

Wednesday, 9 July 2025

(10.00 am)

LADY HALLETT: Ms Carey.

MS CAREY: My Lady, good morning. May I call, please, Professor Susan Hopkins.

PROFESSOR SUSAN HOPKINS (affirmed)

Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 6

LADY HALLETT: Thank you for coming back to help us again, Professor.

THE WITNESS: Thank you.

MS CAREY: Professor, your full name, please?

A. Professor Susan Mary Hopkins.

Q. Professor, you are now formally Chief Medical Adviser to the UKHSA. You were initially appointed to them on an interim basis in October 2021, formally taking up the role in June 2022; is that correct?

A. Correct.

Q. Your qualifications are many and varied -- I won't read them all out -- but prior to joining UKHSA, is it correct that you were the deputy director of the National Infection Service at Public Health England from 2018 to 2020?

A. Yes.

Q. That is a role that you shared. You are also a professor of infectious diseases and health security

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departments, the Department of Health and Social Care in the main, but any other government department can ask for our help and support.

We maintain and are the primary source of infectious diseases surveillance data for the country, whereby those infections are notified to us by a hospital or a community setting, and we have expertise in microbiology, epidemiology, and behavioural science and many other areas with over 30 different specialities working within our organisation.

Q. All right. If we just scroll down on the page that helpfully has been put up, I think the four bullet points there probably summarise PHE's role: obviously conducting scientific and clinical research; as you've just mentioned, collecting data on notified infection outbreaks; and as we're going to come on to look at in this module, producing the guidance on IPC measures and indeed supporting the production of guidance owned by others, and there are various other bullets that people can read for themselves there.

You mentioned there health protection teams, and we haven't heard a great deal of evidence about those. Can you summarise for us the role of health protection teams or, HPTs.

And Professor, can I just remind you to speak

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at UCL in London?

A. Yes.

Q. And you maintain an active research portfolio?

A. Correct. And I also remain in clinical practice as well.

Q. Thank you. You have prepared a lengthy statement, over 181 pages, on behalf of UKHSA for Module 6, and I'm going to ask you about a number of different topics in your evidence that I hope will conclude this morning or very shortly thereafter.

Can I start, please, though, with a summary of PHE's, as it then was, role in respect of adult social care. And if it helps you, Professor, I'm at your paragraph 2.15. Because I think you make the point there that PHE and UKHSA does not have direct responsibility for delivery of adult social care, nor for its regulation?

A. Correct. So PHE's role in response to adult social care prior to the pandemic and UKHSA now, is really to provide advice and support to directors of public health, local authorities, and directly to care homes, where asked, in response to infectious diseases or other external threats. We do this through our regional health protection teams.

Our role is also to provide advice to the government

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a little more slowly and I will try to do the same.

A. Great. So, first of all, we in the UKHSA and our predecessor organisations have nine regional health protection teams corresponding to the sort of geographic regions of England. This covers England only. In those regions there are specialist consultants and health protection. By that, I mean a medical or professionally qualified public health consultant, not from an agency, who lead teams who provide advice and support to any range of outbreaks across any setting in that location-based approach. So hospitals, prisons, adult social care homes, et cetera.

They worked very closely with their stakeholders, particularly stakeholders in local government and local authorities with directors of public health. They work across the health system and health system network providing their expertise and advice on individual cases for any infectious diseases that may need follow-up or care, providing advice on outbreaks and incidents, particularly where the outbreak and incident cannot be managed through the routine measures by either a local authority or a hospital or, indeed, a particular environment themselves.

And they are there as our eyes and ears, if you like, as a national agency on the ground. They collect

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1 data that is reported to them, which is aggregated up
 2 and then made available for our national surveillance
 3 reports.
 4 **Q.** Just pausing you there. I think you said the HPTs were
 5 multi-disciplinary teams. Can you help with why that
 6 was important or beneficial?
 7 **A.** Yes. Well, first of all, we have a range of different
 8 people who have come from a range of different
 9 backgrounds and locations, so many of the individuals
 10 will have previously worked in local authorities, for
 11 example, so will have a close working knowledge of how
 12 local authorities work. Some of the individuals will
 13 have worked in the NHS, for example in -- as infection
 14 prevention and control nurses or as other measures.
 15 Some of them will have been environmental health
 16 officers in local government, and as environmental
 17 health officers in local government, will have been
 18 helping to support local government in how they manage
 19 premises, a wide range of premises, and so -- and we
 20 have individuals who are experts at emergency response.
 21 So all of that comes together to allow people to
 22 bring all of their expertise to bear in the work that's
 23 happening in that place-based approach.
 24 **Q.** Can I ask you this: is it the case that a care home,
 25 perhaps let's take Liverpool, for example, an individual

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1 But the point of the health protection teams is they are
 2 there for everyone in the region, and it is -- you know,
 3 it may be decided that they would redirect that to
 4 somebody who they know is better to answer that question
 5 in the region, based on that system approach at that
 6 place.
 7 **Q.** I think you say in your statement that HPTs provided
 8 a 24/7 out of hours on-call service which is operated
 9 year-round?
 10 **A.** Exactly. So all night long, all day long.
 11 **Q.** All right. Can I, just before we look at the advice and
 12 guidance provided by PHE, just deal with a little bit
 13 background. And I think you make the point, Professor,
 14 in your statement -- I'm at paragraph 4.4 onwards if it
 15 helps you -- that pre-pandemic, there was guidance for
 16 managing outbreaks. And you set at a number of
 17 different pieces of guidance, going back to
 18 October 2012, coming right up to October 2018.
 19 I wonder if we could just look on screen, or have on
 20 screen, please, page 91 of the professor's statement,
 21 and paragraph 7.9.
 22 I just want to look at perhaps what the pre-pandemic
 23 position was, and then we can look at some of the
 24 guidance that existed during the pandemic.
 25 Here are the guidelines from October 2012 on

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1 care home could ring up the HPT for that region and get
 2 advice and/or support? Would it be that director and --
 3 **A.** So it is -- can be that director link. It is also
 4 dependent on the local authority and their size of team
 5 and their capabilities in that local authority. So in
 6 some instances, that local authority may actually say,
 7 "Call us first and we'll deal with the majority, and we
 8 will escalate and work with PHE or UKHSA where we need
 9 additional expertise and support to manage the
 10 infectious disease outbreak."
 11 It's very much hand-in-glove across the system.
 12 **Q.** Right. Does it follow that then a provider who perhaps
 13 ran a number of care homes, if they didn't go down the
 14 local authority route and speak to them for advice, they
 15 equally could come to an HPT?
 16 **A.** Correct.
 17 **Q.** Right. What about domiciliary care? Do domiciliary
 18 care providers have a link in to the HPT?
 19 **A.** So our numbers are available for everybody, actually,
 20 and if you are a domiciliary care provider and you want
 21 advice, you could equally call that number.
 22 It is highly likely, though, that a domiciliary care
 23 provider might call the commissioner of that domiciliary
 24 care first, which may be local government, it may be
 25 the NHS, in order to get their first line of discussion.

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1 management of outbreaks of an acute respiratory illness
 2 in care homes. It contained advice on discharging
 3 patients with flu and presumably other respiratory
 4 illnesses. And we can see there in the italicised part:
 5 "Care home residents admitted to hospital with
 6 a diagnosis of [flu], or other [RVIs] such as ... (RSV),
 7 may remain infectious to others even after discharge
 8 from hospital, and infection control measures as
 9 outlined in PHE guidance are indicated to prevent
 10 transmission ..."
 11 Then if we look down:
 12 "Residents may be discharged from hospital at any
 13 point when the following criteria ..."
 14 When they're clinically -- treatment is finished and
 15 they've recovered, appropriate treatment can be
 16 delivered after discharge, appropriate IPC measures to
 17 prevent transmission are in place, "including single
 18 room dwelling or cohorting".
 19 By cohorting, do you mean that if they've got flu
 20 and someone else in the care home had flu, those two
 21 residents will be in a separate wing or area of the care
 22 home? Is that what you mean by cohorting?
 23 **A.** Yes, we describe that -- we describe that in two ways.
 24 One is where you place individuals to sleep and reside
 25 and share facilities together. The other point is where

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1 you can keep the staff segregated, though I have to say
2 both in hospitals and in care homes, that is very
3 difficult to do, because it is dependent on the number
4 of staff. It isn't ideal, but placing individuals in --
5 sharing a room or a living space or a bathroom is what
6 we try and do.

7 **Q.** And you can see there that if they are able to put the
8 patient, or resident as they become when they come to
9 the home, in a single room or dwelling, that will be
10 continued outside the hospital and for a minimum of
11 five days after the onset of symptoms?

12 So pre-pandemic there was already in place guidance
13 for when flu patients are being treated, to have them
14 discharged when it was appropriate for them to do so,
15 but also guidance to the care home as to how they should
16 treat that patient?

17 **A.** So, for an individual who had symptoms or was diagnosed
18 with an infection, yes.

19 **Q.** Right. The point I'm making, Professor, is that the
20 guidance when we come to look at it is not entirely
21 novel to care homes, the providers, and the adult social
22 care sector, more importantly?

23 **A.** Absolutely, and I would say that we tried to build on
24 established guidance rather than doing 360s, because
25 that would be very difficult in the middle of an

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1 outbreak.

2 So it was the guidance team who held the ideas and
3 the centrality of what was happening across government,
4 what was happening in guidance in general, and then the
5 expertise locally and bringing those together were for
6 the adult social care team.

7 As we went on, we developed a specific adult social
8 care team who held up the core, but from January to
9 April, that was how it was developed.

10 **Q.** Do you think, in the event of a future pandemic, there
11 does need to be a particular cell focused solely on IPC
12 guidance for the adult social care sector, rather than
13 it being held by a UK IPC cell more generally?

14 **A.** Yes, I think from my point of view what we have done as
15 start of the learning from the pandemic is established
16 a core adult social care team in UKHSA, which we are
17 maintaining. It's not the same size as it was in the
18 pandemic but it means that we have individuals who are
19 expert at a national level and who are regularly
20 discussing with the care sector and the care sector
21 fora, and the department, and who can bring in the
22 relevant other expertise, but they hold the centrality
23 of it. And we will maintain that and extend it and
24 expand it in any future emerging infection.

25 **Q.** Just standing back for a second, can you help with why

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1 emergency, to explain and try to discuss with the very
2 many providers. So building on established principles
3 was our process for the majority of the guidance that we
4 produced.

5 **Q.** All right.

6 That can come down. Thank you.

7 The UK IPC Cell guidance that we've considered in
8 other modules as well as this one was primarily for the
9 healthcare sector; do you agree?

10 **A.** Predominantly, yes.

11 **Q.** Right. So can I ask you, are you able to help with who
12 was writing the guidance, generally speaking, from the
13 perspective of the adult social care sector?

14 **A.** So in -- so in PHE we were utilising a team that we had
15 put together especially for writing guidance, because
16 there were so many different pieces of guidance, and
17 trying to bring together the advice that was there for
18 the public, the advice that was -- the changes in
19 government advice, and the advice that we had
20 pre-existing together. So we established a new team as
21 part of the response that would write guidance.

22 That was supplemented, and in particular for adult
23 social care, by our health protection teams, who had the
24 local expertise and who worked with care homes on
25 a daily basis for every other infectious diseases

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1 there wasn't such a team in place pre-pandemic?

2 **A.** Well, I mean, I think predominantly the reason the team
3 wasn't in place pre-pandemic is that we had not needed
4 a specific team before, but also resources were
5 extremely tight, and had been reduced over the previous
6 10 years and therefore we tended to establish teams as
7 we needed them for the occasion, but where possible, we
8 used the generalist knowledge across the agency to
9 provide responses.

10 **Q.** Can we go back to January 2020, please. And PHE
11 developed in January 2020, is this right, guidance
12 primarily for the NHS? It consistently referred to
13 a document known as How to Work Safely. Can you help
14 with, what is, in a nutshell, the How to Work Safely
15 guidance?

16 **A.** So my recollection, and I think this is the How to Work
17 Safely guidance is guidance that was pre-pandemic about
18 care home guidance, how to work safely in care homes,
19 the general IPC guidance that was there for care homes
20 about things they could do to prevent and reduce
21 infections in care homes, things that they might do if
22 they had infections in residents and that then developed
23 subsequently into specific guidance related to adult
24 social care and Covid-19.

25 **Q.** So the January PHE guidance at that time was called the

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1 Wuhan novel coronavirus IPC guidance, and you say at
2 that time it was developed for the NHS as that was the
3 institution with the highest likelihood of dealing with
4 Covid-19 cases as at January 2020.

5 Does it follow, though, that care homes and the
6 adult social care sector, would still be applying 2018
7 or the 2012 guidance, whichever was more appropriate and
8 applicable?

9 **A.** So to take us back to January 2020, we had no cases in
10 the UK. Cases were predominantly identified in small
11 areas in China, not even in wider areas in China at that
12 point, when we released this guidance. And in addition,
13 all of the cases that were being detected anywhere else,
14 even through routine surveillance systems that existed,
15 were not -- were always linked to China and that
16 expanded over time.

17 So at this point it was really for the management of
18 the NHS for a returning traveller, potentially, who was
19 identified with Covid, why we produced that specific
20 guidance.

21 **Q.** Am I right, though, that the first PHE guidance for the
22 ASC, the adult social care sector, was the
23 25 February 2020 guidance?

24 **A.** Yes.

25 **Q.** Can we look at the February guidance, and if it helps

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1 receiving care in a care home or in the community will
2 become infected."

3 Can you help me, Professor, with how that sentence
4 has ended up in this guidance?

5 **A.** Well, I think it was a sentence, a statement at that
6 time. I think it was to reassure care homes that if we
7 were detecting infections that were more widely in the
8 community or more in care homes, when we saw that
9 signal, that the guidance may change again. So it was
10 really highlighting that this was a moment in time and
11 things were changing very rapidly globally and
12 nationally.

13 At the point of this guidance, I think this was just
14 the moment where we were starting to hear cases from
15 Italy, so it was becoming closer. So it was trying to
16 highlight that it was at this moment in time, this is
17 what it says.

18 **LADY HALLETT:** Can I just press you on that,
19 Professor Hopkins.

20 **A.** Yes.

21 **LADY HALLETT:** It's a future -- it's basically expressed to
22 be in the future, it's "therefore very unlikely that
23 anyone receiving care will become infected", it's not
24 "At present we don't have evidence of people in care
25 homes", but it seems to be rather more looking to the

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1 you, Professor, I'm at 4.434 onwards in your statement.

2 Now, can we have up on screen, please, the actual
3 guidance. It's INQ000223341. It's the 25 February
4 guidance.

5 And it's important to note that at this point there
6 was no evidence of transmission at that time in the
7 community, as it says there in the middle of the page,
8 Covid-19 was still designated as a high consequence
9 infectious disease at this time so it was thought that
10 anyone with Covid would be dealt with in specialist
11 settings within hospital, primarily; is that correct?

12 **A.** Yes.

13 **Q.** Notwithstanding that, can we see on page 2:

14 "This guidance is intended for the current position
15 in the UK where there is currently no transmission ...
16 It is therefore very unlikely that anyone receiving care
17 in a home or the community will become infected."

18 And indeed I think there were only 13 confirmed
19 cases in the country, none of which were transmissions
20 in care homes as at the time this guidance was
21 published.

22 **A.** All of them were linked to travel or cases associate
23 with travel.

24 **Q.** Thank you very much. However, it's the sentence that
25 says, "It is therefore very unlikely that anyone

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1 future than "This is the current situation".

2 **A.** I have to say, I think that's probably language that is
3 clunky rather than language that is meant to predict
4 what is going to happen in the next month, two months,
5 three months, based on what we knew in February 2020.

6 **LADY HALLETT:** But if it's clunky language that is meant to
7 be reassuring care homes, it's a bit unfortunate,
8 isn't it?

9 **A.** It is in retrospect, yes.

10 **MS CAREY:** My Lady has stolen the question I was going to
11 ask.

12 **LADY HALLETT:** I'm sorry.

13 **MS CAREY:** Not at all.

14 But really, whether this was liable to provide false
15 reassurance for the care homes, given that you didn't
16 know what was coming across Europe and potentially going
17 to land in the UK, do you -- and I don't want to be
18 unfair in that criticism, but Mr Hancock told us, for
19 example, he thinks it should have said, "Unlikely anyone
20 will be infected" perhaps as a more accurate reflection.
21 What's your observations on that, Professor?

22 **A.** I can imagine that these guidance were being written
23 rapidly. I think one can always look and improve
24 guidance, even after they've been written slowly, and
25 I think that is clunky language and we would want to

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1 improve that language in future events.

2 **Q.** Can I ask you about that, then, because let's imagine in

3 ten years' time we are in the eye of a storm and it's

4 not entirely clear what's coming down the track. What

5 reassurance can we have that there perhaps will be as

6 much put in place to prevent clunky or misguidely (sic)

7 worded guidance, what's going to change in -- when we're

8 in the panic situation that we were this time?

9 **A.** I think I would highlight that this is the first time

10 in -- given that the last pandemic that we saw of

11 respiratory viruses was in 2009, and actually, didn't

12 impact society, community, or adults in care homes in --

13 to any significant effect, that this was the first time

14 that we had seen such a thing on a global scale in this

15 way.

16 My hope would be that what we have set up in UKHSA

17 and what this system has set up more widely is more --

18 better prepared for what we might do in the future.

19 I think we need to keep reiterating and working with the

20 sector and across government, and across local

21 government, to ensure that we are putting adult social

22 care in the centre of future guidance and in thinking of

23 it for pandemics and emerging infection preparedness.

24 That's certainly what we're doing now. That's certainly

25 what we aim to maintain to do and we need to ensure that

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1 preceding guidance that existed for infections in care

2 homes, and particularly respiratory virus infections in

3 care homes, where that was what was the standard

4 guidance and that was what was being declared here.

5 I think when I look back, you know, the -- what we

6 learnt through the pandemic was that face masks had

7 a role. I think we still, as we remember in Module 3,

8 don't quite know the extent of their role, but at this

9 time in the pandemic, and prior to the pandemic, face

10 masks were not used routinely, for individuals who were

11 infected or even for the vast majority of individuals

12 who were being cared for in the community by health

13 professionals.

14 I would highlight that if we suspected somebody had

15 Covid-19 in a care home, the UKHSA HPTs would have been

16 expecting a phone call, and therefore they would have

17 been healthcare workers and advising them, as would a GP

18 or an NHS 111 professional as well. So if anyone

19 suspected an individual, there were multiple healthcare

20 workers who would have got involved in providing advice

21 and care of those individuals.

22 **Q.** Can I just ask you about the second paragraph that we've

23 got up on screen:

24 "PHE recommends the best way to reduce any risk of

25 infection for anyone is good hygiene and avoiding direct

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1 that's at the front and centre of future pandemic

2 planning.

3 **Q.** Can I ask you, please, about page 5 of the guidance, and

4 guidance on face masks as it then was at 25 February.

5 If we look at the top of the page, the paragraph

6 beginning:

7 "During normal day-to-day activities facemasks do

8 not provide protection from respiratory viruses, such as

9 COVID-19 and do not need to be worn by staff in any of

10 these settings. Facemasks are only recommended to be

11 worn by infected individuals when advised by

12 a healthcare worker, to reduce the risk of transmitting

13 the infection to other ..."

14 And then, again, perhaps now the unfortunately

15 phrased sentence:

16 "It remains very unlikely that people receiving care

17 home in a care home or the community will become

18 infected."

19 I know there is an emerging scientific understanding

20 about how Covid transmits, and we're going to come on to

21 look at that, but, just practically speaking, how

22 realistic was it to only advise that face masks were

23 worn when advised by a healthcare worker for people in

24 a residential care setting at this time?

25 **A.** So, I mean, I think this is, again, coming to the

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1 or close contact (within 2 metres) with any potentially

2 infected person."

3 Now, Professor, I'm sure you appreciate that people

4 receiving -- particularly in nursing homes, are

5 receiving personal care for -- across the day,

6 throughout the day. Given that, why is it that PHE are

7 recommending that we reduce close contact when in

8 reality all the care that they're being provided is

9 predominantly close contact?

10 **A.** I agree, care that's being provided is close contact,

11 but there's lots of other more social contacts that can

12 be reduced, and we were at the time trying to highlight

13 that keeping further away and the shortest possible time

14 was going to do that.

15 And again, I think it's really important, and

16 I would like to highlight, that individuals in care

17 homes have social contact with the staff, and it's

18 really important that that is enabled as much as

19 possible. What we were trying to do was provide

20 assurance to the care homes' staff about if they

21 suspected an infected person, that if they removed

22 themselves by 2 metres, that would start to reduce their

23 risk.

24 So it was really trying to frame this in

25 a particular -- given that we did not think there was

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1 community transmission -- I mean, we actually, I think,
 2 in retrospect have found no evidence of community
 3 transmission at this point -- that the individuals were
 4 unlikely to infect others if they were kept at some
 5 distance.
 6 Q. I'm just trying to think about how, practically, that
 7 works on the ground. They have a suspected Covid-19 or
 8 a patient with respiratory-like symptoms. They're not
 9 advised to wear a face mask unless advised, as you have
 10 set out there, but how, realistically, were they to
 11 provide any care if they then had to try to avoid being
 12 within 2 metres of the resident?
 13 A. Well, I mean, if there was somebody with the potential
 14 infection at this time, we would expect individuals --
 15 and in other guidance that was there -- to remove
 16 themselves by 2 metres and call NHS 111 or call UKHSA,
 17 where the individual would have been immediately
 18 conveyed for assessment.
 19 Q. I think -- that can come down, but I think you are aware
 20 that there were a number of concerns raised with the
 21 25 February guidance, and indeed I hope you've seen,
 22 Professor, a spreadsheet that was provided to PHE for
 23 their comment on.
 24 Can I have up on screen, please, INQ000049518. We
 25 may need to expand it.

21

1 A. I'm afraid I don't know the answer to that.
 2 Q. It just seemed to us that if there had been that
 3 engagement, perhaps some of the questions that were
 4 being raised would have been answered in the guidance
 5 before the guidance came out and then they had to do it
 6 in reverse, if you follow me.
 7 A. I can see that.
 8 Q. Can I have a look at one other of the entries.
 9 Can we go to row 5, please.
 10 It's picking up something we've just looked up, the
 11 National Care Forum also raised concerns about: the
 12 personal contact:
 13 "... the section which details how the disease is
 14 spread -- either via being within 2 [metres] of
 15 someone -- or touching their hand -- are both cases that
 16 are extremely likely with front line care staff. The
 17 nature of the job will mean that the provision of
 18 personal care will mean they are close to individuals.
 19 The guidance writes as if this might be the exception --
 20 therefore the expectation in the guidance that everyone
 21 who has had close contact with the person infected
 22 should self-isolate for 14 days is likely to include the
 23 [large] majority of staff within a home setting -- and
 24 potentially large number of a home care team if someone
 25 receives variable visits from different team members."

23

1 And if I use the column A numbering, can you see,
 2 down on the left-hand side of the page, row 2?
 3 On 27 February, the National Care Forum, via
 4 Vic Rayner, had a query or a question about the
 5 guidance, making the point that:
 6 "Care home residents are likely to have their own
 7 room, but in many cases they may be using [a] shared
 8 bathroom ... and the isolation of those or the proposed
 9 'rota' approach to their usage will be very difficult
 10 with people who may need regular support and access to
 11 facilities."
 12 And then the question is -- sorry, that concern of
 13 the National Care Forum is wrapped up into the question:
 14 "How do we protect people who are using shared
 15 facilities such as bathrooms ..."
 16 And if we control over the Excel spreadsheet,
 17 there's reference there to the 25 February guidance.
 18 Then the answer is that the health protection team
 19 are going to provide advice on cleaning.
 20 Can you help me, Professor, with these sort of
 21 queries that the NCF and indeed others were raising,
 22 were they -- were the NCF and others invited to comment
 23 on the PHE guidance before it was published to try to
 24 iron out potential unrealities with the guidance and the
 25 daily realities for their life in providing care?

22

1 Vic Rayner says:
 2 "I am not disagreeing with the advice -- but ...
 3 [really] the way it is written does not in any way
 4 address the very significant implications of a case
 5 being identified in a care home [or] home care or in any
 6 way move forward to understand how the ongoing care of
 7 the individuals in that setting might be addressed."
 8 A real concern there about the care. It's packaged
 9 as:
 10 "What actions should people take when personal
 11 contact is unavoidable?"
 12 And if we scroll over, the PHE answer is:
 13 "At this stage of the response, residents in social
 14 care are unlikely to travel [presumably going back to
 15 the ingress of Covid from abroad] and so are unlikely to
 16 acquire COVID-19. Guidance based on a case-by-case risk
 17 assessment will be provided by the Health Protection
 18 Team ..."
 19 Now, I understand the context in which that answer
 20 is given but clearly, the course of Covid was changing
 21 very rapidly as you've just said. What reassurance was
 22 given to NCF and people like NCF, where they're saying,
 23 "It's very difficult to implement this guidance on the
 24 ground."
 25 Can you help, Professor, with what PHE did about

24

1 that or what advice they were likely to have been given?
 2 **A.** Yeah, so I think, as always, the national guidance is
 3 there to set a framework. Our health protection teams
 4 work with care homes every day to manage any outbreak or
 5 incident in the care home from a very wide variety of
 6 infectious diseases. And so they would often
 7 understand, the particular care home, how it's built,
 8 how it's set out, what the staff are, and work with the
 9 local authority about what that might look like. And so
 10 in a national guidance scenario, setting out the
 11 principle of: if you've got a shared toilet what you do,
 12 if you've got this -- it would make the guidance very
 13 long and unwieldy. But there are some principles.

14 And what actually was happening at the time is the
 15 care homes were calling health protection teams with
 16 questions and the health protection teams themselves
 17 were, you know, utilising their knowledge and awareness
 18 to answer those questions and provide and support the
 19 care home in delivering their risk assessment.

20 I would also add that the risk assessments that --
 21 on how infections spread in care homes were something
 22 that care homes did regularly for respiratory viruses or
 23 gastrointestinal infections that occur.

24 So they are, in some ways, used to this. And what
 25 we were trying to do at this point in February was try

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1 on the 2 March saying, "It is highly likely there is
 2 sustained transmission of Covid in the UK at present",
 3 so within a number of days we'd gone from there being no
 4 community transmission to now "sustained transmission"
 5 and SPI-M-O said:

6 [As read] "It is almost certain that there will be
 7 sustained transmission in the UK in the coming weeks."

8 The next guidance that came out was on 13 March, and
 9 it may be observed that if SPI-M-O are saying on 2 March
 10 "We've got it now in the UK and it's coming", why did it
 11 take another 11 days for the second set of PHE guidance
 12 to be produced?

13 **A.** So just to (unclear), so SPI-M-O paper at the time would
 14 have been a paper to go to SAGE, so for a SAGE
 15 discussion, it wasn't publicly released, so I don't
 16 think those papers were publicly released for a long
 17 time and definitely even within government they were
 18 held quite tightly, so -- as far as I know.
 19 I definitely didn't recollect seeing it as the incident
 20 director for Public Health England at the time.

21 Though, clearly, we'd had our first community case
 22 on 28 February. So that was our first detection in the
 23 community.

24 So from my point of view, the work that was done
 25 over that next couple of weeks, my understanding, from

27

1 and give them some important information that could be
 2 delivered in a national guidance setting while
 3 recognising that the main route for information was
 4 going to be through that established relationship.

5 **LADY HALLETT:** I'm afraid I'm not following what extra
 6 guidance, national guidance, you're giving. Basically
 7 you're telling people running care homes -- this is
 8 guidance directed at the adult social care sector,
 9 isn't it?

10 **A.** Correct.

11 **LADY HALLETT:** You're telling them don't use face masks,
 12 it's not necessary. You're saying don't have contact,
 13 as Ms Carey has just asked you, they can't avoid contact
 14 in most cases, certainly domiciliary care and a lot of
 15 residential care, and you're telling them to have good
 16 hygiene. Well, they're going to have good hygiene
 17 anyway. So I'm really not following what this guidance
 18 directed at the adult social care sector added to what
 19 the care home people would have known anyway.

20 **A.** So I think it was putting it together in one place in --
 21 specifically for Covid-19, based on the good practice
 22 that was there before.

23 **MS CAREY:** Now, Professor, you've made the observation that
 24 as at the time this was drafted, there was no community
 25 transmission. By 2 March, SPI-M-O released a statement

26

1 the team's view I've discussed with when building this
 2 evidence statement as the corporate witness, my
 3 understanding is that they were then discussing this
 4 with the Department, were discussing it with the health
 5 protection teams, were discussing it with the care
 6 homes. So that, again, it was following on from the
 7 answers to the questions from the spreadsheet that
 8 you've shown me, trying to work and utilise all of the
 9 experts across the organisation and externally, to
 10 provide an updated and improved set of guidance for the
 11 next situation where we were seeing some transmission in
 12 the community.

13 **Q.** Do you think, had PHE been aware of the consensus
 14 statement that SPI-M-O had put out, PHE practically
 15 would have been able to respond quicker with guidance
 16 within a couple of days as opposed to 11 days later?

17 **A.** So perhaps, but I think as you've said already, that
 18 actually, there's a -- there's a balance between working
 19 with people ensuring that you're answering all the
 20 questions adequately, ensuring the guidance is meeting
 21 the needs of the sector that it's going out to, and the
 22 speed and haste, and actually, that was a difficult
 23 balance throughout this period.

24 **Q.** Before we then come on to the March guidance just
 25 thinking back to this time, do you think that the

28

1 February guidance perhaps should have highlighted the
 2 possibility that there may be transmission coming, and
 3 warned the care sector to generally monitor the position
 4 more carefully? I don't mean by them looking at the
 5 actual stats but just to say, "We don't quite know
 6 what's coming yet. Please be ready to deal with
 7 infection rates rising if we start reporting them in the
 8 press"?

9 **A.** I think in hindsight, yes. I think that's not what the
 10 general consensus was at that time. So it's important
 11 to try to put oneself back at that moment in
 12 February 2020. I think, as we go forward with the
 13 guidance, trying to have -- and working with care homes
 14 and the care home staff, to have an increased alertness
 15 over general infections is really important and I think
 16 that alertness, awareness, and the closer working
 17 relationships that have developed over the pandemic and
 18 since then actually stand us in good stead.

19 **Q.** In your statement at paragraph 3.29, Professor, you say:
 20 "Asymptomatic infection was documented by the end of
 21 February/March 2020, however the available data remained
 22 inadequate to provide evidence of significant [either]
 23 pre-symptomatic or asymptomatic transmission."
 24 Now, we're aware of the distinction between the two,
 25 I can assure you, but given that asymptomatic infection

29

1 this point what we were doing was utilising the evidence
 2 in the past that said: if you have asymptomatic
 3 infection the likelihood of you transmitting the
 4 respiratory infection is very low, which we'd used for
 5 flu, which had worked as -- in good stead for many other
 6 respiratory viruses over many, many years. And trying
 7 to utilise that rather than change the basis of the
 8 science that we were utilising was what we did at the
 9 start.

10 I think we learnt a lot over those current months
 11 and I think we could consider how that learning would
 12 take us forward in a future infectious diseases
 13 respiratory-related pandemic.

14 **Q.** Can I come on to the March guidance that was published
 15 on 13 March. We know it was in three separate -- one
 16 for residential care, one for home care, and one for
 17 supported living. And I just want to look with you,
 18 please, at sort of the lead-up to that and at the actual
 19 guidance itself.

20 And in your statement, Professor, you say that on
 21 2 March 2020 -- I'm at your paragraph 4.50:
 22 "... Public Health England contacted DHSC to offer
 23 PHE's assistance in developing a response for the social
 24 care sector, particularly in respect of engagement on
 25 a local level with ASC stakeholders."

31

1 was certainly being documented at that stage, do you
 2 think perhaps the February guidance should have been
 3 more cautious and alerted people to the potential of
 4 asymptomatic transmission, albeit you didn't know the
 5 precise extent of asymptomatic transmission at that
 6 point?

7 **A.** So I think it's really important -- I mean, we talk
 8 about how we build on the guidance that has gone before.
 9 I mean, we sit in this room now in a different time, but
 10 with many other infections circulating and, you know,
 11 what we are -- were doing at that point was trying to
 12 highlight the risks of this new and emerging infection
 13 of which we knew very little, but not trying to go into
 14 the world of what it was like in that middle of 2020.

15 From my point of view, we do not routinely and
 16 continue -- so post-pandemic -- do not routinely tell
 17 people to be particularly wary of asymptomatic
 18 infection, for any infections, because what we're trying
 19 to do with infections is to try and find the people who
 20 have got symptoms and treat that disease and prevent
 21 that spreading.

22 And I think Covid-19 was one of those first
 23 infections that we actually saw a very large amount
 24 of -- for respiratory infections, I say -- very large
 25 amount of asymptomatic transmission over time, but at

30

1 Can you help, what was PHE actually offering here?

2 **A.** So my recollection is that the chief exec of PHE at the
 3 time emailed the director of adult social care in the
 4 Department of Health, particularly because, as I've
 5 mentioned already, our health protection teams had
 6 a strong local link with the adult social care sector in
 7 the locality, with the providers and with the
 8 commissioners and local government. And I think it was
 9 generally reflected that the Department of Health and
 10 Social Care had taken on social care responsibilities in
 11 2018 but did not have those strong, robust links with
 12 the sector at the time of the end of February/beginning
 13 of March.

14 And so we were offering our support in the guidance
 15 and any of the areas that the Department wanted to work
 16 with to develop the future adult social care guidance.

17 **Q.** You go on to say that on 8 March, DHSC had emailed
 18 raising concerns that the February PHE guidance was "not
 19 meeting the needs of the care sector". And no doubt
 20 reference, perhaps, to some of those entries we looked
 21 at on that Excel spreadsheet, and DHSC asked for a plan
 22 for updating the guidance.

23 Can we just have a look, please, at the -- really
 24 what was missing from the February guidance, if I can
 25 put it like that, and it might help you if we have

32

1 a look on screen at INQ000325229, page 2, please. Thank
2 you very much.

3 This is an email on 9 March from Ros Roughton to
4 a number of people in PHE talking about the draft
5 guidance, but can we see in that first paragraph the
6 "comments on the guidance headed 'Guidance for social or
7 community and residential settings'", that's the
8 25 February 2020 guidance, isn't it?

9 A. I don't know --

10 Q. -- (overspeaking) --

11 A. -- if the comments on the guidance were on the
12 25 February or the new draft guidance that was being
13 developed.

14 Q. Sorry, they are talking about, I think, changes that
15 they are proposing for the 25 February guidance. All
16 right. And you can see there:

17 [As read] "I recognise the guidance has been through
18 several clearance procedures -- I minimise my comments."

19 The comments are about patients:

20 "We need to be clear it's not just elderly people
21 who are vulnerable. It might also be children with
22 complex conditions".

23 Setting:

24 "The language is all about care settings ... we
25 should be clear that this applies to people being seen

33

1 leading the discussion and engagement with the adult
2 social care sector but that members of PHE such as Paul,
3 as in this email, and others leading on the adult social
4 care guidance, would have been attending those meetings
5 with them.

6 I don't have records of what meetings took place and
7 when they were.

8 Q. Now, the 13 March guidance said that if neither the
9 carer nor the person being cared for was symptomatic, no
10 PPE was required.

11 Given that by 13 March there is now community
12 transmission and I assume PHE -- put the SPI-M-O
13 document to one side -- I assume by 13 March, PHE knew
14 that there was community transmission.

15 A. Yes.

16 Q. Can you help with why there was no reference in the
17 13 March guidance for the need for PPE if neither the
18 carer nor the person being cared for was symptomatic?

19 A. So, again, this is based on the established principle
20 which actually was the same in hospitals; in hospitals
21 if neither the carer -- the patient or the carer had any
22 symptoms, that would not have required PPE either. You
23 only use PPE in hospitals or any other setting, in all
24 the years prior, and at this point in the pandemic in
25 all settings, for individuals who were symptomatic.

35

1 at home by home care workers. It makes clear at one
2 point in the background, but I think the reference
3 continually to care settings seems odd. Could we say
4 'care settings or people's homes'?"

5 There's concern about the definition of close
6 contact.

7 "Missing questions from the sector. This doesn't
8 cover quite a lot of things that I know the care sector
9 would like to see, if the Covid-19 becomes more
10 widespread. This is where the need for more detailed
11 guidance. So do we need to signal 'There will be
12 further guidance on the management of Covid-19 ...
13 settings, in the event that there is a wider outbreak'."

14 LADY HALLETT: Could you remind me, Ms Carey, the date of
15 these comments?

16 MS CAREY: This is 9 March 2020.

17 LADY HALLETT: Thank you.

18 MS CAREY: So it's Ros Roughton raising with PHE a number of
19 concerns about the guidance.

20 Do you know, was any engagement with the care sector
21 being envisaged in the run-up to the publication of the
22 13 March guidance?

23 A. So, again, my understanding is that Ros Roughton and the
24 adult social care team were leading that engagement,
25 that's where the enquiries had come from, and they were

34

1 So I think this is not just as something specific to
2 the adult social care sector; this was the widespread
3 management of infectious diseases, and continues to be
4 the widespread management of the infectious diseases
5 post-pandemic, where PPE is predominantly used for those
6 individuals who are symptomatic.

7 Q. Right. Thank you.

8 Now, clearly that guidance did not protect against
9 asymptomatic transmission. Was there a reason why, as
10 at 13 March, the protection against asymptomatic
11 transmission was not written into the guidance?

12 A. So again, I would say that at this point asymptomatic
13 transmission was thought of as highly unlikely still,
14 not impossible, but actually, the balance of evidence
15 was that that was not what we were seeing in the main.
16 The reports were talking about individuals were being
17 detected with asymptomatic infection but that is not the
18 same as who is most likely to transmit, and the
19 consensus at that time remained that the people most
20 likely to transmit were those with symptoms and not
21 those without symptoms and who were fit and well.

22 Q. For the avoidance of doubt, was the reference to there
23 not being the need for PPE unless the person was
24 symptomatic, or the carer was symptomatic, anything to
25 do with the limited supply of PPE that was prevalent at

36

1 this time?

2 **A.** No, that was the way IPC was managed throughout all

3 sectors. Before and during, at this point.

4 **Q.** Can I ask you about two particular pieces of the

5 13 March guidance.

6 If I could have on screen INQ000300278, page 3. And

7 then we'll look at page 4. And if I could have blown

8 up, please, the bottom paragraph:

9 "How care homes can minimise the risks of

10 transmission."

11 As at 13 March, is it right that PHE advised care

12 home providers to review their visiting policy by asking

13 no one to visit who has suspected Covid-19 or was

14 generally unwell, but there is no blanket ban certainly

15 in this guidance; is that correct?

16 **A.** Correct.

17 **Q.** And can you help with why at this stage care homes

18 weren't advised proactively to ban visitors?

19 **A.** So I mean, I think from my point of view where we stood

20 at that point is that there was community transmission,

21 and we were seeing rising numbers entering hospitals.

22 It got extremely rising numbers over the following

23 couple of weeks. I can't remember the exact number of

24 cases on 13 March but it was definitely below 100 cases

25 detected in the whole country. So that's quite a small

37

1 Now, Professor, can I ask, reference to "isolation

2 precautions", what did that actually mean for the person

3 reading the guidance trying to implement it?

4 **A.** Again, I think it will have had other elements

5 mentioning that. In this guidance it did, as I recall,

6 which is gloves, aprons, and a face mask. And that will

7 have been in other parts, actually -- actually, it says

8 "aprons, gloves and fluid repellent surgical masks" in

9 the next paragraph, and:

10 "If there is a risk of splashing, then eye

11 protection will minimise risk."

12 **Q.** So the isolation precaution was actually to put on

13 various pieces of PPE?

14 **A.** As well as, in -- if isolation is required, a resident's

15 own room should be used.

16 **Q.** Yes.

17 **A.** So it's a group of measures that you do to reduce the

18 risk of infection.

19 **Q.** The reason I ask you this is, if the resident has

20 symptoms of Covid-19, how is the care home to know if

21 isolation is needed or not? I just wonder if this piece

22 of guidance is explicitly clear about what you're

23 telling the care home to do here.

24 **A.** So I think -- I mean, again, I would have to go through

25 it, but I'm pretty sure that it's saying that -- in this

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1 number for a population of 70 million so it was really

2 in the small numbers. But we knew that there was

3 community transmission happening.

4 And from my point of view, what this is again,

5 trying to continue with the standard advice that would

6 have been available in winter, where we ask visitors not

7 to attend if they're unwell with respiratory viruses in

8 general because they can transmit.

9 So in the sense this was trying to highlight for

10 Covid-19 to continue that, to review that, and to

11 highlight that individuals who were visiting should have

12 good hygiene and not be symptomatic with respiratory

13 illness.

14 **Q.** Can I go over the page, please, to page 4 and the

15 guidance issued where a resident has symptoms of

16 Covid-19. If we could just have the top paragraph blown

17 up, thank you.

18 "Care homes are not expected to have dedicated

19 isolation facilities for people living in the home but

20 should implement isolation precautions when someone in

21 the home displays symptoms of COVID-19 in the same way

22 that they would if an individual had [flu]. If

23 isolation is needed, a resident's own whom can be used.

24 Ideally the room should be single bedroom with en suite

25 facilities."

38

1 guidance -- if the individual has Covid-19, that the

2 individual should be isolated, and that in further

3 places in this guidance it will have spoken about

4 calling the health protection team for advice.

5 **Q.** It certainly makes reference to calling the health

6 protection team, but I have checked and it doesn't

7 mention isolating the individual if they have symptoms

8 of Covid-19, and that's why I wanted to ask you about

9 it. Because the only reference to isolation is this

10 paragraph here for people living with Covid-19, that

11 they should implement isolation precautions, ie putting

12 on gloves, masks -- (overspeaking) --

13 **A.** And if isolation was needed, a patient's own room can be

14 used -- (overspeaking) --

15 **Q.** Yes, but how is the care home to know if isolation was

16 needed? You're not directing the care home to isolate.

17 **A.** I understand that you're saying this. I think that with

18 many years of experience in isolation precautions, adult

19 social care would have --

20 **Q.** They would know?

21 **A.** -- would have done that.

22 **Q.** There is nothing in this guidance about how long the

23 patient with symptoms of Covid-19 should be isolated

24 for. Can you help us with why there isn't a time limit

25 or a timeframe put on how long isolation should be for?

40

1 A. I think this was also trying to utilise the generic
 2 guidance that was available for the public that was
 3 issued approximately at the same time, which was that if
 4 you had symptoms of Covid you should isolate for
 5 seven days.
 6 Q. Right.
 7 A. Subsequently in care homes, that was lengthened because
 8 of evidence that elderly people shed the virus for
 9 longer.
 10 Q. Just reading this, it doesn't sound very directive to
 11 care homes, if I could put it like that: you could do
 12 this, you can isolate -- have isolation precautions, if
 13 isolation is needed then isolate, but we're not going to
 14 tell you how long for.
 15 Do you think this was sufficiently clear for care
 16 homes when it was drafted for dealing with people where
 17 they had symptoms of Covid-19?
 18 A. I think, looking at this now in isolation, I'm sure we
 19 could improve the clarity. I think it's really about
 20 the discussions that were being had with the care homes
 21 and the health protection teams at the time.
 22 Q. I ask, Professor, because four or six days later,
 23 depending on which date you look at, we have the
 24 hospital discharge policy coming out to NHSE -- from
 25 NHSE, I should say, on the 17th, and then the actual
 41

1 contact the health protection teams and have
 2 a discussion about the individual management, and
 3 recognising that it was really dependent on the care
 4 home shape, size, building, and that trying to write the
 5 guidance for the very wide variety and sizes, capacity,
 6 capability, was quite challenging.
 7 So I think the words are not necessarily -- not as
 8 instructive as -- delivered as points of "you must do"
 9 in order to facilitate the various challenges that the
 10 care home sector might have had in delivering it.
 11 Q. Now, two weeks after this guidance there was the
 12 Washington care home results published.
 13 If it helps you, it's at your paragraph 3.30
 14 onwards.
 15 But on 27 March the Washington care home study
 16 published an early release of their findings. And
 17 without taking you to the precise detail, do you agree,
 18 Professor, it was an important study in relation to
 19 asymptomatic transmission at that stage because it
 20 tended to suggest that there was evidence now of
 21 asymptomatic transmission?
 22 A. So that's not what the study had said, actually. The
 23 study highlighted that it referenced potentially
 24 asymptomatic infection. It said that this may suggest
 25 that there is and the relative contribution remained
 43

1 guidance that accompanied it on 19 March.
 2 So, given that we're about to have expedited
 3 discharges, do you think, on reflection, that the
 4 13 March guidance should have been more explicitly clear
 5 about the need to isolate people with Covid-19 symptoms?
 6 A. I would highlight that PHE did not know about the
 7 17 March guidance at this time or on 17 March.
 8 Q. Yeah. So you have the left hand and the right hand not
 9 necessarily knowing what they're doing?
 10 A. I'm afraid so.
 11 Q. Leaving the care home in the middle without the explicit
 12 guidance to isolate the resident if they have Covid-19,
 13 but the hope and expectation that they will know from
 14 previous guidance that they should be isolating; is that
 15 what it comes to?
 16 A. Well, I think that -- I mean, I recognise the challenges
 17 looking at this guidance. I completely do. In
 18 hindsight, five years later, I look at it cold and it
 19 looks like this. I think it's important to acknowledge
 20 that. And important to build that into improved
 21 guidance for the future.
 22 The point at the time was that there was established
 23 procedures for isolating individuals with respiratory
 24 infections, and this was building on this and talking
 25 about Covid-19, with the ability for every care home to
 42

1 uncertain. And so it's really important that it was
 2 actually the study that -- when it came out, there was
 3 a lot interest globally because it was the first care
 4 home study.
 5 I would highlight that three out of the 23 that
 6 tested positive remained asymptomatic throughout, so it
 7 was really potentially highlighting that people were
 8 testing positive before they developed symptoms, and
 9 that gave us an early inclination on that.
 10 Q. Right. Notwithstanding that, though, it was evidence
 11 now, of some asymptomatic transmission; do you agree?
 12 A. I think there was potential. I don't think we can say
 13 for definite.
 14 Q. All right, so you wouldn't -- (overspeaking) --
 15 A. It was a single study in a single care home with a small
 16 number of residents, and where we needed to build on
 17 this and understand it better.
 18 Q. Right. So what were the implications, if any, of the
 19 Washington study on consequent guidance?
 20 A. So, I mean, I think that, first of all, the implications
 21 on that were really about highlighting -- I think the
 22 following week we released the sort of wider guidance
 23 about wearing PPE more regularly for all staff and
 24 residents in care homes and hospitals, particularly
 25 because of the asymptomatic infection risk. That's the
 44

1 first thing.

2 Secondly, it really help us to ensure that we were
3 developing our own studies that were larger and across
4 a multiple variety of care homes, which was subsequently
5 done at the Easter weekend, less than a couple of weeks
6 later, as soon as we had testing capability.

7 And it fed into, then, the wider guidance that was
8 subsequently developed on care homes, and to the idea
9 that we would have wider testing in care homes at
10 subsequent moments.

11 **Q.** Bearing that in mind, on 2 April there was the
12 'Admission and Care of Residents during COVID-19
13 Incident in a Care Home' guidance, more easily expressed
14 as the "April admissions guidance", and I'd like to ask
15 you about that please, and it may help if we look at it
16 on screen.

17 Could I have on screen INQ000528401_4, please.

18 This is from the April admissions guidance, and I'd
19 like to ask you, Professor, please, about the paragraph
20 there with the bold highlighting in it.

21 It makes the point that the care sector is looking
22 after many of the most vulnerable people in our society,
23 that in the national effort the care sector plays
24 a vital role in accepting patients as they are
25 discharged.

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1 guidance now, because I think it's far too certain,
2 especially as knowledge was evolving. I don't and
3 I can't say why it was decided to put those exact words
4 in there, and I think, looking back, it is potentially
5 too reassuring to the sector from where we are right
6 now.

7 But I would then also add is -- is when we talk
8 about asymptomatic infection it could mean every single
9 person in the care home and every single staff. So it's
10 trying to weigh up the balance of finding the people who
11 have got symptoms who you want to ensure they are not
12 spreading, versus the rest of the care home residents
13 and staff where you want to ensure that they can
14 continue to live their lives as much as possible, and be
15 cared for in the way that's right for them.

16 So it's always that sort of balance of risk and
17 benefits in this.

18 **Q.** Right. You say now you can't answer now why or who
19 inserted it, why it was included. Do you know whether
20 it was designed to ensure that hospital discharges
21 didn't get blocked by care homes? Is that really what
22 the tenor of this was about?

23 **A.** So I definitely recall that there was a large amount of
24 discussions about ensuring that hospitals had the space
25 to look after the severely ill individuals of all ages

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1 "Residents may also be admitted to a care home from
2 a home setting. Some of these patients may have
3 COVID-19, whether symptomatic or asymptomatic. All of
4 these patients can be safely cared for in a care home if
5 this guidance is followed."

6 In this guidance, there was advice that symptomatic
7 residents be isolated and cared for in a single room.
8 There was no advice to isolate asymptomatic admissions
9 to a care home. Can you help us with the sentence "All
10 of these patients can be safely cared for in a care home
11 if this guidance is followed"? Because many may think
12 that was a rather bold claim to make. And so what does
13 PHE say to that?

14 **A.** So, first of all, just my recollection of this guidance,
15 this is the guidance that was led by the department --
16 coordinated by the department, with NHS, CQC and Public
17 Health England.

18 **Q.** Yes.

19 **A.** So it was a consensus guidance across the four
20 organisations. The final version of this guidance will
21 have been reviewed by ministers and seen by the office
22 for the CMO and reviewed by them as well.

23 So it will have had a lot of different views in it.
24 I think -- again, on learning, there's very few times
25 that I would say all or a hundred per cent or in

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1 who required hospital admission, hospital treatments
2 that are only available in hospitals. And at this
3 point, there were increasing worries that we were going
4 to run out of hospital beds. Nightingale hospitals were
5 being built, for example, to try to provide extra
6 capacity.

7 I also know that in the routine, as we set out at
8 the very start of the looking at the guidance, care --
9 individuals are discharged from a hospital to a care
10 home once they've had their initial acute episode
11 treated, whilst they may still have elements of
12 infection. And of course, on a normal basis, many
13 individuals get discharged from a care home who may be
14 asymptomatic as well, but we don't routinely test them
15 for other infections.

16 **Q.** Can I ask you about PHE's work in the build-up to the
17 consensus admissions guidance, if I can call it that.

18 Can we have up on screen, please, your
19 paragraph 7.16 at pages 94 and 95. And if it helps you,
20 Professor, I'm at paragraph 7.16 in your statement,
21 because as I understand it, prior to the April
22 admissions guidance, PHE had been developing its own
23 internal operation guidance for healthcare protection
24 teams to effectively manage outbreaks, and can I tell
25 you where I'm going, just to help everyone else

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1 following, what PHE were working on does not accord with
2 what appeared in the April admissions guidance? Do you
3 agree with that as a very broad proposition?

4 **A.** I think, actually, lots of it does. There are a couple
5 of elements that do not and I think it's worth pulling
6 those out a little bit more.

7 **Q.** Yes.

8 **A.** My understanding and, again, from the teams who were
9 doing this, and from the health protection teams who
10 were developing this, to help them in their job, that
11 this was being done in -- to help the teams do -- in
12 response to the NHS guidance that had been released.

13 **Q.** Right.

14 **A.** So my understanding is that this guidance had started to
15 be developed on 22 March, so it was very much a first
16 draft, while then the Department asked for the agencies
17 to come together.

18 **Q.** If we look at paragraph 7.16, this is what PHE were
19 going to -- in developing the guidance at that stage.
20 They make the point that decisions on transfers need to
21 be carefully considered, taking into account local
22 epidemiology and capacity.

23 Put aside the healthcare tracking, but go down to
24 the "General principles" if I may. Thank you very much.

25 "Transfers into the care home": where there is an
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1 home has got a single case of Covid-19, ideally all
2 transfers in should be avoided to protect new residents
3 but if appropriate, facilities for isolation and
4 cohorting of asymptomatic contacts can be assured, and
5 transfers can be considered.

6 And if there's no Covid in the care home, previously
7 confirmed cases of Covid who have no longer got symptoms
8 and they've been isolated can then be transferred.

9 Now, do you agree that on any view that is a more
10 restrictive approach than what ended up in the 2 April
11 admissions guidance?

12 **A.** I absolutely agree this is more restrictive. I also
13 think there are things in this that probably wouldn't
14 have got through all the phases of clearance in the
15 organisation because of some of the language that's been
16 used, but I think that from my point of view, the point
17 of -- the consensus guidance that came out was that it
18 was bringing together the views of all of the
19 organisations involved, the Department of Health, CQC,
20 NHS England, and PHE, to agree the balance of the risks
21 and benefits for both the discharges from hospital and
22 to protect the care homes. So I don't think it was
23 binary one or the other.

24 **Q.** In due course there are emails where NHS England
25 certainly were concerned that this might create blocks
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1 ongoing outbreak of Covid-19 in the care home, PHE were
2 intending to advise against any transfers of
3 asymptomatic patients into the care home to avoid,
4 presumably, them becoming infected by the care home
5 that's already got the outbreak; is that right?

6 **A.** Yes, and again, this would be predominantly people
7 coming from hospitals or the communities. So it would
8 affect both, where people are returning from a hospital
9 or returning from the community. That is particularly
10 challenging, I think, in the element where you're trying
11 to ensure that you'd free up beds in hospitals. So it's
12 recognising that, and I think, again, it's clunky
13 language because it talks about patients. I'm not sure
14 where those patients, if it's a hospital patient, for
15 example, versus a resident.

16 **Q.** Right. But it was going to be PHE's position that if
17 the care home has got an outbreak, you don't send anyone
18 into that care home, in a nutshell?

19 **A.** That's generally regarded as the scenario that they
20 would try and follow but I think you can see that if in
21 -- if there is a situation where somebody needs to be
22 admitted to the care home, where there is an outbreak,
23 you would try and segregate those individuals from other
24 individuals who are known to be infected.

25 **Q.** If we could scroll down a bit further, where the care
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1 in the system, their phrase not mine, I hasten to add.
2 Do you think, however, that PHE should have held
3 a firmer line and said, "I'm afraid, if we've got cases
4 of Covid-19 in the care home or no cases, there does
5 need to be more restrictions on allowing admissions in"?

6 **A.** So I think this is always a sort of balancing act
7 between organisations, and a balancing act of what the
8 directions are from government, as well, actually, as an
9 executive agency. So we can talk on the evidence, and
10 we can talk on where we know there's evidence, and then
11 where we have unknowns at the time. At this point in
12 time, there was a priority to free up beds in hospitals
13 for the -- and that was one of the priorities for
14 government. I think when I look at this and balance it
15 with the other component, the piece that I would say in
16 retrospect, as we've moved on and understand more about
17 the virus, is how can people come into the care home and
18 then be safely isolated as much as possible in the care
19 home, is the piece that could have been strengthened in
20 this, rather than all of the elements that are sitting
21 here in front of you in this guidance.

22 **LADY HALLETT:** Sorry to interrupt, but had PHE been more
23 insistent about what precautions should be taken, it
24 might have forced other government organisations or
25 departments to consider step-down facilities or
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1 something. In other words, not taking a Covid-positive
 2 patient because they were a patient before they're
 3 discharged from hospital, and putting them into a care
 4 home where you had a lot of very vulnerable people.

5 **A.** So step-down facilities were considered and were part of
 6 the plan, as I recall, both on the 17th and subsequent
 7 19 March guidance that was released from the NHS.
 8 I think clearly it depends -- every day an individual,
 9 and especially an elderly individual who remained in
 10 hospital as hospitals were rising with the number of
 11 cases of Covid, also increased their risk of getting
 12 Covid. And so there was this worry at the time that if
 13 individuals stayed in hospital for prolonged period of
 14 times, then they were having an increasing risk of
 15 Covid.

16 **LADY HALLETT:** No, but we're talking about somebody whose
 17 had symptoms, who has already got Covid.

18 **A.** So the individuals with Covid who had symptoms, in the
 19 discharge guidance, they were only accepted into the
 20 care home if the care home had isolation facilities for
 21 them. That was the -- on the guidance that came out in
 22 April, individuals who had had Covid in hospital,
 23 confirmed and treated, unless they had completed
 24 a prolonged isolation period they were asked to be
 25 isolated in the care home or were sent to another

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1 share a bathroom, how could the bathroom be cleaned
 2 after their use? So it wasn't as binary as if they
 3 didn't have a bathroom they couldn't use a bathroom, but
 4 what are the elements that you could do that would clean
 5 and protect the bathroom from being a transmission risk
 6 to others?

7 And all of those require the care home to think
 8 about it for risk assessment, and this is not just for
 9 Covid, they would do this for norovirus in care homes or
 10 flu in care homes as well.

11 **Q.** You say in your statement that -- thank you that can
 12 come down -- that there was a meeting on 24 March
 13 between PHE officials and NHS England in which concerns
 14 about the guidance were discussed, and I think on
 15 25 March you say this:

16 "... recognising the pressures on acute beds, PHE
 17 'agreed that we go ahead with the NHSE proposed
 18 changes ...' ..."

19 In short, discharge anyone who was fit, as
 20 IPC guidance will be able to mitigate the risks, my
 21 paraphrasing.

22 Why did PHE agree to go with the NHSE position?

23 **A.** So I think what that's saying is that the -- as I've
 24 just already highlighted, if an individual had diagnosed
 25 Covid-19 and needed to complete their isolation period,

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1 facility.

2 **LADY HALLETT:** Thank you.

3 **A.** So that's really clear.

4 **LADY HALLETT:** -- (overspeaking) --

5 **A.** No, no, we would not have accepted that. The challenge
 6 is the individuals who had been in a hospital who had no
 7 symptoms, and where the risk was rising. It's those
 8 individuals who had no symptoms that I think is the
 9 piece in the middle that there was an argument about.

10 **LADY HALLETT:** I follow. Thank you.

11 **MS CAREY:** May I ask you Professor, you mentioned there
 12 a number of times about the need for being able to
 13 safely isolate patients. Did PHE know how many care
 14 homes had the capacity to safely isolate?

15 **A.** I don't think -- I certainly wouldn't have had a number.
 16 We did know the structures of care homes and locally
 17 between the local authority and the health protection
 18 team. They could have had that discussion. Care homes
 19 were generally mixed -- some -- there was very few care
 20 homes that shared bedrooms but there were many more care
 21 homes that shared bathrooms and therefore it was, could
 22 you isolate a single bathroom to a single patient if
 23 they needed it? Could they use a commode in their
 24 bedroom for that short period, were all of the things
 25 that would have been considered. Or if they had to

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1 they would need to be isolated in the care home. But if
 2 an individual was asymptomatic, had not been clearly
 3 clarified as somebody who had symptoms with Covid-19,
 4 then those individuals would be able to return to a care
 5 home.

6 That was the bit of contention, and at the time, the
 7 challenge, as I understand it, was trying to find the
 8 balance of freeing up hospital beds and ensuring that we
 9 didn't keep people in hospital beds whose risk would
 10 increase every day they stayed in hospital for Covid-19.
 11 And also then ensuring that we protected the care homes
 12 in as much as possible at the moment in time.

13 We can look back at that and say we would take
 14 a different risk judgement now, but that was the risk
 15 judgement that was taken at the time.

16 **Q.** Can I just perhaps deal with one final piece of guidance
 17 before we take our mid-morning break.

18 On 8 April there was guidance for those who provide
 19 unpaid care by friends or family.

20 Can I have up on screen, please, INQ000327821_6.

21 This is guidance from 8 April. And one can see
 22 there that for unpaid carers, face masks were not
 23 recommended, they are not considered an effective means
 24 of preventing the spread of infection.

25 Is that right as of 8 April, Professor?

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1 **A.** So at 8 April as unpaid carers, so this is people in the
2 community, we were not recommending for the general
3 population face masks in general. That came some time
4 later. So clearly at this point in time, we were
5 recommending widespread use for face masks in hospitals
6 and care settings and other closed settings at that
7 point, but we'd were not recommending them in the
8 community.

9 And that follows the sort of general community
10 guidance and written in the -- in respect of that for
11 unpaid carers in the community, who were often family or
12 friends of individuals.

13 **Q.** Yes. You say:

14 "Facemasks play an important role in clinical
15 settings, such as hospitals, where staff are trained in
16 the use of ... (PPE) but there is little evidence of
17 benefit from their general use outside of these
18 settings."

19 Can you help me, upon what was it based the phrase
20 "there is little evidence of [their] benefit".

21 **A.** So clearly it wasn't any Covid-19 studies because it
22 wouldn't -- there wasn't any time to do them at that
23 point. But it was based on years of evidence for
24 respiratory infection, about the use of face masks to
25 prevent the spread of respiratory infections when

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1 community outbreaks were happening, particularly flu,
2 preventing infections in households, in transmission
3 when the individual is infected where other members of
4 the household wear a face mask, and there were multiple
5 other attempts in both populations or in settings to see
6 whether face masks reduced the risk of spread.

7 In the vast majority of them, actually in all of
8 them at that time, there was very -- there was no
9 evidence that these were an effective measure of
10 reducing it.

11 I think what was different and what we came to
12 recognise with Covid-19, going back to some of the
13 evidence in Module 3, was even a small benefit of
14 reducing spread was something that we should utilise,
15 which is why we moved to widespread face mask use in the
16 pandemic, and why I think in a future respiratory
17 pandemic we would use them much earlier, be it cloth, if
18 we had a shortage of paper ones, but that idea that
19 there is an element of a barrier, and that we would take
20 any element of a barrier to reduce spread.

21 **MS CAREY:** Thank you very much.

22 Would that be a convenient moment?

23 **LADY HALLETT:** Certainly. I shall return at 11.30.

24 **MS CAREY:** Thank you very much.

25 **(11.16 am)**

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1 **(A short break)**

2 **(11.30 am)**

3 **LADY HALLETT:** Ms Carey.

4 **MS CAREY:** Thank you, my Lady.

5 Professor, we were in April 2020 and can I ask you
6 briefly about the Easter 6 study which was conducted
7 over 10 to 13 April. It's at your paragraph 3.31, but
8 in a nutshell, this was a study of six care homes in
9 London the result of which showed that 43% of the
10 residents tested were asymptomatic. I know you give the
11 full figures in your statement but time precludes me
12 from going there today.

13 And you also say that the study showed multiple
14 lineages in each of the six care homes suggesting
15 there'd been an outbreak -- sorry, that in each outbreak
16 there'd been multiple introductions of the virus. Just
17 help me with what you meant by that.

18 **A.** Yes, so I'll take the background numbers as read in the
19 statement, but the lineage is just to explain.

20 So viruses mutate as they spread from one person to
21 the next and by doing generic analysis of those viruses
22 we are able to look at the amount of times it has
23 mutated, and we're able to then determine whether those
24 mutations are related to each other, so it could happen
25 from moving from one virus -- person to the next which

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1 might have one or two minor changes in the virus where
2 we see changes that are more than ten changes, or more
3 than 20 changes, then we know those are very separate
4 moments of entry.

5 What we -- what this was really important in doing
6 and highlighting was that, in a normal outbreak where
7 something comes in and spreads around the care home, we
8 would see that all of the viruses that we detected were
9 very closely clustered together, usually with zero to
10 two or three changes in the virus genome. When we say
11 that there's at least six, it means that at least six
12 are so far apart from each other they have to have been
13 introduced separately from separate events.

14 We can't say, there may be some that are on the
15 borderline which is why we won't go and say, "We think
16 there's ten", we will say where we think the minimum is.
17 And I think it really highlighted to us, was that there
18 were multiple ways the viruses could get into care
19 homes -- which we knew before we started, but it really
20 helped us. It helped us determine that, actually,
21 across these care homes, the same virus was in different
22 care homes, and those care homes could be linked by
23 workers, they may be linked by a hospital, there were
24 lots of differently linkages, but it showed that we
25 weren't seeing something go into a single care home,

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spread and then close down, that it was moving from care home to care home.

And it was the first time we saw that.

And also, and again, this is the important bit from an asymptomatic infection and transmission, we could see that individuals who were asymptomatic and also had the same virus with somebody who was symptomatic. And so it started to give us some more insights, recognising that this study was done at a point in time, so we didn't know who was negative at the start and when they became positive, but at least it made us understand that this wasn't one thing that happened to one care home, it was lots of things happening across care homes in general.

Q. And you said that each cluster of outbreak included a member of staff, indicating a strong likelihood that staff played a critical role as a vector of transmission of the virus.

A. Yes, and again, you know, if something had come into a care home by one route and then spread around the care home, for many other infectious diseases we would see that very few staff were infected, for example, whereas here we could see that there was lots of different incursions, and that each different cluster that we could see, clustered around a staff member rather than clustering around a group of patients, or sorry, a group

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a week after we did the study, which -- it might seem normal, but that's quite exceptional in trying to get something written up and sent up.

But we were getting insights on a daily basis.

Q. The 15 April action plan announced that there would be PCR testing for all patients discharged from hospital into care homes. It started with those admissions from hospitals and then it was rolled out from admissions into care homes from the community. Can you help, were there any statistics or data to support the decision to focus on testing patients from hospital into care homes first before the rollout into the community?

A. So I think -- and again, I think this is, you know, the information and the intelligence, and I use the "intelligence" word as a way of collecting information that was being highlighted to us from care homes. So care homes were reporting that they could see an individual come from a hospital and then some clusters.

Of course that was something they could recognise as an event. They couldn't recognise where the infection may be coming in by a visitor or by another resident or by a staff member, because those things were happening every day.

But we took that seriously, and in taking that seriously, we decided, well, that was one single

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of residents who lived on a particular floor, for example, so it may be residents on different floors or it may have been in different ways.

And that gave us some insight into how the infection was spreading.

Q. Do you know, because on 15 April the action plan was published, did Easter 6 findings feature or factor into the guidance that came out on 15 April in the action plan?

A. So and again, I went through my records on the dates, I don't think we had the full data on the Easter 6 by the time that happened, but what we were seeing and the insights that people were talking about that weekend because when we -- we literally had people go out to the care homes and come back and report, that was definitely feeding in, because that was being reported on a daily basis to our calls that we had together, where people were reporting on what was happening.

So it was, in effect, the health protection teams who were dealing with the incidents and outbreaks that were reporting to the national teams, reporting to the individuals who were looking after adult social care nationally and in government, reporting to the CMO. All of that was coming together. But my recollection is that we first sent the report up on Easter 6 less than

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intervention that we could do. I will recall that there was quite a lot of discussion because there was worry that by doing a PCR test on a resident, patient turning into a resident when they get into a care home, it might give a false sense of assurance or reassurance. So my recollection on April 15 guidance or shortly thereafter, we also said to isolate those individuals coming from hospitals.

So we were trying to mitigate what we could as the knowledge and evidence was emerging, and we were trying to reduce the risk of infection outbreaks in care homes, through lots of different measures.

Q. There was some How to Work Safely Guidance published on 17 April, initially on how to work safely in care homes. It was, then, ten days later for how to work safely in domiciliary care; can you help as to why the two pieces of guidance were not published at the same time? Why was domiciliary care later?

A. I can't in absolute know why it was done differently. I can only speculate at this point that it was likely that the adult social care was prioritised, and that the work on that was therefore done first and then work with domiciliary care providers and others took place afterwards. But I don't know exactly why those were published on different dates.

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1 Q. Two things, may I ask you to slow down, slightly,
2 a message from the stenographer, please.
3 A. Sorry.
4 Q. And secondly this: you just mentioned there that the
5 care homes were prioritised, can I just ask you
6 Professor, there's certainly a sense by some of those
7 working in adult social care that care homes were
8 prioritised first, then domiciliary care was looked at
9 and then unpaid care was thought of in third place, my
10 phrase, not anyone else's. Do you think there was such
11 a hierarchy in terms of getting out guidance for the
12 different parts of the social care sector?
13 A. So I think the -- there was a recognition, first of all,
14 that this was affecting all parts of society. And there
15 was also recognition to prioritise areas where the most
16 risk was potentially occurring and where the most
17 infections were being reported. So that we managed the
18 components of that.
19 I recall -- I think there's a note of a meeting with
20 the Secretary of State where he asked the priority to be
21 care homes, and as an executive agency and as agencies
22 working, we would have therefore followed his
23 recommendation.
24 Q. Right. Just sticking with the How to Work Safely
25 guidance, can I have up on screen, please, INQ000571064.

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1 providers."
2 Then if we follow up on the email chain:
3 "Éamonn O'Moore is going to reply, saying:
4 "Thanks Ros -- [the PHE] and his team are having
5 a further meeting about this but on the specific
6 question on compliance [of the masks] with standards,
7 I am advised that it is for HSE to advise on PPE
8 standards and that there [is a single point of contact]
9 SPOC is ..."
10 And he gives an email.
11 "... I suggest perhaps useful to go to them with
12 your query?
13 Then if we go up the page just once more,
14 Dr Jane Townson, on behalf of the UK Homecare
15 Association says to DHSC:
16 "... [I'm] very unhappy to being fobbed off by PHE
17 in this way, being signposted to a faceless generic
18 email address. We consider this to be rude and
19 dismissive."
20 And she points out the number of people that are in
21 the Homecare Association:
22 "Thank you for agreeing to find a real senior person
23 for us to engage with -- we very much appreciate your
24 support."

25 Tensions and feelings may be running high, but

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1 Can we go to page 4.
2 This talks about the guidance that was issued, how
3 to work safely for home care that had been published
4 a few days before. And essentially there's an email
5 here, Professor, to help you, from the Homecare
6 Association. It's copying in PHE and DHSC.
7 But there were a number of concerns raised by the
8 Homecare Association about that How to Work Safely
9 guidance.
10 And we can see them there set out: suppliers were
11 offering masks that don't conform to that published
12 guidance. The specification wasn't right and they
13 didn't have sufficient stocks.
14 There was said to be a disparity in the guidance
15 between two tables that recipients of the guidance were
16 asked to look at.
17 And thirdly, there, a massive discrepancy between
18 the requirements of PPE and the available supply.
19 So this was brought to the attention of PHE. And if
20 I could just follow the email thread back to page 3.
21 We can see -- sorry, page 2, it's my fault. There
22 we are, page 2. If we see the bottom email in this
23 chain, Ros Roughton asks colleagues of yours at PHE:
24 "Anything we can do to expedite a response [to the
25 Homecare Association's concern]? It will really help

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1 nonetheless, there is a concern brought to PHE about the
2 practicalities in a number of respects of that guidance,
3 and perhaps an answer that wasn't as practical as it
4 could have been.
5 Can you help with why PHE weren't able to tailor the
6 guidance or respond to Homecare Association's concerns
7 perhaps as quickly and properly as they ought to have
8 done?
9 A. I mean, I am looking at this not having been involved in
10 any of it at the time, and can only -- look, the vast
11 majority of the people involved in this are no longer in
12 the organisation, so it's quite difficult to actually
13 even go back and ask them their recollections.
14 I would highlight two things. The first is that the
15 Health and Safety Executive were the people who decided
16 the requirements for each level of PPE, and we just --
17 we had a lot of time discussing it with their chief
18 scientist and with their advisers at the time, but of
19 course we in PHE could not give out their personal email
20 addresses. That would have not been the role for us as
21 an organisation. And we ourselves were also using their
22 SPOC email to contact them. Again, because it's
23 a 24/7 response that they were doing, like many of us,
24 so rather than individual -- emailing an individual who
25 may be out or in meetings, trying to have SPOC emails

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1 was considered good practice. So a single point of
2 contact.

3 So I sort of look at that and go, well, we were all
4 trying to have somebody who could answer an email
5 promptly rather than give to it a named individual.

6 That's one aspect.

7 On the other aspect, I mean, I recognise and
8 I really do remember the moment in time where the
9 challenge of getting the right masks out to people,
10 they -- varying differentiations of the masks, were they
11 type 2, were they type 2R, were they type 1? What could
12 be used safely, was a very big discussion point.

13 And actually, part of this came down to what was in
14 health and safety legislation, and required in health
15 and safety legislation, versus what we thought was good
16 enough at the time. And actually, again, I think rather
17 than looking at this and trying to understand what
18 happened, I think the thing for us to is to have a clear
19 listing of: if you don't have this mask, then use this,
20 as a protection element.

21 And I think I would reflect that, you know, the more
22 widespread use even at this time when there was a lack
23 of proper high-quality fluid-resistant surgical masks of
24 advising people to use a cloth mask as a measure, may
25 have been helpful, but that was felt to be a line that

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1 of them are also private providers so they may be
2 commissioned by a family relative like you or I might do
3 for our parents, for example, to provide care in their
4 home.

5 And so from my understanding is that there was
6 a very large number of domiciliary care providers. The
7 majority, but not all, were CQC registered, depending on
8 whether they met the CQC registration criteria. They
9 were delivering care in different people's homes and it
10 may vary from week to week so it wasn't clear, the
11 individual. There were and there are no central records
12 of who domiciliary care is being provided to in this
13 country and that remains the case.

14 And so trying to understand who the care is being
15 provided to, the level of risk to those individuals,
16 trying to understand the way through to the domiciliary
17 care providers and understanding, you know, they
18 describe there are 650,000 individuals here, how we get
19 that information to the right place was something that
20 was really being built during the pandemic. It's
21 wrapped up, to some extent now, within the adult social
22 care and the social care forums that remain in place.
23 But I still think it is a difficult and challenging area
24 to understand what the guidance should be, and how the
25 guidance for caring for somebody in their own home,

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1 we hadn't crossed before and so people were very anxious
2 about going into a new direction in this space.

3 This is the sort of element where I think discussing
4 with the people, the population, and outside an outbreak
5 setting becomes very helpful.

6 **Q.** Can I jump forward in time now, please, just quickly
7 deal with a couple of different issues.

8 In your statement, you have a section dealing with
9 rapid evidence reviews that Public Health England were
10 asked to conduct. And in a number of different
11 points -- at a number of points in the pandemic,
12 starting on 13 May, PHE were asked to identify and
13 examine evidence of transmission of Covid-19 within care
14 homes, and in domiciliary care. But you made the point
15 that in relation to domiciliary care, there were no
16 studies identified and if I can wrap it up, that
17 persisted through a number of different reviews into
18 2021?

19 Why was there such an absence of evidence relating
20 to transmission in domiciliary care?

21 **A.** So I'll try and explain this and I'm sure domiciliary
22 care providers would be much better at doing this than
23 I could ever do it. But, if you like, domiciliary care
24 providers are often commissioned by local authorities,
25 by the NHS, to provide care in someone's home, but some

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1 often for short periods of time, and where that line is
2 between an individual and carer and provider line.

3 So I think it is the challenge of that, and it's
4 also, I think, the challenge that the majority of this
5 is outside central government, if you like, so it very
6 much sits within local government and the local system
7 in what is paid for by the local system versus what is
8 paid for by the individual themselves.

9 **Q.** You've enunciated there a number of the challenges with
10 conducting studies in the domiciliary care sector, but
11 do you consider that UKHSA as it now is, is able to
12 remedy that research gap or is there any work going on
13 to try and understand better transmission routes in
14 domiciliary care?

15 **A.** So it's really -- I mean, I maintain it's extremely
16 different because it's essentially looking at
17 transmission studies in individuals' own homes, which
18 are again, when we talk about care homes and the
19 complexity of who visits people in a care home and who
20 is involved, that complexity is even greater in
21 someone's own home where a domiciliary care provider may
22 visit any time from a couple of times a week to multiple
23 times a day, but for short periods, and they may have
24 other family members living in that house with them who
25 may have multiple ways of moving in and out of that

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house, and other visitors.

So I think pinpointing routes of transmission in that setting will always remain complex.

What we tried to do during the pandemic and what we will try and do in any future pandemic is work with academic researchers to try and understand transmissions in households, and I think in looking at those studies, we will work with the academic researchers about whether they can have more complex households under study that may involve types of domiciliary care. But those studies require the consent from the individuals, and it also requires quite a lot of testing. So when we did household transmission studies, it required us to test the index case and all the household residents, every day over the course of a few weeks, and that can be quite challenging, especially if someone needs care themselves.

Q. Can I turn to Vivaldi, please. We heard from Professor Shallcross last week that you approached her on 8 May about the need for the Vivaldi Study. Are you able to tell us briefly, please, Professor, why you asked Professor Shallcross to set up Vivaldi?

A. So I'll put it in three ways if that's okay. The first is that the staff in PHE who are doing epidemiological studies, including the Easter 6 study, were working flat

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thought it would be beneficial to have somebody who was outside government conducting that work.

Q. Did you get any sense from others of your colleagues in Public Health England that they didn't want the Vivaldi Study to take place? Was there any reticence or reluctance about finding out just how bad infection rates were in care homes?

A. I literally do not recall that. I think there was some upset that I had gone externally, just because people consider themselves able to do all of these, but as the incident director at the time, I was balancing the resources of all our teams and what they were needing to do --

Q. Can I just interrupt you there. Does that explain why Vivaldi could not be done in Public Health England, as it were?

A. So I mean, it -- we would -- we were really limited by our resource at the time and I think the number of studies that we were trying to do were challenging. I myself was one of the people who raised the idea, but I had just started the SIREN study and I had got quite a lot of people engaged on doing it and I was worried that we were going to spread ourselves too thin and therefore using external partners, which we do all of the time and which many academic researchers were involved in a lot

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out. We were hiring new people all of the time but we had a limited number of people to deliver the studies that we were already doing. We had people who were trying to do response and guidance, and as well as laboratory testing.

So people were really working at their maximum limit.

So that's the first thing.

Second of all, while we had done the Easter 6 study and while we have done some small studies in care homes before, I knew from Laura Shallcross's research and some engagement I'd had with her, that she had developed a very strong relationship with the Four Seasons care home, one of the reasons why it became known as the Vivaldi Study, as part of her research that she's doing on antimicrobial resistance, which is why we had interacted.

And thirdly, I also felt, a bit like the ONS study, there's quite some value of an external organisation in doing these studies as they have the ability to be independent and be seen as independent. While I believe, and continue to believe, that our research is independent and we are able to do research and publish research independent from government, I think at this point in the pandemic, with the care home work, I really

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of the research work in the pandemic, was a way of building that resource and expertise, and Laura is -- has training in public health and worked in adult social care so was the perfect person to take this on.

Q. We've heard from her about the results, I'm not going to ask you about them, Professor, but can I just ask you about perhaps the data sharing that led to the Vivaldi results. I think there is a concern that perhaps there was difficulty in getting Public Health England's data into the NHS Foundry, which was then used by Vivaldi. Were you aware of those difficulties?

A. So I was aware that there was generally difficulties in getting the data across to Foundry but that wasn't just for Vivaldi, it was in general, and it was trying to ensure that the COPI notice that came out originally that was --

Q. Control of patient information?

A. -- control of patient information, was directed to NHS Digital and was not including Public Health England and its data so we had to get specific advice about whether we could put all of this data into this domain. What I would say from that is we need better ways of sharing information across government departments and the health and care sector all of the time and not need to construct them in emergencies.

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1 Q. All right. Was the COPI notice varied, then, to enable
 2 Public Health England -- (overspeaking) --
 3 A. We were given legal advice that we could follow it.
 4 Q. All right, fine. Just one other question, please, about
 5 Vivaldi. Mr Hancock, in this statement, made the
 6 observation that in the summer of 2020, Public Health
 7 England was the source for his view that staff movement
 8 was the main source of transmission. Are you able to
 9 help with whether there was any PHE research, paper,
 10 information provided to Mr Hancock which may have led to
 11 him believing that staff transmission was the main
 12 source of transmission as opposed to a source of
 13 transmission?
 14 A. So clearly I listened to Mr Hancock's evidence last week
 15 and we asked the teams to find if there was a document.
 16 We cannot find a document that relates to that.
 17 Clearly this will have been discussed, particularly
 18 in the adult social care ministerial meetings, I was not
 19 in those adult social care ministerial meetings so
 20 I don't know the word and framing that might have been
 21 used. I think the Vivaldi report, of which I was
 22 a co-author, so I was quite clear on it, highlighted the
 23 variety of different ways that infection could get into
 24 care homes, and was able to show that staff, movement
 25 across care homes, lack of sick pay and other factors

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1 really important in this setting, within our adult
 2 social care team and our infection prevention and
 3 control team in UKHSA, they are currently working with
 4 the adult social care sector, with a very wide group of
 5 stakeholders, to set up infection prevention and control
 6 guidance that will be the basis for anything for the
 7 future. And they're taking their time to do that, to do
 8 it right, and in consultation right now, in order to
 9 have the basis and principles for any future epidemic or
 10 pandemic, and which is what we would utilise in the
 11 future.
 12 And I think that's the right way to do it: to have
 13 as much of this bedded in, to work through the problems,
 14 because trying to work through it in a week in an
 15 emergency with 10,000 care homes and lots of different
 16 organisations, is an extremely challenging time. And
 17 I can look back and reflect and say we could do it
 18 better, but I still think it wouldn't have been optimal.
 19 Q. Different topic there, please, and hospital discharges.
 20 And I think you said this morning that you weren't aware
 21 of the NHS England letters that were about to come out
 22 on 17 and 19 March. In your statement you say you
 23 weren't formally aware. Does that mean that PHE were
 24 informally aware?

25 A. Well, I mean, we've gone back and tried to check.

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1 was a route, but as I recall it details that it couldn't
 2 determine the relationship with hospitals partly because
 3 of missing data.
 4 Q. Do you know whether Public Health England tried to
 5 present the Vivaldi data as its own?
 6 A. No.
 7 Q. Just finally on guidance, I suspect we've talked about
 8 it enough, you may be familiar, Professor, with
 9 a concern that guidance came out either too late or last
 10 minute on a Friday, was not sufficiently clear, or was
 11 contradictory. From a Module 6 perspective, because
 12 I know we've discussed this before, were you aware of
 13 complaints and concerns like that?
 14 And if it so, is there anything practically that can
 15 be done to try to prevent that in the event of a future
 16 pandemic?
 17 A. Look, I recognise this, and it was really a difficult
 18 moment when basically, if people were releasing guidance
 19 on a Friday -- you'll recall that I discussed this a lot
 20 in Module 3 -- and we really tried not to release
 21 guidance on a Friday. What that meant was sometimes
 22 guidance was ready on a Friday and held over till
 23 Monday, which then talks about the delay of releasing
 24 it, but there was always nuances.

25 To move to the future, and I think the future is

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1 I mean, I can't say somebody didn't receive a phone call
 2 or our comms team weren't made aware, but it was not
 3 emailed to us that we can find in our records.
 4 The 17th was definitely a surprise, to me, as the
 5 incident director. I think the 19th, we were expecting
 6 something further to come out, given the 17th letter.
 7 Q. Right. What I'd like to look at, though, perhaps in
 8 slightly slower time, because it's important, is the
 9 data linkage report, at INQ000234332.

10 And if I can have up on screen, please, the
 11 executive summary.

12 This was a data linkage report published on
 13 1 July 2021, and -- thank you.

14 If we just scroll down, we can see there that from
 15 43,398 care home residents who tested positive between
 16 30 January and 12 October 2020, it ended up that 97 of
 17 those outbreaks, or 1.6%, were identified as potentially
 18 seeded from hospital-associated Covid-19.

19 I just want to hear from you, please, what one can
 20 deduce from this and why the data linkage report was
 21 asked to be set up and what it shows us.

22 A. So the -- the SAGE, so Scientific Advisory Group for
 23 Emergencies, and the Social Care Working Group,
 24 a subgroup of that, and also, as I remember, the
 25 National Audit Office report, brought together and said

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1 that we need to look at the data that we have and try to
2 understand -- what -- how best we can understand
3 hospital-associated infections into care homes.

4 So this was a piece of work done by one of our
5 epidemiological teams, where, as always, they set out
6 very clearly the case definitions so they can track and
7 follow things over time. And what they do in doing that
8 is they define what they believe is a hospital-acquired
9 infection versus a hospital-associated infection,
10 associated meaning the individual may have spent some
11 days in a hospital but some days in a care home, so you
12 can't determine the cause and effect, whereas "acquired"
13 means that they were in hospital for a period of time
14 and then stayed in hospital and got this infection.

15 Q. Right.

16 A. So we have different ways of looking at those things.

17 And in this in particular, they also looked at
18 whether the case -- the incident case that was detected,
19 so the positive case, was detected -- is the first case
20 in a care home or was detected within 48 hours of the
21 first case being detected. So in that very immediate
22 period where you might have missed it or they may have
23 been potentially pre-symptomatic or asymptomatic, and
24 transmitted to someone else and not tested first.

25 So it was trying to basically come up with robust

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1 less testing done than was done later when we started to
2 do whole care home testing.

3 Q. Now, that's an important caveat, because clearly it's
4 covering a longer period of time, but certainly in the
5 early months there wasn't the capacity of testing that
6 we had later on.

7 Can I just ask you that, though, do you think this
8 executive summary, and I appreciate the full paper does
9 add that caveat, but do you think there should have been
10 that caveat highlighted in the exec summary? Or
11 "limitation" might be a better way of putting it.

12 A. Usually the executive summary highlights the main facts
13 that you find. There is usually a discussion section
14 that highlights all the potential caveats, such as
15 testing amount, the size of the care homes, and the
16 other components.

17 Q. Now, some people may think that 97 positive cases, or
18 1.6%, call it what you will, seems a very low number of
19 potentially -- outbreaks coming from hospital-acquired
20 infection. Were PHE surprised by that number?

21 A. Yes.

22 Q. Did you think it was going to be higher?

23 A. Yes.

24 Q. What did you do when the findings came
25 out -- (overspeaking) --

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1 definitions, using the data that we had, which was the
2 pillar 1 and pillar 2 testing data at the time, mainly
3 pillar 1, of course, until late May, early June, but
4 pillar 1 and pillar 2 testing, link those to a care
5 home's residential postcode -- again, not the perfect,
6 but the best that we could do -- and then utilising
7 NHS Digital hospital records to determine which of those
8 individuals had been in hospital in the preceding
9 14 days.

10 So quite a lot of data, linkage, all of the hospital
11 records were looked at, all of the testing records were
12 looked at, and using definitions that were pre-defined
13 coming down and rolling through to meet this particular
14 criteria.

15 Q. So are we essentially saying that if the person caught
16 Covid in the hospital and then was discharged to a care
17 home, you could track it through to work out whether
18 that hospital-acquired infection ended up seeding
19 infections in the care home? Or is that too simplistic
20 a summary?

21 A. If they had had a positive test. So recognising we
22 could only do this if they had a positive test. And
23 I will highlight, and we did highlight in the report,
24 and for any publication that followed it, that we
25 recognise that particularly in March and April there was

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1 A. Well, we looked at all of the other data that we could
2 find; was there any other data that we could find that
3 we could see and look at? I think then we looked at the
4 fact that maybe the individuals weren't tested when they
5 came from hospital, maybe they remained asymptomatic, as
6 asymptomatic infection transmission was definitely more
7 on our awareness by the time this report was being done.
8 We looked and checked that we had the best matching that
9 was available, how we were missing things, and I think,
10 again with all of that, we then continued the study for
11 the rest of the pandemic, so that we could look at it
12 over time.

13 I think -- the thing I would say, and I think it's
14 really important, and I think there is what we call an
15 epicurve in this report, there's definitely more
16 epicurves in the final report. What that -- is clear is
17 that the vast majority of the infections in the care
18 homes and the outbreaks in the care homes occurred from
19 mid-March to mid-April, and would say that was the
20 period of the real challenge in testing but one of the
21 reasons why we went on to continue to do this over time
22 to try and understand it better. And even subsequently,
23 when we were doing whole care home testing and whole
24 care home repeat testing in outbreaks, despite there
25 being other measures, care home outbreaks being seeded

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1 by hospitals ran to 3-4% in the winter of 2020, when
2 lots of other care home outbreaks were caused by other
3 reasons.

4 So I think in time we were, like, clearly this was
5 an underestimate, but we did not know and we cannot know
6 in retrospect what the real estimate was.

7 **Q.** No, because of the lack of testing in that --
8 particularly in that key month.

9 May I ask you for your comment on this: Mr Hancock
10 gave evidence that he considered it was a spurious level
11 of advocacy (sic). What did PHE say to that? Accuracy.

12 **A.** Well, this is clearly delineated in the report, we
13 report numbers in the reports. We often then go and
14 look at what's called a confidence interval but I don't
15 think a confidence interval would have helped us here,
16 and, actually, given all of the variation and the
17 explanations that we have talked about would not have
18 really brought anything to light. It would have told us
19 that the number of outbreaks in a care home ranged from
20 0.5% to 3%. I don't think that would have materially
21 changed the outcome here, which is the reasons for this,
22 at the time, were multi-varied and multi-focused and, if
23 anything, the underestimate was based on the lack of
24 testing rather than what the true estimate was.

25 **Q.** May I ask you, so that we can have your views on it, did

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1 policy changes in the first wave.

2 Can you help, from Public Health England's
3 perspective, was there any research done on how much
4 infection was brought in by visitors or was it not
5 possible to do so because of the ban?

6 **A.** So I think, you know, it was really challenging, wasn't
7 it? So, first of all, in the early points in the --
8 there was always something about visitors, as there was
9 always in preceding guidance, and reducing visitors in
10 situations of incidents and outbreaks or infections.
11 From my point of view, I think that in order to
12 understand, like, the lack of evidence means that there
13 was no evidence available for us to see. And when
14 people looked at it, not just in studies that Public
15 Health England had done, but other studies around the
16 world, there was -- nothing had been published that said
17 that visitors were bringing the majority of the
18 infection in or even the minority of the infection in.

19 But there was clearly a risk to it, and remained
20 a risk in both directions of visitors bringing the --
21 potentially bringing infection in and visitors also then
22 potentially acquiring infection in visiting a care home
23 and transmitting it to other members.

24 So I think that, you know, that's where we came to,
25 that was what we talked about. I think this was really

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1 PHE want to show low figures of infections being seeded
2 from hospitals given its role in formulating the
3 guidance and perhaps some of the, with hindsight, flaws
4 in that guidance?

5 **A.** So my belief, then, and my continued belief now is that
6 my scientists have a high degree of ethics and
7 propriety. They design studies and they publish the
8 methodology for those studies, and then the reports they
9 publish are related to those. They do not hide data and
10 if they did so they would be up on ethical misconduct.
11 I believed that then and I believe that now, and that is
12 the expected behaviour of all our staff.

13 **Q.** Thank you very much.

14 Can I turn to visiting, please, Professor, and just
15 a few questions on this. I know there was various
16 guidance that was put out in due course in relation to
17 visiting, but can I ask you, please, about your
18 paragraph 8.22, and in November 2020 the SAGE Social
19 Care Working Group published a consensus statement on
20 family or friend visitor policy into care home
21 settings -- thank you very much. It's on screen, if it
22 helps you, Professor -- and the key findings from that:
23 that there was a lack of evidence on the risk of
24 introduction and transmission of infection from
25 visitors, although this partly may be due to timing of

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1 at a point in November 2020 where the visiting
2 restrictions had already been in place for quite a long
3 time. The increasing social distress of residents, and
4 of their families, was increasing as time went on.
5 I know myself, I didn't see my parents for 20 months and
6 that was a long time. And so at this point, I think we
7 were trying to see how we could possibly get the right
8 level of visiting in to keep the risks low, but to
9 ensure that people had the right social environment for
10 their longer-term care, because this is no longer an
11 acute emergency. We could all see that this was going
12 to last quite some more time.

13 **Q.** Two things, please, on that. Is there any work being
14 done now by UKHSA, or anyone else, to perhaps try and
15 work out the extent to which, if at all, visitors
16 brought in or are capable of bringing in an infection?

17 **A.** I mean, this comes back to what I talked about really
18 for domiciliary care. You would have to have testing of
19 visitors all the time. I would say that in the
20 following winter when Omicron was present and when
21 Omicron was circulating in high prevalence in the
22 community, we did get visitors to test going into care
23 homes and we did detect, in visitors going into care
24 homes, people with high levels of virus through those
25 was lateral flow tests, and therefore they were excluded

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from visiting.

I think that sort of approach was useful as a protective measure once we had a test that we could use in realtime.

I would argue that a PCR test was not good enough for that because the time to take it, get it to the laboratory, get the result, and then do the visit would have taken too long. But in, you know, it would be nice to be able to see when infection is circulating at high levels in the community, how we could enable visiting for the residents and for the individuals who are being visited, and reduce the risk of infection.

Q. The Inquiry has seen some evidence that makes reference to an ongoing piece of work being conducted by UKHSA to quantify the benefits and risks of visitors. Are you able to give us, Professor, any update on that piece of work?

A. Yes. So this was using a tool that was developed many years ago, as I understand, by researchers in adult social care, looking at quality of life tools in adult social care. It's called the ASCOT tool. And it's a piece that is there for adult social care managers, care homes managers, and other individuals who provide care to look at the risks and benefits of the care they provide and how that can improve the quality of life of

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Q. A different topic, please. I'd like to ask you about data and surveillance by PHE and now UKHSA.

I think you say in your statement at paragraph 11.8 onwards that there were clearly some weaknesses in this area at the start of the pandemic, either there was no data or the data that there was most not linked and not collected in a standardised way.

And indeed, last week, Mr Hancock made reference to one of his WhatsApp messages from July 2020 where, to use his phrase, not mine, that PHE -- he had no tolerance for "crap data", by which he was referring to PHE data.

Help us, please, with what were the real practical issues with either -- well, obviously with having no data, that's obvious, but the non-linkage and the non-collection in a standardised way?

A. Yes, so I would say that data improved quite dramatically through the open sharing of data and the COPI notice during the pandemic. But much of that, as I recall saying in Module 3 as well, has returned to baseline.

The -- first off, the data that we received from laboratories on confirmed cases often only has a name of the individual, the date of birth, as the required. We ideally receive the NHS number and their postcode, but

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residents in care homes or in other settings.

What UKHSA commissioned post-pandemic is working with some individuals who are experts and developed this tool, is to develop a set of teaching slides and tools that could be used to get people to really understand the individual, and those training slides are now used by our guidance teams so that they consider the individual whilst developing guidance, and those training slides have been disseminated to local authorities and to care providers.

We can share those with the Inquiry, but what it really does is it puts an individual at the centre of the guidance and then asks what changes in the quality of life you're doing by each of the aspects, and gets you to do an assessment of that, and also asks you to think about what's the deprivation of liberty, what are the changes you're making, and how that might affect them and their family.

I think it's really good because it brings person-centred care to the centre of developing guidance, and so we are now utilising that to train people about when they write guidance, and using it as a training tool for others, and we're waiting for the formal academic report from it about how that tool is being evaluated with the sector.

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many of the postcodes of the residents of the individuals is not complete. That's preceding the pandemic and -- while it's better now, because systems have been put in place, it's still not perfect.

Q. Can I just pause you, Professor.

A. Yes.

Q. We've heard that from a number of different witnesses, and it sound so straightforward just to put on some of us postcode and the like. What is the difficulty here?

A. Well, for example, say the care home or the GP in the community is sending the sample with the form, and they don't include some details, then the hospital laboratory or the laboratory receiving it don't have those details. We try to utilise being able to link it up to what's called the NHS Spine, but sometimes the details are wrong on the form, and therefore you just have missing data.

We would all like if it was better, and it is much better than it was, but it's still far from perfect.

But it doesn't say if the individual is residing in a care home when we receive the sample. And so, as I mentioned earlier, we have to infer that sometimes from using the postcode.

Q. Yes.

A. But that's not perfect, because for those of you who

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1 have studied geography and geographers, usually
 2 30 houses are within the same postcode. Sometimes
 3 a bigger care home would have its own, but that's the
 4 challenge that we have in trying to make those
 5 assumptions.

6 **Q.** And do you know if anything is being done to try to
 7 remedy what, on any view, is potentially quite basic
 8 information, pieces of information being included?

9 **A.** Yes, there is stuff being done, but not enough. And
 10 there are some components that I think we could improve
 11 on. It might, you know, require more than gentle
 12 encouragement, but I think -- so, for example, at the
 13 moment GP records don't include, by definition, whether
 14 somebody is residing in a care home when they're looking
 15 after them. That's pretty straightforward. We could
 16 improve that we knew if someone was being admitted to
 17 hospital that they were in a care home, because at the
 18 moment it can be recorded that they're coming in from
 19 a care home, but it can equally be recorded they're
 20 coming in from their own residence, which of course they
 21 are.

22 So those sort of things would make at least linkage
 23 of data easier and better. I do think, though, we need
 24 to think through what we would like to see from
 25 care homes and --

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1 than asking for a new, separate care record system to be
 2 introduced. Because everyone in a care home should have
 3 a GP and, therefore, including it on the GP records and
 4 being able to extract that easily from the GP record
 5 would be a big step forward.

6 **Q.** And would that -- it sounds obvious -- play an important
 7 role in UKHSA being able to track infectious diseases,
 8 track other data trends that they needed to monitor? Is
 9 it really that straightforward? It helps
 10 you -- (overspeaking) -- surveillance?

11 **A.** If we were then able to access all of the -- so if we
 12 were able to access that data and we had permissions to
 13 utilise it, we can link it with all of the infection
 14 data that we receive, and are able to generate reports.

15 **Q.** Is access now difficult in the absence of a COPI notice?

16 **A.** So -- but, again, that can be delivered by regulation.

17 **Q.** Mr Hancock said to us that he thought there should be
 18 a national centralised database on all communicable
 19 diseases run by UKHSA. Does UKHSA have a view on that,
 20 Professor?

21 **A.** So UKHSA, as did prior organisations, collects data
 22 under the Health Protection Regulations, which are
 23 regulations that allow us to require individuals with
 24 potential syndromes of disease, which are the suspected
 25 Covid, calling us, or GPs who see someone with

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1 **Q.** That's what I was going to ask.

2 **A.** Of course.

3 **Q.** Two things then, please, when you delphically said that
 4 they might need more than gentle encouragement, what do
 5 you actually mean by that, Professor? Do you mean
 6 legislation, regulation, what are -- (overspeaking) --

7 **A.** Yes. I mean, you know, if you want something to be
 8 done, even though it might not be done perfectly,
 9 legislation is where you start, because that requires
 10 people to deliver something. Everything else is on best
 11 endeavours.

12 **Q.** We've heard there's no national -- or no relevant
 13 national data system. What do you say on behalf of
 14 UKHSA that it should cover?

15 **A.** Well -- so, for example, we hold an NHS number,
 16 uniquely, each of us, and we hold that from cradle to
 17 grave. And I recognise people come into the country at
 18 different ages, but they get given an NHS number.
 19 Somehow linking who was in a care home and the CQC
 20 registration number with that NHS number would be a huge
 21 step forward in allowing us to understand infections
 22 better.

23 And that's, I suppose, where I come from, is at
 24 least recording that in GP records and making it
 25 available would not be as big as infrastructure change

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1 chickenpox or measles. We also have the ability to
 2 collect laboratory data from a variety of infections
 3 that are listed.

4 It is -- we do not have all of the infections that
 5 can occur. Those -- each of those infections that are
 6 put on and each of the laboratory have to go through
 7 a system of review, public consultation, and,
 8 ultimately, secondary legislation in order to
 9 deliver it.

10 Personally, it would be of great help to us if we
 11 could collect all of the both positive and negative
 12 data, because that would allow us to know who was
 13 tested. And what we did during Covid-19, but what we
 14 only have at the moment for Covid and flu and a small
 15 number of respiratory viruses -- tests data that was
 16 performed. Because that would allow us immediately to
 17 track who's being tested and who's being positive and be
 18 able to link that.

19 That does require not just regulation and
 20 legislation, potentially, but also technological
 21 funding, both to the laboratories that are doing it at
 22 the moment and to UKHSA. The scale and size of that may
 23 be too large for the current financial climate, but
 24 that's what is required: regulation and technology to
 25 interface this.

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1 **Q.** Moving aside from care homes for a moment, you say in
2 your statement that whilst rapid progress was made with
3 outbreak surveillance for Covid-19, this was
4 intrinsically much more difficult for domiciliary care",
5 I suspect for the reasons you already outlined.

6 But is there anything that can be done or is being
7 done in relation to trying improving domiciliary care
8 data?

9 **A.** So, again, I think this is even, you know, a step more
10 complicated than care homes, because while, as I said,
11 GPs will know who's in a care home and each GP will be
12 looking at it, domiciliary care can be transient, so it
13 can be in one week and it mightn't be on the next. So
14 that will be much more difficult to record.

15 We are not recording anything centrally in UKHSA,
16 partly because our focus is on infections. So I think
17 that question on domiciliary care would probably be best
18 answered by the Department, and on what they may wish to
19 collect in that setting.

20 **Q.** Couple of final topics, please. You mentioned at the
21 beginning of your evidence that UKHSA has now
22 established a dedicated adult social care team, albeit
23 the size may expand or contract depending on any
24 outbreak. Do you know whether that team includes
25 considering, the views of stakeholders, including those

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1 from across the country, through NERVTAG, New and
2 Emerging Respiratory Viral Threat Assessment Group,
3 through SAGE, Science Advisory Group for Emergencies,
4 and I think the consensus view at that time, that
5 asymptomatic transmission was a small part, or a very
6 minimal part to play, really changed over that time
7 period and I think by mid-April we were recognising it
8 more in the UK, but I would note that WHO were reluctant
9 to mention it and I think their first mention of it was
10 probably three months later.

11 So I think we were trying to follow the science,
12 trying to learn the evidence as we went along, and
13 trying to express that.

14 I think I might reflect that ministers were learning
15 a lot of new things at that time and we know that not
16 everything can be taken in through rapid meetings, often
17 30 minutes, covering a lot of components. We were
18 trying to express that evidence in the best way that we
19 knew, and it may have been that some people were more
20 certain about the evidence that they knew than they
21 might otherwise have been.

22 One of the things that I learned in communicating
23 was to communicate my uncertainty, and, you know, we
24 increasingly use the probability yardstick as a way of
25 identifying how certain we are about things in a way

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1 who are recipients of adult social care?

2 **A.** Yes. So the adult social care team works with the
3 social care and adult social care stakeholder fora which
4 has patient representative groups on it and resident
5 representative groups on it. My understanding is that,
6 where possible, they are looking at the views of
7 residents in care homes, and I think it's really
8 important that it's not just the residents in care homes
9 but their families who can often express their views,
10 especially if they've got dementia or complex care
11 needs, very well, in advocating for the care that they
12 require.

13 **Q.** A couple of observations, please, that we've heard about
14 in evidence that I'd like UKHSA's comments on.
15 Mr Hancock told us that he found it difficult to get PHE
16 to take on board planning assumptions based on
17 asymptomatic transmission, and he was critical of the
18 advice not changing until April. What do UKHSA say
19 about that?

20 **A.** So I wasn't in meetings with Mr Hancock in March and
21 April. I started meeting him in May, as I recall.
22 I think that, as always, we were being driven by the
23 evidence that was -- we knew from prior infections and
24 from before. This evidence was also getting discussed
25 with expert advisory groups so we had multiple experts

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1 that we can describe on a visual scale, as well as
2 making a sentence and stating it.

3 And I think that's really important in emergencies,
4 that when you try and write it down, you try and state
5 how certain you are of it and how confident you are in
6 it, and you try and communicate uncertainty, and perhaps
7 if we'd -- if that had been clearer, then ministers may
8 have changed their decisions but may not have either.

9 **Q.** Do you think that communication of uncertainty is
10 something that perhaps should have featured, to some
11 extent, in some of the guidance that we looked at
12 earlier this morning?

13 **A.** I agree, and I think that the challenge always in
14 guidance is to simplify it and boil it down to the
15 simplest things, but I do also think that communicating
16 uncertainty in the face of an emerging pandemic is
17 really important, and also trying to ensure that people
18 are aware of what we're trying to do to improve our
19 uncertainty.

20 **Q.** Finally this: in your statement you set out a number of
21 different recommendations, and I wasn't going to take
22 you through all of them, Professor, but is there one
23 particular one you would urge her Ladyship to consider?
24 It doesn't even have to be one that's included in your
25 statement.

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1 A. Well, I will always go to -- can I go to two? Is that
 2 okay?
 3 Q. Yes, you've got five minutes.
 4 A. I'll do it quickly. So the first one is -- I mean,
 5 I think developing guidance because this was such a big
 6 part of this, pre-pandemic, and having principles for
 7 guidance laid out in advance of an emergency, so that we
 8 are able to bring in stakeholders' views, the lived
 9 view, into that guidance, so that people understand why
 10 we're saying things, for me is really important.
 11 And the second, I think, is everything that we can
 12 do to improve data allows us to assess things better in
 13 those early days, and ensure that we're able to evaluate
 14 the interventions in the best way possible.
 15 Where I think the first is, we can do within the
 16 resources that we have in UKHSA, the second requires
 17 a whole-of-government and a whole-of-system approach and
 18 does require additional finance for technology and data
 19 and digital to put together, but, you know, data is
 20 critical in being able to make decisions, especially in
 21 emergencies.
 22 MS CAREY: Thank you very much.
 23 My Lady, they are all the questions that I ask.
 24 LADY HALLETT: Thank you, Ms Carey.
 25 Ms Morris.

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1 and how it went. But that was not in place in March.
 2 Q. So the learning was: yes, we need to be sighted. Does
 3 it follow then that you should ideally have been sighted
 4 on this when it happened?
 5 A. We should have been. I don't think it would have
 6 necessarily changed what we could have done at that
 7 time, but I think we should have been sighted.
 8 Q. Thank you.
 9 In her statement for Module 3, Amanda Pritchard, the
 10 then chief operating officer of the NHS, said that on
 11 17 March discussions took place at the NHS National
 12 Incident Response Board meeting about the hospital
 13 discharge guidance -- I think you were also at that
 14 meeting with Ms Pritchard -- and there was discussions
 15 in that meeting around consideration to be given about
 16 testing practices at the discharge point to support safe
 17 care home discharges. Did PHE take that issue further,
 18 that consideration of testing before discharge?
 19 A. So I don't recall that meeting. I don't know if I was
 20 at that meeting. I definitely don't have any
 21 recollection more than five years later on anything that
 22 you're mentioning now.
 23 Q. Okay. So do I take it from that answer that you don't
 24 recall PHE being tasked to consider anything regarding
 25 testing from hospital discharge into care homes?

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1 Ms Morris is just there.
 2 Questions from MS MORRIS KC
 3 MS MORRIS: Thank you, my Lady.
 4 Good afternoon, Professor Hopkins. I ask questions
 5 on behalf of the Covid Bereaved Families for Justice UK.
 6 I'm going to ask you questions on three topics. I'm
 7 grateful to Ms Carey for covering in some detail one of
 8 my topics I was going to address with you, that was
 9 around domiciliary care.
 10 I'm going to focus my questions first of all back on
 11 the March 2020 hospital discharge policy.
 12 You've used the word in your evidence today that you
 13 were "surprised", on 17 March 2020, by the DHSC policy.
 14 Should, in your view, Public Health England have been
 15 cited on that policy at the ground level rather than
 16 being surprised?
 17 A. So it was an NHS England, not DHSC, just to -- so
 18 clearly, as organisations who send out information, we
 19 don't see all to the information that goes out on
 20 a routine basis -- today or any day, that goes out to
 21 organisations. However, what we learnt in the pandemic
 22 and what we learnt really in events like this, was that
 23 we needed a single clearing system, which is what we
 24 developed, it was a single clearing system for all
 25 guidance going out that was clear on who saw what, when,

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1 A. No.
 2 Q. Were you involved in any conversations at PHE about
 3 whether discharging policy could be deferred, pending
 4 further capacity building around testing?
 5 A. No.
 6 Q. Ms Pritchard went on to say in her statement that by
 7 1 April, NHS England understood that a large number of
 8 hospitals may already have moved to be testing
 9 symptomatic and some asymptomatic patients before
 10 discharging them into a care home. Was PHE made aware
 11 of that?
 12 A. So not that which hospitals were, but I think I included
 13 in our statement, and we have records, of numbers of
 14 people saying, "If you can test and you have capacity,
 15 then please do."
 16 This is not a decision of no testing required, but
 17 it's a balance of prioritisation of your testing needs.
 18 So I don't know what individual hospitals were deciding
 19 at that point.
 20 Q. Okay. So her evidence is that she -- that they thought
 21 some -- that may have been -- but you say that PHE
 22 weren't aware that -- (overspeaking) --
 23 A. So we wouldn't have known which hospitals.
 24 Q. Okay, all right.
 25 My question is, then, does -- if there was some

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1 testing going on, does that indicate a recognition by
2 clinicians within the hospital at that stage that there
3 was an on-the-ground appreciation that it was
4 inappropriate to discharge patients to care homes
5 without that testing where there was capacity to do so?

6 **A.** So I think what we were trying to do was understand
7 where we could test more. So, for example, in hospitals
8 at that time, individuals may have been tested because
9 they were developing symptoms in hospital, they may have
10 been developed because they were a contact of a case in
11 hospital, and they may have been tested because that, if
12 there was capacity, it would be good to know before they
13 were discharged.

14 But this was a balance of ensuring that the
15 individual was at the right place of -- for their
16 residence, for their ongoing care, and ensuring that the
17 testing capacity was prioritised to the individuals who
18 needed it for their own care.

19 **Q.** So whilst recognising that testing doesn't remove all
20 risks associated with, for example, asymptomatic
21 transmission, do you agree that the requirement to test
22 before discharging into care homes should have been
23 introduced before April 2020 -- 15 April?

24 **A.** So, first of all, when we introduced it on
25 April 15, 2020, it was really important that it was

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1 King's Counsel has touched on some of the underlying
2 emails that were exchanged around 24 March on the topic.

3 One of those emails referenced from the deputy SRO
4 for PHE, Professor Johnstone, who noted that, quote
5 "mustn't be pushed into agreeing with the consensus
6 guidance". He also said that he had only found out on
7 24 March that this guidance was being written at all, so
8 there seemed to be some surprise expressed that this
9 additional guidance was being prepared.

10 The internal PHE emails record that in a meeting --
11 there was a view expressed by Mr Winn, the NHSE Director
12 for Aging in his team that:

13 [As read] "The overall balance should be about
14 reducing the risk of care homes not taking back existing
15 residents or new transfers."

16 And it was noted in the email that their words were:

17 [As read] "It should be made clear to care homes
18 that they should only refuse patients in the most
19 extreme cases."

20 An email chain the following day shows that you
21 reviewed the NHSE changes and that ultimately they were
22 agreed by the PHE.

23 So do you agree that the NHSE insistence that social
24 care should only refuse to admit transfers "in extreme
25 cases" was incorrect, having regard to ASC governance

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1 introduced not just as a test and discharge; it was
2 a test, discharge, and continue in isolation. Partly
3 because we really did not know at that point in time
4 what a negative test meant. So, for example, a positive
5 test we were very clear on, but we did not know how long
6 a person would be negative before they became positive,
7 and so there was a lot of anxieties about -- the false
8 reassurance of a negative test at that time, and it
9 continued for some time.

10 So I think, from my point of view, this was
11 a balance on what capacity there is in testing, where do
12 we prioritise that capacity which we were prioritising
13 to test in care homes, in hospitals where they had
14 capacity to test. We had a list of criteria that we had
15 sent to them in early March about how they would
16 prioritise testing in hospital, which included being
17 a contact of a case, et cetera.

18 So that would have been part of the considerations,
19 I think, rather than just purely discharge testing into
20 care homes. It would have been one of the many
21 considerations hospitals would have done in prioritising
22 their testing.

23 **Q.** Moving, then, to the April admissions guidance. You
24 have been asked some questions about that 2 April,
25 you've termed it consensus guidance. And Ms Carey

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1 arrangements and their providers' duties to safeguard
2 residents within those care homes and their staff?

3 **A.** So I think at the time there were two very diametrically
4 opposed components that we were trying to bring together
5 in that consensus guidance. I think it's really
6 important that care home providers are able to do an
7 adequate risk assessment for their -- the individuals
8 who they are admitting and that, equally, where -- the
9 NHS needs to understand the views of the wider sector
10 whilst they're developing guidance, as well.

11 I think it's really important that we remember the
12 moment where the hospitals were worried that they were
13 not going to have sufficient beds to care for
14 individuals, and we had seen that take place in other
15 countries in Europe and in North America. So it was
16 a real, live risk.

17 However, I think my view is that coming out of this
18 pandemic, and where we are now, we should really look at
19 what we can do to balance the needs on both sides, and
20 that needs to bring together the care sector more
21 eloquently into the centre of this conversation, rather
22 than aside.

23 **Q.** I appreciate that forward-looking recommendation, but on
24 24 March, between then and 2 April, you're very clear to
25 say you're trying to find a balance but was the reality

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1 that PHE was pushed into adopting this wording with
 2 fewer safeguards for the adult social care sector?
 3 **A.** So I think this is, as I've said, a consensus. So it's
 4 not being pushed one way or another. PHE, I think at
 5 the time, highlighted when somebody with Covid or known
 6 to have Covid was coming back, what that needed to be
 7 done. It highlighted what needed to be done for
 8 individuals who were asymptomatic who developed
 9 symptoms, and it was trying to draw that balance between
 10 ensuring that there were spaces in hospitals and safety
 11 in care homes, and a recognition in care homes in what
 12 they could do.

13 So I think there's a balance on both sides and, as
 14 always, being brought together by the Department of
 15 Health to look across the different systems and bring
 16 the whole system together.

17 **Q.** My third and final topic is returning to the issue of
 18 data, please, and in particular, the PHE linkage report.
 19 Because you say in your statement that the evidence
 20 suggests that hospital discharge was not the dominant
 21 cause of outbreaks, and that outbreak levels were
 22 broadly consistent with infection rates in the
 23 community. There's no caveats in your statement, and
 24 you mentioned, in answer to Ms Carey's questions, about
 25 whether there were any caveats in the PHE linkage report

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1 office responsible for creating the Vivaldi Study,
 2 suggested that therefore extreme caution should be
 3 utilised when trying to understand the PHE linkage
 4 report; would you agree with that?

5 **A.** So I think the initial report was developed, and the
 6 subsequent fuller reports that are in peer-reviewed
 7 publications were also developed, and actually, they
 8 look at the same data and as it was developed over time,
 9 over a prolonged period of time. So even in the winter
 10 of 2020/2021, and the subsequent period of time, the
 11 amount of infections that were able to be diagnosed
 12 coming into care homes was extremely low, despite the
 13 whole care home testing being available.

14 So, of course, we should always be cautious on data,
 15 we are cautious on all aspects of data, and particularly
 16 in the data from -- any data from March, April, where
 17 there were limitations in testing. However, the data,
 18 as I've said previously, lays out the definitions that's
 19 utilised, lays out how the data was analysed, and
 20 applied that consistently over a prolonged period of
 21 time to try and give the best assessment they could from
 22 the routine data.

23 Always you should have caution in the data, you
 24 always need to understand how the data is developed and
 25 delivered, but it's clearly described in the reports and

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1 from July 2021 itself, and that can, of course, be
 2 checked.

3 You accepted, in response to Ms Carey's questions,
 4 that the PHE data linkage report was based on the
 5 Pillar 1, in part on the Pillar 1 data that PHE had been
 6 using in 2020, if I've understood that correctly.

7 **A.** The data in the reports is Pillar 1 and Pillar 2.

8 **Q.** Yes, but the Pillar 1 data is limited up until May
 9 2020 -- (overspeaking) --

10 **A.** That's the only data that was available till the start
 11 of April, but from April it was Pillar 1 and Pillar 2.

12 **Q.** And the important caveat to that is that the Pillar 1
 13 data had limited testing capacity available to it?

14 **A.** Pillar 2 had none before that started in April. So
 15 Pillar 1 was the only capacity that was available to the
 16 country until April.

17 **Q.** Understood. So, and you have accepted, as well, this
 18 morning that it's likely that that 1.6% is likely to be
 19 an underestimate and the limitations, the caveats are
 20 around the testing capacity at that point, that data
 21 point?

22 **A.** Correct.

23 **Q.** Thank you. So there are limitations, there are caveats
 24 that can be applied to it. Mr Donaldson, who is an
 25 official at the heart of the Covid-19 response, an

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1 in the final peer reviewed publication.

2 **Q.** All right, thank you. Mr Donaldson goes on in his
 3 witness statement to tell the Chair that he:

4 "... repeatedly witnessed how relevant members of
 5 PHE and SAGE who had overseen and failed to warn against
 6 or properly mitigate the tragic initial errors
 7 consistently used inadequate methods and extremely
 8 faulty data which played down the seriousness of the
 9 problem in care homes."

10 Would you agree?

11 **A.** So I'd like to see Mr Donaldson's evidence. I don't
 12 recognise that.

13 **Q.** In his concluding remarks, and it may be helpful,
 14 a lengthier paragraph, for this to be put on the screen,
 15 please.

16 It's INQ000598578, at page 35.

17 You are likely to be able to read quicker than I can
 18 speak.

19 **A.** It's not up on the screen yet.

20 **Q.** It's paragraph 111 of Mr Donaldson's statement. Thank
 21 you very much.

22 I'll just read it for the record. He says:

23 "In summary, we had to create Vivaldi because PHE
 24 and DHSC ASC Policy teams had failed to do so. We had
 25 to use outsiders because they wouldn't and perhaps

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couldn't do it themselves. Parts of PHE and DHSC ASC effectively tried to stop Vivaldi happening, then tried to stop it reporting, then tried to avoid acting on the results, then tried to stop the creation and use of our data dashboard. Having tried to stop our initial report, PHE first tried to ignore it, then tried to steal it and present it as their own, then tried to re-interpret it as just identifying its own previous policy failings. DHSC refused to share data, even when ordered to by ministers, and regularly proposed not telling ministers important information. I believe that this all suggests that a pattern of disfunction that helps to explain why things were so bad with care home policymaking at the start of the pandemic, and gives a broader clues as to the systemic problems Covid revealed."

What's your response to this statement?

A. So clearly, when we talk about PHE and DHSC, it talks about large umbrella organisations. They -- organisations were increasing in size very, very rapidly. I was at the centre of the Vivaldi creation, as I've said in my previous statements in -- for Module 7, and also I've seen Laura's statement for Module 6, which I had not seen until it was released. So, from my point of view, clearly, as a member of PHE

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really important. They were presented at the data group which John Hatwell, one of the officials in the department leading pillar 4 brought together, where I was presenting the SIREN results at the same time. So we were presenting the results in real time, often off the top of our heads in doing it. We were relying on lots of people to share those data across organisations, and we were putting them into SAGE and to other components as fast as possible.

Clearly, sometimes it was not fast enough, right? I completely sit back and go: how could we have done things faster? But people were really working very hard. I never saw people steal data, though I'm sure that people were presenting slides that other people had utilised for another presentation over here, or there were two meetings going on and different people did it.

So, for me, this just doesn't recognise and feel how I worked throughout the pandemic, and particularly in those early months of Vivaldi.

You know, we continued to support Vivaldi as NHS Test and Trace, and we continue to support Vivaldi now as UKHSA. I think it's an important study. It was the first of its kind in the UK and globally. And, for me, everyone was there to support it, and I just don't recognise this.

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staff and as the incident director, I was involved in its construction. So some of it just doesn't clearly recognise to me.

I discussed its development and its production with the adult social care policy team. As I would, because I wouldn't do these things by myself. And clearly, I already highlighted why we went outside, resourcing numbers of technical experts, and the availability of studies like that is to have independence.

I did everything I could to facilitate it personally and I know that lots of other people did too, in order to get it through ethics committee, right protocols, ensure that we get the data across.

So, you know, what I would say is the organisations were very big and they increased very, very rapidly in this time, and I have no doubt there was friction, and I have no doubt that there were individuals who were worried about components of it.

Is that how it felt to me as the incident director?

No, people were by and large trying their best.

Sometimes you had to get things done a bit faster, and sometimes you had to mobilise resource from here to there, but that was part of acting in an emergency and a response.

In terms of the results, I thought the results were

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MS MORRIS: Thank you. Those are my questions.

Thank you, my Lady.

LADY HALLETT: Thank you, Ms Morris.

Ms Beattie.

Ms Beattie is over there.

Questions from MS BEATTIE

MS BEATTIE: Thank you, Professor Hopkins. I ask questions on behalf of Disabled People's Organisations.

You tell us in your statement that the PHE existed to protect and improve of the nation's health and wellbeing and reduce health inequalities; is that generally right?

A. Correct.

Q. Now on 15 May 2020, the ONS released data on deaths involving Covid-19 in the care sector, and that covered deaths among care home residents and deaths of recipients of domiciliary care.

And if we could have a particular page brought up on screen, please, it's INQ000252648, page 16. While that's coming up, that showed that, for the reporting period, there were 3,161 deaths of recipients of domiciliary care in England.

And this -- it's the second paragraph in that page, if it could be highlighted, please.

So there were 3,161 deaths of recipients of

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domiciliary care in England. This was 1,990 deaths higher than the preceding 3-year average for the same period.

And just to make that easier to understand, I think that's a 2.7 times increase in the rate. But the ONS also said that the proportion of the increased deaths which involved Covid was lower for domiciliary care than for care home residents.

So my question is, did the fact that there was a much higher rate of death, 2.7 times in domiciliary care, but a lower proportion of deaths which involved Covid, require further investigation to identify whether that significant increase in domiciliary care deaths was due not only -- or not to Covid infection, but to other aspects and indirect impacts of the pandemic response?

A. So I'll start this by the framing. I think the CMO, Chris Whitty, has used that is in the past.

So when we'd were considering the impact of the pandemic and the impact of Covid, not only did we direct consider the direct harms of Covid-19, but the indirect harms of the fact -- of things that we were doing in order to reduce the risk of transmission of Covid-19, and balancing those and trying to look through them at those different lenses at different times.

So I don't know why this was, but one can speculate

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statistics throughout the pandemic, from PHE. That's now done by the Department of Health with the Office for Health Improvement and Disparities, looking at excess deaths for lots of different reasons. And we know that excess deaths in the community were also related to other causes, such as ischaemic heart disease, such as other pneumonias.

So I don't know on the exact cause of each of these domiciliary residents which we would have utilised the ONS data to try to understand this better. But clearly the key component is that the -- Public Health England would have utilised the data that was available in order to try to understand all of the causes of excess deaths, which were wide ranging.

Q. Did it result in any changed guidance on domiciliary care and how that was being managed as part of the pandemic response?

A. I can't tell you whether this exact report resulted in a piece of guidance change at this distance, I'm afraid.

Q. And I'd also like to ask about visiting restrictions and the March residential care guidance which you were taken to before. It doesn't need to be brought up, but that said that care home providers should review their visiting policy and that the review should also consider the wellbeing of residents and the positive impact of

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that it is -- if individuals were having less domiciliary care, if they were having less family and friends visiting them, then they may have got sick and died or -- and not been recognised.

It also may be that these were not quoted on the death certificate, because that's what ONS would have utilised, as being suspected Covid. So recognising that at the time and all the way through the pandemic, on the death certificate, when you use the words "Covid-19", you can use them where the clinician who verifies the death considers that Covid-19 is either causing or at least partially responsible to the death of the individual.

So the individuals just may -- who were certifying the deaths, may not have recognised that Covid-19 was an influence, or it may have been another cause. Clearly there's lots of different reasons for this.

Q. Right. So, Professor Hopkins, you have said there that one can speculate. Aside from speculating now, what further review or investigation did the PHE carry out at the time, once it was known that there was this very significant increased death rate, but possibly due to other factors?

A. So again, we looked at lots of different death statistics and we produced excess mortality death

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seeing friends and family.

People with learning disabilities, people with dementia and those with communication needs may be especially reliant on their family and friends, including for daily communication about health and welfare needs, to communicate fundamental things like experiencing pain and discomfort and, indeed, to receive care itself, and I think you commented on that earlier in your evidence about families often being able to express those views of people with dementia or complex care needs.

Is it right that beyond that broad reference to the wellbeing of residents and the positive impact of seeing friends and family, that March guidance was completely unspecific about those needs that would need to be taken into account by residential and care home providers in deciding on visiting?

A. So again, I think this was building on evidence and guidance and how care homes managed care home admissions all the time, so I think that it would have been something in this emergency guidance that we would have gone into, how they would do that and what they would do that. There would be an expectation on care home managers that they would be able to do a risk assessment and decide which residents might need a family or

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1 visitor to visit them, which residents would be able to
2 do that via -- remotely, via phone, or others, and that
3 would really be to the local authority, directors of
4 adult social care, local authority directors of public
5 health, as well as the health protection teams, to
6 support care homes if they had questions on that.

7 **Q.** So in the context of all the messaging about stopping
8 visits, was it enough to rely on homes to do, I think
9 what you're saying, that they -- you think that they
10 would have always done, rather than expressly setting
11 out that where visits were not possible following risk
12 assessment, there needed to be alternative means
13 provided so that those communication needs could
14 continue to be respected and people would not be
15 isolated?

16 **A.** So I think that that is a valid point that I think came
17 through in future visiting guidance as I recall. At the
18 point this was trying to reduce infection in care homes,
19 so it was not the focus of this guidance at that time.

20 **Q.** And I think you say in your statement that you consulted
21 the Department's group of trusted stakeholders on
22 guidance and included -- including specifically on
23 getting feedback and suggestions on guidance content.
24 Was that done for this visiting guidance -- or what was
25 said in this guidance about visiting?

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1 Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 6

2 **MS CAREY:** Professor, your full name, please.

3 **A.** Jennifer Margaret Harries.

4 **Q.** Not your first time here, we all know, but I do that
5 have a number of questions to ask you in particular
6 about the adult social care sector, and for those who
7 are perhaps not familiar with this module or the
8 evidence you have previously given, you are, I think,
9 still the chief executive of the UKHSA?

10 **A.** No, so I retired at the end of May, so I'm here in my
11 own right and no longer a senior civil servant.

12 **Q.** Thank you very much for correcting us.

13 You were Deputy Chief Medical Officer for England
14 from 15 July 2019 to 31 March 2021?

15 **A.** Yes.

16 **Q.** And it's in that capacity that we have asked you on
17 behalf of M6 to provide a witness statement, so my
18 questions are going to be focused on your role as the
19 DCMO, as it is colloquially known.

20 You set out your professional background in your
21 statement. You are a clinical doctor with specialist
22 training in public health medicine; you hold a number of
23 different degrees and qualifications, but perhaps
24 pertinently to your role and indeed your role in social
25 care, before your appointment as DCMO, you were the

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1 **A.** So as I recall and as it says in the statement, the
2 March 17 had some stakeholder group involvement.
3 I think the stakeholder group involvement got better
4 over time, so I don't think it was probably optimal at
5 that point.

6 **MS BEATTIE:** Thank you, my Lady.

7 **LADY HALLETT:** Thank you very much, Ms Beattie.

8 That completes the questions we have for you,
9 Professor Hopkins. I'm not allowed to make guarantees
10 but I'm fairly confident that we won't have to burden
11 you again, and I appreciate it's not just a burden on
12 you but it's a burden on the colleagues who help provide
13 the statement and then support you in coming here today.
14 So thank you for all the help you have given so far.

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

16 **LADY HALLETT:** And I hope it's the end. I'm sure you do.
17 1.55.

18 **(12.54 pm)**

(The Short Adjournment)

20 **(1.58 pm)^sp checked**

21 **LADY HALLETT:** Hello again, Professor Harries.

22 **THE WITNESS:** Good afternoon.

23 **MS CAREY:** My Lady, may Professor Dame Jenny Harries be
24 sworn, please.

25 **DAME JENNY HARRIES (affirmed)**

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1 regional director for the south of England within PHE
2 from 2013 to 2019; is that correct?

3 **A.** Yes.

4 **Q.** You, had also, before that, I think, worked as
5 a Director of Public Health?

6 **A.** Yes.

7 **Q.** In both Norfolk and Waveney, Swindon and, indeed,
8 Monmouthshire?

9 **A.** Yes.

10 **Q.** Can you just help us, is there anything in particular,
11 in your former role as Director of Public Health which
12 has helped you with your advice that you gave in the
13 pandemic?

14 **A.** Yes, definitely. In fact, the reason I ever came into
15 the centre of government was because I would sit as
16 a Director of Public Health and think: how is this
17 guidance or this plan or policy going to work here? And
18 it was actually to try to ensure that the visit of
19 local, if you like, was imparted to national decision
20 makers, which was generally very well received, so
21 there's been -- it's good but it's -- it means that the
22 working, for example, as part of -- as the chief officer
23 in a local authority, you work alongside the Director
24 of Adult Social Services. In some local authorities,
25 the Director of Public Health actually is the Director

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1 of Adult Social Services and will oversee them and vice
2 versa.

3 **Q.** You have been involved in a number of UK public health
4 responses and health protection incidents, and indeed,
5 your previous roles in hospital health boards and in
6 local authorities you say:

7 [As read] "... afforded me experience of both health
8 and care services ..."

9 **A.** Yes.

10 **Q.** "... their commissioning and their delivery and indeed
11 the functions of local councils."

12 A couple of things on that before we descend to some
13 detail. In your role as Director of Public Health in
14 Wales in Monmouthshire, was there anything in particular
15 about your experience there that might have meant there
16 are particular vulnerabilities in the Welsh adult social
17 care sector that you're able to speak to?

18 **A.** So it's a little bit difficult, because I think the time
19 period from when I was working, whereas my most recent
20 posts have been in England, so I think that would
21 probably not be appropriate to comment. I can comment
22 on data in due course in relation
23 to -- (overspeaking) --

24 **Q.** We'll come to that.

25 **A.** Thank you.

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1 that I found.

2 **Q.** All right, we're going to come perhaps to look at some
3 examples of the focus being on perhaps the healthcare
4 side as opposed to the social care side.

5 Before we do, though, you summarise the deputy chief
6 medical officer's role as primarily being one to provide
7 advice.

8 **A.** Yes.

9 **Q.** Often at short notice?

10 **A.** Yes.

11 **Q.** And working with tight deadlines. And I think
12 throughout the pandemic, you had engagement with both
13 Mr Hancock and, indeed, Helen Whately, the minister?

14 **A.** Yes.

15 **Q.** You also had engagement, you say in your statement, with
16 directors of public health. And I'm at your
17 paragraph 3.7, Professor, (v), if it helps you. You
18 said you actively linked with directors of public
19 health, many of whom you had worked with, presumably in
20 some of your previous roles?

21 In what way did that assist you in advising as DCMO?

22 **A.** It's always good to have a -- two-way flows of
23 information, I would like to check if somebody said,
24 "This is what the directors of public health think", it
25 is always good to check with the directors of public

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1 **Q.** Throughout your time as DCMO, did you get any sense of
2 whether there were other people you were working
3 alongside who had both a hospital or healthcare aspect
4 within their knowledge, and the social care or were you
5 a sort of rarity, if I may put it like that?

6 **A.** There are people -- and when we talk about the
7 Department of Health, obviously there are organisations
8 aligned to that, so in the start of the pandemic, Public
9 Health England, for example. And some of the people
10 working in UKHSA now are ex-directors of public health,
11 so they have quite a lot of knowledge from the ground,
12 in the same way that I did.

13 But equally, the standard Civil Service model is
14 that somebody moves around a department, and they tend
15 to, not always -- because people come with different
16 skills -- they tend to move between departments to get
17 experience of that department's function and role, and
18 I suppose the point to raise is I was quite surprised.

19 My DCMO role was the first where I had actually
20 worked directly in government, in the centre of
21 government, and I was quite surprised at how focused the
22 Department of Health was on my -- at the time of the
23 start of the pandemic, on health, and NHS, and clinical
24 topics, in comparison to adult social care.

25 I know that's a topic, and I think that is a point

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1 health that that is what they do think.

2 I had a number of them who would provide
3 information, almost what I would say, what's the real
4 picture on the ground, and I would speak to some of them
5 in different parts of the UK because clearly the
6 pandemic hit different places in different ways, and the
7 infrastructures were different.

8 I think the key thing that I did at the start,
9 bearing in mind that the CMO was relatively new into
10 the -- into that role, as well, was to encourage the
11 establishment of a CMO to directors of public health
12 meeting which continues to this day, but was not in
13 place routinely prior to that. If the CMO wasn't there
14 I would chair that meeting and it acted, I felt, as
15 a conduit and professional airing space, if you like, so
16 that directors of public health could hear directly from
17 the centre on professional issues but also raise some of
18 those issues back.

19 **Q.** May I ask you, then, please, about an email.

20 Could we have up on screen, please, INQ000151538.
21 It's an email exchange including you, Professor, from
22 6 March, 2020, so relatively early on. And if I could
23 just help cite you, perhaps, on page 3 there, thank you
24 very much. There was work under way about a meeting
25 that we're going to come on to look at the minutes of,

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1 involving -- sorry:
 2 "... works underway including in [Public Health
 3 England], NHSE [and] I ... DHSC issues ... include
 4 identifying the categories and identifying the
 5 individuals; the model for those in domiciliary care;
 6 mental health and avoiding isolation ..."
 7 Are you able to help now, what was being referred to
 8 as "the model" for those in domiciliary care?
 9 A. So this is now a very long time ago --
 10 Q. I know.
 11 A. -- and it's quite difficult to remember the detail. I
 12 don't remember the detail of a model. What I see in
 13 that email is me -- in that advisory role what I also
 14 tried to do was connect people across the system, so it
 15 usually wasn't my role to do things but if I was aware
 16 somebody was considering something to make sure they
 17 were aligned and not duplicating.
 18 So I -- it probably just refers to developing
 19 guidance, effectively, I would think.
 20 Q. All right, and if we go to the bottom of page 1 and I'm
 21 afraid the email continues into page 2 -- thank you very
 22 much. This is an email at the top of the page from you.
 23 You've thanked the recipient.
 24 "Definitely needs to come back through CMOs office.
 25 A key point on this -- both for safe management of
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1 those.
 2 What this is actually doing is flagging politely:
 3 will you please remember directors of public health and
 4 local authorities.
 5 Q. Why do you think people might -- or the department might
 6 have needed that polite reminder?
 7 A. For the reasons which I started with, which is most of
 8 the department's work, for very good reasons, was highly
 9 focused on the health side and often on political
 10 imperatives. Waiting lists. We only need to think what
 11 people see on the front of the pages.
 12 But I think there's an important point here, as
 13 well, which is, as I think many witnesses have said
 14 before, the department did not actually have control
 15 over local authorities or directors of public health, so
 16 the sort of standard Civil Service expectation generally
 17 is that you put something up on one department, you take
 18 the message across, and then it goes down the other
 19 department side.
 20 But where you have a professional direct linkage,
 21 I felt that it was one that needed to be used,
 22 particularly right at the start of the global pandemic.
 23 Q. You make the observation in your statement, Professor,
 24 that there was no dedicated team in place at the start
 25 for the adult social care response. And if it helps you
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1 patients, but also links to imminent potential messages
 2 on communities -- is to clearly identify (and show we
 3 have identified) the linkage into [local authorities]
 4 and Directors of Public Health.
 5 "I am quietly working very hard to keep all 152 of
 6 the latter behind CMO so that they can be a sensible
 7 extended arm of the scientific message in top tier and
 8 unitary councils."
 9 Now, you may have sort of alluded to this in your
 10 earlier answers, but what was the quiet work you were
 11 undertaking, and why was that necessary?
 12 A. Well, it was basically to ensure that -- directors of
 13 public health are really important. They will be the
 14 CMOs, if you like, of their local authorities, and they
 15 know how the top of the system works as well as local
 16 system, whereas some parts of national won't, and vice
 17 versa. So, actually, using -- working with them so that
 18 they understood why decisions were being made on what
 19 scientific evidence meant that they could act as
 20 a conduit of good evidence-based intervention back to
 21 their local authorities.
 22 So it's not so much that they was -- there's always
 23 a risk that people will go in different directions if
 24 you leave an information space, and it was really to do
 25 that. And so the meeting that I referred to was one of
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1 there, it's a meeting on 11 February 2020, where you
 2 make the observation:
 3 "... there was no substantive dedicated G6 [role]
 4 (a role below a Deputy Director role) or team in place
 5 for the adult social care response."
 6 I'm not suggesting it was your responsibility, but
 7 do you know or have any sense of why there wasn't a team
 8 already in place dealing with adult social care?
 9 A. So I think I was asked to comment on a paper, so just --
 10 on an email, so just for clarity, there clearly were
 11 people working on adult social care. I would not like
 12 the Chair to think that there were no resources. But
 13 when it came to a sort of emergency response like this,
 14 it's very clear from the chain that that sort of
 15 capacity was not there, whereas if you looked at the
 16 health side, there were immediately people to identify,
 17 to respond or prioritise their existing work.
 18 Q. And you say there that indeed at that meeting -- we
 19 don't need to look at it, but there were a number of
 20 slides put up at that meeting which mentioned social
 21 care only briefly, and the predominant focus at that
 22 point was on healthcare.
 23 Now, one can understand the need to look at the
 24 healthcare aspect, but did it mean that there was less
 25 people saying, "But what about the implications of this
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1 on social care?"

2 How did it actually play out without having that

3 expertise and that knowledge?

4 **A.** So, again, this is difficult because it's a long time

5 ago. My sense, actually, was that the ministers, so the

6 Secretary of State and the Minister were very, very

7 observant on to what needed -- actually, because there

8 wasn't so much of a routine cadre of officials working

9 to this in the same way or the same intensity routinely

10 on the health side, that -- there wasn't -- as I say,

11 there wasn't a group to turn to.

12 Usually if you're challenged to do something, you

13 find the group nearest to that topic, that policy topic,

14 and actually what happened here was there was

15 a recognition that more staff and more resource was

16 needed, hence the comments about appointments, but there

17 wasn't an existing team there to bulk up, if you like.

18 **Q.** Did that not hamper the response, though, if you haven't

19 got that team to turn to? That's what I'm --

20 **A.** Well, I think, going back to the point about

21 understanding, and this comes through, and perhaps why

22 you will see my name appearing more frequently at the

23 start, and then I sort of drop back more to my usual

24 role was, I -- and it could be a personal perception --

25 I sensed that officials often did not appreciate how

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1 I think in a number of places though, in your

2 statement, you make the observation there was limited

3 understanding in the Department about adult social care

4 generally. Other people might put it as adult social

5 care being an afterthought. Is that something you would

6 agree with or not? I see you pull a face there.

7 **A.** So that's quite a pejorative statement. I think what

8 I would say is, departments tend to be driven by

9 political imperatives. They have to, reasonably,

10 respond to the requests of ministers, and as I say,

11 I wouldn't like to suggest this was an issue of

12 individuals at that time. The fact is, which we might

13 come back to at the end, there is a wider imbalance

14 historically between the attention that has been paid to

15 the National Health Service and the attention that has

16 been paid perhaps even to community services in

17 comparison to hospital services, but certainly into care

18 services. And to my mind, they are very, very firmly

19 linked and should be on a continuum.

20 **Q.** Can we go to the meeting, please, of 11 February of

21 2020, and could I have up on screen, please,

22 INQ000049363.

23 It's an adult social care coronavirus meeting. We

24 can see that you are present, along with a number of

25 other names that we are familiar with, and Ros Roughton

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1 care systems worked, how they were commissioned, what

2 the data flows were -- or not, as we might come on to --

3 and therefore there's a risk of not engaging the right

4 people to take that forward.

5 Now, again, this changed dramatically through the

6 first few months, but this is what I felt was the

7 existing position. It wasn't just for social care,

8 though. I think this issue about the departmental -- so

9 there was an incident very early on around declaring

10 a very major incident in the Wirral, when passengers

11 were coming back, where I personally -- I volunteered

12 and said, "Shall I ring the chief executive and see if

13 we can avert this?" Because it didn't feel necessary,

14 to me.

15 What I realised was, people -- they understood the

16 theory of the emergency response, they didn't quite

17 realise why the Chief Executive in the Wirral, who was

18 totally responsive, would be worried, and how they could

19 help.

20 So it's kind of this lack of tangible understanding

21 of how people would feel if they were sitting in a local

22 authority or a care home or wherever it might be, and

23 that was the national local disconnect.

24 **Q.** "Disconnect" was going to be the word I used.

25 I understood -- thank you, Professor.

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1 says this -- stated:

2 "... there is a tripartite plan to dealing with

3 Coronavirus and Social Care."

4 One:

5 "Raising awareness in the sector to promote

6 prevention."

7 I know it's difficult now looking back five years

8 ago, but raising awareness about what? What particular

9 aspect of Covid-19 needed raising awareness in

10 February 2020?

11 **A.** I honestly can't remember. I would be guessing, I'm

12 afraid.

13 **Q.** All right. There was a plan to deal with preparing for

14 the reasonable worst case planning assumptions, and then

15 putting in place the appropriate staffing and resourcing

16 and, in fact, Professor, we know from DHSC that the team

17 exponentially increased over this period of time.

18 But could we go to the second page and action 1:

19 "The Adult Social Care team is to work with David L

20 to draft clear lines on who has responsibility for

21 response (noting [the secretary's] steer that primary

22 planning responsibility is for [local authorities]),

23 ahead of the planned publication of [the Covid] plan.

24 [Chris Wormald] noted that this should be framed in the

25 context of how we will support planning nationally."

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1 Did you agree or have any observations into input
2 into the clear lines of responsibility lying with local
3 authorities?
4 **A.** I, yeah, I can talk to the action below, which is to my
5 name, but in a meeting like this, I would be there,
6 I would put in comments and have them always listened
7 to, and challenged or accepted as appropriate. I don't
8 remember anything particular about this.
9 **Q.** All right. If we go to the action that involved you,
10 I think it's paragraph 6 and action 3:
11 "There is a need to provide some clinical advice to
12 cover what should happen when there is a case in a care
13 home (to include vice on isolation, delay of transfer of
14 care out of hospital, moving patients). This should
15 include an assessment of the practicalities of the
16 option, so will require input from the [Chief Social
17 Worker] [is that] and the ASC team?"
18 **A.** Yes.
19 **Q.** And it says:
20 "DCMO to draft clinical advice on response to a case
21 in a care home ASAP. This will likely to require input
22 from [those]."
23 So this is in February, pre the hospital discharge
24 policy.
25 **A.** Yes.

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1 **Q.** Yes. So you're noting there the difficulties around how
2 unpaid carers and domiciliary care in particular --
3 around how isolation would work in those particular
4 settings, and lack of information flow between private
5 sector providers and the local resilience forums and
6 what the triggers would be in a reasonable worst-case
7 scenario.
8 Can I break those down, Professor. The lack of
9 information flow between the private sector providers
10 and the LRFs, do you know what was being spoken about
11 there?
12 **A.** So this goes back to did people understand? So, as
13 I know you've heard many times before, adult social care
14 is effectively a large private sector model. Now,
15 it's -- if you're thinking of in people's wellbeing and
16 health, that can sometimes be a tricky way of thinking,
17 and it doesn't feel very person-focused, but that is the
18 reality of the provision model which has been in this
19 country for decades.
20 And so when I'm talking there about private sector
21 care providers, these are all individual providers of
22 different sizes, or potentially chains, most of whom
23 will have contracts with local authorities. And the
24 local authorities will have data but they will not
25 necessarily have data which is relevant to this. So

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1 **Q.** But can you help us with what was being discussed here
2 and why DCMO was being asked to draft clinical advice?
3 **A.** Well, she shouldn't have been. So in fact I think there
4 is a subsequent email afterwards where I politely say
5 this is not what I would normally do, and this is
6 usually a role for Public Health England, but obviously
7 try to align things.
8 Actually, at this time, Covid was a high-consequence
9 infectious disease, so in fact it would have been very
10 clear what would happen and was already in guidance,
11 which is any case would not be managed in a care home.
12 So there's a slight -- and I think when I responded
13 it was all along those lines. There were two points.
14 One is what would happen now and then there is
15 a longer-term wider issue about planning for cases when
16 there are a number of cases across the country.
17 **Q.** Bullet point 8:
18 "JH noted ... there are some difficulties around
19 informal carers ..."
20 Do you mean unpaid carers?
21 **A.** Yes. I mean, basically I think I was highlighting, just
22 to reinforce, that not all care happens in hospitals,
23 and not all social care happens in care homes, and there
24 were a large number of other care recipients who needed
25 to be considered.

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1 they might have contract data, how many people have gone
2 through and have they paid the right things, but
3 actually what you wanted to know here are all the things
4 that you have been asking questions before.
5 The other point here is that it mentions LRFs, and
6 in the early discussions I think there was a sense that
7 the local resilience fora would be the focus of
8 controlled support and distribution. And they did play
9 a really critical part in things like testing and some
10 PPE distribution, but -- and again I think there is an
11 email. The problem with the LRF -- so I used to go to
12 LRFs as a chair on STAC, so a scientific group, but
13 also, on occasion, my chief executive in Swindon, for
14 example, would delegate the role to me, so I would go as
15 the chief executive of the local authority, and people
16 centrally did not seem to understand that the LRF was
17 just made up of people who did their jobs routinely and
18 then came to the LRF on top of it. So that they didn't
19 have a routine system, usually, of receiving data, they
20 would work together to make their routine data streams
21 beneficial for an incident.
22 So it was really trying to highlight some of those
23 issues.
24 **Q.** Picking up on that answer, you say in your
25 paragraph 5.12 that:

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1 "... in the early phase of the pandemic few people
2 in DHSC had direct or practical experience of having
3 worked in or with care homes, the commissioning of care
4 home services, understanding the local connections which
5 would underpin the ASC emergency response ..."

6 And so is this perhaps an example of that they
7 didn't really understand how the LRFs worked and -- not
8 the limitations of them but just how they weren't geared
9 up for a pandemic response?

10 A. I felt there was an over-expectation because if you look
11 into a pandemic approaching, every single senior
12 representative, whether it be the police or the chief
13 executive from the hospital or the chief executive of
14 the local authority, has already got all of their work
15 cut out, and so to expect -- you know, the group would
16 work well together, I'm sure, but there was no extra
17 resource, it was a potential of double-counting, was
18 how -- I was trying to warn people not to rely too much
19 on it.

20 It's not a body in itself, I think that -- and it
21 doesn't have an -- it has a very small funding stream.
22 But it's not another big organisation that you're
23 suddenly going to pull to respond a pandemic.

24 Q. You said that in your view, lack of data, which we'll
25 come on to, and the limited understanding of how the ASC

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1 us a little bit more detail about why there were
2 potentially being plans developed in isolation given
3 that if there were expedited discharges, inevitably some
4 of those discharges would result in people being
5 discharged to the adult social care sector?

6 A. So I will be moderately outspoken in this. The routine
7 thing is that the health -- having worked in local
8 authorities, the health service tends to be quite -- the
9 hospital service, I would say, tends to be quite
10 dominant, historically, and therefore actually the
11 system would tend to work from the hospital health
12 service side. I think PHE colleagues who were linked
13 into the health protection -- you know, they have their
14 own health protection teams in the regions, were very
15 used to working on outbreaks and with colleagues in care
16 settings or with local authorities. But there's always
17 been a natural sort of divide somehow between -- I say
18 this on a long career as I leave it now -- between the
19 health side and the community elements.

20 And so what tends to happen is that everybody goes
21 off to do their work, which is entirely right, because
22 they all have different skills, but then the tricks not
23 allowing the two bits to develop independently too far
24 because you then can't join them together successfully,
25 and you tend to end up with disparate messaging and

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1 sector practically operated meant that the ASC response
2 required considerable and urgent efforts in that early
3 period.

4 A. Yes.

5 Q. Are we talking February, March --

6 A. Yes.

7 Q. -- April?

8 A. Yes, I mean, I think this -- whenever it was -- this
9 meeting and then I think there was another one at the
10 start of March --

11 Q. Yes.

12 A. -- where it was absolutely recognise by ministers that
13 there was a lot of work to do and then things really
14 moved.

15 Q. As at February 2020 and in the lead-up to the expedited
16 discharge from hospitals policy, I think you said in
17 your statement that you were -- you contacted colleagues
18 at NHS England and PHE to request further information on
19 their pandemic preparations and how they would interact
20 with the adult social care sector.

21 You said:

22 [As read] "I was concerned that the two would be
23 developed in isolation, given the usual higher focus on
24 acute hospital care."

25 Can you just help us with, if you're able, to give

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1 slightly incoherent messaging, as well.

2 Q. In your statement, at your paragraph 5.19, you said:

3 "It was clear [to you] from both the technical
4 public health knowledge and practical experience of work
5 in the ... hospital sector, that demand on hospitals
6 would rise rapidly ..."

7 A. Yes.

8 Q. Understood. And that:

9 "... in the event of a severe COVID-19 wave ...
10 there would be a foreseeable need to free up capacity by
11 discharging [of patients] ..."

12 And you said:

13 "To this extent, it was something which was always
14 known to be a realistic possibility as soon as it became
15 apparent that [Covid was on the increase]."

16 But was it realistic to the ASC sector? Do you
17 think they could see or were they ever told: it is
18 really likely, as at February into March, before the
19 actual letters went out from NHS England, that the
20 discharges were coming?

21 A. I'm going to state the obvious which is probably that is
22 a question to ask the ASC sector. There is, going back
23 to previous planning, clearly there is an expectation
24 through flu planning, for example, or whatever the issue
25 might be, that if cases rise in one part of the system,

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people need to move. But there are other reasons for doing that, as well, which we might come on to, which is you do not want elderly, frail people sitting in a hospital waiting for a rising tide of cases.

So whether the adult social care sector either had been advised or had absorbed, because I think they're also quite different things -- I think lots of people realised why theoretical plans that had been discussed over many, many years had been discussed when they were hit with the reality of a pandemic.

Q. Did you ever get any feedback given that you had a number of contacts from your previous roles, a sense of it was a surprise to them that there was going to be an expedited discharge policy?

A. I don't think I can comment on that. What I can comment on, though, is from feedback which I did include, for example from directors of public health, which is probably my more direct link into some of the conversations at the time, was that actually even the LRFs were standing up their -- we could see a big pandemic coming. Even the LRFs were not standing up their strategic coordination groups uniformly across the country. So that, to me, meant some people had logged the enormity of the task ahead, and others had not quite done it.

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guidance also, it has never been the expectation that if a care home cannot isolate effectively, that there was always -- it wasn't a requirement to accept, it was a requirement to put your hand up and say, "Actually, we can't do this."

Q. Please say if this is an unfair question, Professor, but did you get any sense, as DCMO, whether those that you were advising understood that there may be care homes that couldn't isolate?

A. I think I can't answer that. I mean, even -- this is where the national/local comes in, because if I, for example, went to an individual consultant in disease control at one of the now UKHSA health protection teams, they would know probably which of their care homes were better able to do that or not, because it is so dependent on things like building size, whether there's sufficient staffing, how good the IPC training is. A whole host of things. And so it's very difficult to say that. What you can say is it would be variable across the country. And I think at national level people would understand that.

Q. Some of the guidance, and you've set it out in your statement, you were sighted upon and asked to advise upon, but not necessarily every single piece of guidance that came out, but can I just ask you about this: the

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Q. Your statement sets out, and I'm not going to go through it all, the rationale and the reasons for potentially why an expedited discharge policy is required, but you do say this, you say:

"Lastly, I did not consider it inherently an unreasonable ask of [the adult social care sector] to isolate infectious cases."

Can you help, from your perspective as DCMO, why you didn't consider that to be an unreasonable ask.

A. Because actually, basically -- I recognise this was a novel disease, but basically, the asks of isolation and the hierarchies of control around IPC are the same that you would apply for any -- for any respiratory infectious disease. And so I think PHE guidance on flu had been updated in 2018, all of the isolation requirements and risk assessments were there, and care homes did link with, and would report outbreaks into, health protection teams and to CQC.

I mean, there is a wider issue as to, if you like, how far the country has questioned the capabilities and capacity for care homes to do that and what levels have been accepted historically. But based on what had been accepted routinely, then yes, there was a reasonable expectation, I think.

I think also, again we might come to this, in that

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13 March guidance advised that a care home should implement what they called "isolation precautions" when someone displayed symptoms. By 2 April it said expressly symptomatic people should be isolated. And by 15 April it said isolate whether they're symptomatic or asymptomatic. So it varied across that six weeks or so period.

From your perspective as DCMO, do you think that variation was a reasonable response or should it have said from the get-go, "isolate everyone"?

A. So this will go back to discussing what was known about asymptomatic infection and, completely separately, asymptomatic transmission over that time period, and we may well come on to some of the studies because that time period was actually quite critical. It was -- I'm trying to remember my dates now, but at the point that lockdown was called, which was right in the middle of that, the preceding week, the testing was prioritised, actually identified how -- what level of community transmission there was, by increasing the testing of those patients coming in and effectively extrapolating backwards.

We then had exactly the same -- we started to have, initially, sort of, rumblings of reports from the US, for example, on long-term care facilities, and then over

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the Easter period, so they're all starting to come together, were the first proper UK studies, and they got stronger, so there was sort of an initial test, how many people have we got here, then we had a period prevalence study, then we've had cohort studies.

So this is a rising tide of information, and coming through that period, and I think -- so I think it's right that the guidance changed. I think the differentiation is right in the progressive term. One can look back and start to query precisely on which date which person knew which piece of information on whether the timing was right. It feels about right, to me.

I think we also need to remember it's hugely difficult to get practical information out, so, for example, if the NHS or PHE was publishing guidance, it would need to be gridded on the national slot so it aligned with political announcements of changes, and that's very difficult. So you can have guidance ready, or almost ready, or whizzing around the system, or being signed off by different ministers in different departments, and then going out.

Q. I jumped ahead a little. I just want to ask a few questions about pre-pandemic planning to the extent that you can help as DCMO, and could I have up on screen, please, INQ000151466. It's back on -- it's actually

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messaging and the actions are all aligned.

Q. Can we come on to one of the meetings that perhaps looks at a little bit more of the potential planning, and the "Coronavirus [and] Social Care meeting" on 6 March 2020.

And can we have up on screen INQ000049530 in the first instance.

Professor, you were present at that meeting along with Mr Hancock. I think Chris Wormald was there, Helen Whately was there. We can see other names with which we are now familiar. And the secretary opened the meeting by stating:

"... the impact of coronavirus [has posed] a complicated set of problems ..."

And essentially calling it, in his phase, needing to be "gripped", and Helen Whately noted "we needed to ramp up preparedness around social care".

Now, as DCMO, did you have any role in preparedness for social care or were you simply just advising on plans if they were brought to your attention?

A. So there was a social care department, if you like, group. I wasn't part of that. Obviously I would be called in to advise as appropriate on anything that they felt I could.

Q. You had noted in that meeting reference to the Washington State study in nursing homes, where there was

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Valentine's Day, 2020. It's an email from you to a number of people in NHS England, and you say there to Keith Willett:

"[The Secretary of State] is, entirely appropriately, becoming very focused on the ASC planning in" -- is that reasonable worst-case scenario?

A. Yes.

Q. "... you may remember/be aware this was a significant weak interface when we exercised Operation Cygnus."

And are you able to, briefly, explain to us: what was the weak interface?

A. Well, largely, that -- actually, I have checked back on the -- what the objective of Operation Cygnus was, and I won't get the terminology quite right but the objective actually was around looking at the policy implications of a pandemic rather than actually the operational side. So I may be slightly moving ahead, but obviously if you haven't got clarity on the policy, you clearly won't have clarity on the operational side.

And so what I was signalling here was, this wasn't very well defined when that was exercised before, so can we try and do something now, ahead of it, and stay together? Which again, this was the whole point about if you can see there's going to be high demand in health services and care services, making sure that the

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mortality rate of 30% in that study. Now, in fact, the study didn't come on to publish various other results --

A. No.

Q. -- until the end of the month, but you'd obviously got sight of an early indication of --

A. Well, we always are looking across the world and linking with other professions to try to get early insight, but it's important, when you do that, that actually the final publication or final data is there, or you sometimes get misinformation.

But in this case I think it was around 27.2% for residents. But noting as well, which I think Ros did, that this was a long-term care facility in the US and the demographic and the health status of those in it may well be different.

So this was a signal that says, in exactly the same way that the Secretary of State and minister for care had said was, we need to really be looking at this. It doesn't necessarily say that is what would happen in the UK.

Q. No, I follow that, but this is a warning shot, if I can put it like that --

A. Yes.

Q. -- of potentially significant numbers -- (overspeaking) --

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1 A. -- starting to be early feed coming in.
 2 Q. All right. So, this is us at 6 March.
 3 Then if we scroll down the page a little bit we can
 4 see there Chris Wormald's asking for more data about the
 5 reasons why people are staying in care homes.
 6 And then the next bullet point you flagged that:
 7 "... the majority of the people that we're talking
 8 about are receiving domiciliary care too. [Secretary
 9 of State] agreed that we should be thinking about this
 10 in the following hierarchy: residential Home, nursing
 11 homes, domiciliary care."
 12 Can I break down the constituent parts of that,
 13 please. You were flagging that the majority of people
 14 were receiving domiciliary care. Why would you need to
 15 bring this up in this meeting?
 16 A. So I would flag -- I've gone back to look at this
 17 minute. I don't think this is a well expressed minute,
 18 let's put it that way. Might have been because of the
 19 urgency.
 20 So I think what that sentence was saying, I was
 21 flagging that actually the numbers in domiciliary care
 22 were enormous. More so than in care. There are
 23 different risks to it, but it was just to make sure that
 24 we got the proportionality of approach across the whole
 25 of the sector and we didn't only focus on care homes.

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1 A. Sorry, can I just add one thing to that?
 2 Q. Yes.
 3 A. The only other differentiation that might come up is
 4 because -- actually in a nursing home, of course, there
 5 are theoretically -- we might come back to -- more,
 6 there's more clinical capacity, and so when you're
 7 looking at a whole nation trying to say where are you
 8 going to have respiratory care particularly or step-down
 9 clinical facilities, then obviously a nursing home in
 10 theory should have more clinical capacity to address
 11 that. So that might be another differentiation. But
 12 that's not the order, of course, in which they're
 13 described here. I think that -- to my mind, that's
 14 probably just a red herring.
 15 Q. Thank you.
 16 Down the page you updated the meeting on your call
 17 with the directors of public health, I think we've
 18 discussed that.
 19 Can I go over the page, please, to the second bullet
 20 point:
 21 "[The secretary] summarised ... a lot of work to be
 22 done ... [across] 10 different areas: workforce,
 23 financial support ... excess deaths ... data, support
 24 for non-Covid illnesses, equipment [which included PPE]
 25 [and] LRF readiness [and] collaboration ..."

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1 Q. Can you help at all with the next sentence, which says:
 2 "[The Secretary of State] agreed that we should be
 3 thinking about this in the following hierarchy ..."
 4 Do you know what the "this" was referring to?
 5 A. My sense is it was actually what we needed to do, so
 6 a very general one, but again it's a long time ago. I'm
 7 sure your next question will be on the word "hierarchy".
 8 Q. It is.
 9 A. And I have reflected on this because -- for -- two
 10 things, which is what made me look at the rest of the
 11 email, because there's some very strange expressions in
 12 this email. For example, somewhere further down I think
 13 it talks about "excessive deaths", whereas in fact it
 14 should be "excess deaths". So I'm not reading a lot
 15 into the word "hierarchy". I think whoever was doing
 16 the minute was probably quite new at the minutes.
 17 I do -- I am very comfortable that all of those groups
 18 were being actively considered and discussed.
 19 Q. Did you get any sense, though, that there was a priority
 20 being given to residential homes over nursing homes?
 21 A. Not between residential and nursing, no. I mean, the
 22 risks that were coming through, partly because of the
 23 data, were very much focused on residential and nursing,
 24 but that felt proportionate.
 25 Q. Right. Was there any, can you recall now whether --

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1 Do you know how much, if at all now, IPC and
 2 isolation was discussed in this meeting?
 3 A. I don't think that level of detail would have been
 4 discussed. Clearly PPE is mentioned, and sometimes
 5 people write that instead of IPC, that's a, sort of,
 6 shorthand. It clearly isn't the same thing. But
 7 I don't think -- the detail of isolation facilities
 8 would not have been. But bear in mind this is quite
 9 a high-level meeting.
 10 Q. All right. And just a little bit further down, there is
 11 a bullet point starts:
 12 "There was a discussion on how we stop carers making
 13 uninformed decisions and sending people to hospital
 14 unnecessarily."
 15 Do you know now what the reference to "uninformed
 16 decision making" was about?
 17 A. I don't, I'm afraid. I can't remember this. I don't
 18 think it's associated, I can see my name at the next
 19 bit.
 20 Q. Yes.
 21 A. I can explain the next sentence.
 22 Q. Well, can I come on to the next sentence --
 23 A. I don't think they're necessarily linked, is my point.
 24 Q. Right. So you don't think necessarily the sentences are
 25 linked and, in any event, you can't, at this remove,

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1 recall now what the reference to the uninformed
 2 decisions was?
 3 **A.** No.
 4 **Q.** All right. The next sentence is:
 5 "DCMO JH noted not all LRFs have SCGs ..."
 6 Strategic --
 7 **A.** Coordinating groups.
 8 **Q.** "... coordinating groups stood up at the moment, the
 9 local context is probably not playing through, flagging
 10 [local authorities] are getting FOIs ..."
 11 Is an FOI a request --
 12 **A.** Yes.
 13 **Q.** -- "[Freedom of Information requests] on excessive
 14 deaths. This is having an impact on capacity."
 15 **A.** Yes.
 16 **Q.** Can you help explain there what is going on in that
 17 sentence?
 18 **A.** So take that as a separate bullet from the "DCMO JH",
 19 and then I can explain it. This goes back to the point
 20 I just made which is that, actually, different parts of
 21 the countries were not seeing the risk coming at the
 22 same intensity and understanding.
 23 So some of the LRFs were stood up and in active mode
 24 planning avidly, but I had reports back, you know,
 25 privately through directors of public health that not

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1 people but I think that was accepted. What was perhaps,
 2 I felt, needed reinforcing was, the fact that the cadre
 3 of workers who were critical to this part of the
 4 service, actually, if they weren't able to isolate and
 5 have the right incentives, not only would they be an
 6 increased risk to themselves and others but they would
 7 effectively have no incentive to stop working. They
 8 wouldn't be able to because they wouldn't have any pay
 9 coming in.
 10 **Q.** Thank you. That concludes what I wanted to ask about
 11 that particular note.
 12 We know that thereafter, there was various guidance
 13 issued in mid- March and early April, and indeed in
 14 mid-April. Clearly the testing developed and capacity
 15 for testing increased throughout that six-week or so
 16 period. But can I ask you, please, about your
 17 paragraph 5.5[0] in your statement, and in particular
 18 your concern about the advice given to residents about
 19 isolation.
 20 **A.** Yes.
 21 **Q.** Because you say:
 22 "[You] continued to advise on that point up to
 23 2 April where, working directly with PHE, I reviewed and
 24 advised on the isolation period in care homes and
 25 whether it should be required for 7 or 14 days."

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1 all of them had quite -- were quite in that active phase
 2 yet. And then, it's probably saying already that some
 3 of the questioning coming back into the local
 4 authorities was starting to have an impact on people's
 5 capacity to respond to things. So -- which was an
 6 inevitable feature, I think, going through the pandemic.
 7 **Q.** And just finally on this meeting, a little bit lower
 8 down the page, you are flagging:
 9 "... these are really vulnerable people."
 10 Were you talking about staff or --
 11 **A.** Both.
 12 **Q.** -- recipients of care? Both?
 13 **A.** Both.
 14 **Q.** Right. You reiterated:
 15 "... that these workers are low paid, they need
 16 protection that they receive pay otherwise these may
 17 continue to work at risk."
 18 **A.** Yeah.
 19 **Q.** Were you essentially saying there that you were worried
 20 that they might continue to work because if they didn't
 21 they couldn't afford not to?
 22 **A.** Clearly the articulation is also a bit awry in that
 23 sentence, as well, which makes me worry about the rest
 24 of it. But yes, that's the effect of it, I mean,
 25 firstly that the people being cared for were vulnerable

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1 Perhaps if we could have up on screen your
 2 paragraph, it might help those following.
 3 Can we have up INQ000587394_0029.
 4 You've set out there in italics various -- what the
 5 agreed position was, which isn't entirely replicated in
 6 the 2 April guidance or indeed in the 15 April guidance,
 7 but can you just help us now, just standing back,
 8 Professor, why, from your perspective, was it so
 9 important that there were isolation periods written into
 10 the guidance.
 11 **A.** Well, obviously you needed an isolation period. We were
 12 writing -- that applied to the whole population, if you
 13 tested positive. And that's good -- it was good
 14 clinical practice. The issue here, as you've seen here,
 15 is we had an elderly and potentially frail group of
 16 individuals in a care home setting with high contacts,
 17 a vulnerable group, and then the immunosenescence, so
 18 the decrease in the effectiveness of your immune system
 19 as you age, is also an important point.
 20 What I had just flagged in picking up -- so I would
 21 be sent guidance quite frequently and I'd try to spot
 22 things, particularly to align them or to try to spot
 23 anything that was inaccurate.
 24 What I've spotted was that we -- in fact that PHE
 25 had written in a 14-day period of isolation, which was

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1 fine, but it actually wasn't consistent with what we
 2 were doing for the rest of the public.
 3 So the reason I queried it was: are we saying that
 4 this is what we would want to do? Or, you know, are you
 5 advising something different for this group because --
 6 actually, is that fair, if you're advising a care worker
 7 that they need a seven-day isolation period after
 8 infection and you're advising a 14-day period for an
 9 elderly person? Is that fair in equality? Or is there
 10 a good rationale for advising something differently?
 11 And what the rationale was: we need to protect this
 12 population. And the 14 days went in.
 13 **Q.** And on 2 April, guidance that came out advised that
 14 there should be isolation of symptomatic residents. It
 15 didn't say anything at that time about isolation of
 16 asymptomatic individuals --
 17 **A.** So we are getting slightly confused, I think, because
 18 this, I think, relates to individuals who had tested
 19 positive and were running out their isolation period.
 20 **Q.** Right, okay.
 21 **A.** So this will be -- I know there's a separate issue but
 22 this will be either when they are discharged well, or to
 23 complete a period of isolation after they were positive,
 24 I think. But it's not clear again in this chain,
 25 actually, and again, it's difficult five years later to

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1 shouldn't be the thing. The really important thing is
 2 the isolation, not the test.
 3 **Q.** Yeah. In fact you said --
 4 **A.** The test is good for clinical care. That's exactly why
 5 it's a priority.
 6 **Q.** Yes. You said, I think in M7, it's an adjunct but it's
 7 not the main intervention for keeping an individual
 8 safe.
 9 **A.** Yes.
 10 **Q.** Given that that is your view on this, do you think in
 11 advising the ministers you pressed home enough the need
 12 for there to be isolation written into the guidance,
 13 particularly given we didn't even have testing and
 14 testing is not the sole answer anyway?
 15 **A.** So I've tried to go back over some of my emails.
 16 I don't know if we're coming on to this later, but in
 17 the 2 April guidance -- I mean, often what would happen,
 18 I would see these, I would put comments in, and then
 19 I wouldn't necessarily see the final version. So the
 20 final version of 2 April did not come past my desk, nor
 21 did come of the comments, but I had contributed.
 22 And in the feedback to the minister, who was
 23 quite -- minister for care, who was absolutely asking
 24 all the right questions: do we want to do this? Should
 25 we be discharging patients with Covid into a care home?

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1 be precise.
 2 **Q.** Right. So from your perspective though, as DCMO,
 3 clearly you were cognisant of the need for there to be
 4 isolation periods for the symptomatic patient who was
 5 being discharged to a care home?
 6 **A.** Or the well patient who had been discharged to the care
 7 home.
 8 **Q.** All right.
 9 **A.** And I felt that. This longer period, we'll surely come
 10 on to this, but the -- recognised that an extra seven
 11 days of isolation can be quite disabling for all sorts
 12 of other reasons for an individual, but it's not just
 13 the individual, it was everybody else in the care home
 14 who had to be considered.
 15 **Q.** From your perspective, though, the need for isolation
 16 was blindingly obvious, if I may put it like that?
 17 **A.** Yes.
 18 **Q.** And I think you said to M7 that one of the reasons for
 19 that was the test only told you that you were negative
 20 at any --
 21 **A.** The focus on the test is really -- I class it as an
 22 adjunct to an intervention. It's quite good to know, it
 23 might change some people's behaviours in some ways. You
 24 know, if you know somebody is absolutely positive, then
 25 it might actually pay more attention to them, but that

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1 I had gone back and said that we should -- there was an
 2 expectation for risk assessment to ensure that
 3 appropriate isolation facilities are available.
 4 That I don't think has somehow come into a last
 5 version.
 6 **Q.** In your statement, around this time, at paragraph 5.54,
 7 Professor, you make reference to on 1 April you and
 8 others provided comments to the Department of Health on
 9 a "Dear colleagues" letter that was being drafted go
 10 from the secretary to MPs to update them on the
 11 response:
 12 "The content was centred on acute health sector."
 13 And you flagged both the omission in the draft and
 14 the critical importance in ensuring the care sector --
 15 sorry -- care staff and critically (sic) of their work
 16 to the response was recognised in the correspondence.
 17 And I just want to ask you about why now in April,
 18 we've been flagging now for a while, if I may say, the
 19 need for the care sector to be considered, you've been
 20 trying to raise its profile, ensure that people are
 21 aware of the diverse needs of that sector. Can you help
 22 with why perhaps that message hadn't landed and you
 23 needed to rephrase the "dear colleagues" letter?
 24 **A.** So I'll preface this with there were some very, very
 25 brilliant people working in the social care team in the

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Department of Health, hugely hard, who did recognise theirs. But a bit like some of the work on shielding, you can say things once or twice or three or four times but you struggle to reach everybody in big departments and right across government, as well.

So, yes, you can see -- I think I've got a few emails here where I start them by "I know I sound like a stuck record but". It was important and people didn't get the intonation right at all.

I used to think if I received this sitting in a care home, sitting with my dad, who I had just commissioned services for, sitting as Director of Public Health, how would I feel about it? And often the language did not feel right. And I would usually try and comment on them but clearly I wasn't seeing -- it wasn't my job to be clearing every letter or seeing things. Where I found them, I would comment.

Q. One other topic, please, about your paragraph 5.63, and the extent to which the ingress of Covid into residential settings could have been foreseen and considered prior to April, and you say, perhaps if we could have it on screen, it might help those following; could I have page 34, thank you very much.

You were asked, Professor Harries, to what extent the ingress of Covid into care settings had been

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to 80 year one, this is not, I realise there will be sensitivities around age but, actually, this is just a risk factor. It is a huge risk factor which was not predicted, I think, to the extent that it affected that group.

Q. You say that:

"Whilst ASC settings would be expected to manage respiratory or gastrointestinal infections ... IPC skills and capacity were probably weaker than in the NHS. In most geographies specialist IPC skills and training capacity previously offered by some public health teams had decreased since the transition of public health from Primary Care Trusts to [local authorities]. Even in residential nursing settings, the majority of care was provided by non-clinical staff."

If that was recognised that there was a lack of training and skills around IPC, clearly that was another factor to be borne in mind at the time of the expedited discharge policy. Do you think people understood, the ministers that were making the decisions, that perhaps there were -- there was a weakness in the IPC skills in the sector?

A. So I think where I've put "recognised", I recognised, many public health colleagues recognised, I'm not sure everybody recognised and, actually, even now if you say,

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foreseen and considered, and you said:

"It was logical that a virus which could be transmitted from person to person via the respiratory route was likely to ingress ... what was not known ... was the extent to which the elderly would be disproportionately affected by COVID-19."

May I ask you about that, because we've heard a number of pieces of evidence to suggest that actually those living in care homes and in those settings were always more likely to be considered to be more vulnerable, to particularly respiratory illnesses, and I don't want anyone to misunderstand what you were saying there, can you help with why it was phrased what was not known initially was the extent to which the elderly would be disproportionately affected?

A. I think it's the proportionality of the risk. So yes, we would expect that; yes, for the reasons of immunosenescence and the high contact environment, all of those things, those are longstanding risks for the future and need to be paid attention to. They are well known to a large degree because it happens with flu every year and we might want to reset our expectations of how much flu we can prevent and what interventions we should take, but I do think here the startling difference in age, particularly as you get above the 75

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IPC to most people, which is why I commented on the earlier letter, they think PPE and that is not what infection prevention and control is. And so there was definitely loss. I know with my own move from the -- having a public health team in a health primary care trust, and moving it to a local authority, I worked very hard to retain two very experienced IPC nurses, but most teams were not that lucky and most teams don't have them now. And I think, for others to confirm, that in the NHS now, there has been a gradual tailing down of infection prevention and control -- I think it's now starting to pick up again because people realise how critical it is.

Q. I understand that in the NHS, but just thinking about the adult social care sector, do you have any views, Professor, on who should be responsible for delivering IPC training in both pre- and normal -- in both pandemic and non-pandemic times?

A. So there's a formal and an informal answer. The reason I use my example, for example, of my team was because although it wasn't their formal responsibility, they used to do quite a bit of training, both on -- for things like vaccination and for infection prevention and control.

The actual answer to the question is, if you have

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1 a private provider provision, it is up to the manager of
 2 the services and the provider to ensure that adequate
 3 IPC controls are in place, and if they are accepting
 4 patients in, for example, in flu seasons and things,
 5 then I think they have that responsibility. The
 6 practical problem comes -- and I'm sure many will
 7 understand this -- which is if you have a fragile system
 8 of care, you then have a problem which is if a standard
 9 or an ability is not there, you do need to look after
 10 those people and so I think sometimes, I've been in
 11 conversations where, you know, care homes are about to
 12 be closed down, and then you have to balance the risks
 13 of the care to the individuals who are losing their
 14 home, effectively, over what standard you're trying to
 15 implement for different parts of systematic provision.

16 But I think the actual answer is the provider of the
 17 service, and so all services should have that and
 18 I think the CQC should be ensuring that they do.

19 **Q.** Well, that was my next -- who should be responsible for
 20 checking that the training is in place? That's with the
 21 CQC.

22 May I just ask you this, though, I think there's
 23 been an acknowledgement that there is a significantly
 24 high turnover of staff in the adult social care sector,
 25 and given the high turnover, therefore, a need to

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1 crucial both in care homes which have reported cases and
 2 those which have not."

3 We've concentrated a lot on those that had positive
 4 outbreaks. Why was it important that SAGE was
 5 recognising the need for testing in those homes which
 6 did not have outbreaks of Covid 19?

7 **A.** Well, because by 12 May, some of the evidence now has
 8 been properly collated and come through, and it was very
 9 clear that there were significant rates of asymptomatic
 10 infection and, likely, transmission, I'm not quite sure
 11 proportionate of that, but -- and that therefore
 12 actually testing all of these was the case.

13 As the -- just a couple of points, actually. On
 14 12 May it was actually the Care Home Working Group, so
 15 this is an error on my part --

16 **Q.** Ah, not the Social Care Working --

17 **A.** And I was not the co-chair at this point, yes, because
 18 it changed, partly because I changed it, so we might
 19 come on to that later.

20 **Q.** Right.

21 **A.** But yes, but I think by this time, by May, because of
 22 the studies that had come through, so the Easter 6, the
 23 first tranche of the Vivaldi work, which was being
 24 reported as it was being done, then it was very clear
 25 that we needed to do that.

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1 presumably roll out training with increasing frequency.

2 Do you think there needs to be any changes or
 3 amendments to the view that it should be the manager who
 4 conducts the training or is responsible for ensuring
 5 there is training, and the CQC for ensuring that the
 6 training is in place, given that high turnover?

7 **A.** I'd come up with a different answer, which is, if you
 8 reduce your turnover, have better career pathways and
 9 proper recognition of care workers, you will retain them
 10 longer and the education and IPC and the pride in the
 11 work that they do. I think the turnover is the problem.
 12 It's the same, actually, it's a turnover of patients in
 13 hospitals. You get risks and this is in staff in social
 14 care settings.

15 **Q.** May I move before we break, my Lady, to one slightly
 16 different topic, and I'd like to ask you about a SAGE
 17 Social Care Working Group paper from 12 May.

18 It's at your paragraph 5.64 in your statement, but
 19 can I have on screen INQ000587394_35.

20 We can see there that, as at 12 May, the SAGE Social
 21 Care Working Group presented a care home analysis paper
 22 of the 35th meeting of SAGE and you were at that
 23 meeting. And as at May the minutes record that there
 24 was:

25 "Extensive testing of both residents and staff is

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1 As time went on, and when it was the Social Care
 2 Working Group and I was chairing, actually it became
 3 very evident that what we needed to be doing was testing
 4 staff regularly. And you could test patients,
 5 residents, for whom actually it was quite an invasive
 6 test with the PCR, much less frequently and still be
 7 safe.

8 **Q.** Can I just pause you there. So there was the --
 9 initially, a SAGE Care Home Working Group, as
 10 I understand it, which then became the Social Care
 11 Working Group. And you were the co-chair of which,
 12 Professor?

13 **A.** The latter. So I think what happened -- I wasn't
 14 involved -- SAGE had a number -- SAGE saw the numbers
 15 rising and set up a small group, largely of modellers
 16 and data scientists, to see if they could see what was
 17 happening and look at some of the causes. That was set
 18 up under Professor Ian Hall, who I think you're speaking
 19 to later this week, and he, and it was called the Care
 20 Home Working Group, because it was just looking as
 21 a task and finish group at care home numbers.

22 **Q.** Right.

23 **A.** When it became obvious that there was a problem, and
 24 I was asked by Patrick Vallance to come in and chair
 25 from -- I think I was asked on 2 July, I came in towards

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1 the end of that month, and then I recognised this was
 2 not just a care home issue, we needed to look at social
 3 care, renamed it, reformed the terms of reference, and
 4 then set in -- (overspeaking) --
 5 **Q.** So essentially you broadened the remit of the group?
 6 **A.** Totally, to recognise this broader area of
 7 investigation.
 8 **Q.** Thank you. I diverted just to make sure we had that
 9 clear in our mind.
 10 So this is the SAGE Care Home Working Group making
 11 this presentation?
 12 **A.** Yes.
 13 **Q.** Hence the focus on the care homes. Paragraph 21 there
 14 states:
 15 "Workforce management and behaviours are key factors
 16 in transmission. SAGE reiterated the need to minimise,
 17 and ideally avoid completely, staff moving between
 18 homes. This presents a challenge to the operating model
 19 of many care home providers."
 20 Professor, may I just forward, because we know there
 21 were many attempts throughout 2020 to either potentially
 22 bring in legislation, to restrict staff movement, but
 23 generally a move towards trying to do so. And I just
 24 want to understand from your perspective as DCMO, were
 25 you asked to advise at all about how, practically or

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1 **A.** Yes. So the Vivaldi Study was one of those that has
 2 come out of that and obviously in different capacities
 3 I have supported and funded where we could, going
 4 forward.
 5 But there were other ones. So PHE obviously did the
 6 Easter 6 study in the earlier one, there were studies in
 7 barracks, which is not a care home, but it still gives
 8 a sense of trying to understand how ingress of virus is
 9 occurring.
 10 **MS CAREY:** My Lady, would that be a convenient moment for --
 11 **LADY HALLETT:** It would, certainly. I shall return at 3.20.
 12 **MS CAREY:** Thank you very much.

13 (3.05 pm)

14 (A short break)

15 (3.20 pm)

16 **LADY HALLETT:** Ms Carey.17 **MS CAREY:** Thank you, my Lady.

18 Professor, can I turn to September 2020 onwards and
 19 a few questions, please, about that.

20 Could we have on screen pages 40 and 41 of your
 21 statement -- thank you very much -- and that's at the
 22 bottom paragraph, 5.79. You say on 13 September you
 23 advised colleagues within DHSC and Public Health England
 24 with respect to protection of care homes. You were
 25 seeking urgent further investigation, given the

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1 otherwise, it was going to be to restrict staff
 2 movement?

3 **A.** So that wasn't my responsibility. I mean, clearly
 4 I recognise this, I promote it, if you like, and advise
 5 there's a clinical risk, but that was well recognised in
 6 the department as well. Ministers were working very
 7 hard to try to understand how they could implement
 8 something whilst keeping people safe.

9 So, on the one hand, you had a safety risk around
 10 infection but if you can't provide a service, it's so
 11 fragile it falls over, that is a risk in the opposite
 12 direction.

13 **Q.** Just finally, dealing with the minutes of this, a little
 14 bit further down the page, paragraph 25, SAGE Care Home
 15 Working Group made reference to:

16 "Further targeted studies, including to understand
 17 [the] variation in scale of outbreaks between different
 18 care homes and the reasons for this, are needed."

19 Was DCMO or the office of the CMO involved in any
 20 way that you can recall now in asking for further
 21 studies to be undertaken, and if so can you remember
 22 what those studies were?

23 **A.** So I was aware there was work on this, and in fact
 24 I think you heard from Professor Laura --

25 **Q.** Shallcross.

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1 significant impact of the first wave and the rapid
 2 approaching winter and what you describe as a relatively
 3 short window of opportunity to understand, take action
 4 on any risks that could be mitigated.

5 And have I got this correctly, when we look at what
 6 you have set out in your statement, you were summarising
 7 where you were at for DHSC and PHE?

8 So if we have a look at where you were at and we go
 9 further down that paragraph, there's some italicised
 10 points. As at 13 September, or thereabouts, there
 11 wasn't any very strong evidence that hospitals were
 12 a causative risk factor in care homes through
 13 transmission of infection via discharge policies.

14 Upon what evidence was that assertion based, please?

15 **A.** So if I just go back to the Care Home Working Group and
 16 where I took over. So there was a lot of concern
 17 generally amongst clinicians, ministers, about the care
 18 homes particularly, and the risks. I was asked to chair
 19 what was then the Care Home Working Group. I reviewed
 20 the group there. What I wanted to do was go back
 21 completely in an unbiased way to basics and say: hang
 22 on, there's a lot of noise about this; what do we
 23 actually know? And coming completely fresh to the
 24 evidence.

25 So although I'd been in the SAGE group when work was

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presented, I hadn't been part of that.

And so I had gone back and run a summit which included colleagues from right across the UK, it included virologists, it included people who'd done research in the care sector, so worked alongside care, it included people like Laura, who had been working -- Shallcross, who'd been working on the first stages of the Vivaldi Study. And just trying to put every head in the room, whether the work had been published or not.

The easiest way to say what we knew is that the consensus statement from May '22 -- now, I know this seems a long way down the line but there is a reason for this because, actually, the evidence that is in that was broadly presented in person, even though it was not yet published at the symposium in September.

Q. Right.

A. So that statement broadly aligns with the early evidence coming through from all of the different studies across the UK, in particular things like genomic studies in East Anglia.

Q. But this document is just designed to give an overview to DHSC and PHE of where you are at as at --

A. So this was not -- this email, I think I'll need to go to the bottom of it, but I'm pretty sure this was not actually really trying to -- I think I was a bit

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risk of transmission was for what are described as other peripatetic professionals, ie GPs going and out of care homes.

A. Yes.

Q. The association between the size of the home and the risk of the outbreak, I think we've heard evidence about that before. And can I just ask you about one of the bullet points further down the page. You say:

"We know there are cases/outbreaks in care homes where no visiting has been allowed in recent weeks which still suggests that the workforce is a particular risk."

And it may be worth keeping those points in mind when we look at visiting in a moment. Does it follow, though, that as at September there is still a concern that there is -- a main risk of transmission was still coming from staff?

A. Yes, I think that was -- I mean, there are different ingress routes, which I think have been identified, but all of the pointers were moving in that direction. And this is not to single out staff, it's actually because they were part of their local communities, and actually what you saw was, when the community rates rose, the staff rates rose as well. So the trick here was to make sure not only that the care residents were protected but the staff were protected as they came in.

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agitated there actually. What I could see was some early new data coming in that said what the infection rates were in staff and residents that had just come in, and what you were starting to see was after a lull, there was quite a steep rise. Given the information, which is broadly listed here, it's just a summary version of it, there's evidence elsewhere, this was just a summarised thing, what I actually wanted to do was say: at this particular point we have an opportunity to look at this care worker force and say why are the rates going up so much? But there was -- as soon as, of course, they go up everywhere then you've lost the opportunity to investigate. So I was really trying to say, is anybody working to really ask these people what they're doing, so that we could see if there was any mitigation ahead of the winter that we hadn't thought of.

Q. We can see there that one of the bullet points says there is not any strong evidence that visitors are particularly high in disease transmission risk, if any.

A. Yes.

Q. And I'm going to come back to visiting in a moment but just remember that was in this document.

A. Yes.

Q. You make the observation that you didn't know what the

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The really important -- the reason I sent this was, you'll see in the -- two bullet points down from that it said there were over 1,800 positive cases last week in care homes, compared to just over 600 the previous week.

So what you were seeing was this rise. And what I wanted to do was try and see if we could stop it.

Q. Right. I think though it did rise as we went through --

A. Yes, it did.

Q. -- the autumn of 2020 and into that winter?

A. This was an investigative window, though. This is why I might sound slightly agitated in the email because I was trying to say: is anybody doing anything?

Q. Later that month, on 21 September, you called together what was called a symposium?

A. Yes.

Q. A care symposium, which you organised as the co-chair of the SAGE care working group. And what was the aim of the symposium? What was it trying to do?

A. This is what I -- what I'd said further -- it was really a very strong narrative and belief, for many good reasons that you can see without deep investigation, that discharge from hospitals was seeding infection into care homes. What I wanted to do was just strip the whole thing away and say: let's put every single piece of evidence that we have, what evidence is growing,

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1 different types of methodologies for reviewing that, and
2 put it all in one place. And the September or November
3 consensus statement was the outcome from that symposium.

4 **Q.** Right.

5 **A.** But the May '22 one, there's a reason for why it was so
6 late, actually says the same thing, and is articulated
7 much more -- it highlights the methodological soundness
8 of the different studies we were looking at.

9 **Q.** Since you mention it, are you able to help us there,
10 Professor, with why it was that the consensus statement
11 that came out in 2022 so late when in fact it was based
12 on findings from much earlier on?

13 **A.** So it will be good thing to ask Professor Hall
14 tomorrow -- and there are some interesting points on
15 this, so I come from a position where I'm an unbiased
16 public health critical analyst, and you're looking to
17 see what evidence is there and not be sidetracked by red
18 herrings or pre-considerations. You absolutely need to
19 say: what does this mean? What could it mean? Two or
20 three different things, and then follow down each path.

21 One of the problems I think with the consensus
22 statement, because it happened a little bit with the
23 first one, was that although there was very significant
24 consensus, there was One Voice, I think, which found it
25 quite difficult to sign up to the consensus.

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1 **Q.** But was it a UK-wide symposium?

2 **A.** It was basically anybody who had -- it was a really wide
3 invitation. Anybody who was working on this area: can
4 you please come and let's share thoughts and push them
5 around and challenge each other to see what the evidence
6 says.

7 **Q.** Right. We'll look at some of the key findings.

8 Can I have on screen, please, INQ000074994_0002 and
9 you set out, I think there are four -- there were six
10 key findings, we won't, perhaps, go through them all,
11 but 4.1:

12 "Although staff-to-staff transmission has been
13 observed to have been a contributory factor in specific
14 outbreaks, it is important not to generalise to all
15 outbreaks and emphasise one route over another without
16 clear evidence -- studies undertaken so far indicate
17 multiple introductions are common."

18 Indeed, Professor Hopkins told us that,
19 Professor Shallcross has told us that, so that's not
20 particularly new to the Inquiry now.

21 **A.** No.

22 **Q.** "Clusters ... have been observed ... many outbreaks
23 involve cases that are spread out over a longer period
24 indicating multiple introduction ... different
25 lineages."

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1 **Q.** Yes.

2 **A.** And so much of the wording, I think looking back now and
3 reviewing that and the one we put out, is quite
4 carefully managed. I understand the sensitivities
5 around that, but for me, it is really important that we
6 look honestly at the evidence and not -- because
7 otherwise we put in the wrong protections and miss the
8 opportunities.

9 **Q.** Well, can I pause you there, Professor, because it may
10 be that Mr Hall is better placed to deal with the
11 sensitivities and differing views about
12 the -- (overspeaking) --

13 **A.** He was -- (overspeaking) --

14 **Q.** So perhaps we'll leave that for him to answer.

15 **A.** Yes.

16 **Q.** But you set out in your statement a number of the
17 participants, not all of the participants. Can I ask
18 you, did anyone representing the Welsh Government or
19 public health bodies in Wales participate in this care
20 symposium?

21 **A.** Yes, I think that was not an inclusive list that's there
22 and there is, on the '22 statement, there is some Public
23 Health Wales evidence which was actually included then,
24 particularly people working on the SAIL data, I think.
25 But I wouldn't be able to say precise names just now.

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1 Then there is:

2 "The retrospective genomic analysis and seropositive
3 studies in care homes ... find evidence for multiple
4 routes of virus ingress ... but [again] are not
5 systematic enough to quantify the relative frequency of
6 different routes of ingress."

7 May I pause there, Professor. Professor Shallcross
8 has told us there's at least, I think, six or seven
9 potential routes in, and it's not easy to test visitors
10 or necessarily to test, perhaps, healthcare
11 professionals coming in, but do you think from now
12 looking back, there should be more research done perhaps
13 on the more obvious routes --

14 **A.** Yes.

15 **Q.** -- (overspeaking) -- visitors?

16 **A.** This to me, in fairness, actually NIHR funding, whether
17 it be in social care, whether it be more in community,
18 has tended to be focused on hospital and obvious
19 healthcare systems and there is a definite move now into
20 funding research, which is much more community-focused
21 including social care.

22 **Q.** And just on next page, 4.3:

23 "The weight of evidence is stronger in some areas
24 than others, however. Evidence of staff to staff
25 transmission has emerged in the genomic analysis ([with]

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1 high confidence). [But] Weak evidence on hospital
2 discharge and modelling the impact of visitors ... does
3 not suggest a dominant causal link to outbreaks from
4 these sources."

5 The "weak evidence on hospital discharge", can you
6 help us now with what research or studies that was
7 referring to?

8 **A.** Yeah, the -- and we need to -- don't assume that the
9 evidence -- so the evidence can be not compelling, if
10 you like, not robust in one study, or it might because
11 there isn't much of it, albeit -- there's a whole load
12 of reasons for writing "weak", but what we're saying is,
13 you can't say definitively a specific number on all of
14 this at any particular point.

15 But actually there were two main studies. There had
16 been a request from the Public Accounts Committee,
17 I think it comes through the statements more as being
18 commissioned in November but, to be honest, that's what
19 we were working on as well. And the approach at that
20 point, separate from the other studies across the UK,
21 was to look at the data in two different ways. One was
22 to follow confirmed cases out from hospital, and that
23 was the PHE study.

24 **Q.** Yes.

25 **A.** Recognising not everybody got tested. The other one was
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1 looked very specifically -- they'd even gone to pulling
2 out clinical case records, and from Northern Ireland,
3 and then there was a paper from Wales as well.

4 **Q.** Right. Thank you. That document can come down.

5 But you -- the symposium considered a number of
6 things may contribute to future improvements, and one of
7 those that was further research was carried on into the
8 extent to which the physical layout of the care home
9 influenced transmission.

10 Do you know what research, if any, was in fact
11 carried out on the physical state in the care home?

12 **A.** So I think it would be a good question to further
13 explore with Professor Hall, because it was actually one
14 of the things that was picked up by the environmental
15 group of SAGE, and he took the -- so there was a linkage
16 through to make sure the right questions were asked.
17 I'm not quite sure where the detail of that is now.

18 **Q.** All right. Well, we can follow that up with him, thank
19 you very much.

20 Does it follow, though, if we just stand back, as at
21 September 2020 there simply wasn't enough evidence to
22 say which route of transmission of Covid into care homes
23 was the most dominant. You know, there were a number of
24 them, but not which of any of them were the most
25 dominant.

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1 to do it the other way around, and almost look from care
2 homes back in to those who'd been in hospital. So the
3 two different lenses.

4 And what you would anticipate was either they'd say
5 much the same thing, in which you'd have confidence,
6 they wouldn't be exactly the same, or they'd come up
7 with startlingly different ones, in which case you'd
8 say: what's our hypothesis here? And then you add to
9 it, you build a picture from different studies.

10 Now, NHSE/I worked on the Care Home In (unclear)
11 study. It's not reported here but it was being reported
12 as it was done into the care group at that time on
13 a weekly basis, as was the Vivaldi Study as well.

14 So one of the good things about that working group
15 was we could pick up information. If there was
16 something really strong and robust -- later on, on
17 testing protocols, for example -- it could go rapidly
18 through to the care minister and change policy.

19 So those were two key pieces of research. And then
20 at that symposium we had very strong evidence from the
21 genomic analysis because you need to follow the cases
22 through, and look at the lineage, to see how they're
23 related, if you like, to other cases.

24 And then there were a number of other studies which
25 are in the May '22 paper, from Scotland, where they'd
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1 **A.** No, I wouldn't say that. I think whereas you couldn't
2 have a very precise number, I know we -- you know, the
3 PHE one says 1.6%, but actually it's -- whatever numbers
4 you're using, you're bound to come up with some sort of
5 precision estimate. It's 1-2%. And what was
6 interesting was, when you looked at studies which had
7 been done with different data in different UK countries,
8 they all came up with roughly 1-2%. That will be an
9 underestimate, but actually when we look at the genomic
10 studies, I think it was around 5%. So I think
11 somewhere, by putting all of this together, it's
12 definitely not the dominant ingress route.

13 When you -- the reason for -- and I think there is
14 confusion about why we're using size of outbreak, but
15 actually, there was a very, very consistent trend that
16 when you started to do -- I don't know, tell me if I'm
17 getting lost, but you do multivariate analyses, so
18 you're looking at lots of different characteristics of
19 the care home or the staffing together, or you do
20 univariate, you just look at one thing. When you put
21 them together to adjust, all of that difference -- the
22 thing that really stands out is the size of the care
23 home and then the -- which effectively is the number of
24 contact -- people coming in and out of the care home.

25 **Q.** We may have been slightly at cross purposes. I think,
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1 if I understand your evidence correctly, you are saying
 2 when you look at all of the various studies that are
 3 looking -- were looking at the extent to which hospital
 4 discharges were a route of ingress, they were definitely
 5 not the dominant.
 6 **A.** Yes.
 7 **Q.** But my question to you was, was it possible to say,
 8 having looked at all of the studies, which was the
 9 dominant route?
 10 **A.** So this is what I'm saying, I think the -- from -- you
 11 have to build a picture, this is the issue with science,
 12 you're building a picture in a different direction all
 13 the time, so there's definitely -- I'm sure there were
 14 some cases from hospital admission in, that would depend
 15 on how good isolation control was, all sorts of things,
 16 but the dominant route from the evidence that we have is
 17 through staff.
 18 **Q.** Staff. Thank you very much.
 19 May I ask you, please, briefly about designated
 20 settings, and I think you'd deal with this at your
 21 paragraph 5.86, Professor, but clearly we know that in
 22 the winter of 2020 into 2021, there was a move towards
 23 identifying care homes that could be a designated
 24 setting to receive a Covid-positive patient being
 25 discharged from hospital, and did you have some concerns
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1 what you're likely to be doing then is deconditioning
 2 them for the care home, their final, familiar
 3 destination, if you like, to support them.
 4 The point I make is not to say that not all of those
 5 are overwhelming risks, and it depends on -- you do need
 6 really good infection control in that designated
 7 setting, the point is there are -- as with all of Covid,
 8 there are balanced arguments and risks and they all need
 9 to be considered.
 10 **Q.** Speaking of balances, may we turn to visiting, please.
 11 We've looked at a number of pieces of or little
 12 excerpts from documents which have suggested,
 13 essentially, there was an absence of evidence regarding
 14 the risk that visitors pose and the amount of Covid that
 15 they brought into care homes. And it's really, you set
 16 out in your statement a number of ways in which you were
 17 asked to advise about visiting, but given that absence
 18 of evidence that visitors were a, certainly a
 19 significant cause of infection in homes, do you think
 20 that the balance of the visiting policies were right?
 21 **A.** So number 1, it's an absence of evidence it's not
 22 evidence of absence. That is really important. When,
 23 because there was a shutdown of visiting for quite a few
 24 months, as we all know, and clearly that caused concern
 25 for other reasons, but during that time you could draw
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1 about the designated settings policy and, if so, what
 2 were they?
 3 **A.** So it was a policy that was suggested and on the face of
 4 it, it looked very sensible, but I tend -- I always look
 5 from both sides and say what are the benefits and what
 6 are the risks? And if you, perhaps, shine a different
 7 light on it to the one which is the one most people see,
 8 you start to build a picture of potential increased
 9 risk. So if I put all -- I did support the policy in
 10 the end, but if I just put the increased risk position,
 11 so number 1, if, you know, in theory, people were
 12 worried about discharge from hospitals, what you're
 13 doing is taking everybody from a hospital and putting
 14 them in one place. So I which case you might build
 15 a new hot bed of cases where they're all -- if the
 16 infection control is not absolutely perfect, you will
 17 actually build a higher-risk environment.
 18 Number 2, the individual will, often elderly/frail,
 19 every time you move that individual, their mortality
 20 statistic goes up, regardless of what's going on. So
 21 you're then moving them twice.
 22 The second point is if you put them into that
 23 environment and then want to move them on back to their
 24 care home, they will have had two 14-day isolation
 25 periods, so they are out of society for two weeks, and
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 1 very little conclusion.
 2 We looked at this, and I again, a second big piece
 3 of work, was to actually try and do some work in the
 4 care group which tried to assess what that risk was and
 5 then what the balance of risk was in the opposite
 6 direction, taking into account quality of life,
 7 isolation, all of those sorts of things which people
 8 have spoken very eloquently of.
 9 There is some modelling in that and there is an
 10 email here somewhere which was very, very rough, so do
 11 not take this as modelling, where we estimated how many
 12 times a visitor might come in in comparison to the risk
 13 that a staff member comes in, and then tried to attach
 14 a number to it to quantify.
 15 On that basis it was an insignificant risk, but you
 16 need to bear in mind both there is a theoretical risk,
 17 and two, the data was just not available.
 18 **Q.** Given that there was an absence of evidence about the
 19 risk that a visitor might pose to bringing in -- by
 20 bringing in Covid into a care home, do you think, when
 21 you stand back and look at it, that the trajectory of
 22 visiting guidance as it was across 2020 into 2021 and
 23 2022 struck the right balance now? And I'm asking you
 24 with the benefit of hindsight, I appreciate.
 25 **A.** I think it's very difficult, because the biggest problem
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with care homes is when a visitor comes in or whenever there is an intervention about stepping across the care home threshold, you are not only looking at the individual; you are looking at everybody else who is frail and living in that environment, and therefore, trying to, you know, an individual elderly person, my father, for example, I was commissioning services for him right before the pandemic, he would have dropped all the risks and said, "I just want a visitor" and I'm sure we will hear that many times, but if there is -- there is a real risk of people bringing in infection regardless of whether we have the data every time community rates rise.

And so the trick I think in getting this right is to recognise that and not say it's not existent, but to say how much are we able to tolerate? There's a societal or a care home or a family question. And then, what is the balance? The thing which I've heard but is probably not true in my experience, is that people didn't understand the real harm that can be done and people did, and you can see that coming through the advice that was going up to ministers, and there is a quantifiable harm level which we tried to include. But it's very difficult, at the end of the day if you want to balance these things, it's very different because it comes down to individual

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least two authorities in the North are advising homes not to use the [lateral flow test] ... for either staff, relatives or visitors as they are not assured of the accuracy of the tests."

I don't need to descend to the detail, but can you help us, Professor, was there an issue with the accuracy of lateral flow tests?

A. In short, no. It's the understanding of what they were being used for. So a lateral flow, for example, for an -- is relevant for a short-time period for those people who were most infectious and most likely to transmit infection.

So, for something like a visitor coming in, it was brilliant. It was like an open opportunity, I think, for -- so this was actually quite sad, in many ways, that people who wanted visits -- it's still an adjunct, but for a short time period. They're not perfect, as is any test, but they were a good adjunct to safe visiting. So it moved the risk dial in a slightly -- in a more positive direction.

The problem here was that the -- as with many things, that the communication around the risks and the utilisation of them was going in different ways. And so I think, when we go to the next page probably, you'll see that the people in Test and Trace, effectively,

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values and the people we most need to understand values of are those people in care homes and actually trying to elicit a value for them is also very difficult.

Q. If anyone would like to read any more about this, at your paragraph 9.11 you make the observation that:

"[An] individual's risk appetite is ultimately a personal decision. For instance, in respect of visiting, it would be quite reasonable for one individual and their family to prioritise social interaction and another to prioritise self-isolation."

I'm not going to ask you about that any more, but I would like to ask you about lateral flow tests in relation to visiting, and your paragraph 6.16, Professor.

Could we have on screen, please, INQ000153358. It's an email chain, I hope. And could we go to page 2 into 3.

We are jumping now into the -- we can see there -- late November of 2020. And Vic Rayner from the National Care Forum is writing to DHSC colleagues, and I think in due course you end up being copied in on some of this thread, but to put it into context, lateral flow tests are now available, and Vic Rayner says:

"Morning all -- and apologies [for emailing] at the weekend. We have ... been informed by a member that at

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under Dido Harding, were rapidly, for good reasons, trying to get these out to care homes and get the logistics going, but they'd gone well ahead of assuring people like directors of public health, who would understand that, what was happening.

Q. Can we just follow the email thread. It is, minister emails Susan Hopkins, basically copying in the email from Vic Rayner. And if we go up, it looks like, then, that DHSC are preparing a response to Minister Whately, and we can see there:

"The letter from Sheffield [local authority] to care homes in their area arose from their lack of information on the rollout of [lateral flow devices] to care homes ..."

A. Yes.

Q. "... and asked for care homes to pause their rollout until they had further clarifications."

And they'd spoken to the director of public health: "... who concurs with the view that LFDs in addition to PPE and IPC, where visiting is occurring can reduce risk further. However, he wishes to be assured that the training and education of care home staff and the operational delivery of these pilots is of high standard."

And we can see the response the minister concludes:

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1 "We believe that the introduction of [lateral flow
2 devices] for visitors where the visit is planned in the
3 best interest of the residents will further reduce the
4 risk of COVID transmission, when used appropriately with
5 the other risk mitigation measures ..."

6 Was there a concern that it might be an either/or,
7 that people would have the test and then they wouldn't
8 use IPC measures or PPE --

9 **A.** There was a lot of unhelpful media noise around LFDs.
10 It's very difficult to control. These people were
11 anxious. The tests need interpreting carefully and
12 their use case needs explaining carefully. And I think
13 it all settled down. Of course we all ended up using
14 them, I think with the recognised limitations of them.

15 So this was a draft -- a letter draft response for
16 Minister Whately to sign off to send out to give that
17 assurance.

18 **Q.** And I think you were asked, if we just follow the final
19 page, page 1 of this, you were asked by Susan Hopkins to
20 have a look at the email thread, and can you just help
21 us with -- you're saying there:

22 "I've been working with Eamonn [who I think is in
23 PHE] and Jane to urgently revise draft visiting guidance
24 to get the right balance in the wording and advice
25 between legal rights/responsibilities, detriment from

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1 designing them, you link them -- it's the alignment
2 issue -- back with clinicians or public health experts
3 and people who understand what is happening on the
4 ground. So everybody understands the purpose and
5 ambition, the risks and limitations. And then it can
6 all go out safely.

7 **Q.** I don't wish to minimise it, but it's a communications
8 issue here --

9 **A.** It's an alignment issue. And it's different because --
10 I mean, you will know, I came in behind -- it's one of
11 the motivations for taking -- going for that role was to
12 actually try to pull it together. Because both parts
13 independently were doing fabulous things, but they
14 weren't aligned, and it caused quite a lot of
15 controversy.

16 **Q.** A slightly different topic, please, and your
17 paragraph 7.4, if it helps you, Professor, but the
18 age-old question of data in the adult social care
19 sector. And you say in your statement that
20 particularly -- the data systems in Wales particularly
21 were more comprehensively linked but with a much smaller
22 demographic, presumably because there's fewer people in
23 Wales; is that what you meant by that?

24 **A.** So the population in Wales is about 3 million so it is
25 only like a couple of counties here, if you like. You

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1 isolation, and then the introduction of visiting with
2 LFDs which we are all aware is an increased risk to care
3 homes rather than a reduction."

4 Why did you phrase it in that way, Professor?

5 **A.** So just to reinforce the minute you do start opening up
6 to further footfall you are increasing the risk. So
7 it's not -- because there was a slight anxiety that
8 everybody would just say: ooh, we've got a test here
9 now, no problem, don't worry about the IPC, we're all
10 safe.

11 And of course, actually, what we wanted to do was
12 have visitors come in and still recognise that there was
13 an increased risk if we are going in and out,
14 theoretical, small probably, but we needed to manage
15 that. And we needed to support those visitors to learn
16 good IPC practice as well, because then -- and they're
17 actually very positive intervention that way, because
18 they're totally motivated on keeping their loved ones
19 safe.

20 So it was to flag that at the start, but then to go
21 on -- and in fact what I was trying to do, you'll see
22 this email, it went back to Susan, but what I was trying
23 to do was quietly -- it went to Dido Harding as well,
24 and what I was trying to do was politely say: please can
25 you make sure that when you're rolling out services and

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1 have to keep this in mind because sometimes, if you're,
2 as I say, as a self-confessed Welsh resident now, you
3 need to bear that in mind, things that work in Wales
4 will not necessarily work elsewhere.

5 But what they have done, and for many years, they
6 have SAIL data, and I can't remember what the acronym
7 stands for, but effectively you are linking much more
8 health service into community-level data and so the
9 automatic linkage is there and therefore exploring some
10 of these sorts of problems is generally easier.

11 **Q.** And did -- do you know whether that -- not necessarily
12 the same system, but the way that the data is linked in
13 Wales could be replicated in England, given its vastly
14 bigger size?

15 **A.** So data, as we have heard, is really challenging. If
16 we're getting on to the "what would you do in the
17 future" sort of question, I'd want to be even more
18 ambitious than that. For the reasons that we've just
19 said, I think the care sector is under-researched, so
20 when we get these questions, we don't know. There is
21 a movement to move health services more into the
22 community and if we're going to improve health and the
23 quality of life for individuals in an aging demographic
24 generally, then we should be much more ambitious on the
25 data.

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1 So, for example, what we actually need is not just
 2 a care home link, we need care homes and GPs and
 3 hospitals and pharmacies all linked together, and local
 4 authorities, sorry, I shouldn't miss that out. So that,
 5 you know, if you're in a -- and I don't mean to position
 6 any of us because I'm now in the aged group -- let's
 7 take me as an example. If I'm now an aged person in my
 8 community, and I go into hospital and get transferred
 9 to, you know, a care home and then back home, I want
 10 people to know where I am, and at which point I went,
 11 because that transit point or what treatment I've had is
 12 critical to understanding where I may have acquired an
 13 infection or not, or whether a treatment has been
 14 successful, and until we get that linked, we're not
 15 going to have the answers and we're still going to be
 16 asking the same questions.

17 **Q.** It brings me on to your reflections and lessons learned
 18 part of your statement, Professor, and you say at your
 19 paragraph 9.2:

20 "In [your] view, the division of responsibility and
 21 the ownership of risks in respect of ASC as between
 22 providers, local government and central government,
 23 needs to be given proper consideration."

24 Now, bearing in mind we can't change the entire
 25 make-up of the system but can you just help us, are you
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1 something which is a national consideration at which
 2 point everybody flips to national control, or you have
 3 a different care provision for the country.

4 I personally, if I'm allowed -- my second point,
 5 which is I firmly think that the care sector is just not
 6 recognised as an equal component of the health and care
 7 system. So that is the first thing that can be done
 8 within the Department of Health. It is now, I mean,
 9 I think huge progress has been made by the ministers,
 10 actually, and particularly Helen Whately in leading the
 11 work, she moved it right forward and things like the
 12 Capacity Tracker are still operational, and has moved it
 13 a long way.

14 But it needs equal recognition because it will give
 15 better outcomes for people and better outcomes for
 16 health and care services.

17 **Q.** One other matter that we have touched on in your
 18 evidence, Professor, was the difficulties in potentially
 19 restricting staff movement between the care settings and
 20 I just wondered whether you had any reflections or
 21 observations on what could practically be done to try
 22 and limit or restrict staff movement during a pandemic.

23 **A.** So it's still very difficult because it will still
 24 require a balance of risk to individuals. If you have
 25 no workforce to look after elderly, frail individuals,
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1 able to give us an example of how a better division of
 2 responsibility would help the pandemic response?

3 **A.** I think if the data systems were as I've just described,
 4 it's not even just the pandemic response. I mean, if we
 5 have demands (unclear) I think we could have better
 6 health and better health outcomes, particularly for
 7 those in more deprived areas. So there is a wider
 8 health issue here and we shouldn't just be preparing for
 9 pandemics --

10 **Q.** It's not that I disagree with that but the terms for
 11 this Inquiry are --

12 **A.** No, I agree, but it will help pandemics and it has
 13 a bonus, a benefit, it does help pandemic preparedness,
 14 because if you're trying to -- let's suppose we had
 15 a treatment for something, or we need -- we've got a new
 16 vaccine. They will automatically be aligned. We won't
 17 have regressed back to the position we had pre-pandemic.

18 I think on this there is a wider issue for me. So
 19 clearly government can or -- it's a government decision
 20 where they put responsibility for this, but having --
 21 I don't think there has been adequate recognition of the
 22 private provider provision for adult social care. You
 23 can't suddenly have, in my mind, a private provision and
 24 then expect a national response, unless there is
 25 something in between. So either somebody has to design
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1 that's worse than -- probably than having a potential
 2 risk of infection. I go back to my first point which is
 3 if you equalise the opportunity, the career progression,
 4 which again, ministers have been doing recently, to try
 5 and improve and equalise the recognition between Health
 6 and Care, then some of those issues will go away.

7 **MS CAREY:** Thank you.

8 My Lady, they're all the questions I ask.

9 **LADY HALLETT:** Thank you very much, Ms Carey.

10 A few more questions, Professor.

11 Ms Morris who is just there.

12 **Questions from MS MORRIS KC**

13 **MS MORRIS:** Thank you.

14 Good afternoon, Professor Harries. I ask questions
 15 on behalf of the Covid Bereaved Families for Justice UK.
 16 A few short topics, please.

17 First of all, I want to ask you a bit more about
 18 preparedness. At the beginning of your evidence, it may
 19 feel like a long time ago, Ms Carey asked you about
 20 earlier response plannings and, in particular, a meeting
 21 on 11 February 2020. It's not going to be a memory
 22 test, I appreciate you may not have a direct memory of
 23 it but you did say in your statement that the meeting
 24 slides from that meeting said that social care will need
 25 central oversight that covers local authority and
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private providers. So my question is, do you agree that as of February 2020, and really before -- even before the emergence of Covid-19, there was no plan in place to ensure that effective oversight and support to the sector?

A. I don't think that's quite the same thing. So I think first of all, the comments are actually what came out of the meeting -- they weren't mine -- just for clarity. I think they were coming from the meeting. I think what that was saying was that was a mechanism that needed to be focused on.

My comments earlier about the recognised provision of care in the country is one where there needs to be some sort of systematic oversight. There was a system. It predominantly came, if you were looking from a central government position, it would be local authorities who contract with those providers and then MHCLG who oversee that area of work.

But I think there is opportunity to improve it by some substantial way.

Q. Thank you. My second topic, planning for safe discharge from hospital, and moving forward in time from the 11 February, I think after that meeting you were sent a follow-up email about some actions that were allocated to you, namely to draft clinical guidance on a response

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between February and March to look at that the hospital discharge?

A. So I think, I haven't got the paper up on the screen but I think that the one thing I was specifically charged with was the management of the case, if you like, and that actually belonged to PHE so that should not have been tasked to me and I think you can see that back and in fact that's what PHE did.

The second one was, I wrote to Keith Willett, so the DCMO role does not do things usually, this was actually inappropriate tasking because usually some other operational part of the system will do, and then I will comment or challenge on behalf of ministers.

Q. I see.

A. So the first one was PHE did it, and I linked with them. The second one was that email, and I linked with Keith Willett, and you will see through many of the things we've discussed what I was trying to do, although I'm not operational, was trying to make sure the things, as the work was progressing, there was alignment. And ministers also were doing that, because you can see on that 6 March meeting which the Secretary of State called was trying to, I think, NHSE were in that meeting as well, I was trying to make sure all these moving parts were moving together.

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to Covid in care homes. And there was an email exchange that you've looked at already with Ms Carey, the Valentine's Day emails, Professor Willett, was one of the recipients of that.

But in your initial reply on 12 February, you said that there were two elements to the task that you'd been given. The first was about containment, the containment phase of handling of cases within social care; and secondly, managing large numbers of patients in the face of an epidemic, and you said that second part in particular would include decanting as clinically safely as possible large numbers of patients from the wards to the community and social care sector and then potentially onwards, so it's that decanting which envisages discharge from hospital.

You said in those emails that those two tasks should run in parallel, and you raised the issue of decanting patients in subsequent emails to Professor Willett at the NHSE, so despite this very early consideration by you of the importance of clinically safely decanting patients from hospital, you say that you didn't then have any significant input into the 19 March discharge requirements, so I kind of want to explore with you what you did do, having been tasked with it, and identifying those two workstreams in parallel, what did you do

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Q. So given your role in that February and March period, would you have been expected to have been consulted in any way about the impact on the adult social care sector by the discharge policy?

A. Not specifically -- normally -- well, actually, at that stage, this was pre triple lock, I would not necessarily see guidance. It depended on whether people who were -- normally, if you were developing policy in slower time, you would expect something to come up to CMO's office for a view, or sometimes an early meeting to set a direction, but in this case we were in the middle of a -- or we'd got a pandemic brewing, and so I would not normally -- some of the guidance, as we've seen, came across my desk. Many of the final copies, I was not in the final emails to, and that's how it worked, until we got to around 21 May when the triple lock came in.

Q. All right. Moving then to the admissions advice, so the 2 April and that guidance, I just want to clarify with you, if I may, some of the evidence you've given in response to Ms Carey's questions and in respect of isolation in particular. Are you saying that it's obvious that anyone discharged from hospital, whether positive, negative test or untested, should be isolated? Have I understood that correctly?

A. No, that's not what -- I think the comments that I sent

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back -- the minister raised some very sensible questions and was quite persistent in the email exchanges that were coming back and she would often copy me in to get my view, as well. So the questions she was particularly concerned about was a discharge of a Covid-positive patient, into a care home, and what -- whether this was a reasonable thing to do, and what -- whether it was safe to do it.

So my responses on those was to flag that we expected -- I expected a risk assessment to be done by the local care home -- receiving home, that there were adequate isolation facilities. Now, as long as there are, then it is a reasonable thing to do, and the debate about the seven and 14 days was, actually, to extend the normal period of isolation to make sure that the frailty of people in that environment was recognised.

Q. I understand that, but in your statement you say that onward isolation was of more importance in transmission control than a single negative test.

A. Yes.

Q. You explained the limitations of --

A. Yes.

Q. -- of negative tests. And you said the strongest mitigation was a robust isolation period regardless of whether the patient or resident had tested negative or

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evidence around asymptomatic infection starts and then, the important one, the asymptomatic transmission, and they are not the same thing. Somebody who is asymptotically infected but not transmitting infection is not going to be a risk to others.

Somebody, once you have discovered a high proportion of asymptomatic transmission, then the policy changes.

I have actually, it's quite interesting because I have looked at international comparators on this and one, for example, which I was quite surprised at, was Singapore because I was trying to see where were we in the asymptomatic transmission line, and actually they didn't change their policy until the month after the UK changed theirs on hospital transmission.

Q. So we're talking about 2 April guidance in my question.

A. Yes. I'm saying Singapore changed theirs in May.

Q. Understood. Okay.

My last topic is around data. You've given your reflections already about how data can be better utilised going forward, but I just want to ask you this as the then co-chair of the SAGE Social Care Working Group. In his statement, Alasdair Donaldson, who was working with the Vivaldi Study, tells the chair that he:

"... repeatedly witnessed how relevant members of PHE and SAGE who had overseen and failed to warn

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positive at the point of discharge.

A. Yes.

Q. So I'm asking whether we can infer from that that your advice was isolation was the key measure in respect of -- (overspeaking) --

A. So I think -- I know everybody has got very hung up on testing. I mean, importantly, there was not enough testing and that was not the main prevention. It comes back, then, to a more general issue which is what was the probability or likelihood of an individual having Covid when they left and what was the balance of risk? So I think one of the things we haven't discussed here is if, for example, you put in a policy that says every individual who leaves hospital is going to go into 14 days' isolation even if they are unbelievably well and ready to go, they need to come out of hospital because, actually, they're sitting in the path of a pandemic and they're likely to decondition.

The question then is, given all the comments we've just had about the visiting, do you want to put somebody in 14 days' isolation when they have no symptoms and are otherwise well, and we know it will be harmful in other ways to their health? And that is a -- we're back to this balance question of what is the right thing to do.

And that right thing to do starts to change when the

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against or properly mitigate the tragic initial errors consistently used inadequate methods and extremely faulty data which played down the seriousness of the problem in care homes."

What's your response to that?

A. So I had to -- I don't remember Mr Donaldson from this, and clearly the lead investigator was Professor Shallcross, for Vivaldi, who came and gave evidence, I think, in the last couple of days.

I think, from the statement, Mr Donaldson himself says he has no background, I think he is -- has a history background. There is no science, epidemiology, or data background. And I think that is important, because understanding the methodology behind these things, like confidence intervals around outcomes and the problems with data, are absolutely critical to understanding the validity of research.

And all of the data issues -- there are numerous data issues -- they are all outlined in -- particularly well -- they were alluded to in the -- in the early 20 consensus statement. They are very clearly outlined in the May 22 statement. They were all known. And that's why there were two studies looking in different directions and why we don't use one study alone.

What we're looking at is information which is either

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diverging -- evidence which either starts to diverge or connects together, and in this case we've got about seven different pieces of information studies which start moving in the right direction -- all in the -- sorry, not in the right direction, all in the same direction. And so all of the -- there are big problems with the data. They're all outlined and they're all taken into account.

MS MORRIS: Thank you.

Thank you, my Lady.

LADY HALLETT: Thank you, Ms Morris.

Mr Straw, I think.

Mr Straw is over there.

Questions from MR STRAW KC

MR STRAW: Good afternoon, Professor. I represent John's Campaign, The Patients Association and Care Rights UK.

At paragraphs 5.7 and 5.36 of your statement you draw attention to the fact that many of those who draw on care outside care homes receive it from family or community carers, and you note that this support is vital, and that you cannot safely isolate somebody who needs assistance with their activities of daily living.

In your view, did the government sufficiently understand the vital importance of this support, particularly early in the pandemic?

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Would you agree with that?

A. No, but I do -- I mean, I think what we saw throughout the pandemic, people understood that. You'll have seen from many of the statements that have been exhibited today, certainly I was making those comments and I know many are equally, if not more, able to do that in different parts of particularly Public Health England at the time.

The difficulty is what do you do and where do you draw the balance? Because we've also noted that individuals with dementia had a higher mortality rate. And that's almost inevitably linked to the fact that they may well not be able to understand or implement control measures as well, that their life might be more chaotic, if you like, in some ways, when you're trying to control for infectious disease. And so trying to -- the balance goes back to this point, whether it be visiting or whether it be infection control, that -- that then becomes an issue of where does the risk need -- and risk line need to be drawn?

So I don't think it's a lack of recognition; I think it's a lack of a not very easy answer.

Q. Later in your statement, at paragraph 5.69, you explain that you gave advice that risk assessments should occur to determine visits policy and perhaps to try to find

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A. Yes, I think so. In many areas of pandemic response not everything will be written down. This is slightly problematic. It doesn't mean it wasn't recognised. And it doesn't also mean there's an easy answer to it.

And I think that when guidance was created -- I've seen some of the comments back -- I think one from Age UK in one of the statements, for example, which says -- almost says: well, does government not realise you can't give care in a 15-minute patch, for example?

But I think this is an interpretation issue. So what you want to do is try to minimise risk whilst recognising that some risk is actually not able to be taken away completely. And clearly, if you have people who, on a daily basis, need support with their daily living, then you have to have prolonged close contact and you need to make that as safe as possible.

Q. There is a linked question, in that at paragraph 5.36 you discuss dementia wards, and note that, there, "personal contact is essential ... wellbeing and demise imminent without it".

A number of stakeholders consider that often during the pandemic, Covid infection control was prioritised and the need for this essential care for people with dementia and similar people was given insufficient weight.

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that not very easy answer, in specific settings. And you note that some residents' lives would be at risk for reasons other than Covid-19.

Firstly, are you aware that in the first wave in England, the majority of residents in care homes' deaths were caused by non-Covid causes?

A. I don't think I could -- I think we need to specify that much more carefully before I could agree with that, because, as we've heard on lots of the data issues, there were excess deaths in the first wave. Some of that is still not entirely clear. There are direct deaths, there are indirect deaths. So I think that's quite -- I wouldn't concede, if you like, to that particular statement. I think it's much more nuanced than that.

The point that I think you are drawing the fact to is, and I have acknowledged, is there is a risk of mortality and morbidity alongside a pure risk of infection and infectious disease. And again, the problem with care homes is that risk pertains to not just the individual that's being considered by their family or their visitors, but actually the transfer of that risk on to a whole care home of residents again.

So I'm very empathetic, as I think you can see, to the risks, and aware of them. Trying to draw that line

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1 is more of a societal or individual care home issue.

2 I think also what happened -- I mean, a couple of
3 things that need recognising. Number one, I don't think
4 there was ever any legal denial, if you like, of
5 visiting. I think this is quite important. So I know
6 in one of the studies I think something like 93% of care
7 homes had stopped their visiting by 23 March, if
8 I remember. That wasn't on an edict that came out from
9 government. And I know that many care homes were very
10 worried, which I understand as well, about things like
11 their insurance and trying to have some sort of
12 backstop, if you like, some sort of delineation between
13 where you should veer on one side of infection safety
14 and where you should veer on the other side.

15 So the -- if somebody was at the end of life or at
16 risk of life, which I think is where you're going, then
17 there was always a recognition in -- I think in each of
18 the guidance documents that went out. How it was
19 implemented, and the difficulties of that for individual
20 providers, is quite tricky.

21 **Q.** Going back to your recommendations for site-specific
22 risk assessments, there's evidence that they were often
23 not carried out. Are you aware of that? And can you
24 give any views on what more could have been done to
25 ensure that they were carried out?

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1 was. So things like how good was their infection
2 control usually, if you like, but they'd also have an
3 understanding of the epidemiology as well. And then the
4 care home itself would have a very good idea, one would
5 hope, with relatives, of the individual risks attached
6 to an individual resident.

7 But none of these are easy answers, which I think
8 what is clearly established.

9 **Q.** Slightly different topic. You explain later, at
10 paragraph 5.74, that in July 2020 you asked the Social
11 Care Working Group to examine whether balanced guidance
12 could be produced which specifically included wider
13 exploration of quality of life considerations.

14 Now, firstly, by "wider exploration", do you mean
15 the adverse impact of the restrictions themselves, for
16 example non-Covid deaths, non-Covid illness and so on?

17 **A.** No, more on an individual. So this was saying, as
18 you've just described, if you had any individual
19 resident, they would be at risk of infection, but they
20 would equally, to different degrees, depending on their
21 underlying health status, physical status, conditioning,
22 you know, be at risk from deterioration for others
23 reasons.

24 So, for example, an individual who will not eat
25 unless they have an assured member of their family with

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1 **A.** Is this risk assessment for visiting?

2 **Q.** Yes.

3 **A.** I mean, again, this is a whole -- you cannot have
4 a blanket statement from a national level -- or to my
5 mind -- I'll rephrase that, I'm now an individual, not
6 a representative of government -- you cannot have
7 a blanket statement that goes out that says: absolutely
8 this is what's going to happen in every single care home
9 across the country.

10 For all of the reasons which you've just said:
11 because you will have mixed populations of residents
12 with different risks and different needs.

13 And the only way to do that -- it's the same, in
14 some ways, as the infection control in hospitals,
15 because in the background you will have different
16 epidemiology with very high rates at some points in the
17 pandemic of infection in some areas, and almost nothing
18 in another, and those risk profiles are different.

19 So I would not know, in all of the thousands of care
20 homes, when I was sitting in the Department of Health,
21 how many, or not, care homes had done formal risk
22 assessments. I do know that what we tried to do was get
23 a system where -- which directors of public health could
24 almost help with, because they would have a sense from
25 local authorities how robust the care home provision

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1 them is at immediate significant risk if they are not
2 maintaining an adequate dietary intake.

3 What we were trying to do, though -- there was
4 a holistic wellbeing issue. What I had heard from the
5 ground up was -- was that care homes particularly were
6 concerned about insurance. I'm not saying they -- they
7 clearly were concerned about their residents, but that
8 was seen to be quite a negative angle on whether they
9 felt able to open up a little bit more to visiting.

10 So what we tried to do was say: okay, if we could
11 produce some -- what might look like quite scientific
12 evidence, but some really strong evidence that
13 highlighted where the balance of risk was, that then
14 care home managers would feel comfortable to use that to
15 open up their visiting proportionately.

16 The difficulty we found, and you'll see it when it
17 comes around to that November guidance, was -- we had
18 all sorts of people in the room who had worked on
19 quality of life in care homes with elderly residents --
20 was this issue of, for every kind of expression of it,
21 you need a value to be derived from the individuals
22 themselves. And that's incredibly difficult from
23 somebody with dementia anyway, and really difficult in
24 the middle of a pandemic.

25 Now, the work which I think Professor Hopkins

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1 referenced around the ASCOT study, so using an adult
2 social care outcome tool, starts to try and address some
3 of those issues, when we do not have a pandemic raging,
4 so that we can perhaps develop better balanced guidance
5 for the future.

6 **MR STRAW:** I think that's my ten minutes, thank you very
7 much.

8 **LADY HALLETT:** Thank you, Mr Straw.

9 Just the last few questions from Ms Beattie, who is
10 over there.

11 **Questions from MS BEATTIE**

12 **MS BEATTIE:** Thank you, Professor Harries. I ask questions
13 on behalf of Disabled People's Organisations.

14 On 5 March 2020 you attended a social care
15 coronavirus meeting with the Minister of State for Care,
16 Helen Whately, and senior department officials. And
17 just to be clear and to avoid any confusion, this is not
18 the 6 March meeting which Ms Carey took you to, but the
19 day before, 5 March. It's also not a memory test so
20 I'll proceed with the questions but if the document
21 could just be brought up to assist Professor Harries,
22 it's INQ000595303.

23 And this meeting considered local authority
24 planning. At that time the Minister for Care expressed
25 concern about the only two plans she had seen, a process
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1 right?

2 **A.** Yes, so --

3 **Q.** And --

4 **A.** So in the bullet above that it says:

5 "There are hugely detailed plans sitting at local
6 levels that may not surface."

7 So as in, there is some information there but if you
8 send a message out from the LRF you might not find it
9 all, but equally, I think what Minister Whately found
10 was, which is part of the problem, actually there
11 weren't plans sitting above that and I think this, this
12 comes back to, at the end of the day, the -- there is a
13 care home provision in an LRF area is still a private
14 business.

15 I mean, I was trying to think through how this
16 related. So for example, I know this is slightly
17 diverging but just an example, if you will indulge me,
18 there are risks, for example, around meat producers,
19 cold meat producers. We do not go to private businesses
20 generally and expect them to have plans. They have
21 plans for some safety issues. The issue here is, if you
22 have a private provision model where the responsibility
23 is sitting in normal times with that provider, it won't
24 always be available to an LRF and it won't almost be
25 known.

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1 was still being set up to assure local authority plans,
2 and the second-last bullet point on that page shows that
3 you had a call lined up locally to get some soft
4 intelligence on plans.

5 So what soft intelligence did you get on local
6 authority plans?

7 **A.** Rather predictably, from memory, and I think it also was
8 where the SRG, the strategic -- sorry, SCG coordinating
9 group information came back, which was this was
10 variable. There are -- there were plans because I think
11 in this one I did give some assurance that for
12 individual care homes there are sometimes very detailed
13 plans because if care homes have had a flu outbreak, for
14 example, they will be working with local systems and
15 have some very detailed knowledge, but at this sort of
16 level, trying to get plans for every care home right
17 across a system and pull it into an LRF, as the minister
18 found, it was -- well, many were absent, and the
19 quality, I think, was variable, as well.

20 So, in theory, there should be plans there. In
21 practice, it's not -- it's not as immediately available,
22 if you like, in -- for the pandemic as it was.

23 **Q.** Sorry, Professor Harries, I think your answer is
24 referring to detailed plans at an individual care home
25 level rather than a local authority level; is that
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1 **Q.** Well, Professor Harries, I think there was
2 responsibility sitting at local authority level not just
3 at individual care home level and obviously an
4 individual care home plan wouldn't be of any use for
5 covering domiciliary care, for example, would it?

6 **A.** Well, it depends on what the type of provider was. If
7 they were contracted to provide domiciliary care, then
8 it would be.

9 **Q.** Did you ever see a domiciliary care plan?

10 **A.** Well, I would not be operating at this -- I have seen
11 them historically when I've worked in local authorities,
12 but not in my recent role, no.

13 **Q.** So is the, sort of, upshot that you didn't get any
14 assurance about the existence and adequacy of plans
15 either at local authority level --

16 **A.** So this wasn't -- (overspeaking) -- this was for the
17 Minister to get assurance and for me, then, would have
18 been, had I been -- seen some plans, she may have asked
19 me how adequate those plans were in relation to public
20 health or risk prevention.

21 **Q.** But sorry, from the call that you had to get some soft
22 intelligence, is the upshot that the intelligence you
23 got was either no plans or not adequate?

24 **A.** So the call was -- I was having general calls with
25 directors of public health to understand what it felt
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1 like on the ground to see whether the plans were
2 available and whether they were coming forward, and so
3 the answer, as I started with, was, there's a variable
4 response. In some areas it would be quite good; in
5 others, there would be very little. Inconsistent.

6 **Q.** I think in your statement you said in any event the
7 majority focus of the 2018 pandemic plans was
8 theoretical, rather than practically exercised; is that
9 right?

10 **A.** I think that is a fair comment for which we've heard in
11 earlier modules, which is, you do need plans and they
12 need to be ready to respond, and you don't necessarily
13 need one that is this pathogen-specific because you
14 don't have the response.

15 But actually, having something which nobody has
16 exercised, so I would doubt that many care homes across
17 the country, even if they have their own plans, have
18 actually exercised them.

19 **Q.** So given that was your view of those 2018 plans and what
20 you learned of the plans from the soft intelligence
21 call, was it not misguided, in your view, to be relying
22 on them at all for the Covid response?

23 **A.** Well, I think the minister didn't. That was -- what
24 they -- particularly, I mean, the Under-Secretary of
25 State, but that's exactly what was coming out of this

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1 meeting the next day.

2 **Q.** Moving to visiting, you've been asked already some
3 questions about what was happening in July 2020 and that
4 you asked the working group to begin work, then, to see
5 if a balanced approach to guidance could be produced
6 which explored wider quality of life considerations.
7 How, at any times, did the homes' visiting guidance take
8 into account that reasonable adjustments were needed so
9 that disabled people, including people with learning
10 disabilities, people who have hearing impairments, are
11 deaf, those who use British Sign Language as their first
12 language, or have visual impairments, could have equal
13 access and contacts with their family and friends and
14 external carers?

15 **A.** So it's a probably a question that you should probably
16 have directed to Professor Hopkins this morning because
17 again, without trying to appear not responsible -- it
18 wasn't my area of responsibility -- I do know, obviously
19 from previous roles, that the guidance in terms of
20 trying to, you know, it was produced in different
21 scripts and what have you. There is an access issue to
22 information generally, and there is always, in guidance,
23 a clause that seems, to my mind, perhaps, to have been
24 misinterpreted, which is if it is essential for
25 visiting, there has never been a block to visiting.

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1 meeting. And the meeting on 6 March was actually
2 looking at these, that was felt to be not adequate for
3 where we needed to go and so that is why the Secretary
4 of State and Minister called the meeting on 6 March, to
5 actually move the thing forward and if the plans weren't
6 there, then actually we needed a different approach. So
7 that was why they then moved to the meeting the next
8 day.

9 **Q.** Right. And so I think we'd seen, in the Covid plan that
10 had been published already by then, that a reassurance
11 that LRFs had plans and that was what was being relied
12 on, but one, when we get to the action plan for adult
13 social care which was published on 15 April, we don't
14 see any reference to local authorities plans. So does
15 that reflect what you've just told us, that they were in
16 a sense abandoned for these --

17 **A.** Again, I need to be very clear what my role is. I would
18 advise on things if asked, so the adult social care plan
19 is probably one to ask of Minister Whately or members
20 from the Department of Health, but I think, as you have
21 identified, that actually, the Minister and the
22 Secretary of State called the meeting the next day
23 partly because actually they weren't comfortable and
24 they did not feel fully assured, and they wanted to make
25 sure that there was action. That's why they put in the

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1 There is a balanced risk about it, which has to be taken
2 into account, but government did not sit at the top and
3 say nobody can visit somebody who is disabled, or what
4 have you.

5 The issue is, about getting the balance of that
6 right.

7 And so I don't think any of the guidance, which
8 again, was not my personal responsibility, actually
9 absolutely forbids. There is no legal reason for people
10 not to -- (overspeaking) --

11 **Q.** You accept, Professor Harries, there is a difference
12 between absolutely forbidding and actually setting out
13 what steps might be needed, and also that I think in
14 your previous evidence you were explaining that a lot of
15 these decisions about visiting come back, I think you
16 said, to individual values, risk appetite being
17 ultimately a personal decision, and that it's difficult
18 to try to elicit a value for those things. But would
19 you accept that some of these are very objective, very
20 real barriers which don't need any eliciting of personal
21 values -- (overspeaking) --

22 **A.** Well, I think two things, which I -- I feel as though
23 we're perhaps going over the same ground, so my
24 apologies, but I'll perhaps say two things.

25 So, number one, the work I tried to do in the care

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working group was completely novel and was proactive on my part to try to get some sort of framework around this for guidance going forward, that actually worked for guidance, but actually worked for those supporting individuals, whether it be in domiciliary or whether it be in care homes.

So that's the first one, because that has not been produced before, and it was extremely difficult. We broadly had to stop trying to do it at that time, and then it's now being taken forward as long-term issue -- a long-term programme.

And then the point I made earlier which is around individual local assessment. It is -- you could not possibly write at national level a whole list of things which would work for every single person across the country. It just doesn't work. And hence my point of reinforcing that the guidance that is there does say, I'm pretty confident, that if it is a detrimental issue, if you like, of significance, then visiting should be allowed.

I cannot control, and neither could anybody at national level, precisely what was happening in each care home or each service across the country.

I think probably where we would very clearly align is to try to improve that going forward, and my approach

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to that was to try to establish some sort of evidence framework which allowed people locally to be confident in the decisions, balanced decisions about opening up and risk to visiting.

MS BEATTIE: Thank you, my Lady.

LADY HALLETT: Thank you very much, Ms Beattie.

I'm fairly confident, Professor, that that completes the demands that we will be making on you personally.

I think we're probably making demands on the departments for which you work again, but I think that's the end for you. Thank you very much indeed for all your help to the Inquiry. I appreciate we've called on you -- how many times now?

THE WITNESS: Quite a lot. I think every module but one.

LADY HALLETT: Anyway, I wish you a long and happy retirement.

THE WITNESS: Thank you.

LADY HALLETT: Very well, I shall return for 10.00 tomorrow.

(4.31 pm)

(The hearing adjourned until 10.00 am the following day)

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