wanted to bring out, and she said:

"Actually, if you have an effective test, trace, isolate and support system, you can both reduce the number of deaths and reduce the number and length of lockdowns ...

"So, for the system TTIS to work, all elements of it

have to work. So even if you were very good at testing and tracing, if you can't help people -- facilitate them to isolate, you're not going to help them control the spread of the infection ...

"[I] hope the Inquiry can bring cool, calm, rational evidence to this discussion to show how test, trace, isolate and support, together with other pandemic preparedness and responses can mitigate both the number of deaths and the lockdowns and economic and social damage."

I would echo those words of Professor Fulop, my Lady. We do not want, in the future, to be in a room watching another judge and lawyers bemoan the state of the next pandemic, and people, one by one, standing up and saying, "Well, why did we not learn the lessons of Lady Hallett's Inquiry? Why were those lessons not implemented by government?"

Because there will be another pandemic.

My Lady, we invite you and your team to bring cool, calm, rational analysis to your conclusions, and, in terms of purposeful leadership, to craft bold recommendations that the present government cannot, we hope, ignore, but that they will bring them in, and act upon them expeditiously and comprehensively, because the legacy that Professor Pillay talks about is not one to

be proud of at the moment. We are back in the situation of 2020, if not worse, in terms of many aspects such as health inequalities, and that cannot be sustained.

My Lady, thank you.

LADY HALLETT: Thank you very much, Ms Munroe.

Ms Parsons. You can't escape me. I think I saw you over there.

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

MS PARSONS: Thank you, my Lady.

These closing submissions are made on behalf of the Covid-19 Bereaved Families for Justice Cymru. As my Lady knows, the issue of nosocomial infection for many of the group's members is of paramount importance. That is because so many of them had loved ones who died having caught Covid in hospitals and in care homes, the very places that they should have been protected.

Given the importance of testing, and in particular asymptomatic testing, in the prevention of nosocomial infection, the members of the group of have listened with the utmost care to the evidence in this module. What they have heard has angered them.

Where is the recognition that delays in testing and failures to test frequently enough actually cost lives? Where is the awareness that, far from being a question

of hindsight, things could and should have been done better at the time? Where are the reflections on how to do things better in the future?

As witness after witness from Wales set about defending the decisions they took, engaging in political point scoring as and when the opportunity arose, members of the Bereaved Families for Justice Cymru felt that the deaths of their loved ones were treated as, at best, a statistical inevitability and, at worst, an irrelevance.

This closing is focused on testing, but, my Lady, that is not the only issue, of course. The tracing programme was inadequate in Wales. Amongst other things, it completely overlooked care homes, and the proximity app, as they called it, introduced presumably because of its anticipated value, had very low take-up levels. Tracing and other matters of concern for the group will be addressed in written submissions.

Turning then, my Lady, to the first point: delay in recognition by the Welsh Government of the value of asymptomatic testing.

The Inquiry has heard expert evidence about when the scientific community acknowledged asymptomatic transmission. Professor Fraser told you the evidence of asymptomatic transmission emerged quite clearly

throughout February and March 2020.

Sir Paul Nurse told the Inquiry there was ample evidence from very early on of asymptomatic transmission, and he cited studies in Hong Kong, China, Italy, the cruise ship, and so on.

Professor Harries said Public Health England was aware of research from the Centre for Disease Control as early as 3 April 2020, that reported very high levels of asymptomatic transmission in care homes. Their own study, the "Easter Six" as she referred to it, confirmed the same.

On 14 April 2020 the GO-Science advice confirmed that asymptomatic infection represents a large proportion of transmission.

That was the same date that Sir Paul Nurse and fellow scientists at the Crick Institute wrote to Mr Hancock to urge asymptomatic testing of healthcare workers, a priority cohort given their potential exposure to the virus and given their proximity to vulnerable people.

Mr Hancock told the Inquiry that that was also the date, on 14 April 2020, from which they started making testing decisions on the basis of asymptomatic transmission.

What of the position in Wales? On 29 March 2020,

Public Health Wales advised that, with respect to care homes, if new or existing residents do not have any symptoms, there is no value in testing for the presence of coronavirus.

Mr Drakeford used almost identical language in the Senedd. On 29 April 2020 he told the Senedd, when asked about testing in care homes, that:

"The clinical evidence tells us there is no value in doing so."

And on 6 May he doubled down and told the Senedd that he had not seen any evidence that asymptomatic testing had any clinical value in homes where there was no coronavirus in circulation.

Explanations for these bizarre statements were offered by Mr Gething to you, he relegated them to the cut and thrust of the debating chamber, and by Dr Howe, who pointed out that the statement was conditional on there being no coronavirus in circulation.

But however one interprets these comments, my Lady, one thing is clear: there was no change to their baseline flawed assumption until mid-May 2020.

The Welsh Government cited new SAGE advice of 12 May 2020 as the pivotal moment for change. But this entirely misses the point: it wasn't new at all. As has just been set out, the Welsh Government had the

scientific evidence.

We know that whatever difficulties there may have been with communications at a ministerial level, there was a high degree of collaboration between the UK CMOs, chief scientific advisers, and public health agencies. To quote Dr Frank Atherton:

"The science is the same across the four nations."

What is the explanation for this delay, my Lady? Was it incompetence? A failure to appreciate the significance of asymptomatic transmission and the need for testing? Was it a wilful disregard for the science, driven by concerns about the testing capacity and the impact of a positive test on staffing levels?

Whatever the reason, the delay undoubtedly calls into question the view expressed by Mr Drakeford in evidence to you, that:

"In Wales ... we planned first and then we announced. And sometimes that makes us look like we were later doing things than was happening elsewhere, but I believe that our method was more effective."

What was more effective, the group asks, about a delay which endangered the lives of so many of the most vulnerable in Wales?

The Bereaved Families for Justice Cymru made reference to their opening submission to the question

posed by Counsel to the Inquiry in Module 2B, namely whether the Welsh Government's position on asymptomatic testing was a position that could genuinely and reasonably be held. And we submit that it is abundantly clear from the evidence you have heard that it is not.

Moving to the second part of these submissions, my Lady: delays and failures in the testing regime for priority groups.

Care homes first. Nosocomial infections were rife within care homes in Wales, and they were allowed to seed within these settings because of delays and failures to implement proper testing regimes.

In the next module, my Lady, you'll hear from the owner and manager of a care home in North Wales who was crying out for testing of her residents and staff because it was glaringly obvious to her, as someone working on the front line, that routine testing was essential.

Her increasingly desperate messages to the Welsh Government, in April and May 2020, included the following warning as to access to testing:

"I do not know how long it is going to be before relatives of the deceased speak to one another and realise they are not going to be treated with the same importance as England, less than 9 miles from here.

They would be horrified to learn that the Welsh Government has decided it is not important enough."

Well, my Lady, they have been speaking, and they are horrified.

As we know, the Welsh Government delayed routine testing of all hospital patients being discharged into care homes. It issued an apology in its opening submissions. They said this:

"There ought not to have been a delay between 15 April 2020 when the risk came to the fore ... and the [publication] of guidance on 29 April 2020."

However, no actual explanation has been provided for that delay.

Worse still, there has been no explanation as to why it took until 16 May 2020, that's one month after the risk came to the fore, to announce routine testing for residents of large care homes, and why it took until 15 June, that's two months after the risk came to the fore, to announce routine testing of patients in all care homes of all sizes, and of care home workers.

Lack of testing capacity is an unsatisfactory explanation. It points to a chronic failure to plan, and an inability to scale up effectively. It leaves aside the issue of consistent underuse of tests in Wales.

Second, care home -- healthcare workers. As already mentioned, experts recognised early on that routine testing of healthcare workers was, to quote Sir Paul Nurse, "absolutely essential". It would help prevent nosocomial infection and would maintain, rather than complete, workforce levels. However, in Wales, routine testing of healthcare workers was not introduced until 14 December 2020.

Of course, lateral flow tests only became widely available in November 2020, but my Lady, that does not explain, firstly, why greater use of existing capacity was not used to test before 14 December 2020, and secondly, and more importantly, why even when lateral tests were available, routine testing took until the end of March 2021, after wave 2, to roll out.

In January 2021, at the height of wave 2, and at the height of nosocomial infection in Wales, usage was just 24%. That translates, my Lady, to roughly 120,000 tests per week, of which 30,000 were used. That leaves 90,000 tests, my Lady, more than enough to test on a weekly basis Wales' healthcare workforce.

Various explanations have been put forward to explain underuse of tests in Wales. Mr Drakeford, in oral evidence and Mr Gething in writing, told you that you can't run a system at full throttle. You need to

keep some tests back for an emergency, and you need to keep some tests for non-Covid matters.

Those points may very well be true, but such explanations cannot justify the scale of underuse.

Dr Howe told you that testing capacity didn't mean sampling capacity, but, my Lady, that explanation for underuse is even more troubling. What it means is that by January 2021, Wales had failed to develop sufficient infrastructure such that it could only use 24% of its testing capacity.

Routine testing of patients. The Welsh Government announced testing of all patients on admission to hospitals on 3 June 2020 and, again, on 15 July 2020. Reminders had to be sent out to NHS Wales directors in September 2020 because the policy was not being implemented properly.

It was not until 28 January 2021 that the Welsh Government introduced repeat testing of patients every five days. But problems in testing and repeat testing endured, notwithstanding reminders and notwithstanding new policies. The Audit Wales report of March 2021, "Test, Trace and Protect: an overview of progress to date" reported that there has been no regular testing during a patient's hospital stay unless patients have developed symptoms. The report concluded that

nosocomial infections could have been reduced by more effective testing, including more frequent testing during a patient's stay.

This much known is by the group, my Lady. Many of their loved ones fell victim to basic testing failures. More frustratingly, witnesses offered no explanation for such failures. As with the failure in routine testing of healthcare workers, blame was simply laid at the door of the health boards. No attempt to explain why this was so. And, of course, without insights or reflections, there is no hope for lessons learned.

Finally, my Lady, one last point, before concluding, on the range of symptoms. The group observes that alongside the failure to identify infections within vulnerable communities by refusing to test asymptomatically, the Welsh Government also limited symptomatic testing to a narrow range of symptoms.

In March 2021, well after wider systems were known, Wales continued to confine national messaging to the cardinal three symptoms. As Dr Howe admitted, this decision would have meant that people with the virus remained untested.

Like so many aspects of the testing regime, the decision making here demonstrated the very opposite of a precautionary approach in action.

To conclude, my Lady, delays and failures characterised the testing regime in Wales. Mr Hancock urged you at the start of his evidence not to consider each module in isolation, issues were inevitably interlinked and developed concurrently.

There is much to be said for taking a composite view. Notwithstanding the hard work of many in Wales during the pandemic, failures and delays in testing sat alongside a failure to vaccinate, a failure to ensure proper infection prevention and control, and a failure to provide PPE and other essential equipment. The cumulative effect was devastating on the most vulnerable person in Wales, and unless there is a genuine reflection of what went wrong, and lessons learned, failures are destined to be repeated.

Thank you.

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

Ms Mitchell.

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

DR MITCHELL: My Lady, I appear as instructed by Aamer Anwar & Company on behalf of the Scottish Covid Bereaved.

The Inquiry heard from the Scottish Government witnesses yesterday and also some relevant expert evidence this morning, and the Scottish Covid Bereaved

will take time to consider the evidence before making full written submissions to the Inquiry.

Those submissions will include the familiar themes of the importance of preparedness, the need for data, and providing proper support to individuals, as well as specific recommendations relating to the importance of a testing system and protecting the most vulnerable in nursing and care homes.

In the opening submissions, the bereaved highlighted that throughout the UK, the lack of attention to the test, trace and isolate system meant that in the early days of the pandemic, work had to be done to try to put in place functioning systems. Instead of using experts who understood virology, creation of a new system was outsourced.

As this module proceeded, the Scottish Covid Bereaved could not help but think of the time, money and lives lost as a result of the original longstanding failures to have in place the necessary systems. The Scottish Covid Bereaved are alarmed to hear the evidence of the dismantling of this crucial infrastructure built up over the pandemic, and share the concerns of Professor Pillay.

Whilst these systems may not be the focus of immediate political concern or media headlines, they are

essential to the health of the nation. As Lord Bethell told the Inquiry, there is a direct link between the defunding of prevention-style public health and not being ready for the next pandemic.

Any system of test, trace and isolate can also only be effective if the people identified can be supported. The use of the stick of enforcement in fines rather than the carrot of support led to many of our lowest paid and most vulnerable being forced to choose between isolating and supporting themselves.

The inevitable consequences of those choices was highlighted in the evidence of Baroness Harding, who gave evidence that if more money had been allocated from the test and trace budget to isolation support, she strongly suspected that fewer would have died and infection rates would have been lower.

Many of the bereaved came into this module, and indeed this Inquiry, with specific concerns, amongst many others, about the discharge of Covid-positive patients from hospitals into care and nursing homes without testing, the issue of asymptomatic testing, about the lack of routine testing for residents or staff, about the movement of staff between care homes without testing, and with testing being restricted to those displaying the so-called "cardinal symptoms".

There has been little in this model to assuage those concerns. No doubt more will be heard on these topics in the next module.

The bereaved took the contents of the correspondence from Ed Humpherson to Scott Heald of Public Health Scotland that the data was consistent with a causal relationship between positivity and outbreak to be self-evident. It appears to the bereaved that, even at the time, the only ones who failed to grasp this link were the politicians and civil servants in charge of developing and implementing policies.

Many of the bereaved knew that the discharge of positive patients, or patients for whom no test had been carried out, was causing loss and suffering in our care and nursing homes.

The bereaved are still struggling to understand why this obvious point seems so difficult to grasp.

In this module the representatives of the Scottish Government relied upon a by now familiar lament: that decisions taken by the UK Government had impacts on the finances available to the Scottish Government.

Whilst the bereaved have some sympathy with that position, and consider that more could and should have been done to fund the response to the pandemic, they note that there is unlikely to be government in Europe,

or indeed worldwide, that didn't wish to have more funds available to it during the pandemic.

It is by looking at the budgets and examining what a government were and were not willing to fund during the pandemic that priorities can be seen. Whilst the Scottish Government say that they would have liked to have seen a longer transition to the Test and Protect scheme in Scotland but were restrained by a reduction in funding, the question does remain as to what sacrifices were considered to allow the scheme to continue for longer.

As in Module 5, the bereaved appreciate that, whatever criticisms may be levelled, there was a great deal of hard work and dedication from a great number of public servants, scientists, testing staff, and others who were trying their best to help the public. The bereaved wish to thank them, and the people of Scotland who tested and isolated, for all their efforts.

These are the oral submissions of the Scottish Covid Bereaved.

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

Very well, I think we shall break there and I shall return this afternoon at 1.55.

MS CARTWRIGHT: Thank you.

(12.55 pm)

(The Short Adjournment)

(1.55 pm)

LADY HALLETT: Mr Wilcock.

Closing statement on behalf of Northern Ireland Covid Bereaved Families for Justice by MR WILCOCK KC

MR WILCOCK: My Lady, as you know, I represent Northern Ireland Covid Bereaved Families for Justice.

In his 1989 report into the Clapham rail disaster, the later to become Mr Justice Anthony Hidden stated that:

"There is almost no human action or decision that cannot be made to look more flawed and less sensible in the misleading light of hindsight. It is essential that the critic should keep himself [or herself] constantly aware of that fact."

That my Lady knows, these wise words did not prevent the learned judge to be from making firm observations of a general nature and criticisms of individuals after what was then a famously long and thorough inquiry into events of November 1988.

And, my Lady, we seek to make observations of a general nature, and, where appropriate, criticisms of the test and trace response to the coronavirus pandemic in Northern Ireland, particularly in early 2020.

And there was a sense of relief throughout

Northern Ireland on 11 January 2020, when the five main political parties re-entered devolved government after a three-year hiatus. And as you heard in M2C, this hiatus was not caused by any dispute over the disastrous state of the health system in Northern Ireland at that stage.

Indeed, your Ladyship may recall Robin Swann's evidence that, when it came to allocating ministerial positions under the bespoke D'Hondt procedures, agreed as part of the Good Friday Belfast Agreement, both of the two major parties chose to prioritise other areas of policy apart from health and declined the opportunity to take responsibility for the Department of Health.

So, on 11 January, Robin Swann, forced to choose between the Department of Agriculture and the Department of Health, became Minister for Health, just as the first swell of coronavirus was visible on the horizon.

And, my Lady, no doubt this governmental inexperience increased the challenge he and other members of the Northern Ireland Executive faced in responding to the events which then unfolded. Equally, what Professor McKee described as the "sustained disinvestment in public health", which years of concentrating on other matters had allowed to continue, inevitably formed part of the practical backdrop to the

events you have heard in this and other modules.

And, my Lady, Sir Michael McBride was aware that there were, in his words to you, major, major issues with testing capacity in Northern Ireland in early 2020. He knew it, and the permanent secretary to the Department of Health knew it, as you heard in his evidence in M2C.

And many of those I represent were surprised, therefore, to read in his statement for this module that the then Minister for Health, Mr Swann, could not recall receiving information on the pre-pandemic capacity for the existing laboratories' testing capabilities in Northern Ireland.

Now, it's a matter for you, but you will recall his convoluted answers when he was asked the simple question whether he had discussed this issue with Mr Pengelly, and we suggest that his failure to simply confirm that he had, whatever other reviews into the pathology services in Northern Ireland had been going on before his appointment, since 2017, effectively confirms that he had not even talked through this obviously vital issue with his senior civil servant after he took office in 2020.

Why does this matter? It matters because the lack of communication within the Northern Irish Government

about capacity doesn't stop there.

Baroness Foster told you that she never heard from the Department of Health or the Chief Medical Officer that there were any significant concerns around the issues of capability or scalability, and that she -- her words -- perhaps naively believed that during this period there was an assumption within the Department of Health and more widely that the capability of test and trace would be sufficient to identify cases in Northern Ireland as they arose.

My Lady, you know a lot of the tensions that existed between the Department of Health and the Executive, from Module 2C. As far as this module is concerned, that tension resulted in the abject evidence, you may think, of the then First Minister, Baroness Foster, telling you this time last week that:

"... without ... papers being brought to the Executive Committee we did not have the capability or the information to scrutinise or challenge the detail ... being done within the Department of Health."

The present First Minister, Mrs O'Neill, was perhaps more assertive in that she told you that she was of the view even before the meeting of 16 March 2020 that testing should have been a priority in terms of allocation of resources. It would seem, however, that

this enthusiasm was not enough to lead her to ask the obvious questions or to flush out the answers needed about capacity because she also candidly admitted that prior to the meeting of the Executive on 16 March, she was not aware of the inability of the Department of Health, or the Public Health Agency, to undertake effective testing of the population.

Now my Lady, maybe this lack of curiosity on behalf of the two most senior elected politicians in Northern Ireland may be the result of a system designed to preserve ministerial autonomy. It may even have been the result of inexperience or overwhelm. More damningly, however, it may be also a clear indication that however they now wish to portray their thinking five years later, neither the then First or deputy First Ministers were fully across the issues at hand as the coronavirus pandemic hit these shores.

So Baroness Foster told you that she was in what she called "receive mode" when she listens in to the UK discussions at the COBR meeting on 12 March, when the decision was made by the UK to move from 'contain' to 'delay'. Neither she nor Mrs O'Neill appears to have appreciated that an inevitable consequence of this decision was that even though four days previously, even Professor McBride had been of the view that Northern

Ireland was possibly a week behind the trajectory across the Irish Sea, certainly in London, Northern Ireland was about to suspend all community testing.

But Mr Swann told you that not only did the First Ministers never ask him about capacity issues but he didn't feel the need to explain to the leaders of the Executive he was part of that he was going to stop community testing because of that COBR meeting on 12 March, because he had no doubt that that meeting confirmed the decision to stop contact tracing.

And furthermore, he wasn't going to raise the issue with them, because, in a nearly childish leap of logic, they'd not used their powers to refer the decision to the Executive.

Now, there can be no doubt, as Baroness Foster told you at the start of her evidence, that there was, at this early stage of the reformed Executive, a sense of trying to build relationships again after the tense hiatus between 2017 and 2020, and maybe this is what explains the failure of either the Minister for Health or the First Ministers to simply informally discuss these important and fast-moving events in a way that one might expect in more mature political institutions.

Maybe this is what explains Mr Swann's perception that Mrs O'Neill was "being highly critical" of all of

his responses in terms of combatting Covid, as if this criticism was inherently unwarranted, or that a joint holder of the office of the First Minister was not entitled to contemporaneously critique the wider government response to the pandemic.

But in a mature democracy, simple criticism, potentially founded in an entirely reasonable difference of opinion, would be no reason by itself to go it alone and cut out the rest of the Executive from your thinking. And that's why we asked Mr Swann whether the few exceptions to him simply asking the Executive of policy changes he had made all post-date August 2021.

And my Lady, when he was questioned by your counsel, Mr Swann told you that he'd seen a statement from Dr McClean and the Public Health Agency, where she'd gone on to say that the Public Health Agency did not challenge his decision to stop Test and Trace in March 2020.

In opening this case to you, we remarked upon the fact that Dr McClean was not being called to give evidence, but fortunately we had seen a statement from her giving her views that the decision to stop community testing had been, in her words, counterintuitive to public health practitioners.

It was therefore a surprise to us to hear Dr Swann's

reference to a further statement provided by Dr McClean to your Inquiry. It turns out that whilst Mr Swann had seemingly had access to this statement dated 9 May this year, it was not disclosed to us until partway through the hearing on 21 May, when Mr Swann was giving evidence.

Had we had time to fully digest this 51-page statement, we might have sought permission to contextualise his assertion that the comments he referred to were in any way significant. Because as Mr Swann must have known, what Dr McClean actually said in her second statement was that the reason the PHA did not express any concern about this decision at this point was not only that their role, as you heard in evidence, was purely operational and not strategic, but because it was a decision made at policy level by the Department of Health.

And so we come on to the Executive meeting of 16 March, when, after the event, the Executive first discussed the decision to stop community testing. And Baroness Foster told you that it gave her no joy to read the minutes of this meeting. She described the meeting as fraught, but would not accept that the Executive, the reality, you may think, that the Executive had been distracted in this meeting by the more emotive issues of

whether Belfast should follow London or Dublin in terms of school closures.

Now, my Lady, many of those I represent profoundly disagree with her analysis and they are shocked at the description of their elected representatives shouting over each other, shouting each other down, in a meeting which required cool calculation and analysis of a procedural question of test and trace.

Now many, many people, including people present at this disgraceful meeting in Northern Ireland, worked extremely hard to progress the Test, Trace, and Protect programme. Many positives can be rightly pointed out. The fact that we are in these oral submissions concentrating on the political controversies of March 2020 must not be taken as any suggestion that those that I represent do not appreciate those efforts.

The fact is, however, that whilst as Professor McKee accepted we not be able to quantify it, given the undoubted resource difficulties that did result from Northern Ireland's lack of preparedness, Professor McBride is quite right to say in his written statement that because of the relatively small number of confirmed cases in Northern Ireland at the time, unlike the rest of the United Kingdom, contact tracing had the potential to have a significant impact on the course of the

pandemic and in delaying community transmission.

It is obviously hard for those who lost loved ones in what followed not to wonder: what if?

It's even harder for them to learn the full circumstances of this decision include a lack of preparation exacerbated by years of political failure, a lack of collective curiosity when vital questions needed to be asked, misunderstandings and confusions between our elected representatives when decisions were being taken in Westminster and Belfast, and a politically immature distraction from the real issues when eventually the whole Executive was given the opportunity to discuss a decision that had already been taken.

Now I'm bound to say that many of those that I represent felt that, with the greatest of respect, this political immaturity raised its ugly head even during the evidence that I presented to you.

Your Ladyship knows the hurt felt by many members of the group I represent from the events surrounding Bobby Storey's funeral in June 2020. Equally, however, many saw Baroness Foster's reference to you about this as being the most significant catalyst for the increase in rates of cases that summer as opportunistic, gratuitous, and yet another display of Northern Irish political

whataboutery.

Given, as Professor McBride pointed out in his evidence to you, this increase occurred in the context of a contemporaneous relaxation of NPIs agreed by all the Executive.

So finally, my Lady, against those negatives, can we commend both Baroness Foster and the present First Minister for their recognition that not only does Northern Ireland need to continue to improve its various data deficiencies, of which you must be bored of hearing, but, as Baroness Foster put it, it is "not enough consideration was given to vulnerable groups, to ethnic groups, to those with disabilities, to those who lived alone" in supporting the people of Northern Ireland, and all of that needs to be factored into any strategy that is forthcoming after this strategy.

The current First Minister gave similar evidence, and she told you that:

"... there's more that unites us in politics in the North than divides us. There's more areas where we work together than we have difficulties in. I think just the nature of the pandemic, the newness of it, everybody trying to get to grips with it, meant that there were challenging meetings, but I believe the meeting of the 16th actually led to better decisions further down the

line."

Fine words. Let us hope that those fine words are translated into real action, and that her Executive learns from the mistakes that you have heard about in this module rather than repeats the usual cycle of mistakes in the past.

My Lady, we have deliberately kept our address to you in general terms. We will try and deal with the detail in written terms.

LADY HALLETT: Thank you very much for your help, Mr Wilcock.

Ms Murnaghan -- there you are.

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

MS MURNAGHAN: Good afternoon, my Lady. As you know, I represent the Department of Health in Northern Ireland.

My Lady, in the course of this module the Inquiry has heard evidence, as you know, from the Chief Medical Officer for Northern Ireland, that's Professor Sir Michael McBride, and also from the former Health Minister Mr Robin Swann. The Department also supplied a number of detailed witness statements, and, my Lady, in providing this evidence we hope that the Department has provided a comprehensive overview of the

design and delivery of strategy and policy in relation to the Test, Trace and Isolate programme that was carried out in Northern Ireland, and hopefully, this information will lay the basis for future recommendations.

My Lady, it is the Department's view that there is no doubt that testing and contact tracing services played a critical role in Northern Ireland's pandemic response. The Northern Ireland Test, Trace and Isolate programme, or TTI, did contribute to reducing transmission of the virus and reduced reliance on other non-pharmaceutical interventions.

TTI greatly assisted in protecting the public from the virus, including our most vulnerable. TTI also played a significant role in protecting health and social care services and those who worked within them.

My Lady, the Department reiterates a sentiment that it has expressed before, that, like in other modules, TTI relied on the actions and the response of the public in Northern Ireland, and it is undoubtedly the case that many more lives would have been lost, and the challenges would have been even greater had the public not responded in the way that they did, and for that, my Lady, we would again like to express and place on record our thanks to the public of Northern Ireland.

My Lady, in the course of this module there has been considerable focus on the decision that was taken at the COBR meeting of 12 March 2020, and the consequent pausing of community testing and contact tracing.

The Department has emphasised the reality of the situation in the mid-March 2020, when there was insufficient testing capacity in Northern Ireland to test all of those in the community who were displaying symptoms of Covid-19. As such, the limited testing capacity meant that it was best to prioritise clinical care and those who needed testing, protecting those who were most vulnerable and those caring for them, either in hospitals or in care homes.

Given our finite capacity at that stage, it is submitted that it made little sense to test those in the community who, albeit that they had symptoms, were otherwise well, as this would have inevitably meant diverting critical capacity away from those who needed it most.

My Lady it was also the case that in mid-March 2020 there were clearly severe operational pressures on the contact tracing service which meant that, even if we had all of the required testing capacity, the PHA would have been unable to continue to trace all cases. And it was in that context that even had Northern Ireland continued

to test those with symptoms in the community, the limited capacity available was insufficient to identify all cases that needed to be traced. In turn, this meant that the impact of contact tracing as an effective mitigation to limit the spread of the virus would have been seriously reduced.

My Lady, when contact tracing was paused, testing and tracing was restricted to those at highest risk, such as residents in care homes or patients in hospital.

It is accepted, of course, that the UK-wide Coronavirus: action plan of 3 March 2020 did not explicitly state that testing and contact tracing would stop during the delay phase, but critically, the plan emphasised the need to respond flexibly to the pandemic as understanding developed. And, for example, my Lady, we would direct attention to the planning principle section of the action plan at paragraphs 3.5 and 3.6. We reiterate that the action plan was not intended as a prescriptive step-by-step guide.

It remains the Department's assessment that, in the prevailing context, the move to overall population management approach, as was adopted in the rest of the UK in March 2020, was the most effective way at that time to delay further community transmission.

My Lady, the department contends that critical

learning for a future pandemic is the ability to scale testing capacity quickly at the outset. If unlimited testing capacity had been available in early 2020, it is likely that different and better informed policy choices and decisions could have been made. That unfortunately was not the case.

Also, then, in relation to testing capacity between January and March 2020, the fact that the virus was new and novel undoubtedly posed challenges.

Northern Ireland was appropriately linked into efforts by the Public Health England to develop an assay into the early weeks, in the early weeks, and they stood ready to avail of developments and to commence testing at local regional virus laboratories as quickly as was possible thereafter.

As described in previous modules to this Inquiry, my Lady, the department and the Health Minister during that period had a significant focus on planning and preparation for the anticipated surge in demand for healthcare services and regular updates were provided to the Executive, to the Assembly, to Northern Ireland Civil Service and the wider public in respect of both the seriousness and the urgency of the unfolding situation.

From March 2020 onwards, my Lady, the department

worked at pace and with agility and innovation with its range of partners to scale PCR capacity in the context of global supply and demand challenges.

In addition to joining the National Testing Programme, the department established the Academic Consortium, thereby maximising the existing local testing infrastructure across academia and involving a commercial laboratory. This partnership greatly supplemented the capacity available through our health service laboratory network.

Now, my Lady, I'd like to make some remarks about the evidence from Mrs Hazel Gray and confirm that the department has listened carefully to her evidence and extends its sympathy for her loss. The department acknowledges that routine asymptomatic testing for home carers was only introduced in 2021.

However, we say that it is important that this is viewed in the context of the practical realities of the pandemic. It should be recalled that when Ms Gray's parents contracted Covid-19 in December 2020, the utility and efficacy of using lateral flow devices at scale was still being determined. Indeed, the department and the PHA were only considering the use of lateral flow devices at that stage, and a widespread programme yet been rolled out.

It is also relevant to note, of course, that when routine asymptomatic testing for health and healthcare workers was introduced, such testing was only an additional measure to be deployed alongside a full suite of public health measures, controls and practices that were already in place, such as strict adherence to infection prevention and control policies, and appropriate use of PPE.

Full adherence to extant guidance in this regard was always a requirement, and routine asymptomatic testing did not at any time supersede this.

My Lady, the department contends that it did make considerable and ongoing efforts throughout its pandemic response to prioritise and protect vulnerable groups across a wide range of sectors and settings, and this, we say, has been supported by the evidence we have adduced.

I'd like to say something, then, about contact tracing. In relation --

LADY HALLETT: Provided you keep it short, I'm afraid -- it's not your fault, particularly, Ms Murnaghan, I'm afraid, others have overrun, but you are coming to the end of your time and I'm afraid we've got a lot to get through.

MS MURNAGHAN: Yes, my Lady.

My Lady, I will speed up, in so far as I can.

I don't know that I need to say anything particularly about contact tracing that hasn't been said before. We'd reiterate the efforts that we made, as articulated by Robin Swann, in respect of inequalities and support for vulnerable groups.

We would also highlight the lessons learned that we've set out in our written statement, and we hope that that will assist.

And to conclude, my Lady, we would say that Northern Ireland embarked on a population-wide programme of widespread testing and contact tracing, which was entirely new and unprecedented, and delivered at a scale that had not previously been undertaken.

The fact that this programme was introduced at a time -- we say serves to underline the achievements which were made, and we remain committed, my Lady, to learning anything from your Inquiry. Thank you.

LADY HALLETT: I'm sorry to have had put you off your stride, Ms Murnaghan, you recovered extremely well. Thank you very much.

Mr Dayle.

Closing statement on behalf of the Federation of Ethnic Minority Healthcare Organisations by MR DAYLE

MR DAYLE: Thank you, my Lady, and good afternoon.

As you know, I represent the Federation of Ethnic Minority Healthcare Organisations, or FEMHO. One of the most telling moments in these hearings came from Mr Vaughan Gething, former Minister for Health and Social Care in Wales, in answering a question on to what extent the absence of data on race and ethnicity posed a question for Test, Trace and Isolate, or TTI. He was brutally frank. He answered and I quote:

"I'm not sure it would have made much difference, though, with respect. And that's because the inequalities that we talk about are not a secret. They're not unknown. The healthcare inequalities on the basis of socioeconomic outcome and the fact that black and Asian minority communities typically are over-represented in those least economically advanced communities is not something we don't know about.

"It's like the fact that -- you know, seeing a police force with an overwhelmingly white population issuing fixed charges to 7% of its population, which is out of proportion. You shouldn't be surprised at that. A bit annoyed about it and want to do something about it, yes, but it's not a surprise."

In that one comment, my Lady, Minister Gething laid bare the spectre of structural racism, and how placed in context, TTI, as a strategy for dealing with the

pandemic, presented major challenges within black, Asian and minority ethnic communities.

Remarkably too, Minister Gething's comments was a scaring or a searing indictment, because it acknowledged the foreseeability of these challenges, and portrayed the level of anger that he feels about them.

These are feelings that mirror those of many members of FEMHO too. The Inquiry has spent the last few weeks hearing evidence about the absence of focused thinking on race and ethnicity in the implementation of TTI.

Many following the evidence in this module might have been forced to double up in attentiveness during the evidence of NPCC chair, Mr Martin Hewitt. Asked about the role of race and ethnicity in enforcement of Covid regulations related to TTI, he too was quite candid and said the following:

"I entered my role in the full knowledge of the challenge that policing has in its relationship with minority communities, and particularly the black community."

Asked about how the perception of, and trust in policing might have impacted on the response of the individuals stopped, for example, he told this Inquiry that he was always:

"... very alive to the fact that that engagement

will already start with, if you like, the history that is there in the minds of both the police officer and the young person, or the individual."

It is fair to conclude that this fraught history Mr Hewitt refers to in his answer is one of racism in policing. Mr Hewitt, like Mr Gething before him, foresaw and appreciated the problems of enforcement of Covid regulations, and in the implementation of TTI. With that in mind, Mr Hewitt said that he raised these issues with government when he liaised with them during the pandemic, but understandably, cannot speak to what was done about his expressions of concern.

FEMHO is clear that the pandemic and TTI strategies in response to it didn't create structural racism, health inequality, or racism in policing, but what the pandemic did do was to magnify the factors that combined to make the experience of black, Asian and minority ethnic people worse: economic disparities, overcrowded housing conditions and precarious employment situations.

A powerful illustration of this was the financial support provided to those required to isolate. There has been almost universal agreement among the witnesses during this module's hearings that the financial support for isolation was inadequate. This was not helpful in fighting the virus and disproportionately impacted those

from minority ethnic communities.

My Lady, these hearings have shed light on a chronic tension that exists in Whitehall between scientific or policy advisers and the Treasury. Ultimately the evidence suggests that the Treasury, and the then Chancellor in particular, was more concerned about casting the net very wide, rather than making the net itself sufficient.

Although many witnesses in this module have said in their oral evidence that they were already aware of the existence of health inequalities prior to the pandemic, TTI policies exposed this state of affairs in never-before-seen levels. FEMHO does not argue that government should have eradicated poverty in its response to the pandemic. Instead, FEMHO argues that knowledge of pre-existing inequality should have, but did not, informed the pandemic response and, in this case, the approach to its TTI efforts.

So, framed in human rights terms, the pandemic uncovered issues of economic, social and cultural rights for black, Asian and minority ethnic people, in terms of the structural problems around deprivation, healthcare access, and health outcomes, on the one hand, and issues of civil and political rights in relation to racism and police enforcement on the other hand.

FEMHO admits that there was an abject failure of the UK's senior political leadership to confront this maelstrom regarding the implementation of TTI. Lack of preparation and strategy to mitigate the foreseeable effects of structural racism were the order of the day. These issues bled over into enforcement where policing was already beset by its troublesome history with black and brown communities.

There is scope to build up an outreach platform for TTI during peacetime, we say. In our written submissions we argued that such a platform needs to become part of future pandemic preparedness that targets black and brown communities. It is also important to professionalise the ways that minority ethnic healthcare workers can provide access into their own communities. Their involvement should not be it merely *ad hoc* or situational, but well thought out and systematic, and they should be paid for this. Through deploying the expertise of recognised Community Champions, there will be greater opportunity for buy-in during a crisis.

Above all, and as a matter of policy, FEMHO argues that planning across the healthcare sector should incorporate a focus on how best to utilise representative stakeholders from all levels of the sector, to systematically and proactively engage in

development and implementation of systems like TTI. A failsafe mechanism, such as the Race Equity Decision Audit Tool proposed by FEMHO, ought to be introduced to provide a backstop for ensuring meaningful engagement with equality duties and considerations in policy development and decision making.

Simply put, there needs to be greater involvement of black, Asian and minority ethnic people in the very conception of systems which seek to regulate their lived experience.

So, finally, FEMHO urges the Inquiry not to see the insights from this module as just historical reckoning but as an opportunity for structural inclusion. The question must now be: how will the work of groups like FEMHO become embedded, not as afterthoughts, but as co-designers of public health policy in any future emergency? Inclusion must be built in from beginning, with those most affected not simply consulted, but empowered to shape the systems meant to serve them. That, my Lady, will be the test of any just and effective future response.

Thank you.

LADY HALLETT: Thank you very much indeed, Mr Dayle, I'm very grateful.

Mr Jacobs.

Closing statement on behalf of the Trades Union Congress by MR JACOBS

MR JACOBS: My Lady, on behalf of the Trades Union Congress, we return to the two issues addressed in our opening: supporting self-isolation and test, trace and isolate in education.

On financial support for self-isolation, the Trades Union Congress has been a broken record from the outset of the pandemic and through the course of this Inquiry, unapologetically so, my Lady, because it is an issue of such importance. It is fundamental to an effective test and trace system which saves lives and restricts or even avoids the harms of national lockdowns, particularly for those who continue to attend work in a pandemic, and particularly those on lower wages and in precarious work.

In fact, as this module concerning test, trace and isolate concludes, we almost feel we need to say very little as the narrative told by so much of the evidence has been so clear; universal agreement, as Mr Dayle described it a few moments ago.

As we said in opening, the conclusion should be that financial and other support for self-isolation is a necessity. To be effective, a system of support must be sufficient in amounts to remove the disincentive.

There must be good awareness of the support, and it must be accessible.

As to conceivable arguments to the contrary, there is some reference to scepticism within the Treasury as to whether financial consequences really were an issue for self-isolation. That ignores the simple reality of the loss of two weeks of income for those who cannot afford it, but my Lady, there was also a scientific understanding as to the importance of financial support before the pandemic even began, a chorus of calls from experts and experience throughout the pandemic, and since.

And in any event, my Lady, as Baroness Harding perceived, it didn't really matter what evidence was going to be produced to the Treasury.

The Treasury's reason for reticence really appears to have been first, fraud, a concern of incentivising self-isolation and individuals taking the payment when not infected. As I've observed on behalf of the TUC on a number of occasions, key workers in a variety of sectors were keeping the country going, at risk. They deserved better than the disdain of being viewed as a fraud risk.

But it was also wrong headed. Billions of pounds were spent on test and trace, and a test and trace

system floundering for want of supporting self-isolation, has profound consequences both financially for the country to a level which dwarfs any gaming of the support system, and in terms of loss of life.

Declining or limiting financial support for fear of fraud was a tail wagging an elephant.

The second reason for reticence was the fear of setting precedent and expectations that increased sick pay may endure beyond the end of the pandemic. That, my Lady, was indefensible. It was prioritising a political distaste for sick pay over saving lives in the pandemic, particularly the lives of the most vulnerable.

My Lady, the evidence is clear and the TUC invites the firmest of recommendations. The recommendations must go beyond the principle of financial support and to some of the lessons learned about the mechanics of an effective scheme, as we have described, about its amount, its visibility, and its accessibility.

We turn to test and trace in education. In opening we emphasised the importance of the issue and also expressed some uncertainty as to the extent to which Module 7 was grappling with it. We have since received the Department for Education's statement, it is welcome

that the statement recognises the scale and importance of test and trace in places of education. It notes that 500 million lateral flow tests were distributed for schools testing in the period to March 2022, representing a quarter of the total number of lateral flow tests distributed for England.

It describes test and trace in education as one of the largest testing programmes in society among a cohort with unique and distinctive challenges, and it is noted that education settings led this work, often acting as pioneers in Covid-19 testing.

That is all correct, my Lady, and points to the importance of the issue.

There is an element, we suggest, of the Department for Education marking its own homework. While described as a success, it is striking that there was no broad attempt at asymptomatic testing in places of education until early in 2021, further to a plan to do so announced a few days before Christmas. Reference is made in the statement to the fact that despite logistical challenges, education settings engaged early in planning and delivery of mass testing such that on 8 January 2021, a quarter of schools had started testing.

In one sense, of course, that was impressive, given

the late notice, and the Department for Education rightly described that it would not have been possible without education staff rising to the challenge and making significant personal sacrifices to make it happen. But in its broader context, nine months into a pandemic with lateral flows having been available for some time, it was a shortcoming born of a lack of planning.

A quarter of schools testing on 8 January 2021 was early, given the lateness of the request, but not given the stage of the pandemic.

The Department for Education describes that the late planning and limited preparation of mass lateral flow testing resulted from a worsening epidemiological situation in the run-up to Christmas 2020. That isn't right. As set out in the TUC statement, unions as early as March 2020 were emphasising the importance of testing in education. On 20 May 2020 there was a call for Test and Trace to be in operation before the planned return to school on 1 June 2020. On 11 September 2020, the NEU wrote to the Prime Minister urging the government to ensure regular asymptomatic testing of school and college staff.

The importance of asymptomatic testing was not one that simply appeared in December 2020.

A number of recommendations were set out in the TUC's opening written submissions, all of which, in our submission, remain valid. Core issues are around the advanced and early development of a plan for test and trace in education in collaboration with the sector, who delivers test and trace of pupils and staff, and where, and with what support?

In that respect, it is welcome that the Department for Education considers that a learning should be around early consultation with the sector on how to staff a future testing regime, and giving settings sufficient notice, and that the Department "ideally would want to co-create programmes like this with the sector giving sufficient time to test approaches and understand delivery challenges."

Beyond that, the Department's evidence raises well-founded questions around the provision of training and resources for education settings, and whether education settings should be the delivery route at all for testing of staff and children, or whether a universal at-home community testing offer would be better.

The learning from the pandemic and this Inquiry should seek to move beyond the raising of questions for consideration. First and fundamentally, the co-creation

of a plan for testing in schools shouldn't be something which ideally should happen in the next pandemic, but something which must happen in advance of it.

Second, on a number of occasions throughout the pandemic, and in its evidence to this module, the education unions have argued that testing in respect of those attending school should be led by directors of public health, in contrast to passing all responsibility to schools and school staff. That was also the evidence of Professor Buchan in some of the limited oral evidence that has touched on this issue.

Third, testing should be undertaken at home or in a testing centre or medical setting. That is more effective than education staff inexpertly using ill-equipped spaces within schools to operate as test centres, and it releases schools and staff to the task of teaching.

My Lady, those are our submissions.

LADY HALLETT: Thank you very much for your help, Mr Jacobs.

Mr Gray.

Closing statement on behalf of HM Treasury by MR GRAY

MR GRAY: As my Lady knows, for the purposes of this module, the Treasury -- [inaudible: no microphone]

LADY HALLETT: Sorry, have you got a green light?

MR GRAY: No, it is still red, my Lady.

It is now green, thank you.

LADY HALLETT: Green light now.

MR GRAY: As my Lady knows, for the purposes of this module the Treasury has supplied a detailed corporate witness statement from Mr York-Smith which both annexes additional information and a substantial quantity of relevant contemporaneous documentation.

On 20 May you also heard relatively brief oral evidence from Mr York-Smith and, as recognised by Counsel to the Inquiry on that occasion, it was only possible to touch briefly on some core themes, and the same applies today, and we commend all of the Treasury's evidence to you for consideration in due course.

As you're aware, my Lady, throughout the pandemic Treasury officials worked to inform and advise the Chancellor and departmental ministers in order to support their cabinet-level decision making. And for the purposes of this module, it's right to acknowledge that the Inquiry also has a witness statement from Mr Sunak, the then Chancellor, which addresses in detail the relevant decisions that he took.

My Lady, there are three points that we would make at the outset regarding this module, the broader context in the Treasury's role, before then addressing SSP, the Test and Trace Support Payment, and touch briefly on

lessons learned.

Those three points. First, the policy behind Test and Trace was a health policy. The Lead Government Department, with responsibility for design, operation and delivery, was DHSC. The Treasury's role, as the government's economic and finance ministry, was to discharge its responsibilities, including exercising control over public spending and maintaining economic and financial stability, whilst at the same time necessarily adopting a much higher risk and more flexible approach than usual to spending very, very large sums of public money.

My Lady knows, of that unprecedented public spending, Test and Trace was but only one part, and you may recall the evidence of Ms Little in Module 4 to the effect that Treasury officials worked round the clock to ensure that resources were available when required, for example signing off £1.3 billion for additional specific approvals just during this course of the summer of 2020 whilst the Vaccine Taskforce business case was under consideration.

Secondly, recognising that broader context, we do invite the Inquiry to be cautious when looking at aspects of financial support in isolation. It is important, we respectfully submit, to set any piece of

the jigsaw of economic and financial support provided during the pandemic, which totalled almost £400 billion, within the context of the support provided as a whole.

My Lady knows that the Treasury is currently working with the Inquiry to prepare for Module 9, due to be heard in due course, and has already provided a very large amount of information and material regarding those economic interventions.

And we do submit that any assessment of the adequacy of any particular part of the economic response should be carried out in the context of that economic response as a whole.

And thirdly, as Mr York-Smith highlighted in his evidence, we do also respectfully submit that it is important to view advice given and decisions made in the light of what was known and happening at the relevant time.

The focus of this module, for example, in relation to Statutory Sick Pay has often been in the early months of the pandemic, when understanding of the virus and its future impact was very uncertain, and the health response was also evolving.

For example, the March 2020 decisions around Statutory Sick Pay predated the legal requirement to self-isolate.

Turning to Statutory Sick Pay, and firstly, reach and availability. Notwithstanding the huge uncertainty at the outset of the pandemic, it is, we submit, striking that early steps were taken by the Treasury and the Chancellor to extend the reach and availability of Statutory Sick Pay, including in the March 2020 budget, when the following steps were set out. It became payable from day one of an illness, it was extended to those self-isolating and to carers for individuals self-isolating due to Covid-19.

The requirement for a GP fit note was dispensed with, and rebate provisions were introduced for small and medium businesses with fewer than 250 employees. Statutory Sick Pay could be reclaimed for sickness absence due to Covid-19 for two weeks per employee.

Additionally, in the following month, in April 2020, the Chancellor approved an extension to Statutory Sick Pay to include the approximately 900,000 extremely vulnerable people who had received a shield letter, enabling those employees to use that letter from the NHS as evidence for their employer if necessary.

Secondly, the rate of Statutory Sick Pay. The Treasury of course acknowledges that criticism has been made of the fact that the rate of Statutory Sick Pay was not increased as a result of the pandemic.

However, that criticism does, to us, we respectfully submit, appear to overlook, at least in part, the very broad and substantial set of economic support measures announced in March 2020, which included schemes such as the Coronavirus Job Retention Scheme, or furlough as it's also referred to, and the Self-Employment Income Support Scheme (SEISS), as well as uplifts to other parts of the welfare system, including, importantly, Universal Credit and Working Tax Credit.

As Mr York-Smith explained in his evidence, and as we know my Lady within acknowledge, all these difficult decisions involve competing considerations. There was a need, given the Treasury's responsibilities to the nation, to balance the provision of enormous taxpayer-funded financial support with the need to mitigate the risk of fraud and to avoid creating a perverse incentive not to work.

The Treasury was also sensitive to the fact that Statutory Sick Pay was paid for by businesses, and to the desire of the then ministers not to change permanently the benefits system.

Ultimately, it was for the Chancellor to decide where those difficult lines should be drawn within the vast package of economic support made available during the pandemic.

Test and Trace Support Payment. Through the summer of 2020 the Treasury fully supported the development of the test and trace scheme through the provision of extensive funding, as my Lady knows, totalling approximately £38 billion. In response to requests from ministers and the Prime Minister, firstly in August 2020 the Treasury advised on a pilot scheme to provide compliance payments for workers unable to work from home who were required to self-isolate, and in September 2020, in response to a requirement to provide a greater incentive to self-isolate, the Treasury advised on the Test and Trace Support Payment, or TTSP, Scheme, in respect of which the Chancellor decided to agree that eligible individuals would receive a flat payment of £500 for the then 14 days of isolation.

Again, whilst the Treasury acknowledges that criticism has been directed at the TTSP and in particular the amount paid under it in England of £500, we do respectfully submit that those criticisms require particularly close scrutiny, and may I, for present purposes, advance eight reasons for that.

Firstly, this was an incentive payment. It was not intended to be an income replacement payment, which would have been significantly more complex to deliver, not least because for some people, income may not in

fact have fallen. And my Lady, so far as the reasons behind the £500 are concerned, can I just direct you, for your note, to paragraph 86 of Mr Sunak's witness statement.

Secondly, bare criticism of the rate paid, for example by reference to the National Living Wage, also overlooks, for example, that not all recipients were in full-time employment and also that the TTSP was payable in addition to existing benefits, a number of which were uplifted during the pandemic, and in addition to Statutory Sick Pay.

Indeed, Professor Machin, who we heard from this morning, acknowledges in his report, paragraphs 93 and 94, that CJRS and SEISS delivered net income gains of 10.5% and the temporary uplift of Universal Credit resulted in a net income gain of 2.8%. As a result, as Professor Machin acknowledges in his report, in the short term, disposable income inequality fell during the pandemic as a result of temporary social security enhancement and job support schemes.

Thirdly, as set out in paragraph 148 of Mr York-Smith's witness statement, £50 per day in fact equated to 115% of the National Living Wage for someone working full time.

Fourthly, from December 2020, the 14 days of

isolation reduced to ten days but the rate was not changed, thereby increasing the generosity of the scheme, and the rate remained constant as the self-isolation period was further reduced to seven days in December 2021, and five days in January 2022.

Fifthly, there has been some speculation that an increased payment at a specified level would have made a material difference to self-isolation compliance.

Professor McKee has posited £800 during the course of the professor's evidence, but as Professor McKee acknowledged in his oral evidence on 13 May, page 70 of the published transcript, that's just based on a feeling, rather than grounded in any data. This is not evidence that supports the proposition that an increased payment to any specified or quantifiable amount that would have made a material difference to self-isolation compliance.

Sixthly, in a similar vein, it's been highlighted that in August 2021, the Welsh Government increased the £500 payment to £750. This was in part a response to the ending of the temporary Universal Credit uplift and CJRS. However, from 28 January 2022, the payment reverted to £500. Whilst it's right that self-isolation periods were by then shorter, Professor Machin has highlighted in his report, paragraph 72, that that

decision was also based on feedback from local authorities that the majority of people claiming support under the scheme were losing approximately £200-£300 during the self-isolation period.

And even if that feedback was based on a seven-day isolation period, it does not suggest that the initial £500 payment was clearly insufficient.

LADY HALLETT: These are all valid points, Mr Gray, but I'm afraid I was tough on Ms Murnaghan and I am going to have to be tough on you. Could you start drawing it to a close, please.

MR GRAY: Yes.

LADY HALLETT: I think you have only got to six out of eight points that you wished to make.

MR GRAY: My Lady, the seventh was simply that any flat-rate scheme will create uneven outcomes. As Mr York-Smith said in his evidence, some would have been better off than otherwise.

And eighthly, we do submit that whilst the Treasury is committed to learning from this exercise, some of the criticisms ventilated do reveal a failure to grasp the complexity of delivering a scheme such as this, for example, around central or local authority delivery.

My Lady, very finally, the lessons learned by Treasury in connection with the matters under

consideration of this module, despite it being a health policy, are set out on pages 49 to 54 of Mr York's witness statement.

An additional reflection on behalf of the Treasury, particularly in light of the evidence of Professor Machin, is that issues around the visibility of the scheme and awareness of eligibility may have been more significant than the amount in fact paid and lessons learned should include a better understanding needed of the steps required to raise and increase quickly awareness of support measures upon announcement, and this should involve, we submit, a collaborative approach, including with the interested groups represented before this Inquiry, including the TUC and FEMHO, but the Treasury looks forward to considering any additional recommendations which the Inquiry makes, and will reduce any further submissions to writing.

LADY HALLETT: Thank you.

Ms Drysdale.

Closing statement on behalf of the Scottish Ministers by MS DRYSDALE KC

MS DRYSDALE: My Lady, I appear on behalf of the Scottish Government with, Kenneth Young, Iain Halliday and Kristian Whittaker. The Scottish Government reaffirms its commitment to assisting the Inquiry and has listened

carefully to all Core Participants, including Scottish Covid Bereaved, Covid-19 Bereaved Families for Justice UK, and FEMHO.

Echoing the words of Nicola Boyle from Scottish Covid Bereaved, the Scottish Government will not allow the deaths of those who lost their lives to be in vain. It is committed to learning the necessary lessons to prevent others having to experience what the bereaved have been through. It acknowledges the pain, difficulty, and loneliness caused to so many by the pandemic response. It recognises the devastating emotional impact of restrictions on visiting and being with loved ones at the end of life, and the unequal impact of the pandemic response on people across Scotland.

The Scottish Government will do all that it can to learn lessons, and follow this Inquiry's recommendations, so that unnecessary harm is avoided and lives saved in the future.

The Scottish Government worked effectively, allowing decisions to be taken in extremely challenging and uncertain circumstances. The delivery of testing and contact tracing in Scotland, Test and Protect, was a remarkable achievement delivered by the Scottish Government, in partnership with public agencies.

Nothing like this had ever been done before, and its success is testament to the resilience and determination of the clinical, scientific, support and administrative staff involved.

In this oral closing statement, I will address your Ladyship on the six key chapters from the list of issues: decision making, infrastructure and capacity, key policies, adherence, public communications, and lessons learned.

Turning firstly to decision making. The Scottish Government intended to adopt what became the NHS Covid-19 app in England and Wales, but, due to the evolution of the use of technology within each nation's health service, a single UK contact tracing app was too complex to achieve quickly. It was important for the apps to be interoperable and this was achieved.

At no point was contact tracing wholly dependent on technology. Manual contact tracing continued. The Scottish Government worked in partnership with NHS National Services Scotland and territorial health boards to deliver locally-led contact tracing.

As noted by Professor McKee, using these local public health teams, who have local knowledge and experience, was preferable to using a centralised call centre.

Moving, then, to chapter 2: infrastructure and capacity. The Lighthouse labs are a shining example of the benefits of positive cooperation in a public health emergency. Economies of scale made this the most cost-effective way of processing tests. The Scottish Government built a network of labs across Scotland, including NHS, university and veterinary laboratories, and created a new NHS regional hub.

The Scottish Government considers that the UK should preserve the legacy of the TTI systems. This should include capacity for mass testing and manual and digital contact tracing. It maintains a baseline testing infrastructure by continuing to fund territorial board diagnostic laboratories. In the event of a new pandemic, there would inevitably be a lead-in period for producing tests and Scotland's digital contact tracing systems are on standby to be reactivated.

Genome sequencing service and wastewater monitoring systems continue to test for Covid-19. Operational knowledge has been preserved and data-sharing arrangements enhanced.

This means that Scotland could restart a TTI programme faster than it built one in 2020. This would lessen the impact of any future pandemic response. The main limiting factors would be how quickly trained staff

could be brought online, and the time to develop a new test.

Turning now to chapter 3: key policies. The Scottish Government announced its Self-Isolation Support Grant in September 2020, before it had confirmed consequential funding from the UK Government. In response to regular reviews, the eligibility criteria were widened. It was intended as compensation for wages lost, rather than a reward for isolating.

Testing was scaled up dramatically after March 2020. It was used for more targeted purposes in the early period in order to protect the most vulnerable and ensure that the harms of lockdown did not continue for longer than necessary. On 25 November 2020, testing was expanded to those visiting people in care homes and to the wider adult social care workforce.

Turning now to chapter 4: adherence.

As highlighted by Professor McKee, there is no point in testing someone if they do not isolate in the case of a positive result. Ability to self-isolate was often linked to financial status. Professor Arden referred to an intention-behaviour gap. The Scottish Government recognised this, and put in place a range of financial and practical support for those who were self-isolating to mitigate the barriers to doing so. This holistic

support is cited by Professor Machin as an example of best practice.

The Scottish Government puts inequalities at the heart of policy development and delivery. It has committed to listening and learning as to how that could be further improved. It considered the impact on disproportionately impacted groups when designing and developing the TTI strategy, and agrees with FEMHO that the Public Sector Equality Duty is not simply a tick-box exercise. The Public Sector Equality Duty was embedded in the Scottish Government's approach. Equality impact assessments were undertaken for key policies, including for the TTI strategy.

This highlighted the need for the TTI system to be accessible to people whose first language is not English. Guidance was provided in a range of languages and formats, and the Scottish Government provided accessible testing services through local health boards, allowing people to get tested locally or at home.

To tackle digital exclusion, tests could be booked and results received by telephone and online.

Chapter 5: public communications.

From the outset of the pandemic, the Scottish Government built trust with the public over the pandemic response with open communication. The First Minister

led daily media briefings supported by sign language interpretation, and there was regular polling to understand the effectiveness of communication. The Every Story Matters record has noted that clear and regular messaging from officials in Scotland helped to build confidence in people that they were doing the right thing.

Scotland's response to the pandemic employed a strategy of achieving public compliance through encouragement, persuasion, and support. This informed the decision not to introduce a legal requirement to isolate in Scotland.

Finally, my Lady, turning to lessons learned. The Inquiry has highlighted the losses that people faced during the pandemic, and the Scottish Government acknowledges that it did not get everything right, and it looks forward to receiving the recommendations which your Ladyship will make in due course.

Improvements have already been made to address many of the challenges faced.

The Scottish Government recognises the potential benefits of the federated laboratory model referred to by Professor McNally. This model would include a coordinated network of university, commercial and veterinary diagnostic laboratories providing a more

resilient system.

Analysis by Public Health Scotland has recommended the integration of human, animal, and environmental health laboratories. The Scottish Government supports this recommendation and believes that implementing a federated laboratory model would align closely with this.

In preparation for the next pandemic, data sharing arrangements have been consolidated and enhanced. The Covid-19 Data and Intelligence Network which facilitated rapid data flows has been absorbed into Research Data Scotland and a portal developed for near realtime information exchange.

Counterintuitively the pandemic had some positive effects on the health and social care system in Scotland. The knowledge and infrastructure developed during the pandemic has put Scotland in a stronger position to respond in the future.

In conclusion, my Lady, the Scottish Government recognises that the four nations of the UK should preserve the legacy of the TTI systems for responding to a future pandemic. Scotland could restart a TTI programme faster than it previously could due to enhanced data sharing arrangements, and retain laboratory capacity for testing. But the Scottish

Government recognises that there are lessons to be learnt to ensure that in a future pandemic, TTI systems can contribute more to saving lives, avoiding or reducing the need for non-pharmaceutical interventions, including lockdowns, and to lessening the social and economic impact of any future pandemic response.

The Scottish Government is striving to ensure that lessons identified through its Future Pandemic Preparedness Programme are embedded in policy, so that the government is better able to respond to the next pandemic. It has listened carefully to the evidence from Module 7 and welcomes the Inquiry's scrutiny of the pandemic response in Scotland.

Finally, the Scottish Government wishes to repeat its thanks to the people of Scotland for their support for Test and Protect and the sacrifices made to keep family, friends, neighbours and communities as safe as possible.

Thank you, my Lady.

LADY HALLETT: Thank you, Ms Drysdale.

And lastly, Mr Salisbury.

Closing statement on behalf of the Welsh Government by MR SALISBURY

MR SALISBURY: My Lady, prynhawn da, good afternoon. I appear on behalf of the Welsh Government.

Today, I hope to draw together the Welsh Government's evidence on certain areas that were the subject of questions during the hearings and to propose some recommendations for your consideration.

First, the end of community testing. The Welsh Government ended community testing on 17 March 2020. That decision, which mirrored one taken by the UK Government on 13 March, followed advice from SAGE and Public Health Wales. The intention, based upon that advice, was that the end of community testing would increase the pace of testing for critical hospital functions, targeted testing, and for testing healthcare workers.

In other words, it would place the available tests where they were most needed.

However, as Mr Gething explained, to understand the decision to end community testing in Wales, one must look at the progress of the virus at the time. Once sustained community transmission of the virus in Wales was clear, the country moved from the 'contain' to 'delay' phase. This meant that symptomatic people were advised to stay at home unless they were too unwell to do so. Therefore the need for symptomatic individuals to be tested and then traced and then asked to isolate if positive, was removed.

Welsh Government witnesses were questioned about the timing of the decision to introduce targeted asymptomatic testing within certain settings in mid-May 2020. It was suggested then, as it has been today, that this decision should have been taken sooner.

Mr Drakeford said the Welsh Government followed the scientific advice as it was presented to it. Both he and Mr Gething explained that there needed to be a sufficient body of evidence to justify the prioritisation of tests for asymptomatic testing over other understood and identified priorities.

Mr Gething reminded the Inquiry of the important difference between the understanding of asymptomatic infection and that of asymptomatic transmission, both of which were still developing in the weeks before the decision on 14 May 2020.

He told the Inquiry that the better understanding of asymptomatic transmission coincided with there being greater testing capacity in Wales throughout May 2020, thanks to the UK portals and the increase in NHS Wales' testing capacity.

It's worth remembering that as evidence of asymptomatic transmission was still emerging, on 2 May 2020, the Welsh Government introduced targeted asymptomatic testing in larger care homes and those

homes with confirmed cases. At its root, the Welsh Government's approach to asymptomatic testing involved a balancing exercise. And the point at which that balance was tipped in favour of introducing a programme of asymptomatic testing was in mid-May 2020. That decision followed advice from SAGE on 12 May 2020, communicated to ministers of the Welsh Government on 14 May 2020, and implemented in the following days.

As to testing capacity, both Mr Gething and Mr Drakeford spoke about the apparent gap between the number of available tests and the number of tests taken in the summer of 2020. They explained that this was a time when more tests had become available as part of the Welsh and the UK testing programme. It was also a time of low prevalence of the virus in the population, which meant that the gap between the available tests and those used was both expected and explicable.

Of course, there were times when ministers considered it necessary to exercise more detailed scrutiny of testing capacity and the Inquiry has heard that Mr Gething, quite properly, required full explanations from his officials.

Questions were asked about the uptake of the Covid-19 proximity app. Witnesses were shown a graph which appeared to show a generally lower uptake in Wales

than in England. On the evidence before the Inquiry, it is not clear that a direct comparison with England is comparing like with like. In particular, the graph doesn't take into account the successful local contact tracing system in Wales which meant that less reliance was placed on the proximity app in Wales.

Three important lessons were identified during evidence. First, Mr Drakeford spoke about the use of teams which provide an alternative perspective and a source of challenge to decision makers. You will recall, my Lady, that this is the subject of a recommendation you have already made in Module 1.

Secondly, Mr Gething emphasised the importance of providing financial support and clear advice about that financial support to those advised to self-isolate. Without that support, he cautioned that governments should not be surprised if some choose instead to keep the roof over their family's heads.

Finally, Ms Daniels reflected positively on the programme of black, Asian and minority ethnic community outreach and support in Wales. Both she and Mark Drakeford identified the particular importance of using local communications which are often much more effective than national campaigns in reaching lesser heard groups.

Thank you, my Lady.

MS CARTWRIGHT: Thank you, my Lady. Good afternoon.

(3.14 pm)

(The hearing for Module 7 concluded)

LADY HALLETT: Thank you very much, indeed, Mr Salisbury, I think that completes the process for these hearings.

Thank you, everybody. I shall obviously consider all the submissions that have been made to me orally, and all the written material, very carefully before I make any findings or recommendations.

I know it's not been an easy module to get on and it's taken an awful lot of hard work and grit on behalf of -- on the part of the Inquiry team, obviously, the Core Participants, and their legal representatives, the material providers, the witnesses, and I'm extremely grateful to everybody who has contributed to the completion of this module's hearings so successfully in the time that I made available.

I'd also like to confirm that, as usual with a module, as soon as the Inquiry team have had a chance to take a breath, they will focus again on the report drafting. I obviously wish to publish all reports as soon as I possibly can, but, given my other commitments and given the other reports that are in the drafting, we suspect this will not be before -- publication will not be before summer 2026.

Anyway, thank you, everybody. The next evidential hearing of this Inquiry will be 30 June for M6: Care. Thank you.

I N D E X