

Tuesday, 13 June 2023

(10.00 am)

Opening remarks by THE CHAIR

LADY HALLETT: Good morning, and welcome to the first day of the main hearings of the Covid-19 UK Public Inquiry.

I shall start by hearing opening submissions from Counsel to the Inquiry and from the core participants, and then evidence in Module 1 covering resilience and preparedness for the pandemic.

As people arrived at the hearing centre today, they found a dignified vigil of bereaved family members holding photographs of their loved ones. Their grief was obvious to all. It is on their behalf and on behalf of the millions who suffered and continue to suffer in different ways as a result of the pandemic that I intend to answer the following three questions:

Was the UK properly prepared for a pandemic?

Was the response to it appropriate?

Can we learn lessons for the future?

To conduct the kind of thorough investigation the people of the United Kingdom deserve takes time and a great deal of preparation. An extraordinary amount of work has been done to get us to this point. I wish to commend all those involved: the Inquiry team, both secretariat and legal, the core participants, the

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results of the work we are doing that I am listening to them. Their loss will be recognised. They will be able to contribute to the Inquiry by describing their experiences at community events or sharing their story online or on the phone. Some will contribute by giving evidence at the hearings, and representatives of each of the four bereaved family groups will be called in this module. Some will contribute by helping us design further panels of the tapestry, four panels of which are here today.

We're not the first to decide that the pandemic should be commemorated and I'm happy to acknowledge the excellent work done by others, for example the Covid Chronicles. So many people died and so many people suffered, it is only right that we find various ways to commemorate them and their experience.

The other way in which the bereaved and those who suffered can contribute to the Inquiry is by agreeing to talk about their experience on our impact films.

In a moment, we're going to watch the first of them, in which people from across the four nations of the United Kingdom talk about the devastating impact the pandemic has had on them and on their loved ones. Bereavement is a major theme of this first film, but future films will cover a wider range of experiences.

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witnesses and the material providers. It has been and it will remain a huge task, and I am acutely conscious of the burden I have placed on everyone by the ambitious timetable I have set. But if I am to achieve my aim of making timely recommendations that may save lives and reduce suffering in the future, I had no choice.

My plan, as people now know, is to publish reports as we go along, so that when the hearings for this module finish, work will begin on preparing the report for this module. When that report is ready, it will be published.

In the meantime, the other module teams and I will be working on the next modules.

I have promised many times that those who suffered hardship and loss are and will always be at the heart of the Inquiry, and I have done my very best within the constraints upon me of time, resources and my terms of reference, to fulfil that promise.

I know that there are those who feel that the Inquiry has not sufficiently recognised their loss or listened to them in the way that they feel appropriate. But I hope that they will better understand, as the Inquiry progresses, the very difficult balance I have had to strike.

I hope they will understand when they see the

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The film is extraordinarily moving. It involves people talking in very explicit terms about their suffering and their loss, in a way that will bring back very difficult memories for many people.

I want to thank everyone who agreed to be filmed as part of this, including those not featured in this first film. I can only imagine how difficult it must have been for them to relive those experiences in front of a camera. But please believe it was worthwhile. You have recorded your experience for posterity, and alerted me to issues that I need to explore.

If you do not want to view the film right now, there will be an opportunity to leave the room. The ushers will show you to the refreshments area. The three screens there will not be showing the film, and someone will call you back in once it has finished.

If you're watching the live stream, you may wish to turn off YouTube. The duration is approximately 17 minutes.

Emotional support is available to anyone here at the hearing centre. For those watching online, there is a list of numbers to call on the Inquiry website.

Once the film begins to play, a warning will be displayed for 30 seconds before the first images appear. Once the video has been played, we will reassemble and

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1 I will ask Mr Hugo Keith King's Counsel, Counsel to the
2 Inquiry, to make his opening statement.

3 So would those who would like to leave the hearing
4 room now do so.

5 (Pause)

6 **LADY HALLETT:** Could we play the film, please.

7 (Video played)

8 **LADY HALLETT:** I hope that those who had to leave the room
9 will be able to recover. As soon as we're able to
10 reassemble, we shall do so. Could we send them
11 a message to them, please, ask them if they wish to come
12 back in.

13 (Pause)

14 **LADY HALLETT:** I'm sorry to all of those who found that film
15 particularly distressing. I think it was distressing
16 for everybody, but I'm sure especially so for you. So
17 I'm sorry about that.

18 Mr Keith.

19 **Statement by LEAD COUNSEL TO THE INQUIRY**

20 **MR KEITH:** My Lady, we will likely never know how the Severe
21 Acute Respiratory Syndrome Coronavirus 2, more commonly
22 known as SARS-CoV-2, the virus that caused the Covid-19
23 pandemic, was first transmitted to the human race.
24 Perhaps it came from farmed wild animals that were sold
25 in Wuhan, the capital city of Hubei Province, China,

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1 possibly enquire into all aspects of a pandemic that
2 wrought such damage, and your Inquiry does not seek to
3 do so. You have instead determined that it will focus
4 on those areas of the pandemic and the United Kingdom's
5 response to it that have caused the greatest public
6 concern, and where there may be a need in the public
7 interest to make urgent recommendations so that we may
8 be better prepared in the event of the next national
9 civil emergency to befall us.

10 That module starts today, Module 1. It commences
11 that process. It investigates what the state of the
12 whole country's emergency preparedness response and
13 resilience structure and systems were when the pandemic
14 struck in January 2020.

15 My Lady, I therefore need to set out the briefest of
16 chronologies, because it's important to appreciate and
17 understand, before we hear the evidence concerning the
18 decade before the pandemic, what the reality was in
19 January 2020.

20 So, in late December 2019, a cluster of cases of
21 pneumonia of an unknown origin was detected in
22 Wuhan City, Hubei Province, China. A new strain of
23 coronavirus was subsequently isolated on 7 January 2020.
24 It was identified as SARS-CoV-2.

25 On 10 January, in the United Kingdom, the

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1 infecting market customers and workers. Some have
2 suggested it came from a leak of coronavirus specimens
3 being transplanted to or stored at the Wuhan Institute
4 of Virology.

5 We will also likely never know when the first human
6 infection with SARS-CoV-2 occurred. Minute
7 retrospective examination by scientists of how the
8 genetic sequencing of the virus altered over time
9 suggests that the dates of its emergence could have been
10 any time between mid-October 2019 and mid-December 2019.
11 Certainly the first reported case, reported after the
12 event, was 12 December of 2019.

13 But, my Lady, for this Inquiry's purposes, this
14 knowledge does not matter. What we do know is that the
15 United Kingdom, as with the rest of the world, was
16 struck by a major pandemic.

17 As with all pandemics, the Covid-19 pandemic left in
18 its wake death, misery and incalculable loss, as the
19 impact film that we have just seen, in which we heard
20 from just a tiny proportion of those whose loved ones
21 had died, demonstrates so poignantly. The pandemic did
22 not just alter fundamentally how modern societies across
23 the globe functioned but ended in changed lives on
24 a scale unseen in modern history.

25 No inquiry, however large or however long, could

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1 Department of Health and Social Care, the DHSC,
2 published guidance for health professionals on the
3 assessment and management of suspected United Kingdom
4 cases. On 21 January, the World Health Organisation
5 published its Novel Coronavirus (2019-nCoV) Situation
6 Report - 1. This is the date, in fact, at which the
7 period covered by Module 1 ends.

8 The Situation Report - 1 recorded that, as of
9 20 January, 282 confirmed cases of 2019-nCoV had been
10 reported from four countries, including China, Thailand,
11 Japan, and the Republic of Korea.

12 On 30 January 2020, the second meeting of the
13 International Health Regulations Emergency Committee of
14 the World Health Organisation declared a public health
15 emergency of international concern, but it's notable
16 that they recommended no travel or trade restrictions.
17 The virus and the disease, Covid-19, spread rapidly.
18 The United Kingdom Scientific Advisory Group for
19 Emergencies (SAGE) convened for the first time on
20 22 January and the Civil Contingencies Committee, COBR,
21 met on 24 January 2020. The Foreign and Commonwealth
22 Office issued its first travel advice on 23 January.

23 The first two cases of Covid-19 in England were
24 confirmed on 30 January, and on the same day NHS England
25 declared a serious, level 4 incident.

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1 By the end of January, it was becoming apparent --
2 and, my Lady, the degree to which it was apparent is
3 of course a matter for Module 2 -- that the disease was
4 a respiratory disease which was asymptomatic, meaning
5 that a person infected by the virus may not show any
6 symptoms of it, and for which there was no ready test,
7 no antiviral medicine, no immunity and no vaccine.

8 On 15 February France recorded the first official
9 dealt in Europe from Covid-19. By late February the
10 number of cases outside China had increased 13-fold and
11 the number of affected countries had tripled.
12 A worldwide public health emergency was under way,
13 although a pandemic was not in fact declared by the
14 World Health Organisation until 11 March.

15 The first positive cases in Wales and
16 Northern Ireland were reported on 28 February, and in
17 Scotland on 1 March, although that case related to
18 an outbreak that had occurred a few days earlier --
19 a conference that had occurred a few days earlier, on
20 26 and 27 February. The first death in the
21 United Kingdom, a woman in her 70s, was confirmed on
22 2 March.

23 On 3 March, the DHSC, the Scottish Government, the
24 Welsh Government and the Department of Health in
25 Northern Ireland, published a Coronavirus (COVID-19)

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1 including the establishment of a £5 billion emergency
2 fund to support the NHS and other public services in
3 England and additional NHS funding, measures for
4 additional access to statutory sick pay, contributory
5 employment support allowance, a hardship fund for local
6 councils, and business interruption loans.

7 On 12 March, the then Prime Minister,
8 Boris Johnson MP, announced that the United Kingdom had
9 moved into the delay phase of the coronavirus action
10 plan.

11 My Lady, you will recall that he informed the
12 country that many more families were going to lose loved
13 ones before their time, and he announced that, as part
14 of the attempt to delay the spread of Covid-19, anyone
15 with symptoms, however mild, should stay at home for at
16 least seven days.

17 It is absolutely clear now, with hindsight, that the
18 disease was spiralling out of control. But to what
19 extent was that possibility foreseen, planned for, and
20 guarded against? How ready were the public health
21 structures to deal with this possibility?

22 The reality was that the United Kingdom government
23 announced it would stop all community testing for
24 Covid-19 and focus instead on testing people in
25 hospitals and protecting health workers as it moved from

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1 action plan setting out how they planned to tackle the
2 coronavirus outbreak.

3 Based on the experience of dealing with other
4 infectious diseases and the influenza pandemic
5 preparedness work that had been carried out, the plan
6 stated that the United Kingdom was well prepared to
7 respond in a way that offered substantial protection to
8 the public.

9 Whether that was actually the case will be examined
10 in Module 1.

11 Of course, that is why Module 1, in terms of
12 preparedness, in terms of the response that was
13 expected, that is the focus of your examination.

14 Even at this stage, before hearing the evidence, it
15 is apparent that we might not have been very well
16 prepared at all.

17 On 4 March the DHSC in England announced a campaign
18 focusing on the importance of washing hands, and washing
19 hands for 20 seconds, using soap and water or hand
20 sanitiser. On 6 March the United Kingdom Government
21 announced significant additional funding for rapid
22 diagnostic tests and for the international fund into
23 vaccine research.

24 On 11 March the then Chancellor of the Exchequer,
25 Rishi Sunak MP, announced a package of support,

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1 the contain phase to the delay phase.

2 So it's clear that the system had not adequately
3 foreseen and prepared for the need for mass testing in
4 the event of a non-influenza pandemic.

5 For a flu pandemic, of course, you're most likely to
6 show symptoms. You know you have a bug. You go home,
7 possibly to bed, and you try not to pass it on, and
8 tests aren't needed.

9 On 13 March, the then Welsh Minister for Health and
10 Social Services, Vaughan Gething MS, announced the
11 suspension of a number of NHS services to allow for
12 services and beds to be reallocated and for staff to be
13 redeployed and retrained in priority areas.

14 On 16 March the number of deaths in the
15 United Kingdom rose to 55, with 1,543 confirmed cases.
16 But the likely number of infected cases was probably
17 over 10,000. There was no antiviral medicine and no
18 national pandemic flu service to prescribe it, for the
19 simple reason that Covid-19 was not an influenza virus.

20 The United Kingdom Government commenced daily press
21 conferences. The Prime Minister announced anyone with
22 a high temperature or a new and continuous cough should
23 stay at home for 14 days, and not go out, even to buy
24 food or essentials. The country was told to stop
25 non-essential contact with others and to stop all

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1 unnecessary travel, to start working from home where
2 they possibly could, and to avoid pubs, clubs, theatres,
3 and other such social venues.

4 The same day, the Department for Business, Energy
5 and Industrial Strategy issued a statement calling for
6 businesses to support it by supplying ventilators and
7 ventilator components across the United Kingdom.

8 My Lady, you have directed that we ask to what
9 extent had the system envisaged and prepared for the
10 need for mass provision of personal protective
11 equipment.

12 On 17 March the Chancellor announced £330 billion'
13 worth of government-backed loans and £20 billion in tax
14 cuts and grants. The Foreign and Commonwealth Office
15 advised against all non-essential international travel.
16 France imposed a nationwide lockdown. The then
17 First Minister of Scotland, Nicola Sturgeon MSP, made
18 a statement to the Scottish Parliament setting out the
19 stringent steps that required to be taken. The
20 NHS England Chief Executive, then Sir Simon Stevens, and
21 the NHS England Chief Operating Officer directed the NHS
22 in England to take measures to redirect staff and
23 resources to free up in-patient and critical care
24 capacity. These included the postponement of all
25 non-urgent elective operations, the urgent discharge of

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1 On Friday, 20 March, the Chancellor announced the
2 Coronavirus Job Retention Scheme and payments of grants
3 backdated to 1 March of up to 80% of furloughed workers'
4 salaries.

5 My Lady, cafés, pubs and restaurants were requested
6 to be closed from that night, and nightclubs, gyms, and
7 leisure centres as soon as they reasonably could. In
8 separate televised addresses the then First Minister of
9 Scotland and the First Minister of Wales,
10 Mark Drakeford MS, made similar appeals.

11 At 5 pm on that Sunday, Public Health England
12 figures showed that there were 5,683 cases of Covid in
13 the United Kingdom, and 281 deaths. At that time, the
14 data referred only to deaths in hospitals, and didn't
15 even include deaths in the community, in care homes or
16 in hospices. There had been a rise of 48 deaths since
17 the previous day: 37 in England, seven in Wales, three
18 in Scotland and one in Northern Ireland.

19 The weekly provisional figures for deaths registered
20 in England and Wales with Covid-19 as an underlying or
21 contributory cause calculated by the Office for National
22 Statistics was 103 for the week ending 20 March and 539
23 for the week ending 27 March.

24 On Monday, 23 March, we will recall that the
25 Prime Minister announced severe restrictions on the

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1 all hospital in-patients who were medically fit to
2 leave, and the block buying of capacity in independent
3 hospitals.

4 Was this need for surge capacity something that had
5 been adequately prepared for?

6 On Wednesday, 18 March, the then Secretary of State
7 for Education, Sir Gavin Williamson MP, announced the
8 closure for the end of that week of schools other than
9 for children of critical workers and vulnerable
10 children. Exams and assessments were later cancelled.

11 The Scottish First Minister, the Welsh Minister for
12 Education, Kirsty Williams MS, and the First and deputy
13 First Ministers for Northern Ireland, Baroness
14 Arlene Foster MLA and Michelle O'Neill MLA, made similar
15 announcements.

16 But how developed were those plans for school
17 closures?

18 On 19 March, the Department of Health and Social
19 Care and the Ministry of Housing, Communities and Local
20 Government provided further details of how a £5 billion
21 support package would be given to local authorities.
22 The Defence Secretary, Ben Wallace MP, announced that up
23 to 20,000 MoD and service personnel would be placed on
24 standby to support public services, including by way of
25 driving oxygen tankers around the United Kingdom.

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1 entirety of the United Kingdom in what became known as
2 the first national lockdown.

3 On 24 March, the Senedd, the Welsh Parliament,
4 agreed to a legislative consent motion on the
5 Coronavirus Bill.

6 On 25 March, the Coronavirus Act was passed by the
7 United Kingdom Parliament and received royal assent. It
8 had passed through all the stages in the
9 House of Commons procedure in a single day.

10 Then on 26 March, the lockdown regulations were
11 introduced. The Health Protection (Coronavirus,
12 Restrictions) (England) Regulations were introduced by
13 way of a statutory instrument made by the
14 Secretary of State, Matt Hancock, Member of Parliament,
15 using emergency powers available to him under the Public
16 Health (Control of Disease) Act 1984, and the
17 regulations came into effect the moment that they were
18 made, at 1 pm on the same day.

19 Analogous coronavirus restrictions regulations were
20 made in Scotland and Wales by the Scottish Ministers and
21 the Welsh Ministers.

22 On 28 March Health Protection (Coronavirus,
23 Restrictions) Regulations were also made by the
24 Department of Health in Northern Ireland.

25 I mention, my Lady, the various regulatory

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1 structures because one of the workstreams that had been
 2 progressed in the years leading up to the pandemic was
 3 one of working on a pandemic Bill, a draft pandemic
 4 Bill, to cover for the eventuality of a pandemic
 5 striking the United Kingdom. But in reality, the
 6 lockdown regulations that were made in England were made
 7 under a 1984 Act, the Public Health (Control of Disease)
 8 Act, Scotland under the Coronavirus Act, and in
 9 Northern Ireland under a 1967 piece of legislation.

10 That day, 26 March, the daily death toll went up by
 11 115. The pandemic had the country in its grip.

12 Almost every area of public life across all
 13 four nations, including education, work, travel, the
 14 majority of public services and family life were
 15 adversely affected. The hospitality, retail, travel and
 16 tourism, arts and culture and the sport and leisure
 17 sectors effectively ceased, even places of worship
 18 closed.

19 My Lady, as you know, for very many, what they had
 20 to deal with went far beyond the curtailment of their
 21 normal lives and involved bereavement, serious illness,
 22 deprivation, mental illness, exposure to violence at
 23 home, terrible financial loss, loneliness, and many
 24 other forms of suffering.

25 Health and social care workers, the police and the

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1 normal conditions, had the pandemic not occurred, so
 2 capturing not only confirmed deaths but also Covid-19
 3 deaths that were not correctly diagnosed or reported, as
 4 well as other causes that are attributable to the
 5 pandemic, the figures are likely to be higher still.

6 Research reveals that mortality rates were
 7 significantly higher among people with pre-existing
 8 conditions such as dementia and Alzheimer's disease,
 9 heart disease, high blood pressure and diabetes.

10 Shockingly, mortality was 2.6 times higher in the
 11 most deprived than the least deprived tenth of areas.
 12 People from some ethnic minority groups had
 13 a significantly higher risk of being infected by
 14 Covid-19 and also of dying from it.

15 Covid-19 mortality during the pandemic was highest
 16 in people from the Bangladeshi, Pakistani and Black
 17 Caribbean communities, and mortality rates were higher
 18 among people with a self-reported disability or
 19 a learning disability.

20 So the big question for Module 1 is to what extent
 21 were those terrible outcomes either foreseen or capable
 22 of mitigation?

23 My Lady, the pandemic has had profound financial and
 24 economic consequences. It's put National Health systems
 25 under enormous and continuing pressure. The impact on

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1 emergency services, transport workers, teachers, and
 2 other key workers continued, however, in their places of
 3 work and they put their own lives on the line in terms
 4 of their safety.

5 The months and years that followed, we all recall,
 6 saw death and illness on an unprecedented scale, but
 7 I don't need to set out, even in outline, the events
 8 that followed. The lifting of the first lockdown, the
 9 further lockdowns, the local restrictions, the gradual
 10 differences of approach between the United Kingdom and
 11 the devolved administrations, and finally the route out
 12 of the pandemic afforded by the gift of vaccines.

13 That is because, for the purposes of this module,
 14 the state of preparedness must be measured against the
 15 reality of when the pandemic first struck, January 2020.

16 It's my solemn duty to record that government
 17 figures state that up to 12 May 2023 in England there
 18 have been 192,231 deaths where Covid-19 was recorded on
 19 the death certificate. In Scotland, the figure is
 20 17,603. In Wales, it is 11,848. And in
 21 Northern Ireland, 5,295, making a total across the
 22 United Kingdom of 226,977 lives.

23 My Lady, by the measure of excess deaths or excess
 24 mortality, that is to say the number of deaths from all
 25 causes over and above what would be expected under

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1 the healthcare systems, its operations, its waiting
 2 lists and on elective care has been immense. Millions
 3 of patients have either not sought or received treatment
 4 and the backlog has now reached historic levels.

5 Jobs and businesses have been destroyed, and
 6 livelihoods were taken away. The pandemic disrupted the
 7 education of children and young people, put children at
 8 risk, and has left us with an enduring concern that the
 9 pandemic furthered disparities in attainment and
 10 development.

11 The pandemic impacted the most disadvantaged
 12 communities in society all the more, both in terms of
 13 the consequences of getting the virus and in terms of
 14 the steps taken to combat the virus. Societal damage in
 15 terms of the exacerbation of inequalities and the denial
 16 of access to opportunity has been widespread. Its
 17 impact will be felt for decades to come.

18 My Lady, the emergence of this natural disaster
 19 could not have been avoided. But the key issue is
 20 whether that impact that I have described was
 21 inevitable. Were those terrible consequences inexorable
 22 or were they avoidable or capable of mitigation?

23 The starting point for your Inquiry is that whilst
 24 we may not know the moment that this virus came into
 25 existence, or how exactly it made its way into the human

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1 race, we do know that the possibility of a pandemic had
2 been foretold and thought about. Indeed, it had long
3 been assessed by planners that there was a significant
4 risk of a non-influenza pandemic and an even greater
5 risk of a flu pandemic.

6 Such risks were assessed and thought about, and
7 planned for, and prepared for, and written about by the
8 departments, bodies, agencies, services, responders and
9 personnel who make up the United Kingdom's emergency
10 preparedness, resilience and response structures, the
11 EPRR structure, the first major acronym to which it's my
12 unhappy duty to refer in an area infested by acronyms.

13 But fundamentally, in relation to significant
14 aspects of the Covid-19 pandemic, we were taken by
15 surprise. Huge, urgent and complex policy decisions
16 were required to be taken in relation to shielding,
17 employment support, managing disruption to schools,
18 borders, lockdowns, and non-pharmaceutical
19 interventions, restrictions, social restrictions, and,
20 equally importantly, the profoundly unequal impact of
21 the pandemic on the vulnerable and the marginalised.

22 Few of those areas were anticipated, let alone
23 considered in detail.

24 My Lady, no amount of foresight or planning can
25 guarantee that a country will not make mistakes when

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1 bureaucracy or prescriptive overmanagement or jargon.

2 Most of the evidence over the next six weeks will be
3 concerned with those issues.

4 My Lady, standing back, there can, however, be no
5 proper scrutiny of the pandemic planning -- with which
6 of course you are primarily concerned -- without
7 a simultaneous detailed examination of the actual civil
8 emergency structures upon which pandemic planning rests,
9 because pandemic planning is, of course, just a feature
10 of the wider civil emergency structure.

11 So, my Lady, the Inquiry will be looking at whether,
12 as a nation, we were sufficiently resilient. Resilience
13 is related to capacity and concerns the ability of
14 a country to resist, absorb and recover from shock.

15 The ability to recover is closely connected to the
16 general health and wealth of the country as a whole. It
17 is for this reason that part of the module, as well as
18 later modules in your Inquiry which will focus
19 specifically on inequalities, will explore what state
20 the nation was in as we entered the pandemic. Did the
21 high levels of heart disease, diabetes, respiratory
22 illness and obesity renders us more vulnerable? Had
23 there been a slowdown in health improvement in the
24 decade before? Had health inequalities widened? Did
25 emergency planning sufficiently account for pre-existing

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1 a disease strikes, but that does not mean that we should
2 not strive to be as ready as we sensibly can be. No
3 country can be perfectly prepared, but it can certainly
4 be underprepared, and so it is to the adequacy and
5 sufficiency of those structures, the plans, the steps
6 taken to prepare, and the degree to which the country
7 was resilient, that is to say able to respond and bounce
8 back, that this first phase of the Covid-19 Inquiry
9 turns its attention.

10 Module 1 will ask: were the right EPRR structures in
11 place, the right procedures, the right plans? Was the
12 system of central devolved regional and local government
13 response available and ready to go? Did civil
14 contingency planners think carefully enough about the
15 risks of a pandemic and how they could best prepare for
16 the crises which might develop from those risks?

17 Module 1 will look at whether the EPRR system was
18 effective and practical, that the bodies and structures
19 that populate it were fit for purpose and not
20 duplicative or obsolete.

21 We will ask whether the system was designed to work
22 well under pressure, whether it gave responders,
23 nationally and locally, the proper tools to respond
24 with. We want to know whether the policy documents and
25 planning guidance were useful, and not tarnished with

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1 health and societal inequalities, deprivation,
2 structural racism, and other forms of discrimination
3 which undoubtedly exist in society?

4 As for wealth, it is self-evident that the capacity
5 of any country's public health care and social care
6 systems to be able to cope with a pandemic is
7 constrained by funding, and therefore you need to
8 enquire how well funded were the United Kingdom's health
9 structures. To what degree have our public services,
10 especially those of health and social care, suffered
11 from underinvestment? How well resourced were the
12 United Kingdom's public health structures?

13 My Lady, these questions must be asked. This is not
14 because it lies in the power of your Inquiry to resolve
15 them. The Inquiry plainly cannot of itself bring about
16 general improvements in health, social care or public
17 services, let alone direct that they be made.

18 The questions must be asked because I have no doubt
19 that if you conclude that, as a country, we were
20 insufficiently resilient and that, in future, different
21 political and financial choices may have to be made in
22 order to render us better able to withstand a system
23 shock, you will want to say so.

24 But the need for all these questions is obvious.
25 First, the bereaved and those who otherwise suffered, of

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1 whom there are very many in number, are entitled to know
2 if anything could have been done to prevent their loss
3 or reduce their suffering.

4 Second, if we were shocked by the outbreak of
5 Covid-19, history suggests we should not have been.
6 Epidemics, that is to say the occurrence of a disease in
7 a population at a level that is significantly above the
8 baseline level, occur frequently. They can come on
9 extraordinarily rapidly and spread very quickly. They
10 kill large numbers of people.

11 Pandemics, whilst rarer, are not new. Ever since
12 humans have walked on this earth, pandemic disease --
13 the Black Death, plague, cholera, typhoid, yellow fever,
14 influenza and Ebola -- has walked with us, and
15 scientists are clear that there is an ever-increasing
16 risk of pandemics in the future.

17 Diseases from animals, zoonotic diseases, pose
18 a perpetual threat. A large proportion of those viruses
19 which infect mammals are capable of infecting humans,
20 and many of them have been associated with human deaths.
21 At the same time, diseases are becoming more prevalent
22 and are being spread wider and faster on account of
23 globalisation and urbanisation.

24 So it's vital that international surveillance and
25 alert systems work effectively.

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1 life is the one that is both highly infectious or
2 transmissible and, once transmitted, severe or deadly.

3 At the moment there are two notable subtypes of
4 avian influenza or bird flu that are prevalent. Both
5 have extremely high case fatality rates. Fortuitously
6 they haven't yet sustained human to human transmission.
7 Let us hope they never do. But the possibility cannot
8 be ruled out, which of course adds an even greater
9 impetus for the need to ensure that our systems of
10 preparedness are ready.

11 My Lady, the module is ambitious in terms of its
12 scope. The documentary material which it encompasses is
13 vast. But there is a limit, and I need to make plain
14 what those limits are.

15 First, Module 1 is not an inquiry into all aspects
16 of the United Kingdom's emergency planning systems.
17 It's only an inquiry into those parts of the general
18 structures as is necessary to enable you to answer the
19 questions: were the structures and systems ready for the
20 pandemic that struck and how can we make them better
21 ready for next time?

22 Secondly, Module 1 has a timeframe, and I've already
23 referred to the second date, the end date,
24 21 January 2020, when the Situation Report - 1 was
25 issued by the World Health Organisation. It is beyond

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1 Furthermore, terrible though it is to acknowledge,
2 the rate in the United Kingdom at which Covid-19
3 generally killed those persons who were confirmed to
4 have been infected with it, the case fatality rate, was
5 relatively low, around 1%. The 1918 H1N1 flu pandemic
6 was worse. Its case fatality rate was around 2.5% to 6%
7 and it caused a massive number of deaths worldwide. The
8 estimates of death ranged in that pandemic from
9 17.5 million to 100 million.

10 The case fatality rates of other diseases, such as
11 variant Creutzfeldt-Jakob disease, Ebola and smallpox
12 were also much higher than SARS-CoV-2. Significantly,
13 the case fatality rate of MERS, the Middle East
14 Respiratory Syndrome coronavirus, the disease from
15 camels that erupted in 2012 in the Kingdom of
16 Saudi Arabia, was about 34.3%. SARS -- severe acute
17 respiratory syndrome -- CoV-1, the earlier coronavirus
18 pandemic in 2002, was around 9.6%.

19 The relatively mild swine flu in 2009-10, about
20 which we'll hear a considerable amount of evidence in
21 due course, was less than 0.01%.

22 What is critical, therefore, is transmissibility.
23 The more infectious the disease, the more people are
24 infected and the greater number of people that will die.
25 So the disease which poses the greatest risk to human

26

1 the ability of your Inquiry to go back before June 2009,
2 which was when the World Health Organisation announced
3 that scientific criteria for an influenza pandemic had
4 been met for what became known as the 2009 swine flu
5 pandemic.

6 A third important point is that the Inquiry needs to
7 be aware of the difference between structure, central
8 government departments, regional government, devolved
9 administrations and the like; policy, which is
10 government departments and bodies setting out rules as
11 to how they'll go about deciding what to do; the
12 planning, what is everyone meant to do; and finally,
13 operational response, how services and help are actually
14 provided.

15 They are all important, but operational response is
16 not a matter for Module 1. Equally, issues such as the
17 core political and administrative decision-making, the
18 merits and the timings of national lockdowns, vaccines,
19 the specifics of healthcare, the response of the
20 care sector, the detail of Test and Trace, PPE
21 procurement, financial assistance, the government's
22 response, and the impact of the pandemic on various
23 sectors of the country, particularly including the
24 vulnerable, are for later modules. The more detailed
25 explanation of the way in which the country responded

28

1 has to await those later modules.
 2 May I now then turn to the system for preparedness.
 3 It is obvious, my Lady, that the degree to which
 4 Covid-19 could be prevented from laying waste to society
 5 was a matter within the control of government and the
 6 systems for EPRR which existed. Those systems may not
 7 be able to stop a pandemic in its tracks, but they ought
 8 to be able to put in place measures of understanding
 9 a virus, understanding and forecasting how it might
 10 develop, tracking it, limiting transmission and coping
 11 with the consequences of large scale transmission.

12 In order to see what worked well and what faltered
 13 or failed, I'm afraid it's necessary to have a basic
 14 level of understanding of how the systems were set up.
 15 Many following this opening statement may have some
 16 appreciation of the terms and of the bodies of the
 17 structures, but for those who do not, it's necessary to
 18 set out some short definitions and explanations which
 19 will assist in their understanding of the evidence which
 20 you will shortly hear.

21 My Lady, it is a particularly complicated system.
 22 To help us guide listeners through it, could we have,
 23 please, on the screen, a document prepared by
 24 the Inquiry, INQ000204014.

25 My Lady, this is a document which the Inquiry team
 29

1 Cabinet Office needs to draw on the expertise of other
 2 government departments in its emergency planning, and so
 3 there is something called the lead government
 4 department.

5 In relation to a pandemic, it's obvious that the
 6 lead government department would be the
 7 Department of Health and Social Security, and we can see
 8 in the middle of the screen -- and I emphasise just for
 9 convenience sake we are focusing on the United Kingdom
 10 and England in this schematic design rather than looking
 11 at Scotland, Wales and Northern Ireland, for which there
 12 are, equally, schematic designs of no less importance.

13 So the blue part in the middle of the picture
 14 represents the Department for Health and Social Care.
 15 Lead government departments are the government
 16 departments which are appointed to deal and lead on
 17 issues which affect them most.

18 So, my Lady, one of the questions which you will be
 19 addressing is whether or not this lead government
 20 department model is the correct one for a whole system
 21 civil emergency or do the requirements of this acute
 22 type of crisis require a different approach? If so,
 23 what approach should that be?

24 It is self-evident that in a crisis of the magnitude
 25 of the Covid-19 pandemic, the burden could not solely be

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1 have prepared which sets out the basic structures
 2 concerning EPRR for the United Kingdom and England and
 3 also for Scotland, Wales and Northern Ireland. The INQ
 4 number is just a reference to the Inquiry's electronic
 5 document system. I should say that this is a document
 6 which is evolving. We will improve it as we go along in
 7 light of helpful comments from the core participants and
 8 the various government and devolved administrations of
 9 the United Kingdom.

10 Could we go forward, please, to page 4. That,
 11 my Lady, is a schematic representation of the
 12 United Kingdom and England's emergency preparedness,
 13 resilience and response system.

14 Starting from the top, the Cabinet Office, of whom
 15 of course we've heard much in recent days, is the
 16 government department in the United Kingdom responsible
 17 for supporting the Prime Minister and the Cabinet. It
 18 is composed of various units that support Cabinet
 19 Committees and which co-ordinate the delivery of
 20 government objectives, but primarily working with other
 21 government departments.

22 One of its most important functions is national
 23 security and the co-ordination of the United Kingdom
 24 Government's response to crises.

25 My Lady, it's obvious that in an emergency the
 30

1 carried by the lead government department, because
 2 of course the pandemic affected every part of the
 3 government and of British public life, from education to
 4 the care sector, of course, to the Treasury, to our
 5 finances, our jobs and livelihoods.

6 The Department for Health and Social Care oversees
 7 the National Health Service in England. It oversees the
 8 United Kingdom's arm's length bodies, such as the
 9 United Kingdom Health Security Agency. So a primary
 10 question going into the pandemic was: was the Department
 11 of Health and Social Care adequately prepared? Did it
 12 identify with sufficient adequacy the surge capacity in
 13 terms of hospital infrastructure, clinicians and support
 14 workers that would be required?

15 During the Module 1 timeframe, the Civil
 16 Contingencies Secretariat was the Cabinet Office unit
 17 that managed both the United Kingdom Government's
 18 preparedness for and its response to major nationwide
 19 emergencies. My Lady, it was established in 2001, and
 20 in July 2022, after the pandemic, was split into two
 21 separate functions, focusing on its emergency response
 22 functions, the COBR unit, about which we'll hear a great
 23 deal more, and resilience frameworks called the
 24 Resilience Directorate, and -- thank you very much --
 25 the Civil Contingencies Secretariat has been highlighted

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1 at the top of the screen.
 2 Towards the top right of the screen, you will see
 3 a reference to the National Security Risk Assessment.
 4 The National Security Risk Assessment is
 5 the United Kingdom Government's classified assessment of
 6 the top national level risks facing the United Kingdom.
 7 The assessment focuses on both the likelihood of the
 8 risk occurring and the impact it would have were it to
 9 happen. And it has a public-facing document, the
 10 National Risk Register, which provides information for
 11 those who have contingency planning responsibilities at
 12 a national, regional and local level.
 13 My Lady, we know, of course, what the broad nature
 14 of future emergencies might be. Natural hazards include
 15 global health challenges, animal and plant diseases,
 16 growing antimicrobial resistance, space weather events,
 17 extreme weather, climate change, infrastructure
 18 collapse, or perhaps the unintended consequence of human
 19 endeavour in artificial intelligence. The world is
 20 an uncertain place and risks seem set only to grow.
 21 Though the exact nature of those major risks cannot,
 22 of course, be identified in advance, and because it's
 23 not possible to know in advance with certainty which
 24 risks will crystallise, and how, and because it's not
 25 practical to plan for every major risk, there will

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1 were hit, of course, by a coronavirus. That might
 2 suggest a lack of flexibility or proper foresight. Or
 3 perhaps the policies, plans and structures were so
 4 flexible and broad, so as to cover any reasonable
 5 possibility, that this prevented us from focusing enough
 6 on those particular risks which, as I say, whilst being
 7 perhaps less likely, could cause us more harm.
 8 So a core question in Module 1 will be: to what
 9 extent was thought given to and planning devoted to the
 10 risk of a new emerging infectious disease that was not
 11 influenza? Did the system of planning become
 12 self-validating or complacent so that that question was
 13 not asked, or if it was asked by individuals was not
 14 listened to?
 15 To what extent were the likely consequences of
 16 either influenza or a new and emerging infectious
 17 disease reassessed?
 18 My Lady, the evidence may show that there was
 19 a degree of assumption in the process, that if there was
 20 to be an influenza pandemic, it would be bound to lead
 21 to hundreds of thousands of deaths. This was because
 22 planners positively planned on what was known as the
 23 reasonable worst case scenario, the RWCS, planning for
 24 the worst case that could realistically happen.
 25 The good sense of planning for the worst case that

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1 always be uncertainty.
 2 So the government draws up policies, and those
 3 policies are, by their nature, of more general
 4 application. But both the policies and the planned
 5 operational responses must build in the ability to
 6 respond to the unknown and provide for contingencies.
 7 Government planning must be flexible.
 8 Were the governments of the four countries flexible
 9 enough with their policy making? Was the consideration
 10 of what those risks might be and how they could be
 11 prepared for sufficiently imaginative?
 12 My Lady, you will hear evidence that for many years
 13 an influenza pandemic was assessed as being one of the
 14 most likely risks to the United Kingdom. But what about
 15 other risks that, whilst they might be less likely,
 16 could be just as, if not more, deadly? Did planning
 17 sufficiently address the risk not only of the known but
 18 the unknown, a new pathogen, a new disease, a disease X,
 19 as it's known, with pandemic potential?
 20 Did planners pay sufficient focus on potential
 21 impact as opposed to likelihood?
 22 With Covid, the evidence will demonstrate that the
 23 government thought that the greater risk was
 24 an influenza pandemic and, therefore, devoted more time
 25 and resources to that possibility. In the event, we

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1 could realistically happen is obvious: you need to
 2 prepare everyone to respond to that possibility, to have
 3 enough resources, enough surge capacity, enough room for
 4 manoeuvre in the healthcare and social care systems,
 5 enough PPE and so on. But not at the expense of pausing
 6 and asking: what more can we do to ensure we don't get
 7 to that stage at all?
 8 The evidence may show, simply and terribly, that not
 9 enough people thought to ask, because everybody started
 10 to assume it would be flu. And if it was flu,
 11 diagnostic testing, case detection and isolation are
 12 less effective on account of the shorter incubation
 13 period, and, as I've said, there would always be
 14 antiviral medicine and vaccines and a national pandemic
 15 flu service.
 16 So, my Lady, to what extent did the UK Government
 17 and the devolved administrations have a strategy for
 18 preventing a pandemic from having disastrous effects, as
 19 opposed to dealing with the disastrous effects of the
 20 pandemic and the reasonable worst case scenario which
 21 was assumed to follow?
 22 **LADY HALLETT:** Mr Keith, I have been encouraged to take
 23 regular breaks, as you know, for the purposes of the
 24 stenographer and others. Would that be a convenient
 25 moment? I apologise for interrupting.

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1 **MR KEITH:** It's a very convenient moment.

2 **LADY HALLETT:** Thank you. I shall be back at 11.30.

3 (11.15 am)

4 (A short break)

5 (11.32 am)

6 **LADY HALLETT:** Yes, Mr Keith.

7 **MR KEITH:** My Lady, I was addressing you in relation to
8 whether or not the United Kingdom Government and the
9 devolved administrations had a strategy at all for
10 preventing a pandemic from having disastrous effects, as
11 opposed to dealing with the disastrous effects of the
12 pandemic.

13 Part of the answer may lie in the doctrinal thinking
14 that underpins the emergency preparedness, resilience
15 and response system. So the United Kingdom Government
16 and the devolved administrations adopted what is known
17 as the integrated emergency management structure, and it
18 had six phases: anticipate, assess, prevent, prepare,
19 respond and recover. And this concept underpinned both
20 the approach to emergency preparedness, resilience and
21 response and the revised law and legal arrangements
22 which were introduced into this area in the early 2000s.

23 So one of the issues for you in this module will be
24 whether or not this was the right approach for the
25 United Kingdom and the devolved administrations. Did

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1 all. Equally, there appears to have been a failure to
2 think through the potentially massive impact on
3 education and the economy of trying to control a runaway
4 virus in this way.

5 Was there an element of complacency based on our
6 recent experiences, including the ranking in the Global
7 Health Security Index, our response to swine flu in 2009
8 and the United Kingdom's undoubted successes in ensuring
9 that SARS and MERS did not spread? Did our experience
10 of the 2009 swine flu lead to concerns about
11 overreacting?

12 My Lady, there had been numerous exercises, but to
13 what extent were those exercises adequate in terms of
14 scope and frequency, and the persons who were invited to
15 participate in them? What was learnt from those
16 exercises? What lessons were taken away from them in
17 relation to future risks and future preparedness?

18 At a more fundamental level, therefore, should there
19 be an EPRR agency, an independent agency, to take
20 complete control of national planning, preparedness and
21 resilience? Such an agency might be responsible for
22 managing the structure, with the assistance of the rest
23 of government, checking it and testing it. It could
24 provide advice to the government and the devolved
25 administrations on long-term strategy. It could

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1 this approach, under the integrated emergency management
2 structure, have the right emphasis? Were these stages
3 the right ones? So, for example, although I've made
4 a reference to prevent and prepare, did this doctrinal
5 approach sufficiently ensure that the government thought
6 about how to stop the terrible consequences that it was
7 planning for appearing in the first place?

8 Furthermore, doctrinally, was there sufficient
9 independent and rigorous expert advice? Was that expert
10 advice in the government system sufficient in its range
11 and diversity? Did the government learn sufficiently
12 from the experiences of other countries, especially
13 those such as Taiwan, South Korea and Singapore, who had
14 learned from the SARS-1 and the MERS epidemics, to which
15 I made reference earlier, and whose preparations were in
16 fact more advanced in some ways than our own?

17 Extraordinary though it may seem, given that it's
18 a word that will be forever seared into the national
19 consciousness, there was very little debate pre-pandemic
20 of whether a lockdown might prove to be necessary in the
21 event of a runaway virus, let alone how a lockdown could
22 be avoided.

23 Very little thought was given to how, if it proved
24 to be necessary, something as complex and difficult and
25 damaging as a national lockdown could be put in place at

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1 commission external expertise from the fields of
2 technology, health, economics and the military. Perhaps
3 there should be a central leadership position
4 accountable to Parliament with responsibility for whole
5 system preparedness, resilience and response.

6 My Lady, I mentioned a few moments ago the legal
7 structures which were introduced in the 2000s. One of
8 the most important legal reforms based around this
9 doctrinal approach to which I've made reference was the
10 introduction of the Civil Contingencies Act in 2004.

11 It provided the framework for civil protection in
12 the United Kingdom and it identifies and establishes
13 a set of roles and responsibilities for those involved
14 in EPRR at a local level and allows for the making of
15 emergency regulations to help deal with the most serious
16 of emergencies.

17 If we could have, please, the document, the chart
18 up, INQ000204104-0004, please, at page 4.

19 Thank you.

20 You will see in the bottom left-hand corner of this
21 chart, which is again the United Kingdom and England
22 one, around about August 2019, a reference in the very
23 bottom left-hand corner to local category 1 responders
24 and local category 2 responders.

25 So part 1 of the Civil Contingencies Act 2004

40

1 provided for two groups of responders to an emergency:
 2 category 1 responders, namely the police and the
 3 emergency services, local authorities and the healthcare
 4 system, the NHS; and category 2 responders, utility and
 5 transport providers, water companies, Health and Safety
 6 Executive and communication providers.

7 Now, those category 1 responders are subject to the
 8 full set of civil protection duties. They're required
 9 to assess the risk of emergencies occurring and use this
 10 to inform contingency planning locally. They put in
 11 place the actual emergency plans upon which reliance is
 12 based in the event of a crisis. They put in place
 13 business continuity management arrangements. They make
 14 information available to the public, and they share
 15 information with other local responders to enhance
 16 co-ordination.

17 The category 2 organisations, by contrast, the
 18 co-operating bodies, are less likely to be involved in
 19 planning work, but they will be heavily involved in
 20 incidents that involve their own sector. They have
 21 a lesser set of duties, they're obliged to co-operate
 22 and share information, but they don't and they are not
 23 obliged to react in the same ways as the category 1
 24 organisations.

25 But there are no comparable duties on central

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1 and therefore can best respond to flooding or some
 2 crisis or emergency which envelops a town or a part of
 3 a town or part of the countryside, or the region.

4 But those local resilience forums are, if you like,
 5 at one end, therefore, of these lines of communication.
 6 Is that the best model? Are local resilience forums and
 7 their devolved equivalents adequately resourced,
 8 accountable and led? To what extent did the central
 9 government, when we were hit by the pandemic, deal with
 10 the local resilience forums, ensure that they had what
 11 they needed to be able to respond?

12 In this system, there is a further conundrum, which
 13 is that local resilience forums deal with planning, but
 14 response, when an emergency strikes, is actually in the
 15 hands of a different group, called the strategic
 16 co-ordination groups. I think we should have that in
 17 yellow just above "Local Resilience Forums", if that
 18 could be highlighted, we can see "Strategic
 19 co-ordination groups".

20 These are different bodies, but largely composed of
 21 the same bodies that make up the LRF, the local
 22 resilience forum, and they focus on the actual response
 23 to an emergency. Is there an unnecessary degree of
 24 duplication here?

25 Another important area concerns the Resilience

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1 government. The only legal duties are on those
 2 category 1 and category 2 responders.

3 So in the event of a national crisis which engages
 4 the whole of government, is there a case for the
 5 imposition of legal duties on central government as
 6 well?

7 Across England, local resilience forums support the
 8 planning between all those various bodies. They consist
 9 of the category 1 and category 2 responders and they are
 10 the bodies which plan, which prepare for the crises or
 11 emergencies which might befall the locality.

12 If we look again at the bottom of the page, in the
 13 bottom left-hand corner, we can see local resilience
 14 forums, the bodies into which the local category 1
 15 responders and category 2 responders report. My Lady,
 16 there may be some degree of surprise that in this
 17 important system of emergency response and preparation
 18 the bodies who are primarily concerned with planning for
 19 emergencies, and indeed responding to emergencies,
 20 appear to be right down at the bottom left-hand side of
 21 the page, and to be local. And the reason for that is
 22 that the United Kingdom system works on the basis of
 23 subsidiarity. That principle is designed to ensure that
 24 those with local knowledge make the decisions on the
 25 ground. They are the people who will know the area well

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1 Emergencies Division, halfway up the page on the left.
 2 That is the division which rests within the Ministry of
 3 Housing, Communities and Local Government, now in fact
 4 the Department for Levelling Up, Housing and
 5 Communities, and it provides advice to the local
 6 resilience forums through its resilience advisers, which
 7 we can see a little bit further down the left-hand side
 8 of the page.

9 So, in essence, the Resilience and Emergencies
 10 Division is the liaison with the national and local
 11 tiers of response.

12 So we have already, therefore, an understanding that
 13 in this system you have the Cabinet Office, you have the
 14 lead government department, you have other government
 15 departments, and you have the Resilience and Emergency
 16 Division of the Department for Levelling Up, Housing and
 17 Communities, all concerned with ensuring that the system
 18 works.

19 Is that really the best way of doing it?

20 No less important, as I've earlier said, are the
 21 devolved administrations. Preparedness and resilience
 22 are devolved matters, meaning that they are the
 23 responsibility of each devolved administration and not
 24 of Westminster, and this Inquiry is looking, of course,
 25 at the states of preparedness and resilience in all the

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1 countries.

2 But on the subject of devolution, an important issue
3 therefore immediately arises: has the devolution
4 settlement which has made preparedness and resilience
5 a devolved matter struck the correct balance between the
6 leadership, which is obviously necessary in any whole
7 country civil emergency, whole nation, whole
8 United Kingdom emergency, and the benefits of
9 a tailored, localised response?

10 So if we could, please, then look briefly at page 6
11 in this INQ document, and then go forward -- yes,
12 thank you -- we will see at the top of the page,
13 "Pandemic preparedness and response structures Scotland
14 ... 2019", and because, as I've said, resilience and
15 preparedness are devolved issues, if we could please
16 zoom back out -- thank you -- and see the whole page,
17 you will see, of course, that the vast majority of the
18 bodies in Scotland dealing with preparedness and
19 resilience are Scottish bodies.

20 But the link to the United Kingdom comes from the
21 Cabinet Office, which sits on top of the whole
22 structure, which is why the Cabinet Office is at the top
23 of the chart, and linked through COBR, the Civil
24 Contingencies Secretariat to which I've made reference,
25 the Scientific Advisory Group for Emergencies, down to

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1 groups.

2 My Lady, there are a profusion of bodies.

3 In relation to Northern Ireland, a vital issue is
4 the impact in January -- or what was the impact in
5 January 2020 on preparedness, response and resilience
6 arrangements of the prior collapse in power sharing.

7 My Lady, as is well known, the Good Friday
8 Agreement, or Belfast Agreement, which was signed in
9 April 1998, provided for a new devolved system of
10 government with an Assembly and Executive at Stormont.
11 However, thereafter power sharing, as you know, was
12 suspended a number of times. Most relevantly it was
13 suspended between January 2017, when the then Sinn Féin
14 deputy First Minister, the late Martin McGuinness,
15 resigned, and remained suspended until Saturday,
16 11 January 2020, just as the pandemic was starting to
17 spread to the province.

18 During that time Northern Ireland was managed by
19 civil servants without ministerial oversight. We will
20 therefore be exploring to what extent that lack of
21 ministerial input affected the civil emergency
22 arrangements and, in particular, the inability, because
23 of the collapse of the power sharing agreement, to make
24 any significant improvements to this structure during
25 that interregnum.

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1 the devolved administration level.

2 Page 10, please. The analogous scheme for Wales,
3 broadly speaking, in 2019. Again, you can see that all
4 the bodies in the bottom two-thirds of the page are
5 devolved bodies, and again the link to the
6 United Kingdom comes through the Cabinet Office at the
7 top.

8 Page 14, similarly in relation to Northern Ireland.

9 So, my Lady, you will see from those pages and those
10 schemes that there are a number of important bodies in
11 Scotland, Wales and Northern Ireland which carry out
12 analogous functions to those in Westminster and England.

13 In Scotland -- I won't take you to them -- the
14 Scottish Resilience Partnership. There are regional
15 resilience partnerships. In Scotland, each regional
16 resilience partnership has its own local resilience
17 partnership. There are then a number of ministerial
18 bodies for government resilience. There are government
19 resilience officials, and emergency arrangements were
20 arranged through the Scottish Government resilience
21 room.

22 In Wales we have the Wales Resilience Forum, the
23 Joint Emergency Services Group, local resilience forums.

24 In Northern Ireland, the Civil Contingencies Group,
25 emergency response groups and strategic co-ordination

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1 Those with sharp eyes will see that each of the
2 four nations has its own public health body: Public
3 Health Wales, there is a Public Health Agency in
4 Northern Ireland, and Public Health Scotland; in
5 England, the Health Protection Agency was established in
6 2003. In April 2013, Public Health England was
7 established incorporating the Health Protection Agency
8 alongside public health functions previously carried out
9 by the Department of Health and regional health
10 authorities.

11 Thereafter, and it's not on the scheme because the
12 scheme represents the position in 2020 -- or 2019,
13 rather. In April 2021 the UK Health Security authority
14 was established, which took on parts of Public Health
15 England, focusing on health protection, alongside the
16 functions of NHS Test and Trace and the Joint
17 Biosecurity Centre. But the Public Health England's
18 health improvement functions were transferred to the
19 Department of Health and Social Care.

20 My Lady, another issue, therefore, for Module 1: why
21 did those structural changes occur? Why did they occur
22 when they did? Were they an improvement, particularly
23 the abolition of Public Health England and the
24 bifurcation of public health protection from public
25 health improvement?

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1 What was the state of pandemic readiness and
2 preparedness for each of those bodies?
3 There had also been significant reforms to the
4 national and local systems for public health. The
5 Health and Social Care Act 2012 transferred most public
6 health functions from NHS bodies in England and Wales to
7 local authorities. At the same time, local authorities
8 with public health responsibilities were required to
9 employ a specialist director of public health. Were
10 directors of public health utilised effectively within
11 their local authorities? Did those public health
12 reforms make our public health structures more or less
13 resilient and able to respond to a pandemic?

14 My Lady, all these bodies and entities have to be
15 run, managed and paid for. They have to be supervised
16 and told what to do. Drafting has to be done of
17 a myriad number of policy documents and guidance. They
18 have to be assured, which is just another word for being
19 tested or checked. Who provided oversight as to that
20 state of preparedness of local responders, arm's length
21 bodies, lead government departments, other government
22 departments? And all those processes had to be provided
23 for, discussed, agreed, and put into place.

24 We've seen, my Lady, in the written evidence that
25 relevant bodies, committees and subcommittees within

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1 Of course those areas are only concerned with the
2 health consequences of a pandemic, but a pandemic is
3 prone to affect, as I've said, every area of public
4 life. So where were the plans and how adequate were
5 they for the shielding, employment support, disruption
6 to schools, border policy, lockdowns and, as I've said,
7 the profoundly unequal impact of a pandemic on the
8 vulnerable and marginalised?

9 Lastly, the pandemic struck the United Kingdom just
10 as it was leaving the European Union. That departure
11 required an enormous amount of planning and preparation,
12 particularly to address what were likely to be the
13 severe consequences of a no-deal exit on food and
14 medicine supplies, travel and transport, business,
15 borders and so on. It is clear that such planning, from
16 2018 onwards, crowded out and prevented some or perhaps
17 a majority of the improvements that central government
18 itself understood were required to be made to resilience
19 planning and preparedness.

20 Did the attention therefore paid to the risks of
21 a no-deal exit, Operation Yellowhammer as it was known,
22 drain the resources and capacity that should have been
23 continuing the fight against the next pandemic, that
24 should have been utilised in preparing the
25 United Kingdom for civil emergency?

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1 government were renamed or sometimes disbanded
2 altogether only for other strikingly similar ones to be
3 set up in the immediate aftermath.

4 One might conclude, looking at the schematic
5 schedules, that there was a labyrinthine and confusing
6 picture. Was it really necessary?

7 Were there proper links between central government
8 and local authority, not just tick box consultation?
9 Were there proper communications between central
10 government and the devolved administrations that were
11 not just dependent on the political will of ministers?

12 So, my Lady, standing back, was this civil
13 emergencies system as good as it could be? Were these
14 structures adequate or was their proliferation
15 a hindrance to the United Kingdom's response? What can
16 you do to make this better?

17 Turning, finally, to the end product of all this,
18 how to put actual plans in place so that everybody knows
19 actually what to do in the event of an emergency, how
20 were those plans drawn up, checked and compared? Was
21 there adequate testing of plans for an actual pandemic?
22 Were the structures in place for ensuring that plans for
23 the necessary surge in healthcare and social care
24 provision were there, for stockpiling and distribution
25 of PPE and mass diagnostic testing?

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1 Or did all that generic and operational planning in
2 fact lead to people being better trained and well
3 marshalled and, in fact, better prepared to deal with
4 Covid, and also to the existence of improved trade
5 medicine and supply links?

6 My Lady, on the evidence so far, but it will be
7 a matter for you, we very much fear that it was the
8 former.

9 One of the most important features of Module 1 will
10 be to consider whether health inequalities were
11 appropriately considered in the planning for a pandemic,
12 and I leave this issue to last in reflection of the fact
13 that it is an issue which will find its reflection
14 through the entirety of the evidence which you have
15 directed be called in Module 1.

16 The Inquiry will look at how the lives of different
17 types of people with different experiences were regarded
18 by those with a duty of protecting them. For each of
19 the decision-makers, the civil servants and those tasked
20 with the responsibility of preparing our systems, were
21 social and clinical vulnerabilities considered by them
22 at all? When the emergency plans were drawn up, did
23 they have regard to the social inequalities and health
24 inequalities which would undoubtedly be exacerbated by
25 the outcome of that planning? The evidence will reveal

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1 the reality to that question.

2 So, my Lady, there is a great deal to cover.
3 I think I have said quite enough. You will hear now
4 opening statements from counsel representing the
5 Module 1 core participants, and then we will turn to the
6 evidence of the witnesses whom Kate Blackwell
7 King's Counsel and I will then examine.

8 **LADY HALLETT:** Thank you very much indeed, Mr Keith.
9 Mr Weatherby.

10 **Submissions on behalf of Covid-19 Bereaved Families for**
11 **Justice by MR WEATHERBY KC**

12 **MR WEATHERBY:** Good morning, my Lady -- just. I will be
13 about 30 minutes, I hope no more.

14 On 8 June 2015, then Prime Minister David Cameron
15 gave a speech to the G7 in Bavaria. A United Kingdom
16 government press release ahead of the speech said this,
17 and I quote:

18 "In a stark warning to other G7 leaders the PM will
19 say that the world must be far better prepared for
20 future health pandemics that could be more aggressive
21 and harder to contain than the recent Ebola outbreak ...
22 experts have warned that lessons must be learnt from
23 what happened. A more virulent disease in future --
24 transmitted by coughing, like flu or measles
25 for example -- would have a much more devastating impact

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1 storm.

2 The Inquiry experts, Bruce Mann and
3 Professor Alexander, later this week, we anticipate from
4 their report, will conclude that whole system
5 preparedness for a novel disease pandemic in the UK was
6 "wholly inadequate" as at January 2020. How was that
7 allowed to happen? How did that come to pass?

8 What we anticipate will be said was that those same
9 national risk assessments recognised that the impact of
10 flu was assessed as high, with what is termed as the
11 "reasonable worst case scenario" of up to 750,000
12 deaths. But the reasonable worst case scenario for the
13 unknown new disease was put at a far lower figure,
14 between 100 and perhaps 2,000 deaths. No doubt
15 justifications will be given.

16 However, taking Mr Cameron's warning that the next
17 emerging disease might have the characteristics of
18 Ebola, 70% fatality, and the transmissibility of
19 measles, 90% of those without immunity, it's hard to
20 fathom why the UK Government's national risk assessment
21 took such a complacent view of its likely impact and did
22 so repeatedly.

23 For the families, therefore, Module 1 should address
24 the key question of whether the United Kingdom did
25 everything reasonably practicable to prevent

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1 if a better approach is not put in place."

2 That was 2015. The WHO indicate that globally there
3 have been almost 7 million verifiable deaths from Covid.
4 In a recent article in The Economist, Dr Tedros Adhanom
5 Ghebreyesus, Director General of the WHO, said the real
6 number is likely to be around 20 million. Less than
7 five years after Mr Cameron's speech, a virulent disease
8 transmitted by respiratory means had arrived and caused
9 devastation around the world.

10 The bereaved families would like to know, had the
11 better approach that Mr Cameron spoke about been put
12 into place in the United Kingdom, what did his
13 government or those after him do about the threat he had
14 so powerfully raised with world leaders.

15 Whatever the answer to that question, for well over
16 a decade prior to the arrival of Covid, the
17 United Kingdom national risk assessments, as we have
18 just heard, recognised that the threat of a pandemic was
19 high and that the threat was not only flu but also
20 a quite separate type of new and emerging disease
21 unknown. It cannot be said therefore that this terrible
22 disease, this pandemic, was a black swan event, an event
23 so unlikely that it was practically unforeseeable, and
24 nor did its emergence rely upon the coming together on
25 a number of unlikely phenomena in a so-called perfect

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1 a foreseeable pandemic of this type or mitigate its
2 impact if it arrived. Why was there apparently no
3 overall plan, no whole system plan? Was there
4 a minister with overall responsibility, a clear and
5 effective framework to ensure everyone worked together,
6 ensure everyone was properly resourced and trained and
7 had the right equipment, ensured the planners had the
8 right scientific and expert advice, and formulated
9 appropriate contingency plans? Were there proper and
10 sufficient auditing and assurance mechanisms in place to
11 ensure the highest quality preparedness possible? It
12 appears none of this. Mr Keith's very helpful document
13 put up on screen might of itself answer whether there
14 was a clear and effective framework.

15 As we understand the evidence, it appears that the
16 closest to an overall plan was the Department of Health
17 2011 pandemic flu preparedness plan. Was that fit for
18 purpose for a non-flu pandemic in 2020? Why wasn't
19 there this whole system plan?

20 Many civil emergencies are local, as Mr Keith
21 touched on, and require a local response backed up by
22 central government's support only where necessary: the
23 Manchester Arena bombing outrage, or flooding perhaps.
24 But wasn't it obvious that other civil emergencies,
25 including pandemics, are, by their very nature, national

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1 whole system emergencies and require national whole
2 system planning as a result?

3 Why was there apparently such reliance on 2011
4 Department of Health planning? Wasn't it obvious that
5 pandemic planning had to go far beyond public health and
6 healthcare? Options for border controls and screening,
7 travel restrictions and quarantine, maintaining food
8 supplies and public security, enforcing emergency
9 restrictions on movement and assembly, maintaining
10 education and social service systems and protecting the
11 economic wellbeing of the country and jobs, are all
12 matters way beyond the remit of the Department of Health
13 and Social Care.

14 The 2021 National Audit Office report on
15 preparedness for Covid noted that the Cabinet Office,
16 through its Civil Contingencies Secretariat,
17 co-ordinated government planning and response. It found
18 no evidence that there was a consensus on the so-called
19 risk appetite of the government across departments,
20 which means the level of impact the government would
21 deem an acceptable outcome from the particular risk.

22 Indeed, the same report notes that the
23 Cabinet Office told the National Audit Office that the
24 government's risk appetite had changed as the pandemic
25 arrived on our shores, meaning that it lowered the

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1 prevention and mitigation?

2 First and foremost, planning should concentrate on
3 prevention and mitigation, not how to deal with the
4 number of bodies. It is important that no one forgets,
5 amongst all the figures and statistics and percentages,
6 that the true cost of the pandemic should be measured in
7 the lost years, love, happiness, potential and missed
8 milestones of every person who did not survive to see
9 the world return to some version of normal.

10 It's measured in the enduring grief of those we
11 represent for whom the world will never return to
12 normal, because they lost a crucial part of that world,
13 and it will be measured for years to come by those still
14 suffering the effects of long Covid.

15 The Covid-19 Bereaved Families for Justice
16 represents a large and diverse group of bereaved
17 individuals from across the United Kingdom. They come
18 from all walks of life. Many, by dint of their
19 occupations as well as personal circumstances, saw and
20 felt this pandemic on many levels. Many identify
21 structural discrimination and unaddressed health
22 inequalities as contributing to their loss. The
23 families have different areas of interest, different
24 experiences, different questions, but they're united not
25 only by grief but by their determination that the legacy

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1 threshold for the health and societal impact of the
2 pandemic that it deemed acceptable.

3 How, the families ask, was there co-ordination of
4 relevant government departments if they were working to
5 different agendas? Why, the families ask, would
6 planning be done on one basis and then response on
7 another? In fact, the same report indicated that
8 a cross-government working group review in February and
9 March 2020 rated more than 80% of the plans as being
10 unable to meet the demands of any actual incident, and
11 it also noted that the Cabinet Office did not have the
12 remit to carry out oversight or assurance over lead or
13 other government departments.

14 So no central government responsibilities,
15 a co-ordinating secretariat within the Cabinet Office
16 which actually had no oversight or assurance remit or
17 powers, and different government departments working to
18 different agendas and acceptable outcomes. The Inquiry
19 will have to determine whether that was a sensible
20 approach to planning and preparedness for a national
21 emergency or a recipe for chaos and failure.

22 Did planning sufficiently concentrate on the human
23 impact and not process, and did it fatalistically
24 concentrate on dealing with the aftermath of the
25 so-called reasonable worst case scenarios rather than

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1 of this Inquiry, an Inquiry for which they campaigned,
2 is one of justice, accountability, and, most
3 importantly, change.

4 They want to save lives.

5 Jo Goodman believes her father contracted Covid
6 whilst attending an outpatient appointment at his local
7 hospital and sadly died. He was clinically vulnerable.
8 He had not been given advice about the risks or about
9 shielding, and there were no apparent infection controls
10 at the hospital. Jo believes that if there had been
11 proper planning and preparedness and swift action to
12 limit community infections, to implement effective
13 hospital infection controls, and to protect the
14 vulnerable, then her father might not have died. There
15 are, of course, thousands of Jo Goodmans.

16 Jo met Matt Fowler, whose father had also died from
17 Covid, on Facebook in spring of 2020. Matt's dad was
18 a previously healthy man in his 50s. Jo and Matt did
19 not know each other. They lived and live in different
20 parts of the country. Together they formed a support
21 group for others like them, and that subsequently
22 evolved into the CBFFJ UK and a campaign to get answers
23 and to try to achieve changes that meant that their
24 devastating losses would not happen to someone else.

25 They've been joined by 6,500 others from all corners

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1 of the United Kingdom. Amongst them is Saleyha Ahsan,
2 who throughout the pandemic was a frontline doctor
3 within the emergency department at a hospital in Wales
4 and then, specifically for the second wave, within
5 intensive care where she treated critically ill Covid
6 patients, some of whom died.

7 During this period in December 2020, sadly,
8 Saleyha's father, Ahsan-ul-Haq Chaudry, caught Covid and
9 died. Saleyha has produced and reported on a very
10 powerful Channel 4 Dispatches documentary for which she
11 filmed for four months during the pandemic between
12 October 2020 and January 2021 within her own intensive
13 care unit. It's available on Channel 4 and open source.

14 Before training to be a doctor, Saleyha served with
15 the Royal Army Medical Corps. She contrasts the state
16 of preparedness in the British Army -- which
17 incorporates robust regular training, the putting on,
18 taking off and being operational in protective suits,
19 including respirators -- with the state of preparedness
20 she experienced in the NHS where no such training in PPE
21 took place throughout her years at medical school and
22 during her subsequent 14 years as an A&E doctor.

23 Saleyha is one of five siblings, five doctors and
24 a pharmacist. They work in different parts of the UK.
25 In all their individual years of practice, none of them

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1 social care governance for many years, has been
2 an adviser to the Care Quality Commission, and has
3 first-hand knowledge of the lack of contingency planning
4 in the sector. Amongst her questions are: why were
5 there no or insufficient plans to prevent the
6 transmission of Covid between homes due to the use of
7 agency workers, and transfers between homes and
8 hospitals without testing? Where was the protective
9 ring around care homes, as claimed by the former health
10 secretary Matt Hancock?

11 Kim Nutt, the partner of an ambulance care
12 assistant, wants to know why he was not supplied with
13 proper PPE or guidance as to what protective equipment
14 he should wear. The necessity for proper guidance,
15 stockpiles and surge supply of basic equipment should
16 have been obvious if there had been proper preparedness.

17 John Sullivan's daughter lived with a serious
18 disability. He witnessed the lack of any planning to
19 protect her as a disabled person and, to the contrary,
20 he is concerned that a treatment triage tool may have
21 taken account of her disability in a discriminatory way.
22 He wants to know what planning and preparedness there
23 was to protect people especially vulnerable through
24 disability and what regard, if any, there was for
25 combating the effects of structural discrimination

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1 has had any such training in PPE.

2 Neither Saleyha or her siblings were ever party to,
3 involved in or made aware of any preparedness training
4 or learning from exercises such as Cygnus, Cygnet or
5 Alice. They have never been involved locally,
6 regionally or nationally in any policy, clinical or
7 management training exercises relating to an outbreak of
8 an infectious disease. Saleyha asks why, when the
9 merits of clinical practice in protective clothing,
10 training, exercising an awareness of emergency plans for
11 frontline medics and essential service workers are all
12 well known and documented.

13 A disproportionate number of the CBFFJ families are,
14 sadly, from black and brown communities whose loved ones
15 died, often as frontline health or social care staff:
16 doctors, cleaners, cares. Others' loved ones were
17 transport workers or worked in the gig economy. They
18 want to know if structural racism or the
19 disproportionate effects of a pandemic on ethnic
20 minority communities was considered as a part of
21 preparedness and planning, never mind the response to
22 the pandemic, and if not why not.

23 Jean Adamson's father died in a care home to which
24 patients were transferred from hospital without testing.
25 Jean is a consultant who has worked in the area of

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1 against disabled people.

2 Councillor Sarah Bütikofer was the leader of
3 a district council in Norfolk throughout the pandemic
4 and is a bereaved family member. She witnessed
5 first-hand the lack of resourcing and the complete lack
6 of guidance or clear policy from central government
7 relating to multiple issues, such as PPE supplies,
8 lockdowns, vulnerable adult care arrangements, food
9 supplies, and multiple other non-pharmaceutical
10 interventions. She questions: where was the central
11 responsibility for planning and preparedness, and why
12 was there insufficient resourcing?

13 I could of course go on, but I'm sure everyone
14 understands these are real and raw issues for the
15 families. There are of course many, many others:
16 Barbara from South Wales, Martina from Northern Ireland,
17 Ian from Scotland. That is why they've asked you to
18 hear some of their stories within the hearings, to
19 evidence and illustrate the apparent lack of proper
20 planning and preparedness across many sectors. That's
21 why so many of them have stood outside this building
22 today holding photos of their lost loved ones to
23 highlight that their stories must not be forgotten.

24 Essentially, the Inquiry has to address three
25 questions: what happened, what went wrong, and how do we

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1 ensure that everything reasonably possible is done to
2 prevent it happening ever again? Three words: facts,
3 accountability, change. From that perspective, the
4 families suggest that the fundamental topics within the
5 scope of Module 1 are:

6 One, that at UK level who had responsibility for
7 civil emergency resilience, preparedness and planning?
8 Where did the buck stop?

9 Two, who was responsible for assessing the risk of
10 a pandemic, such as Covid, and its likely impact and how
11 was it done? What was that assessment and was it as
12 accurate as it should have been on the available
13 evidence? Was there methodology and evidential basis in
14 the public domain? Was it properly scrutinised and
15 challenged?

16 Three, why was there no whole system plan to prevent
17 such a pandemic or mitigate its effects? Who was
18 responsible for such national planning as there was?
19 Did it take proper and sufficient account of all
20 relevant scientific advice, and did it effectively
21 integrate the individual plans of lead government
22 departments and others?

23 Four, was that planning and preparedness optimal?
24 Was there sufficient understanding of it amongst leading
25 policymakers, including ministers? Was pandemic

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1 Six, to what extent were the citizens of
2 Northern Ireland disadvantaged by the lack of statutory
3 duties on the equivalent of category 1 and 2 responders
4 in Northern Ireland? Why did that gap exist at all?

5 Seven, was there a culture of secrecy surrounding
6 civil emergency planning and preparedness? Did this
7 include scientific advice, in particular from SAGE, and
8 publication of results and lessons learned from a number
9 of pandemic exercises?

10 In our written submissions we reference advice given
11 to Matt Hancock, former health secretary, that
12 publication of Cygnus would lead to criticism of lack of
13 preparedness, a reference which we say is significant in
14 illustrating this issue.

15 Did a closed institutional culture reduce the
16 opportunity for challenge to orthodoxies and did it
17 reduce the autonomy of scientists to frame their own
18 questions rather than be restricted to answering the
19 questions of others? Did a closed culture promote or
20 fail to counteract structural discrimination or to
21 consider health inequalities?

22 Eight, to what extent did austerity reduce the
23 capacity for preparedness? Were resources diverted from
24 civil emergency planning to maintain other business as
25 usual frontline services because decision-makers hoped

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1 planning effectively communicated to frontline essential
2 services and the general public? Was it sufficiently
3 resourced? Was there appropriate exercising and
4 training? Was there sufficient engagement with
5 communities and proper consideration of issues of
6 discrimination and vulnerabilities? Was it adversely
7 affected by the diversion of resources to deal with
8 Brexit? Was it affected by political reservations about
9 the WHO or other international bodies, including those
10 in the EU?

11 Five, in terms of the civil emergencies framework,
12 were the responsibilities on central government clear?
13 Indeed, as we've heard, were there any such
14 responsibilities on central government or was the
15 framework strikingly deficient in that sense?

16 Was there integration of central and local emergency
17 planning and auditing and assurance so as to ensure
18 an optimal and joined-up response?

19 What framework was there to ensure that the
20 UK Government and each of the devolved administrations
21 integrated their approaches?

22 Was there a persistent failure across government to
23 identify, learn and improve on responses to crises, as
24 referred to in the 2022 internal Government Crisis
25 Capabilities Review?

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1 emergencies may well not happen on their watch?

2 Was former Chancellor and architect of austerity,
3 George Osborne, correct when he said that those
4 financial policies fixed the roof while the sun was
5 shining, or is Dr Jonathan Fluxman of Doctors in Unite
6 correct when he described non-NHS public health funding
7 reductions as stripping the lead off the roof to make
8 the buckets to catch the rain?

9 The families expect the evidence will show a lack of
10 responsibility in government for civil emergency
11 preparedness, with little or no ministerial leadership,
12 and a chaos of committees which led to poor planning and
13 ultimately a reactive, rather than proactive, response
14 to the virus. We anticipate the evidence will show that
15 the most fundamental consequence of this was a slow
16 reaction and, with a pandemic, time is of the essence
17 and lost time is measured in lost lives.

18 I've already noted that there was a national risk
19 assessment which correctly identified newly emerging
20 diseases such as Covid as a threat to the UK, but
21 significantly underestimated the likely impact. If that
22 is correct, why? Between the turn of the century and
23 the pandemic, the two serious outbreaks of
24 coronaviruses, SARS and MERS, had, as we've heard, far
25 higher fatality rates than Covid. Neither disease made

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1 a significant impact in the UK, most probably because of
2 their transmissibility or their infection rate being
3 low, but also because swift and effective measures were
4 taken in other countries where they arose.

5 If this was the reason why national risk assessments
6 successively rated the potential impact of pandemic flu
7 as extremely high, but the potential impact of an
8 emerging disease as low, this was a case of reliance on
9 chance outcomes in past outbreaks rather than a properly
10 informed view as to whether a different chance would
11 lead to a catastrophic outcome the next time.

12 According to the NAO report, when asked, the
13 Cabinet Office asserted that:

14 "Diseases such as Ebola were expected to burn
15 themselves out quickly, as had been the case on previous
16 occasions."

17 Learning lessons from the past is vital. Fighting
18 the last war rather than planning for the next one is
19 a fundamental mistake. There is no scientific evidence
20 of an inverse relationship between virulence and
21 transmissibility. David Cameron seems to have
22 understood that in 2015, and indeed it's a fact
23 expressly stated in the 2011 pandemic flu plan itself.

24 Why then did ministers, including Mr Cameron, and
25 scientific advisers not challenge the narrative in

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1 should be in the public domain, except where there is
2 the clearest of national security issues? Such an
3 approach would foster informed discussion, raise
4 evidence beyond that which has been considered behind
5 closed doors, and lead to greater public understanding
6 and engagement and preparedness and planning, and
7 perhaps a greater appetite for proper funding.

8 The Inquiry will have to consider whether the
9 labyrinthine risk and impact assessment processes were a
10 sensible tapestry and finely tuned operation or whether,
11 in reality, it was a hotch potch arrangement, more
12 colander than coherent framework.

13 The stark facts, not hindsight, show that in the
14 years before Covid there was no room for complacency.
15 Going forward, those realities mean there is an urgent
16 need to analyse the past and optimise prevention and
17 mitigation for the future.

18 The UK is of course amongst the richest nations on
19 earth. It has mature institutions, including with
20 respect to health healthcare and public health.
21 Together with Ireland, it's an archipelago, islands,
22 giving it obvious geographical advantages. The UK was
23 well placed to see a pandemic coming and to have
24 effective defences and mitigations, planning, resilience
25 and preparedness. It was well placed to see the

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1 successive national risk assessments that an unknown
2 emerging disease would likely be of relatively low
3 impact and cause a low number of fatalities? That's an
4 important question with which the Inquiry will have to
5 grapple.

6 If there had been actual ministerial responsibility
7 for civil emergency preparedness, and if there was
8 actual central government departmental responsibility,
9 rather than this apparently ad hoc co-ordination role
10 within the Cabinet Office, might there have been greater
11 challenge and scrutiny? Responsibility leads to
12 accountability, leads to better decision-making.
13 Knowledge that the buck lands at the Minister's door
14 concentrates minds. If the scientific advice had been
15 more transparent and scientists were able to determine
16 their own questions and encouraged to challenge
17 orthodoxies, scientific autonomy, would the tendency to
18 group-think, and perhaps complacency, have been
19 impacted?

20 In summary, was the process for risk and impact
21 assessment robust? Was it transparent and open to peer
22 challenge or challenge by policymakers, or were the
23 assessments opaque? Going forward, should there be
24 a presumption that both the methodology and the evidence
25 for the risk and impact assessments of each known threat

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1 necessity to have options, such as border controls and
2 screening of entrants. It was well placed to have
3 learned the importance and methodologies of test and
4 trace used so effectively by other nations -- in
5 particular, in South East Asia -- and for other
6 non-pharmaceutical interventions -- including masks,
7 restrictions on mass assemblies, travel, lockdowns --
8 all to be used intelligently and proactively, which,
9 crucially in this context, means early.

10 Was a lack of incorporation of these measures into
11 planning and preparedness responsible for them being
12 deployed later than was necessary? The families have no
13 doubt this is the case.

14 The UK was well placed to have good plans for PPE
15 stockpiling and surge manufacturing and supply of the
16 same and other things, such as oxygen and medical
17 equipment. Why was the availability of PPE in
18 particular so deficient?

19 If we're right that the use of these measures should
20 have been learned from recent coronavirus history -- and
21 indeed recent history of flu, Ebola and other
22 diseases -- were there actually any UK plans for each of
23 them? Was there resourcing? If so, were the plans and
24 resourcing adequate or was the UK always one step
25 behind, prevaricating, dithering, delaying and hoping

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1 for the best, reacting rather than acting proactively to
2 save lives, minimise disruption and protect communities
3 and the economy?

4 As has been outlined, so far as we understand the
5 position, the Civil Contingencies Secretariat within the
6 Cabinet Office liaised with lead government departments
7 who owned each risk identified on the risk assessments,
8 because the particular risk fell within their area of
9 responsibility. Those lead government departments were
10 expected to have plans for those risks.

11 We do not doubt that it was sensible for the
12 Department of Health to have had a plan for a pandemic,
13 for obvious reasons. For equally obvious reasons, that
14 plan should have been integrated into a whole system
15 plan or at least fully co-ordinated with the plans of
16 multiple other relevant departments and agencies. There
17 was no framework requiring that to happen, and it was
18 beyond the responsibility of the Cabinet Office, whose
19 remit was co-ordination and liaison. To the families,
20 that seems to have been a fundamental failure.

21 There are commonalities to civil emergencies as well
22 as differences. If a minister and department had
23 responsibility for civil emergency preparedness and
24 planning, or even a statutory agency, then it would be
25 responsible for whole system plans for each identified

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1 few real changes were made. Is the reality that by
2 January 2020, despite this realisation that there was
3 a need for change, there was an absence of action, an
4 absence of planning, which would have allowed the UK to
5 react swiftly, leaving government to largely make up the
6 plan as it went along once Covid arrived?

7 Finally, what might such a whole system plan have
8 looked like? Taking the 2011 plan as a starting point,
9 given the experience of MERS and Ebola, and a number of
10 exercises that had taken place since, we might have
11 expected a plan which said more than the bare assertion
12 in the 2011 plan that it could be adapted for non-flu
13 outbreaks.

14 Some aspects of a modern pandemic plan perhaps write
15 themselves. Early genomic sequencing to enable
16 development of tests and establishing immediate vaccine
17 and antiviral research and development, and ensuring
18 manufacturing and laboratory capacity for both testing
19 and vaccines, once available, would be most obvious.
20 Some of these aspects may have been progressed well in
21 this pandemic, although it's less than clear that this
22 was due to government or indeed planning, and we
23 anticipate that there were aspects of testing, roll-out
24 and capacity which was seriously inadequate.

25 But a whole system plan should also recognise that

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1 threat, incorporating the planning not only of the lead
2 department but all the others.

3 There are similarities with JESIP here, the Joint
4 Emergency Services Interoperability Principles. The
5 whole system response can work only if each relevant
6 department, each responder, each agency knows not only
7 its own role but also that of others.

8 Interoperability fails without clarity, joint plans,
9 adequate resourcing, training and exercising. At the
10 local tier level, interoperability between agencies
11 occurs through the local resilience forums that Mr Keith
12 touched upon, joint plans, training and exercising. Why
13 is there no such framework for central government or
14 between central government and the local tier?

15 We'll learn, no doubt, that there were efforts to
16 co-ordinate across government through a myriad of
17 committees. No doubt we'll be told that there was
18 learning and changes made beyond the 2011 pandemic flu
19 plan. But we urge the Inquiry to drill down into what
20 those produced in reality.

21 We do understand from the evidence that there was
22 a realisation that the 2011 planning strategy needed
23 updating, and a pandemic flu preparedness board was
24 established. But its work was stalled because of the
25 preoccupation with readiness for Brexit, and it appears

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1 a newly emerging disease might have different modes of
2 transmission, it might have different longevity of
3 contagion, and it might be transmissible
4 asymptotically. The plan would therefore require a
5 range or menu of options, as proved effective
6 particularly in South East Asia long before 2020.

7 In some respects, the plan would plainly need to be
8 multi-departmental or multi-agency. Screening at
9 airports would need interoperability with airport
10 authorities and the Border Force, as well as public
11 health facilities. Restrictions on assembly would need
12 legal changes and policing. Shielding the vulnerable,
13 combating disproportionate effects due to
14 discrimination, and protecting education and social
15 services provision all necessarily involve
16 interoperability.

17 A whole system plan would also include PPE
18 procurement and stockpiling, and surge supply of
19 equipment and oxygen, antiviral and vaccine development.
20 It would include economic resilience and securing jobs
21 which required Treasury planning and plans for securing
22 food and energy supplies and distribution.

23 With the lead government department system which
24 fragmented preparedness to narrow responsibilities,
25 there was little chance of a rapid, joined-up, effective

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1 response with an array of tools ready-made at its
2 disposal.

3 In conclusion, you will be told by some politicians
4 that austerity put the UK in a good place to respond to
5 the pandemic, but experts will point to its effect on
6 public health and local authority resilience funding.

7 The Inquiry will learn also of what happened to health
8 inequalities concurrently with these cuts, and reasons
9 why the widening of such inequalities might have
10 occurred as a result.

11 We anticipate some senior civil servants will defend
12 the civil contingencies framework and argue that in fact
13 it worked well. But you'll also hear the view of the
14 experts, including Bruce Mann, one of the architects of
15 the current system, who will say not only that UK
16 preparedness was wholly inadequate, but that there
17 should, going forward, be clear responsibilities on
18 central government, clear national standards and
19 competencies, mechanisms of assurance and adequate
20 funding.

21 Indeed, at the time the Civil Contingencies Act was
22 enacted in 2004 there were recommendations that it
23 should contain central government responsibilities, as
24 well as subsidiarity to local responders that Mr Keith
25 has explained earlier, we would argue, an opportunity

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1 families' perspective, it appears that the UK had none
2 of those three things. They want to know why, and they
3 want it to change.

4 **LADY HALLETT:** Thank you very much indeed, Mr Weatherby.
5 I'm very grateful.

6 Mr Lavery.

7 **Submissions on behalf of the Northern Ireland Covid-19**
8 **Bereaved Families for Justice by MR LAVERY KC**

9 **MR LAVERY:** Good afternoon, my Lady.

10 At this stage, your Ladyship knows, but for anybody
11 else watching, that I represent the Northern Ireland
12 Covid-19 Bereaved Families for Justice and, in an
13 approach to this which may find some model in some part
14 of the findings of the Inquiry in the future, we've
15 adopted a joined-up and coherent approach to making our
16 oral and written submissions. So your Ladyship will see
17 that we have produced a joint document, and I commend
18 the submissions of Mr Weatherby to the Inquiry, and to
19 you, my Lady.

20 It is obvious I represent the Northern Ireland
21 bereaved families who lost loved ones, young and old, in
22 a variety of circumstances, including care homes,
23 hospitals, and the community.

24 Our families, my Lady, have been impressed by the
25 robust approach that you and Mr Keith and his team are

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1 lost at that time.

2 The lack of central responsibilities meant there was
3 no single point of responsibility and no mechanism for
4 collaboration cross-department or with other agencies.
5 It meant there was little or no assurance or
6 standard-setting for local responders in local
7 resilience forums, and there was no framework for
8 collaboration and co-ordination with the devolved
9 authorities and administrations.

10 We anticipate Bruce Mann and Professor Alexander
11 will highlight the temptation to pay lip service to
12 responsibilities which are not captured in law,
13 especially when resources are tight.

14 I've addressed at some length the closed nature of
15 the assessments and planning in this area, and asserted
16 that it chilled public discourse and challenge. But we
17 also anticipate that the lack of transparency in
18 preparedness masked the effects of austerity, allowed
19 structural discrimination to continue unchecked, and led
20 to learning from exercises or other events from
21 translating into action.

22 The answers to these questions and what we do about
23 them is vital. If the last three and a half years have
24 taught us anything, proper planning, adequate
25 resourcing, and swift action saves lives. From the

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1 taking. You, my Lady, have -- and your team -- worked
2 incredibly hard to get this Inquiry started in, despite
3 press reports, such a short period of time and we have
4 all, the core participants, been working hard and
5 together with the Inquiry and with the Inquiry team.

6 From what was said by Mr Keith already this morning,
7 we know that he has and you have, my Lady, been
8 listening to the submissions that have been put in
9 writing so far and are considering those very carefully.
10 Our families have faith that this Inquiry will yield the
11 results which they search for.

12 You know, my Lady, that this Inquiry isn't simply
13 about taking a robust approach to individuals, such as
14 former Prime Ministers. It's not a criticism, it's not
15 an Inquiry which will deal with personal criticisms
16 necessarily of those individuals. But of course we know
17 that no individual is going to stand and no government
18 department is going to stand in the way of progress of
19 this Inquiry.

20 This Inquiry, as my clients know, is about the
21 impact -- in this module -- about the impact the lack of
22 preparedness had on them and on society as a whole.

23 As I said, we are here to support you, my Lady, in
24 your task in finding out, in particular for our families
25 from Northern Ireland, was Northern Ireland prepared,

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1 what lessons for the future can be learned, and should
2 anyone or any body be made accountable?

3 There are three areas I just want to look at
4 briefly, and they're the Civil Contingencies Act, which
5 Mr Keith already referred to, some science, and some of
6 the politics involved.

7 A large part of the Civil Contingencies Act 2004 did
8 not actually apply to Northern Ireland, and the problem
9 was not just the devolution scheme but that in 2004 the
10 Executive and Assembly were in suspension,
11 Northern Ireland was under direct rule from Westminster,
12 and the 2004 Act did not confer duties upon Westminster
13 ministers, including those with direct rule powers in
14 Northern Ireland at the time. There was no equivalent
15 devolved legislation ever introduced, despite this being
16 a key recommendation of the Cygnus report, and despite
17 the Northern Ireland Secretary of State's expectation in
18 2005 that Northern Ireland would have "a similar level
19 of protection for its citizens as experienced
20 elsewhere".

21 The statutory obligations pertaining in
22 Northern Ireland, in contrast to the rest of the UK,
23 were mere guidance, my Lady.

24 The lack of cohesiveness is plain from the statement
25 of Ms Allen from the Association of Local Authorities

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1 limited awareness of the extent to which uncertainty and
2 a range of opinion is expressed in scientific
3 discussion."

4 My Lady, Northern Ireland did not attend COBR
5 meetings until 2 March 2020. The Inquiry, we say,
6 should consider recommendations that ensure in future
7 that Northern Ireland Chief Scientific Advisers become
8 part of the UK network and SAGE, and to ensure
9 Northern Ireland attendance at COBR meetings.

10 But, my Lady, there was a lack of knowledge among
11 political leaders as well in relation to central
12 government planning and preparedness and the reasons for
13 it.

14 Michelle O'Neill, the First Minister Designate,
15 accepts a lack of knowledge of or at least inability to
16 recall Exercise Cygnus, despite it occurring while she
17 was Minister for Health.

18 Arlene Foster, likewise, despite being
19 First Minister during Operation Cygnus and the pandemic,
20 does not recall being briefed, "as to the
21 recommendations made on foot of Exercise Cygnus or any
22 steps the Executive Office intended to take to improve
23 pandemic preparedness prior to the Assembly collapsing
24 in January 2017", nor does she recall any steps taken in
25 relation to pandemic preparedness between January 2017

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1 Northern Ireland. It conveys a sense that in the
2 absence of statutory obligations on local authorities
3 there was relative inaction with regard to planning and
4 preparedness, with little, if any, formulation of
5 preparedness policies. The people in Northern Ireland,
6 therefore, were at a distinct disadvantage. They had
7 less statutory protection compared to other citizens in
8 the UK.

9 In terms of science, my Lady, there was
10 a disjuncture between central and devolved government,
11 and this is demonstrated in part by Professor Young, who
12 was the part-time consultant and Chief Scientific
13 Adviser, by his request to join the Chief Scientific
14 Adviser UK network. This request was declined. Only
15 one representative for each devolved administration was
16 allowed.

17 There is no record of Northern Ireland participation
18 in SAGE prior to 29 March 2020. Between 2009 to 2015,
19 the Senior Medical Officer only had observer status,
20 with no speaking rights at the Joint Committee on
21 Vaccination and Immunisation, and the Advisory Committee
22 on Dangerous Pathogens.

23 Northern Ireland had no automatic representation at
24 SAGE, and as McBride put it:

25 "Policymakers in Northern Ireland may have had more

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1 and January 2020.

2 We say this shows a low level of interest in or the
3 impact which Cygnus had on Northern Ireland
4 decision-making.

5 Michelle O'Neill's successor, Robin Swann, who was
6 the Minister for Health during the pandemic, does recall
7 Cygnus and states his belief that the flu plan provided
8 a good foundation for action during the Covid-19
9 pandemic. The Inquiry, my Lady, should of course
10 examine this assertion in light of its exclusive focus
11 on the influenza pandemic.

12 In any event, it's clear that Northern Ireland
13 devolved government failed to implement a coherent
14 response to the pandemic, and you, my Lady, may well
15 find that it was incapable of providing a coherent
16 response.

17 A common theme that runs throughout, common themes,
18 they are: the lack of statutory protection; lack of
19 pandemic co-ordination; and, in general, a lack of
20 preparedness for a pandemic.

21 The context of this is decades of political
22 dysfunction in Northern Ireland. But, my Lady, as
23 Brenda Doherty, who you saw earlier on the film and who
24 made a statement and who you will hear from later on in
25 this module, she put it in these terms, that -- and this

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1 is quoting from her statement:

2 "The vacuum in government was known not only to our
3 members but also to the Westminster government. If that
4 prolonged lack of an Executive was having a detrimental
5 impact on the preparedness and resilience in respect of
6 emergencies in this jurisdiction, the UK Government had
7 a moral and constitutional duty to act to ensure that
8 those living in this jurisdiction would not suffer as
9 a result should there be any emergency."

10 Mr Keith referred earlier to the impact of EU exit
11 preparations and, on 22 January 2020, the pandemic flu
12 subgroup acknowledged that, due to the lack of work done
13 and impact on staff resources because of the EU exit
14 preparations, that Northern Ireland was more than
15 18 months behind the rest of the UK in terms of ensuring
16 sector resilience to any pandemic flu outbreak.

17 My Lady, Mr Keith's remarks were made in terms of
18 the UK generally, and it appears from that that we were
19 even 18 months behind that again.

20 I mentioned Brenda Doherty, my Lady. Her mother, as
21 you heard, Ruth Burke, died on 24 March 2020. She was
22 the fourth person to die from Covid in Northern Ireland,
23 the first woman. She was admitted to hospital on
24 11 March because of high levels of warfarin. There was
25 no testing of patients on admission. The only PPE she

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1 was, as she said, my Lady, no coming home, no seeing her
2 in her coffin, no laying out of her clothes for her to
3 be laid to rest in. The funeral she described. She
4 waited outside locked cemetery gates for the hearse to
5 arrive. There was no carrying of the coffin and the
6 council workers were dressed in white clothes and there
7 was red and white tape around the grave. It all lasted
8 15 minutes -- a "committal" she describes it as, rather
9 than a funeral -- and afterwards they all walked back
10 separately to their own houses.

11 That's one story, my Lady, but the themes in that
12 story and other stories referred to and the other people
13 in Brenda Doherty's statement are there. And then the
14 themes of lack of communication, that not only did these
15 people suffer the death of their loved ones from Covid,
16 and in high proportion the elderly and the vulnerable,
17 people who should have been protected, and like so many
18 others her mother was given Covid in hospital.

19 Preparedness should be meaning the protection of the
20 most vulnerable from death, but also preparedness ought
21 to have contemplated, prepared for and prevented
22 unnecessary or disproportionate, dehumanising,
23 re-traumatising restrictions.

24 So many of our families, my Lady, are picking up the
25 pieces from this clinical estrangement in the final

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1 saw was a disposable apron. She asked the staff about
2 Covid-19, because she had seen footage of it on
3 television and of events in China and mainland Europe.
4 She was told not to worry, it will all be over by the
5 summer.

6 On 19 March, she arrived at the hospital and was
7 told visiting was being stopped, but a nurse let in her
8 for five minutes. At the end of the five minutes, her
9 mother asked why she was leaving. She said she couldn't
10 stay because of the coronavirus restrictions. She told
11 her mum that she'd be home soon and that they all loved
12 her. She waved bye bye and that was the last she saw of
13 her mother.

14 On 23 March, she made a phone call to the hospital
15 but was told that only limited information could be
16 given on the phone but of course, my Lady, there was no
17 other way to get information.

18 Half an hour after that, the Prime Minister
19 announced the lockdown restrictions. She then later
20 received a call asking if she agreed to no unnecessary
21 intervention in relation to her mother, and she thought
22 at that stage: is she going to make it? Can the family
23 be there? And she was told no. Twelve hours later, she
24 received a phone call to say that her mother had passed
25 away without any of her family being by her side. There

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1 phase of their loved ones' lives: no wake, human remains
2 treated like toxic waste.

3 My Lady, preparedness and resilience is not just
4 about science. It's about anticipating and minimising
5 the holistic overall impact of a pandemic and its
6 containment and eradication, the impact of that on human
7 beings.

8 My Lady, our families know that there is no other
9 person better equipped and suited with the forensic
10 expertise and compassion to deliver the truth for the
11 families of what happened, both in this module and the
12 modules to come.

13 Thank you very much for listening to us today.

14 **LADY HALLETT:** Thank you very much indeed, Mr Lavery. You
15 have made some very important points. Thank you very
16 much.

17 I shall break now and return at 2.10.

18 **MR KEITH:** My Lady, I think we may have to reconvene at
19 2.00, only because we have quite a number of openings to
20 get through this afternoon.

21 **LADY HALLETT:** Okay, very well. Sorry. I'm completely
22 misreading the clock. Forgive me everybody. Return
23 at 2.00.

24 (12.53 pm)

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(The short adjournment)

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1 (2.00 pm)

2 **LADY HALLETT:** Right, Ms Heaven.

3 **Submissions on behalf of Covid-19 Bereaved Families for**
4 **Justice Cymru by MS HEAVEN**

5 **MS HEAVEN:** Good afternoon, my Lady.

6 **LADY HALLETT:** Good afternoon.

7 **MS HEAVEN:** I represent the Covid-19 Bereaved Families for
8 Justice Cymru, and as you know we've submitted detailed
9 written submissions which we understand will be
10 published on the Inquiry's website today.

11 The Cymru group is dedicated solely to campaigning
12 for truth, justice and accountability for those bereaved
13 by Covid-19 in Wales. The Cymru group is led by
14 Anna-Louise Marsh-Rees, Sam Smith-Higgins, and
15 Liz Grant, and it's guided by the concerns of its
16 bereaved members across Wales. It is committed to
17 giving a voice to all of those in Wales who are bereaved
18 due to Covid-19, and to ensuring that there is proper
19 scrutiny of all government decision-making relevant to
20 Wales, including those decisions made in Westminster,
21 and by the Welsh Government in Wales.

22 My Lady, as you know from the time that you spent
23 visiting Wales prior to the commencement of these
24 hearings, the people in Wales have experienced and
25 continue to experience suffering and trauma due to the

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1 experience working in sectors heavily impacted by
2 Covid-19, and they experienced shocking conditions as
3 workers on the frontline. They saw first-hand the
4 failures and deficiencies in the Welsh Government's
5 pandemic preparedness, risk management, and civil
6 contingencies planning. The Cymru group have valuable
7 first-hand experience to offer the Inquiry and they
8 welcome the opportunity to participate and give oral
9 evidence and they continue to offer you their full
10 support, and it is hoped that the Inquiry continues to
11 hear as many of the voices of the Welsh bereaved as
12 possible.

13 Now, unlike Scotland, as you know, Wales has not
14 been granted its own public inquiry by the Welsh
15 Government. This Inquiry is therefore the only
16 opportunity the people of Wales will have to ensure that
17 there is proper scrutiny of the decisions of the
18 Welsh Government and their advisers in the planning and
19 response to the Covid-19 pandemic.

20 The people of Wales are looking for answers. They
21 are also looking for accountability, and for failures to
22 be acknowledged so that lessons can be learnt.

23 In the early days of this Inquiry, the Cymru group,
24 the UK Government, the Senedd and indeed this Inquiry
25 itself received repeated assurances from the

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1 devastation caused by Covid-19. As you will also have
2 been told, no doubt, on many occasions, many of those
3 bereaved people feel that they were let down by their
4 government. They feel let down because they have
5 experienced first-hand the consequences of what they
6 consider to be the catastrophic failure of the
7 Welsh Government to adequately prepare for and respond
8 to a pandemic in Wales.

9 I will touch on just a few of the stories relevant
10 to Module 1, but of course there are many, many stories
11 of loss which you will hear as part of Every Story
12 Matters.

13 Like many parts of the United Kingdom, many people
14 in Wales lost loved ones in care homes receiving
15 patients from overwhelmed local NHS Wales hospitals
16 where those care homes had inadequate isolation and
17 inadequate personal protective equipment, PPE.

18 The numbers of those dying in Wales due to
19 hospital-acquired Covid-19 was exceptionally high, and
20 in many cases this was in the context of well known
21 inadequate and poor infection control, and again a lack
22 of PPE.

23 Many of those hospitals, as I said, were known to
24 have inadequate ventilation.

25 Many members of the Cymru group have professional
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1 First Minister for Wales, Mark Drakeford, and the
2 Welsh Government that they were committed to fully
3 engaging with this Inquiry. It is against this
4 background that Mark Drakeford, as First Minister,
5 maintained and continues to maintain that there is no
6 need for Wales to hold its own public inquiry.

7 Mark Drakeford reminded the Right Honourable
8 Boris Johnson MP, as he then was, as Prime Minister,
9 that:

10 "... I would invite you to agree that all public
11 bodies engaging with the Inquiry are expected to
12 consider themselves under a duty of candour. That duty
13 should drive their culture of engagement with
14 the Inquiry and should lead to prompt and comprehensive
15 disclosure of all relevant material to the Inquiry.
16 A duty of candour should also guide the way public body
17 witnesses should approach the Inquiry."

18 The Cymru group do therefore formally wish to say
19 today that they are very disappointed by what they
20 consider to be the inadequate response and engagement by
21 the Welsh Government with this Inquiry in Module 1. In
22 earlier hearings core participants were told by your
23 Counsel to the Inquiry, Mr Keith KC, about the fact that
24 the Welsh Government had submitted first statements
25 containing assertions which were not supported by

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1 documentary evidence.

2 Having received the final witness statements
3 submitted by the Welsh Government and their advisers,
4 the Cymru group remain, frankly, shocked by the brevity
5 and lack of detail in some of those statements. It also
6 appears very disappointing that in some quarters there
7 appears to be a reluctance by certain ministers to take
8 political responsibility for failures to prepare for
9 a pandemic in Wales.

10 As you know, the Cymru group was so concerned with
11 the brevity and gaps in the statements submitted to this
12 Inquiry by First Minister for Wales Mark Drakeford that
13 they raised those concerns directly with your Inquiry
14 legal team.

15 It is important that I briefly touch on some of
16 those concerns today so that the Welsh public, who we
17 know are listening intently, are aware of what appears
18 to be missing from this statement.

19 In outline, Mark Drakeford's statement is
20 exceptionally brief, and it only deals with the period
21 of pandemic preparation for when Mark Drakeford was
22 appointed as First Minister for Wales in 2018.

23 Crucially, it fails to cover in any detail the
24 extended period from 2009 when Mark Drakeford was
25 involved in health and local government policy, both as

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1 questions that the Inquiry must closely scrutinise in
2 relation to Wales are as follows: what did the
3 Welsh Government know and not know in the period under
4 consideration by the Inquiry? What should the
5 Welsh Government have known and what different and
6 better decisions could have been taken by the
7 Welsh Government and their advisers? The Cymru group
8 consider that the following propositions appear, even
9 now, reflected in the evidence before this Inquiry, and
10 we have addressed these in much more detail in our
11 written opening submissions.

12 The Cymru group consider that pandemic planning in
13 Wales was the responsibility of the Welsh Government and
14 not the UK Government. For the avoidance of doubt, it
15 seems to the Cymru group that the First Minister for
16 Wales had ultimate responsibility and oversight for
17 pandemic planning in Wales as chair of the Wales
18 Resilience Forum.

19 The Cymru group consider that pandemic planning,
20 preparedness and resilience in Wales was wholly
21 inadequate, and that includes oversight and enforcement
22 in relation to implementing pandemic recommendations.

23 The evidence before the Inquiry, even at this early
24 stage, reveals that the Welsh Government and their
25 advisers had sufficient notice, knowledge and warnings

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1 a special adviser to the First Minister and a Minister
2 of the Welsh Government.

3 And crucially it fails to mention that as
4 First Minister of Wales, from December 2018 to the
5 current day, Mark Drakeford is head of and responsible
6 for oversight over pandemic planning in Wales as the
7 chair of the Wales Resilience Forum.

8 The statement provided by Carwyn Jones, who
9 of course is a former First Minister of Wales, from 2009
10 to 2018, so that's nine years, which are clearly within
11 the remit of this Inquiry, contains just over four pages
12 on pandemic planning.

13 My Lady, on any view these are fundamental and
14 significant omissions, which leave this Inquiry and the
15 bereaved in Wales at this stage with a significant gap
16 in fully understanding the state of knowledge and
17 decision-making and, ultimately, political
18 accountability in relation to pandemic planning in
19 Wales.

20 It is hoped, therefore, that moving forward there
21 will be a full commitment from the Welsh Government to
22 provide complete and timely disclosure and to providing
23 as much detail as possible on the questions that you ask
24 witnesses in your Rule 9 requests.

25 Now, the Cymru group consider that the critical

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1 of the risks to the lives of people in Wales from
2 a pandemic, including a SARS pandemic, but that they
3 failed to take adequate steps to prepare and build
4 resilience.

5 I'll just touch upon a few examples. Whilst Wales
6 held its own formal planning exercises, so that's
7 Taliesin 2009, Cygnus 2014, and Public Health Wales
8 Dromedary 2015, these exercises appear bureaucratic and
9 merely designed to satisfy administrative requirements
10 rather than address the substance of pandemic planning.

11 In terms of the adequacy of that planning,
12 Exercise Cygnus in 2014 tested the pan-Wales response
13 plan in Wales. However, the outcome document is
14 extremely brief and makes no mention of testing for
15 NHS Wales surge capacity, for example, PPE or RPE
16 demands and stockpiling. There is no mention of the
17 impact of restrictions on free movement. There is no
18 mention of workforce resilience. Just to pick out a few
19 examples.

20 Wales did not formally plan for the impact of any
21 lockdown measures, but tested them only after Covid-19
22 had arrived in the United Kingdom. Whereas England
23 tested for surge capacity, it appears that Wales did
24 not.

25 However, one of the most significant failures on the

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1 part of the Welsh Government was only planning for
2 an influenza pandemic, to the exclusion of planning for
3 other viruses with pandemic potential. This was
4 a catastrophic and unjustifiable failure. Not only had
5 the Welsh Government been warned about a very high death
6 toll from a flu pandemic in the years prior to Covid-19,
7 but there had also been two coronavirus pandemics in the
8 21st century, SARS and the Middle East Respiratory
9 Syndrome.

10 The Inquiry is asked to pay close attention to the
11 witness statement that has been provided to you from the
12 COVID-19 Airborne Transmission Alliance, which
13 systemically dismantles the flaw in the UK and, by
14 extension, the Welsh Government's failure to engage in
15 long-term planning for an aerosol-transmitted SARS
16 virus. The Cymru group endorse and support the crucial
17 work and analysis that has been carried out by the
18 COVID-19 Airborne Transmission Alliance.

19 So what about the implementation of lessons learnt
20 from pandemic planning groups in Wales? There were
21 a profusion of bodies apparently engaging in pandemic
22 planning in Wales, similar to the other devolved nations
23 and indeed to the United Kingdom.

24 For example, we've got the Wales Resilience Forum,
25 we've got the local resilience forums, we've got the

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1 improve infection control and the design and ventilation
2 of Welsh hospitals and care homes to reduce infection.
3 It appears in many of their very early documents that
4 you have before you. The Welsh Government knew that
5 they had to stockpile PPE/RPE but when the Covid-19
6 pandemic hit there was a shortage particularly of
7 FFP3 respiratory masks and, of course, of PPE.

8 The Welsh Government knew they had to plan for
9 excess deaths from a pandemic, including the worst case
10 scenario, and the figures in the documents are 210 to
11 315,000 excess deaths nationally in 15 weeks. There is
12 no evidence of a plan or a strategy to deal with excess
13 deaths or the consequences.

14 To take one small example, there is no evidence for
15 planning for sufficient body bags and storage. There
16 appears to be no evidence of adequate planning in
17 relation to post-death procedures, to protect dignity
18 and to support the Welsh bereaved in the event of
19 a pandemic, and this single failure caused untold
20 suffering in Wales.

21 The Welsh Government knew many years before Covid-19
22 struck that there would be a significant burden on
23 care homes and the care sector and on the vulnerable in
24 the event of a pandemic, and again, my Lady, when you
25 look closely at some of the very earliest Welsh planning

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1 Health Emergency Planning Group, the Wales Risk Group,
2 the Emergency Planning Advisory Group, the Mass Casualty
3 Group, the Training And Exercise Group, and the Wales
4 Pandemic Flu and Preparedness Group, and it goes on.

5 But what are these groups actually doing, the Welsh
6 bereaved ask. For example, were they communicating with
7 any administrations outside Wales? Whilst there were
8 clearly updates and tweaks to pandemic plans in Wales
9 over the years you are considering, the reality is that
10 it was minimal and it was inadequate. There appears to
11 be no evidence that all the groups that I have just
12 mentioned, and indeed many more, or that the formal
13 Welsh pandemic exercises, led to material changes to
14 Wales' level of preparedness and resilience.

15 Welsh hospitals continued with poor ventilation.
16 There was no planning and preparation in Wales for
17 responding to a sudden surge in demand in the social
18 care system. There were inadequate measures taken to
19 refresh or maintain sufficient levels of PPE and other
20 protective equipment stockpiles.

21 In other words, there appears to have been
22 inadequate implementation even for a serious and
23 catastrophic flu pandemic, let alone a pandemic such as
24 Covid-19.

25 The Welsh Government knew that they needed to

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1 documents, you will see those concerns raised. Yet
2 there is no evidence that shows these areas were
3 actually addressed in any real or substantive way.

4 In 2016, Exercise Cygnus revealed that "the UK's
5 current preparedness and response, in terms of its
6 plans, policies and capability, is currently not
7 sufficient to cope with the extreme demands of a severe
8 pandemic that will have a nation-wide impact across all
9 sectors".

10 So the question or one of the questions that
11 the Inquiry must consider is why there had been such
12 a failure in preparedness and resilience prior to 2016,
13 and in particular in Wales, from our clients'
14 perspective.

15 After the warning from Cygnus in 2016, the Cymru
16 group want to know whether the Welsh Government then
17 acted fast enough and seriously enough to prioritise
18 pandemic planning in the way that it warranted. If
19 Brexit or a lack of sufficient budget from the
20 United Kingdom Government is to be used as an excuse by
21 the Welsh Government for not protecting the people of
22 Wales from a pandemic, the Inquiry is asked to ascertain
23 how the Welsh Government sought to address such funding
24 issues.

25 For example, did the Welsh Government consistently

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1 ask the UK Government for more money after devolution
2 for pandemic planning? Did the Welsh Government tell
3 the people of Wales and their Senedd that because of
4 devolution they did not have the resources to adequately
5 prepare for a pandemic and protect the people of Wales?

6 It is now accepted in the statement of
7 Dr Frank Atherton, Wales' Chief Medical Officer since
8 2016, that Wales did fail to plan for long-lasting
9 pandemic and "the plans were inadequate for a two or
10 three-year shock to the system". The Cymru group
11 consider that this concession simply does not go far
12 enough. The truth is that the Welsh plans were wholly
13 inadequate for any widespread and potentially fatal
14 pandemic likely to result in high numbers of deaths, and
15 requiring restrictions, wide-ranging use of protective
16 equipment or wide-scale hospitalisation.

17 So the question is: why did this happen? My Lady,
18 we and, indeed, you are now beginning to see
19 an explanation emerging in the evidence before
20 the Inquiry. If we look at implementation and oversight
21 of pandemic-related recommendations in Wales,
22 Reg Kilpatrick, the Director General for Covid
23 Co-ordination and, from 2013, head of Welsh Government
24 civil contingencies and emergency planning, which
25 of course included pandemic planning, has now told this

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1 oversight of pandemic planning implementation onto civil
2 servants and the Senedd. The Cymru group consider that
3 this gives the Inquiry an insight into the Welsh
4 Government's approach to pandemic planning in the years
5 before Covid-19 and their willingness now to accept some
6 responsibility for what went wrong.

7 In terms of risks arising in the event of
8 a pandemic, the Welsh Government knew from before and
9 during the period under consideration by this Inquiry
10 that a pandemic was right at the top of the UK national
11 security risk register. However, those responsible for
12 pandemic planning in Wales do not appear to have taken
13 sufficient steps to understand and plan for the risks of
14 a pandemic as they would present in Wales. As now
15 acknowledged by Reg Kilpatrick, the national security
16 risk register contained assessments which "provide
17 information at a UK level of analysis rather than one
18 which would serve the Welsh Government". Mr Kilpatrick
19 now accepts that:

20 "Understanding threat and risk at a more
21 disaggregated level is essential to effective
22 preparedness."

23 And as a result he now explains that Wales has its
24 own Wales risk register.

25 However, risk in Wales ought to have been properly

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1 Inquiry that:

2 "Taking forward every recommendation has been
3 challenging against other more immediate priorities, but
4 we have endeavoured to turn learning into best practice
5 where we can and change structures and processes where
6 required for the better."

7 Vaughan Gething, Minister responsible for healthcare
8 in Wales, has admitted that he did not even check
9 whether the learning from Exercise Cygnus 2016 had been
10 implemented, but rather he states that he "assumed
11 absent any advice to the contrary or questions in the
12 Senedd that the lessons of Exercise Cygnus had been
13 applied".

14 Mark Drakeford gives a similar answer in his
15 statement to this Inquiry, namely:

16 "I do not recall any advice from officials from
17 there were any reservations about the state of Wales'
18 pandemic preparedness, nor did I recall any concerns in
19 the Senedd being raised with me."

20 It is deeply shocking to the Cymru group that those
21 with political responsibility for protecting people in
22 Wales from a pandemic did not consider it their job to
23 understand and check the state of pandemic preparedness
24 and resilience in Wales. Instead, there now seems to be
25 a distinct attempt to shift responsibility for the

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1 understood in detail by the Welsh Government at the
2 time, and the Cymru group do ask the Inquiry to get to
3 the bottom of whether or not there was, in fact, a Welsh
4 risk register in place during the relevant period under
5 consideration.

6 The simple fact is that Wales and the Welsh
7 Government did not have an adequate understanding of the
8 risks posed to the people of Wales from a pandemic
9 before and during the relevant period, and this led to
10 much more severe consequences from Covid-19 for
11 vulnerable groups and communities in Wales.

12 For example, pandemic preparedness failed to take
13 account of the acute health inequalities in Wales
14 distinct from the rest of the United Kingdom, and that
15 specifically includes levels of chronic ill health and
16 disability in the older population.

17 Professors Bambra and Sir Michael Marmot in their
18 report indicate that pre-existing health inequalities
19 were considered in no more than in a minimal way in the
20 devolved administrations and even in UK pandemic
21 planning.

22 The Welsh Government should have sought to
23 understand and incorporate considerations of health
24 inequalities that existed in Wales into its pandemic
25 planning as soon as they had the power to do so, which

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1 of course was after devolution in 1999.

2 My Lady, when you consider the explanations that
3 will be offered to you by the Welsh Government as to why
4 they could not fully and adequately build resilience and
5 prepare for a pandemic in Wales, you just need to bear
6 in mind that the Welsh Government have had 24 years
7 since devolution to plan for such a pandemic in a way
8 that best protected the most vulnerable and
9 disadvantaged in our society.

10 There are many other vitally important topics that
11 the Cymru group ask you to scrutinise which, for reasons
12 of time, can't be covered in detail in these submissions
13 today. But, in brief, these include intergovernmental
14 political relations between Wales and the United Kingdom
15 Government; the co-ordination between the United Kingdom
16 Government and the Welsh Government and their medical
17 and scientific advisers; variation in standards in the
18 approach to planning and preparation; the investment in
19 resilience of -- and the resilience of people and the
20 systems in Wales, for example the adequacy of training,
21 information technology and NHS Wales digitisation and
22 data sharing; and finally, planning in relation to
23 post-death procedures, as I've said, to protect the
24 dignity and to support the Welsh bereaved in the event
25 of a pandemic.

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1 pandemic of 1918, Albert Marrin, Emeritus Professor of
2 History at Yeshiva University, wrote in 2018:

3 "When the next pandemic comes, as it surely will
4 someday, perhaps we will be ready to meet it. If we are
5 not, the outcome will be very, very, very dreadful."

6 The Inquiry will come to hear that the UK and
7 Scotland was not prepared, that the capacity of the UK
8 to cope with and recover quickly from difficulties
9 caused by Covid was diminished by years of changes to
10 critical establishment, underfunding, cuts, failures to
11 address inequality, and the effects of Brexit.

12 Despite a belief that the UK was a world leader in
13 preparedness, it quickly and terrifyingly became clear
14 that we were not. The fact is, at best, those in charge
15 sought to prepare for the wrong pandemic. Whilst it may
16 be true that in planning for a pandemic there are,
17 of course, areas of supposition and hypothesis, what
18 ought to have been clear is that years of austerity and
19 the effects of Brexit had left the UK woefully
20 underprepared for the virus that swept our shores.

21 The Inquiry will come to hear from
22 Sir Oliver Letwin, Minister for Government Policy, 2010
23 to 2016, Inquiry reference 000177810 at paragraph 8. He
24 states:

25 "As we all now know, in the event we were much

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1 So, in conclusion, the Cymru group very strongly
2 believe that there was a failure to adequately prepare
3 and build resilience in Wales for a pandemic, and that
4 this caused unnecessary pain, suffering and ultimately
5 death.

6 Through their own experiences, the Cymru group know
7 only too well that in Wales there were many preventable
8 deaths from Covid-19. The Cymru group consider that the
9 Welsh Government must now acknowledge what went wrong.
10 This is vital to ensure that lessons are learnt from the
11 experience of Covid-19 in Wales, so that when the next
12 pandemic arrives Welsh lives are better protected. The
13 Welsh Government must now make a genuine commitment to
14 long-term pandemic planning.

15 Thank you.

16 **LADY HALLETT:** Thank you very much indeed, Ms Heaven, very
17 grateful.

18 Dr Mitchell KC.

19 **Submissions on behalf of Scottish Covid Bereaved by**
20 **DR MITCHELL KC**

21 **DR MITCHELL:** I'm instructed by solicitor Aamer Anwar on
22 behalf of the Scottish Covid Bereaved. My learned
23 juniors Kevin McCaffery and Kevin Henry assist me, along
24 with the solicitors' team, Aamer Anwar & Company.

25 In writing on the "great flu", the influenza

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1 better prepared to deal with the pandemic influenza that
2 we did not face, than we were to deal with the Covid-19
3 that we did face."

4 The Inquiry will also hear from Matt Hancock,
5 Secretary of State for Health and Social Care, July 2018
6 to June 2021, Inquiry statement INQ000181825, at
7 paragraph 6:

8 "On coming into post as Health Secretary I was
9 advised that the UK was a world leader in preparations
10 for a pandemic. Whilst this may have been the heartfelt
11 belief, it did not turn out to be the case when faced
12 with what became known as Covid-19. Once we understood
13 the threat from the disease, the lack of concrete
14 preparedness plans became clear."

15 According to the National Records of Scotland, as at
16 4 June 2023 there were 17,646 deaths in Scotland where
17 Covid-19 was mentioned on the death certificate. Many
18 of those who have died because of poor mental health as
19 a result of the effects of the pandemic will not be
20 recorded as Covid deaths, although it is equally to
21 blame. The same can be said for those who couldn't
22 access medical services which might have saved their
23 lives.

24 The true cost, the true human cost of Covid cannot
25 be calculated in numbers.

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1 Each of these deaths not only represents
2 an individual tragedy, but has affected friends and
3 family, loved ones, colleagues, neighbours of each one
4 who died. No one in the UK has been unaffected by the
5 pandemic.

6 Scottish Covid Bereaved began as part of a Facebook
7 group. They now represent a group of like-minded
8 bereaved individuals who share common goals, not wanting
9 the deaths of their loved ones to have been in vain and
10 for lessons to be learned by governments and public
11 authorities to ensure that no one else will have to
12 suffer in the same way as its members have.

13 The Scottish Covid Bereaved are certain that in
14 sharing lived experiences both throughout the pandemic
15 and afterwards, they will greatly assist the Chair in
16 understanding the impact of the pandemic and the
17 response, how decisions affecting every individual were
18 made, and the lessons which can and must be learned to
19 ensure we are all better prepared to face any future
20 pandemic.

21 While Scottish Covid Bereaved came together as
22 a result of the shared experience of suffering
23 bereavement due to the pandemic, their membership
24 includes those with experience of other consequences of
25 the pandemic: healthcare workers who were on the

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1 Why was the stock of PPE which had been built up and
2 stockpiled at considerable expense since the swine flu
3 epidemic of 2009 not properly monitored for the expiry
4 of items, and why were the necessary replacements not
5 ordered?

6 Why, according to media reports, were millions of
7 items of expired PPE readmitted to the stockpile and
8 relabelled with new expiry dates over the old? What
9 does this say of the UK's preparedness for a pandemic?

10 Were the politicians from the UK and devolved
11 administrations able to put aside political differences
12 and to act in the public interest?

13 Was our NHS in Scotland properly staffed and
14 resourced to allow it to deal with a pandemic of this
15 magnitude?

16 Were our social care services properly staffed and
17 resourced?

18 Were our public health institutions properly funded
19 and structured to allow them to deal with the pandemic?

20 These questions in this module represent only a tiny
21 number of the many questions that in the future will
22 need to be answered, like: did our politicians ignore
23 the science until it was too late? Why were Scotland's
24 Chief Medical Officers, senior nursing officers and many
25 others not invited to important SAGE meetings? Who

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1 frontline of the response to Covid-19, many of whom
2 continue to suffer from trauma as a result of their
3 experiences; members of ethnic minorities who suffer as
4 a result of inequalities in health; sufferers of
5 long Covid, who continue to be affected by a lack of
6 medical knowledge of and treatment for the condition;
7 relatives of an individual who died after having
8 contracted Covid-19 while unvaccinated in custody,
9 illustrating issues of vaccine roll-out in the prison
10 setting and the provision of healthcare for those
11 individuals.

12 Although diverse in experience, the Scottish Covid
13 Bereaved are united in their commitment to ensure that
14 this Inquiry carries out its task properly in this
15 module, and assesses whether the pandemic was properly
16 planned for and whether the UK was adequately ready for
17 the eventuality.

18 My learned friend Mr Keith KC in his opening speech
19 set out many questions that the Inquiry will consider,
20 and those questions are welcomed by the Scottish Covid
21 Bereaved. Here are some further questions that they
22 want answers to.

23 Why were crucial questions not learned from the
24 2002-2004 SARS outbreak, the 2012 MERS outbreak and the
25 pandemic planning exercises?

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1 decided on the deadly steps of releasing untested people
2 into care homes from hospitals whilst relatives, despite
3 having proof of negative Covid tests, were cruelly
4 denied the right to visit their relatives. Why did
5 Downing Street delay the lockdown? What was the
6 scientific justification for Rishi Sunak's Eat Out to
7 Help Out scheme? Why were our governments so slow in
8 acting on asymptomatic and aerosol-generated
9 transmission despite scientific evidence?

10 Today it will be over three years since the first
11 death from Covid-19 took place in this country. In that
12 time probably nearly quarter of a million people have
13 died either directly or indirectly from Covid, as our
14 leaders now stand accused of presiding over a carousel
15 of chaos.

16 In the coming weeks, months and years, the mantra
17 for some who will give evidence to this Inquiry will be
18 "with the benefit of hindsight", but our governments had
19 been tasked with preparing for a pandemic for decades.

20 For a few brief moments in the pandemic, death
21 sparked a universal grief as we were asked to unite
22 behind our nation's politicians and stand on doorsteps,
23 but very quickly we were asked to move on. Now is the
24 time for careful reflection. Those who lost loved ones
25 will no longer be invisible in their misery and it's for

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1 this Inquiry to illuminate the truth of what's happened
2 and why.

3 Over the coming months and years, at times this
4 Inquiry may falter, but it cannot fail. It will come
5 under sustained and repeated attacks. It will suffer
6 legal challenges in its quest to obtain the evidence it
7 needs to shed light on what happened. It must, however,
8 never be afraid to raise its voice for the truth. That
9 is the very least we owe to those who lost their lives
10 and to those in the future who may be saved by the
11 implementation of this Inquiry's findings.

12 The work of this Inquiry may save many more lives in
13 the next pandemic than all the preparation that wasn't
14 done in advance of the Covid pandemic. Governments
15 would do well to remember this when they fail to provide
16 information requested by this Inquiry.

17 No person, no institution, no matter how powerful,
18 whether it be in England, Scotland, Wales or
19 Northern Ireland, Westminster, Holyrood, can obstruct
20 the search for truth.

21 The Scottish Covid Bereaved have and will tell their
22 heartbreaking stories. We will question our leaders,
23 our civil servants, our physicians, because, for the
24 bereaved, the words "truth" and "change" must be the
25 legacy of this Inquiry.

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1 **MR STANTON:** Good afternoon, my Lady.

2 **LADY HALLETT:** I'm hoping we'll get away from having to wait
3 for the lectern to move across the room.

(Pause)

5 **MR STANTON:** My Lady, thank you for this opportunity to
6 address you.

7 The opening statement on behalf of the British
8 Medical Association, the BMA, is as follows: doctors and
9 other healthcare workers were on the front line of the
10 UK's response to Covid-19, and they worked tirelessly to
11 treat and care for patients with Covid and those with
12 other healthcare needs. In doing this, they put
13 themselves at increased risk from the disease itself and
14 from the stress and pressure of working through a public
15 health crisis of this scale.

16 For many doctors and other healthcare workers,
17 deficiencies in pandemic planning and resilience had and
18 continue to have a significant impact on their
19 day-to-day lives.

20 An examination of the decade before the pandemic and
21 of the UK's readiness is essential to ensure the UK is
22 better prepared in the future.

23 This statement seeks to highlight four key areas
24 that the BMA considers should be explored within the
25 Module 1 hearings to assist the Inquiry to identify what

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1 Across the United Kingdom, thousands felt
2 marginalised, isolated, betrayed and lied to as the
3 cries of the dying went unheard. It is for those
4 thousands who died, who can no longer cry out for
5 justice, that the bereaved families fight.

6 The Scottish Covid Bereaved welcomes the
7 commencement of the public hearing for the UK Inquiry
8 and acknowledge the massive amount of work done to date
9 and commend the determination of the Inquiry to uncover
10 the truth, and we intend to fill our role as
11 core participants to support the Inquiry in achieving
12 that end.

13 It is not only in the interests of the Scottish
14 Covid Bereaved but it is in the interests of every
15 person in the United Kingdom that this Inquiry
16 understands what happened, why it happened and what can
17 be done to ensure that when the next pandemic comes, as
18 it surely will some day, we will be prepared.

19 These are the submissions for the Scottish Covid
20 Bereaved.

21 **LADY HALLETT:** Thank you very much indeed, Dr Mitchell, very
22 grateful.

23 Right, I think it's Mr Stanton next.

24 **Submissions on behalf of the British Medical Association by**
25 **MR STANTON**

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1 went wrong and to make appropriate recommendations for
2 much needed change and improvement.

3 It is based on the views and priorities of the BMA's
4 membership, including the overriding priority of all
5 doctors to deliver the best care and treatment for
6 patients.

7 The BMA has gathered extensive feedback from its
8 membership over the course of the pandemic and since,
9 and selected examples are included within this statement
10 to illustrate the points made.

11 First, there was a failure to prepare adequately for
12 a range of pandemic threats. The UK's pandemic planning
13 was predominantly focused on an influenza-style
14 pandemic. This narrow focus was an oversight,
15 particularly as there had been relatively recent
16 coronavirus outbreaks, including SARS in 2002 and MERS
17 in 2012.

18 One consequence of the predominant focus on
19 an influenza-style pandemic was that the UK's response
20 to Covid-19 failed to properly consider the potential
21 for aerosol transmission of the virus.

22 This in turn impacted the public health measures put
23 in place, including the focus on hand washing and the
24 delay in mandating mask wearing for the public.

25 For doctors and other healthcare workers, the

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1 failure in considering aerosol transmission resulted in
2 insufficient stocks of appropriate PPE and inadequate
3 infection prevention and control in healthcare settings.
4 As one doctor in Scotland said:

5 "The PPE guidance was based not on safety, but
6 rather the lack of preparedness."

7 Shockingly, this is the case even now. The current
8 IPC guidance continues to put staff and patients at risk
9 by erroneously stating that fluid-resistant surgical
10 masks are adequate protection for healthcare workers
11 carrying out routine care for Covid positive patients,
12 rather than specifying respirators such as filtering
13 facepiece respirators, often referred to as FFP2 and
14 FFP3 masks, which are recommended by international
15 guidance and by the BMA.

16 The limitations of surgical masks were well known
17 prior to the pandemic, highlighted, for example, in
18 a research report by the Health and Safety Executive in
19 2008. The HSE report noted that whilst surgical masks
20 may reduce residual aerosol risk to some degree, they
21 might not sufficiently reduce the likelihood of
22 transmission, and consequently surgical masks should not
23 be used in situations where close exposure to infectious
24 aerosols is likely.

25 This same 2008 report also predicted the crisis of
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1 While the UK did carry out a planning exercise based
2 on a coronavirus, Exercise Alice in 2016, this exercise
3 did not sufficiently prepare from a wider range of
4 infectious disease threats and, crucially, key lessons
5 from this exercise, as well as transferable learning
6 from pandemic influenza exercises, were not implemented.

7 One of the most significant failures in this regard
8 again concerns the availability and provision of
9 appropriate PPE. The recommendations from
10 Exercise Alice, Exercise Cygnus, also in 2016, and
11 Exercise Iris in 2018 were to review current PPE stocks,
12 to create a pandemic stockpile of PPE, to ensure staff
13 had clear instruction and training in the use of PPE and
14 infection control, and to develop a whole system
15 approach to distribute PPE.

16 However, the failure to implement these
17 recommendations and to properly maintain the
18 PPE stockpiles before the pandemic meant that PPE
19 quickly ran out when Covid hit, and there was no
20 effective plan in place to replenish it through
21 effective procurement systems or local manufacturing
22 capacity.

23 This led to many healthcare staff being forced to
24 work unprotected from the virus, placing them at
25 significant risk.

1 PPE supply, including the following statement:

2 "The widespread use of respirators might be
3 difficult to sustain during a pandemic unless provision
4 is made for their use in advance."

5 As the regulator entrusted with the protection of
6 worker health, the Health and Safety Executive will be
7 in a position to help the Inquiry understand what more
8 should have been done to mitigate the risks to workers
9 of an airborne virus.

10 The BMA has heard from countless doctors who are
11 concerned about the failure to provide adequate
12 protection, including a GP in Northern Ireland who
13 complained that there was:

14 "... no attempt by the health and social care board
15 to follow the science on airborne transmission and the
16 need for staff to have FFP3 masks and HEPA air filters."

17 Governments could and should have been better
18 prepared for the foreseeable risks to doctors and
19 healthcare staff. This would have reduced the serious
20 harm that affected so many of the BMA's members and the
21 wider healthcare workforce, many of whom are today still
22 suffering with long Covid acquired in their workplace.

23 The second key area to highlight is in respect of
24 the failures to implement the recommendations from
25 pandemic planning exercises.

1 The fact that in March 2020 NHS England assured the
2 Health and Social Care Committee that there was
3 sufficient supply of PPE nationally, despite stocks
4 containing less than two weeks' worth of most equipment,
5 suggests serious failures of planning and preparation.

6 Frontline staff often had to go without PPE, buy
7 their own, use home-made, donated or expired items, and
8 re-use single use items. Staff also had to use items
9 that were out of date, with multiple expiry stickers
10 visibly layered on top of each other. Many felt
11 pressured to work without adequate protection, with
12 consequences for their mental and physical health.

13 In a BMA survey, as part of its Covid-19 review, 81%
14 of respondents reported not feeling fully protected
15 during the first wave of the pandemic, and feeling
16 worried or being fearful to speak out about the lack of
17 PPE. That was more commonly reported by doctors from
18 an ethnic minority background and those with
19 a disability or long-term health condition.

20 Commenting on the wholly inadequate supply of PPE,
21 a GP in Northern Ireland said:

22 "We were sent six pairs of gloves and six aprons in
23 an envelope approximately three weeks after the start of
24 lockdown."

25 A doctor in England recalled how they "made our own

1 and bought our own when we could find any, we depended
2 on friends sourcing FFP3 masks and my son's school 3D
3 printing visors".

4 These failures of planning and preparation also led
5 to PPE being procured from organisations with no
6 experience of manufacturing PPE, resulting in PPE being
7 produced and delivered that was unsuitable for use at
8 huge public expense. It also led to the ludicrous
9 spectacle of doctors making aprons from bin liners
10 because they were sturdier than the PPE equipment
11 provided.

12 Another serious failure to implement the
13 recommendations of planning exercises included the
14 identified need for further work to ensure adequate
15 contact tracing and testing capacity, identified in
16 Exercise Iris.

17 The UK made a number of decisions ahead of and
18 during the Covid-19 pandemic in relation to contact
19 tracing which hampered the response. Little
20 consideration was given within pandemic planning
21 policies and strategies to detect and contain the spread
22 of the disease, but rather the emphasis was on how to
23 respond in a situation where there was already
24 significant mortality and morbidity. For pandemic
25 planning policies to be comprehensive and effective,

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1 for staff themselves. As one junior doctor in England
2 told the BMA:

3 "There was a delay in allowing testing of all
4 patients with possible Covid symptoms. I was seeing
5 patients in A&E and being told I could not test them
6 because they had not travelled to relevant countries.
7 When testing was later allowed some of these patients,
8 unsurprisingly, ended up testing positive. I saw these
9 patients with no PPE due to hospital rules around when
10 PPE was allowed to be worn."

11 A further failure to implement key recommendations
12 from planning exercises is in respect of the need for
13 surge capacity in the health service identified in
14 Exercise Cygnus and Exercise Pica in 2018.

15 This issue is closely connected to the next and
16 third key area, which is that the public health system
17 was not in a position to scale up its activity to
18 respond to the pandemic due to a decade or more of
19 reduced funding, resource cuts and reorganisations that
20 caused fragmentation in the system.

21 Public health systems across the UK entered the
22 pandemic without the necessary resources, workforce,
23 capacity and structures to respond at the speed and
24 scale required.

25 The reforms introduced in England by the 2012 Health

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1 both strategies need full consideration.

2 The decision to abandon contact tracing on
3 12 March 2020 was ostensibly because the UK was moving
4 from the contain to the delay stage of the pandemic,
5 although it later emerged that this decision was at
6 least partly due to a lack of capacity. Contact tracing
7 was not reinstated for several months, with Wales being
8 the last nation to restart contact tracing on 1 June,
9 a critical period during which there was sustained
10 transmission of the virus.

11 These issues were compounded by a lack of testing in
12 the community and the NHS. The shortfall in testing
13 capacity is partly due to the UK Government's failure to
14 utilise the 44 pre-existing NHS laboratories and
15 an over-reliance on both the private sector and the
16 seven Lighthouse laboratories. The expense and effort
17 of using these alternative laboratories, which operated
18 independently of public health and NHS infrastructures,
19 and used different software and systems, was unnecessary
20 and created unhelpful fragmentation.

21 The failure to adequately prepare for the testing
22 capacity that was needed left healthcare workers and
23 their patients at increased risk of exposure to
24 Covid-19, particularly at the beginning of the pandemic.
25 Tests were not available for incoming patients or even

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1 and Social Care Act, which moved responsibility for
2 public health into local authorities, fractured the
3 links between public health specialists and
4 NHS colleagues, meaning communication and information
5 sharing was compromised during the pandemic.

6 One public health doctor told the BMA that:

7 "The separation of public health into local
8 authorities and Public Health England meant that many
9 public health consultants and teams in local authorities
10 became deskilled in health protection work. This put
11 a huge burden on the whole workforce, with health
12 protection consultants having to manage the majority of
13 the response and provide detailed guidance and support
14 to local authority colleagues who felt unconfident and
15 unprepared for dealing with infectious disease
16 outbreaks."

17 The reforms also left public health services
18 vulnerable to cuts in local authority spending
19 settlements in the years preceding the pandemic. This
20 decline in funding has coincided with a decline in the
21 size of the public health workforce. To meet the
22 Faculty of Public Health's recommendation from 2021 for
23 the management of full-time public health specialists
24 per capita, the workforce would need to increase by 59%
25 in England, 32% in Scotland, 18% in Wales and 97% in

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1 Northern Ireland.

2 The fourth and final key area to highlight is that
3 the UK entered the pandemic with poor population health,
4 widening health inequalities, and health services that
5 had been consistently underfunded and understaffed.

6 In order to holistically assess the state of the
7 UK's preparedness, it is also important to consider the
8 high levels of population ill health and health
9 inequalities.

10 Before anyone had heard of Covid-19, gains in life
11 expectancy, a key measure of our nation's health, had
12 already started to stall, while health inequalities were
13 widening after a decade of austerity.

14 Severe cuts to public health service and social
15 security funding, amounting to billions of pounds since
16 2010, have negatively impacted the availability of
17 services that are essential for good population health.
18 This in turn hindered the UK's ability to respond
19 effectively to the Covid-19 pandemic.

20 There had also been a marked deterioration within
21 health and care systems in the decade leading up to the
22 Covid-19 pandemic caused by a failure to invest, to
23 ensure adequate capacity, staffing and infrastructure.

24 For instance, the UK went into the pandemic with
25 a very low total number of hospital beds relative to its

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1 population, and very low numbers of ICU beds, which
2 significantly hampered its ability to cope with the
3 number of patients needing hospitalisation with Covid.
4 This, combined with workforce shortages and already high
5 waiting lists, meant that the health service had no
6 ability to step up capacity to cope with the increased
7 demand from Covid-19 alongside the continuation of
8 existing services.

9 As one consultant in England told the BMA:

10 "Being understrength to begin with in terms of
11 staffing and already working with bed occupancy at or
12 above 100% pre-pandemic meant no headroom for managing
13 the eventual large increase in demand that came."

14 These failures to ensure a resilient, well-resourced
15 health and care system were brutally exposed by the
16 pandemic, and the systems are now in an even worse
17 state, with more people waiting for care than ever,
18 a staggering 7.4 million patients in England alone,
19 unsafe bed occupancy levels, acute staffing shortages,
20 neglected infrastructure, and deteriorating equipment.

21 This, in the BMA's view, is the elephant in the room
22 when considering issues of planning, preparation and
23 resilience, and unless it is acknowledged and addressed,
24 the same mistakes are destined to be repeated.

25 Thank you, my Lady.

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1 **LADY HALLETT:** Thank you very much indeed, Mr Stanton.
2 Mr Jacobs.

3 **Submissions on behalf of the Trades Union Congress by**
4 **MR JACOBS**

5 **MR JACOBS:** Good afternoon, my Lady, I appear on behalf of
6 the Trades Union Congress, the TUC, instructed by
7 Thompsons Solicitors.

8 The TUC brings together 5.5 million working people
9 who make up its 48 member unions and who span a wide
10 range of sectors profoundly affected by the Covid-19
11 pandemic.

12 In this module, the TUC is working in partnership
13 with the Wales TUC, the Scottish TUC, and the
14 Northern Ireland Committee of the Irish Congress of
15 Trade Unions. The Scottish TUC and the Irish Congress
16 of Trade Unions are separate organisations to the TUC
17 but with shared purposes and aims, and together we seek
18 to represent the interests in this Inquiry of a great
19 many unions, all listed in our written opening, right
20 across the four nations of the UK.

21 My Lady, I start with three points of context.

22 The first is that of loss and sacrifice. Given our
23 interests, we focus on the loss and sacrifice during the
24 pandemic of the working population. Those in health and
25 social care were truly on the front line of a national

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1 emergency. Of course, so many others also kept the
2 country going: those who stacked our shelves, who drove
3 the buses and trains so that key workers could attend
4 work, who delivered parcels to our doors, who worked the
5 production lines so food and necessary goods could
6 continue to be produced, who cleaned our transport and
7 public buildings, and so many others.

8 Far too many died. In the period March to
9 December 2020 alone, there were 8,000 deaths of working
10 age people related to Covid-19. Those occupations with
11 the highest death rates over that period were the
12 elementary occupations: caring, leisure and other
13 service occupations, and process plant and machine
14 operatives.

15 The factors driving the difference in death rates
16 are multifactorial. Certainly it appears to have been
17 those in jobs with regular exposure to Covid-19 and
18 those working in close proximity to others that had
19 higher death rates than compared with the general
20 working population. But those occupations also
21 intersect with other factors of ethnicity, low pay and
22 poverty, insecure work, poor housing and higher rates of
23 pre-existing health conditions.

24 Significantly, it was not just loss, it was
25 avoidable loss. The Inquiry will hear evidence that the

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1 UK fared poorly in terms of death rates as compared with
2 countries of comparable resource.

3 The second point of context is to reflect on the
4 symbolic importance of this Inquiry having reached the
5 first day of its substantive hearings. It is
6 an important Inquiry. If it is effective, it will bring
7 truth and understanding to many thousands who wish to
8 better understand the circumstances that led to the
9 deaths of loved ones. The Inquiry will also be forward
10 looking and will seek to learn lessons. If the country
11 when confronted with the next pandemic, as it
12 undoubtedly will, has the benefit of lessons learned
13 from this Inquiry, it is no hyperbole to say that this
14 Inquiry has the opportunity to reduce avoidable deaths
15 by their thousands.

16 It is also a challenging Inquiry, given its scope,
17 and we take this moment to commend the Inquiry for
18 having reached substantive hearings in such
19 a comparatively short timeframe.

20 My Lady, we have not agreed on all matters, but we
21 absolutely recognise the industry of the Inquiry team
22 and its desire and yours to get it right. We are
23 confident that much good work has been done by this
24 Inquiry to get it on its way.

25 The third point of context is a less positive one.

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1 The position taken by the Cabinet Office is
2 corrosive because it damages confidence in this Inquiry.
3 It smacks of having something to hide, of fighting tooth
4 and nail to avoid revealing all to the Inquiry.

5 Fundamentally, the judicial review will not really
6 solve anything but a point of legal construction. What
7 the public want to know is not whether the High Court
8 will force the Cabinet Office to provide documents, but
9 whether the Cabinet Office can approach this Inquiry,
10 not just now but going forward, with the spirit of
11 openness and candour that we deserve.

12 Those in the Cabinet either have the will to respond
13 openly to this Inquiry or they do not, and that's not
14 a question that can be answered by the High Court. It
15 is a matter of regret, it appears to us, that these
16 substantive hearings start under something of a cloud.

17 I turn to summarise, my Lady, very briefly, six
18 themes that we believe are emerging in the evidence
19 collected by this Inquiry in Module 1.

20 The first is the legacy of austerity. We believe
21 this to be a central theme. It rests on a simple but
22 inescapable truth, that public services stretched to
23 breaking point by over a decade of budget cuts will be
24 severely impaired in their ability to cope with the
25 shock of a national emergency such as a pandemic.

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1 It concerns the openness and candour, or lack of it, of
2 the current Westminster government. The Inquiry, and
3 more importantly the public, deserve openness and
4 candour from those who governed during the pandemic and
5 who govern now.

6 At the preliminary hearing in Module 2 last Tuesday,
7 this Inquiry made absolutely clear, yet again, the
8 difficulties that have been created by Cabinet Office
9 refusals to provide documents that this Inquiry wants to
10 see. A number of core participants shared expressions
11 of concern.

12 The response of the Cabinet Office was a letter of
13 Friday refusing to provide any of the disputed documents
14 but pending the judicial review that is to be heard on
15 30 June or shortly thereafter. It is refusing even to
16 return Boris Johnson's diaries to him, as it knows that
17 Mr Johnson intends to provide them to the Inquiry.

18 Mr Johnson himself has been complaining to The Times
19 newspaper of the Cabinet Office foot dragging in its
20 responses to the Inquiry, of wasting public time and
21 money by delaying the Inquiry, and of deliberately
22 frustrating the Inquiry's work.

23 My Lady, the infighting jars with the terrible
24 losses described in the impact film that we watched this
25 morning.

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1 It will be a striking feature of the evidence that
2 so many witnesses from across government, particularly
3 in the devolved nations, from those at the centre of
4 public health services and health and social care and
5 from a range of professional organisations will describe
6 the disastrous consequences of austerity.

7 It impaired our national preparedness and resilience
8 in a number of ways. It certainly impacted the
9 resilience and capacity of public services, but it also
10 exacerbated the deep structural, social and health
11 inequalities that exist in our society.

12 Public health services will be hollowed out and so
13 services are less able to address those inequalities.
14 There is also a clear link between economic deprivation
15 and health inequality, but a serious of welfare benefit
16 cuts hit the poorest in society, particularly those with
17 children and of working age.

18 Since 2010, £14 billion has been cut from support to
19 households through social security and welfare benefits,
20 predominantly in the period 2010 to 2016, when
21 David Cameron was Prime Minister and George Osborne the
22 Chancellor.

23 Rates of in-work poverty have increased. Going into
24 the pandemic, the UK was suffering from deteriorating
25 health and widening health inequalities. They meant

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1 that the health and social care sectors were treating
2 a population with significant and growing health
3 problems. Decreasing funding and increasing need
4 creates a perfect storm. It also meant that the impact
5 of a pandemic on many of the higher risk occupations,
6 those who continued to attend work and have exposure to
7 the virus and work in proximity with others in
8 elementary occupations, processing plants, care
9 occupations, and others, like the 57-year old taxi
10 driver we heard about in the film this morning, was
11 an impact upon a working population that already had
12 worsening rather than improving levels of health.

13 Austerity also almost eradicated any meaningful
14 service able to enforce health and safety in workplaces.
15 The primary regulator for health and safety in places of
16 work is the Health and Safety Executive. In ten years
17 of austerity, its government funding dropped from
18 £231 million each year to £123 million.

19 On 11 May 2020, as many had or were returning to
20 work, Boris Johnson sought to provide reassurance that
21 the HSE would be undertaking spot inspections to make
22 sure that businesses were keeping employees safe, but
23 that was a vacuous reassurance in circumstances that
24 austerity had left the HSE so depleted in its resources.

25 By early June 2020 the HSE had already received over
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1 year, a workforce burnt out by the demands of the
2 preceding years and vacancies at a five-year high.

3 If we are to fare better and prevent such
4 devastating loss of life in the next health emergency,
5 appropriate levels of funding and a long-term recovery
6 strategy must be implemented.

7 The third theme is capacity and resilience of our
8 social care sector. Prior to the pandemic, plans for
9 the NHS to surge capacity in an emergency placed
10 significance reliance on the ability of the social
11 care sector to provide additional bed capacity. But as
12 with healthcare, the social care sector has huge
13 problems with capacity and staffing. The evidence will
14 also indicate that it barely featured in pandemic
15 planning.

16 The fourth theme is fragmentation of our public
17 services. The organisational structures of our public
18 health services have in recent years undergone near
19 constant reorganisations. This morning Mr Keith showed
20 us a helpful organogram. It provides a visual and
21 striking representation of a fragmented system which
22 looks much more like a bowl of spaghetti than a clear
23 and co-ordinated framework for a cogent national
24 response.

25 On behalf of the British Medical Association,
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1 6,000 additional concerns from workers about social
2 distancing and other pandemic-related matters, but those
3 concerns resulted in the sum total of 47 physical
4 inspections of workplaces and one prohibition notice.
5 It was a regulator utterly bereft of any teeth.

6 The lessons learnt in this Inquiry as to pandemic
7 planning and preparedness will no doubt be many and
8 varied, but the central and salutary lesson from the
9 pandemic should be a fundamental re-evaluation of the
10 critical importance and value of our public services.
11 Specific planning for future pandemics must rest on
12 a foundation of public services that are valued and
13 adequately funded. We agree with the observation made
14 a few moments ago that it is the elephant in the room.

15 The second theme is capacity in our healthcare
16 system. The impression of the NHS collapsing in on
17 itself under the weight of increased demand and
18 decreasing funding is familiar. It would run hot each
19 winter from winter flu, let alone a novel coronavirus.
20 Due to problems with funding, staffing, equipment, bed
21 spaces and waiting lists, the NHS in early 2020 did not
22 have the capacity to meet existing demand, and not
23 an urgent new one.

24 It is a crisis which continues to develop, with NHS
25 waiting lists reaching 7.33 million in March of this
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1 fragmentation in healthcare has just been described, but
2 it is also an acute problem in the social care sector.
3 In social care, the problem has not been so much one of
4 repeated restructuring and reorganisation, but one of
5 neglect. There has been no attempt to structure at all.

6 Adult social care in England is now provided by
7 around 18,000 organisations. The overall workforce is
8 larger than that in the NHS: 1.54 million people work in
9 adult social care compared to 1.37 million in the NHS.

10 Yet there is no equivalent to NHS England which
11 seeks to provide some strategy and direction to the
12 sector. The TUC has repeatedly called for a national
13 social care forum to bring together government, unions,
14 employers, commissioners and providers to co-ordinate
15 the delivery and development of services and include
16 a negotiation of a much-needed workforce strategy.

17 Co-ordinating a national effort across a hotch potch
18 of private organisations is quite obviously impossible.
19 In terms of data, the Inquiry will hear that records in
20 relation to the care sector are vitally lacking. At the
21 beginning of the pandemic, no single national database
22 existed and local authority records were incapable of
23 providing a clear picture of the number of people
24 needing social care or working in the care sector, nor
25 their demographic characteristics.
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1 It was not known and is in fact still not known with
2 any level of precision how many residential care homes
3 were in operation across the UK.

4 The overall picture is of key functions central to
5 pandemic response being fragmented and spread across
6 the NHS, Public Health England, local authorities,
7 a myriad of other agencies, and the many thousands of
8 social care providers, without a clear means of national
9 oversight and co-ordination.

10 The fifth theme is a failure of localism. The
11 structure of the Civil Contingencies Act is to focus
12 many of the responsibilities for planning for
13 emergencies on local organisations, as Mr Keith
14 described this morning. There is much to value in
15 effective localised resilience mechanisms built on
16 strong local knowledge, but those local resilience
17 mechanisms were not only under-resourced but also
18 inadequately connected with national preparedness
19 exercises and national decision-making on
20 non-pharmaceutical interventions.

21 The sixth theme is not so much a theme that is
22 emerging amongst the evidence but one that we are
23 concerned is not emerging. It is pandemic preparedness
24 across the whole range of workplaces.

25 Many of the highest risk occupations were outside of
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1 differences in these respects between the devolved
2 nations.

3 In England the arrangements for working with
4 professional and representative organisations across
5 sectors are limited. Elsewhere, particularly in Wales,
6 there is an approach of social partnership in which
7 there were pre-existing and improving structures to
8 enable partnership working between the government and
9 industries. That is critical on matters such as the
10 production of adequate workplace guidance and the
11 government being able to quickly being alerted and
12 respond to challenges faced in different workplaces.

13 Repeatedly in the pandemic, guidance documents
14 affecting millions at work were produced with virtually
15 no notice or consultation.

16 There is also, crucially, a need for fair work.
17 Many frontline workers who faced the highest death rates
18 were in low paid jobs with poor employment rights. One
19 of the most important non-pharmaceutical interventions
20 was self-isolation, but those working, for example, in
21 a processing plant, will very often face the
22 difficulties of being in insecure work, of experiencing
23 in-work poverty, and have, at most, a right to extremely
24 limited sick pay, if anything.

25 For many, self-isolation would be a choice between
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1 healthcare and were in the elementary occupations. In
2 any pandemic, there will be a need for food to be
3 produced, for parcels to be delivered, for transport to
4 operate and so on. Preparedness for these sorts of
5 sectors is crucial. It is where the virus can spread if
6 not managed appropriately; it is where the death rate
7 was at its highest; and it is where much of the unequal
8 impact of a pandemic is felt.

9 Preparedness is a necessity for these sectors too,
10 and achieving that objective requires a focus of central
11 government and local authorities. These sectors operate
12 very substantially in the private sector and so the
13 demands of preparedness and pandemic response are
14 different. It must be a responsibility of government in
15 planning for a pandemic to identify where there will
16 likely be a need to step in to support industries,
17 including on matters such as the procurement of PPE.
18 Many sectors on the frontline were without necessary PPE
19 for significant periods. This Inquiry should consider
20 in this module the extent to which pandemic planning
21 considered such issues.

22 There also needs to be effective mechanisms for
23 joint working between government and the relevant
24 industries, including unions. The Inquiry in this
25 module, and certainly in Module 2, will hear of
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1 not self-isolating or self-isolating but not having the
2 money to live and eat.

3 The TUC has raised repeated concerns about the
4 limitations of statutory sick pay and repeatedly raised
5 it during the pandemic in connection with the
6 effectiveness of self-isolation.

7 The government response on sick pay was unplanned
8 for and late. It was also half-hearted. In the single
9 month of the Eat Out to Help Out scheme, the government
10 spent £840 million on supporting dining out. The
11 following month, local authorities were given only
12 £50 million to fund the self-isolation support payment
13 scheme to support the many thousands of key workers on
14 low pay who would struggle to live if they were to
15 self-isolate.

16 My Lady, that is our opening, and of course there is
17 more detail in our written opening.

18 Finally, one theme of this module will be resilience
19 of services. It may be, my Lady, that you, having
20 courageously reached the foothills of this Inquiry,
21 another reservoir of resilience upon which we are
22 dependent is yours, and we stand ready to resist --
23 assist, rather. A key difference!

24 **LADY HALLETT:** Thank you very much, Mr Jacobs.

25 On the basis of resilience, I think we all need
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1 a break, so I shall be back just after half past,
2 15 minutes from now, please.

3 (3.17 pm)

4 (A short break)

5 (3.30 pm)

6 **LADY HALLETT:** Right, I think we have Ms Murnaghan, who
7 needs to get a flight.

8 **Submissions on behalf of the Northern Ireland Department of**
9 **Health by MS MURNAGHAN KC**

10 **MS MURNAGHAN:** That is correct, my Lady.

11 Good afternoon. I make this opening statement on
12 behalf of the Northern Ireland Department of Health,
13 which I will refer to in the course of the statement as
14 being "the department".

15 The purpose, my Lady, of this opening statement is
16 to outline the evidence that has and will be given in
17 respect of the systems, the structures and the processes
18 relevant to pandemic preparedness in Northern Ireland.

19 I wish to begin by conveying the department's
20 sincere condolences to those who have suffered
21 bereavement as a result of the Covid-19 pandemic. The
22 department also expresses its sympathy and support for
23 everyone across the country who is living with or who
24 has suffered from this disease.

25 The department extends its sincere condolences to
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1 care so as to ensure improvement in the physical and
2 mental health of people in Northern Ireland, in the
3 prevention, the diagnosis and the treatment of illness,
4 and in the social wellbeing of people in
5 Northern Ireland.

6 Accordingly, the department is responsible for
7 health and social care legislation and policy, and is
8 the lead government department for responding to health
9 consequences of emergencies. It was in this role that
10 the department assumed responsibility for the health
11 response to the Covid-19 pandemic.

12 The department is headed by a Permanent Secretary.
13 The role of the Permanent Secretary in the department is
14 to act as the principal accounting officer and the
15 principal adviser to the Minister for Health.

16 Another important aspect of the department's
17 structures is that, until April 2022, it had 17 arm's
18 length bodies. These arm's length bodies helped the
19 department achieve its objectives. However, in
20 March 2022 one of those arm's length bodies, namely the
21 Health and Social Care Board, was dissolved and its
22 functions were transferred back into the department.
23 Those functions now reside within the newly established
24 Strategic Planning and Performance Group that is held
25 within the department. The functions, therefore, of the

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1 those who have lost loved ones or who have had their
2 lives turned upside-down by this disease.

3 In our lifetime, this crisis was unprecedented, and
4 the pandemic had a direct and dramatic impact on the
5 daily lives of every single occupant of these islands.
6 The department acknowledges the huge losses that many
7 amongst us have suffered and, in some cases, continue to
8 suffer.

9 The department also wishes to emphasise its
10 gratitude to and support for healthcare workers. The
11 department has an extraordinary appreciation and respect
12 for healthcare workers who, during this pandemic,
13 selflessly put their lives on the line to protect the
14 whole of the community. These healthcare workers
15 unflinchingly acted for the benefit of us all in times
16 of great uncertainty and danger, and for that we thank
17 them sincerely.

18 I also take this opening statement as an opportunity
19 to clarify some of the important aspects of the
20 structure of the department and the health and social
21 care system in Northern Ireland.

22 The department's key statutory responsibilities
23 arise on foot of the Health and Social Care (Reform) Act
24 (Northern Ireland) 2009. These core responsibilities
25 are to promote an integrated system of health and social
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1 department and its arm's length bodies are often
2 referred to by the umbrella term of health and social
3 care", or HSC, and similarly reference is made to
4 arm's length bodies as being HSC bodies.

5 However, the department believes that it is
6 important to note that these terms are merely
7 colloquialisms, and HSC is used as a shorthand for the
8 health and social care system as a whole in
9 Northern Ireland. There has never been an organisation
10 called Health and Social Care Northern Ireland.

11 Whilst arm's length bodies are accountable to the
12 department, again it is emphasised that they are
13 themselves separate legal entities.

14 In these opening remarks, it is asserted that the
15 department's main priority from day one was the
16 protection of Northern Ireland's citizens from the virus
17 and supporting efforts to contain the spread of the
18 virus. In giving a very high level overview of the
19 department's state of preparedness, it should be noted
20 that there has been a clear structure providing a level
21 of protection and emergency response to the people of
22 Northern Ireland, which was consistent with elsewhere in
23 the United Kingdom.

24 The Northern Ireland Civil Contingencies Framework
25 was first published in 2005, following the introduction

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1 of the Civil Contingencies Act in 2004. An updated
2 version of the framework was published in 2011. This
3 affords Northern Ireland the same level of protection
4 and emergency preparedness as elsewhere in the UK.

5 Despite the framework not being a statutory
6 instrument, it is implemented in the same way as if it
7 were legislation. The framework required the department
8 to maintain, review and update its emergency response
9 plan.

10 The department undertakes emergency preparedness and
11 planning on an ongoing basis in order to maintain
12 readiness and to respond to any emergency with health
13 and social care consequences.

14 As part of the department's responsibility for
15 leading the health response to a pandemic, it
16 participated in UK-wide pandemic influenza planning as
17 well as participating in working groups and UK
18 governance structures and a range of activities to test
19 and exercise plans.

20 Consequently the department has been able to benefit
21 from lessons learnt and revise the department's
22 emergency response plan.

23 When the World Health Organisation declared the
24 coronavirus outbreak as a public health emergency of
25 international concern in January 2020, it became rapidly

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1 that it is better prepared for the future.

2 In this, the Inquiry's first module, the Inquiry's
3 focus will be on preparedness of, amongst others, this
4 department and its ability to scale up its pandemic
5 plans in order to address the demands placed on the
6 broader health and social care system. The department
7 has provided evidence to the Inquiry in a range of
8 areas, including how it was able to increase capacity
9 for diagnosing, laboratory testing and procedures for
10 testing and contact tracing, in consequence of the
11 implementation and adaptation of their preparedness
12 plans.

13 The department worked closely with health
14 authorities and government departments across the UK and
15 Ireland in a joint effort to significantly contribute to
16 the general understanding of how the virus spread, in
17 order to assist in controlling its further spread and to
18 provide support as necessary.

19 It is also noted that additional funding was
20 provided from the UK Government to assist in addressing
21 the challenges of the pandemic. In circumstances such
22 as a pandemic, the inescapable reality is that smaller
23 administrations such as Northern Ireland will inevitably
24 need to look to the more extensive resources in other
25 parts of the United Kingdom in order to help it react in

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1 apparent that Covid-19 would challenge the existing
2 emergency response mechanisms globally as well as in
3 Northern Ireland.

4 The rapid spread of the virus also highlighted the
5 importance of co-operation across UK and further afield
6 and the sharing of information which the department
7 carried out with its counterparts in the
8 Republic of Ireland.

9 The department and its arm's length bodies activated
10 their emergency response plans and followed the command
11 and control structures, the systems and the processes
12 which had previously been put in place to manage its
13 response.

14 The experience of the pandemic has highlighted that
15 the timely exchange of information and co-ordination of
16 measures between the devolved administrations to assist
17 in containing the spread of the virus was a crucial
18 element for an effective and a coherent response.

19 Undoubtedly the department has benefited from the
20 dedication of civil servants, of personnel in
21 arm's length bodies, and from frontline HSC workers, all
22 of whom worked tirelessly to manage and overcome the
23 pandemic. Nevertheless, the department recognises that
24 there are lessons to be learnt and hopes that this
25 Inquiry will help us identify those lessons to ensure

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1 a timely way.

2 Furthermore, we consider it appropriate to highlight
3 that all of the decisions required of the devolved
4 administration were taken locally on advice from the
5 Northern Ireland Civil Service. The pandemic planning
6 and the system preparedness in Northern Ireland prior to
7 March 2020, including those developments and changes
8 which were implemented during the course of the
9 pandemic, has been detailed in a number of statements
10 lodged with the Inquiry from our key professionals.

11 We consider that the evidence submitted by the
12 department has shown how continuous learning occurred
13 throughout the pandemic. This learning was, in part, as
14 a consequence of increased and evolving scientific
15 understanding of the virus, of its transmission, the
16 disease severity and development, and the persistence of
17 immunity. Throughout these first stages there were
18 improvements in Northern Ireland's reaction to the
19 pandemic as a result of increased availability of
20 testing, improvements in pandemic modelling, improved
21 understanding of individual and population behaviours,
22 and how they were influenced by modelling, and by the
23 development of vaccines and how their rapid deployment
24 was effected, as well as by the impact of
25 non-pharmaceutical interventions. We include in that

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1 contact tracing and isolation as well as novel
2 therapeutic treatments. These developments were used to
3 inform policy and appropriate responses.

4 I should also, my Lady, make a brief remark about
5 the preparations Northern Ireland had undertaken for
6 a no-deal EU exit. Whilst these preparations did divert
7 some of our focus away from pandemic preparedness
8 planning, as was no doubt the case for all four nations
9 of the United Kingdom, on the positive side the many
10 aspects of additional training, improvements in the
11 resilience of supply chains, and the preparedness to
12 manage the potential consequences were, when considered
13 overall, thought to be advantageous.

14 The benefits included local and regional increased
15 buffer stocks and stockpiles for medicines and medical
16 devices, clinical consumables and the enhanced
17 multi-agency command and control training undertaken by
18 all Northern Ireland departments and multi-agency
19 responders.

20 These EU exit preparations also helped to finalise
21 the building of a dedicated and bespoke departmental
22 emergency operations centre facility, and they also
23 served to clarify processes, roles and responsibilities
24 for emergency responses within the department.

25 This also had the benefit of meaning that the
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1 the three-year period that required specific
2 consideration by the Executive.

3 In conclusion, my Lady, the department would
4 reiterate that it is very aware of the far-reaching and
5 devastating impacts that the pandemic had on all aspects
6 of society, and is acutely conscious of the enduring
7 consequences that continue to be experienced by our
8 health service.

9 The department also recognises that the Inquiry is
10 uniquely placed to identify learnings and
11 recommendations that should help shape future responses.
12 It is for these reasons that the department places the
13 utmost importance on this Inquiry. As such, the
14 department reiterates its firm commitment to this
15 Inquiry and stands ready to assist in any way that it
16 can. Given the potential for another pandemic, it is
17 essential that lessons are identified and fully learnt
18 across health and social care and all parts of
19 government.

20 The department welcomes the opportunity to provide
21 this opening statement and it is hoped that this brief
22 overview of the health and social care structure, the
23 systems and processes in Northern Ireland in relation to
24 pandemic preparedness has been useful in setting the
25 scene.

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1 department had a cohort of recently trained staff who
2 were able to assist with the response to the Covid-19
3 pandemic from the outset.

4 While it is fair to say that no one in
5 Northern Ireland could have reasonably anticipated the
6 scale of the challenges caused by the pandemic, or
7 indeed anticipated the steps necessary to prevent our
8 health and social care system from being overwhelmed,
9 nonetheless there are important lessons for the future.

10 The department is motivated to ensure that there is
11 longer-term horizon scanning to identify future risks in
12 tandem with actively building future capacity and
13 capability to identify and respond to these future
14 risks.

15 Undoubtedly, managing a pandemic on this scale is
16 the most significant challenge for any government, and
17 indeed it was particularly difficult for a newly formed
18 Executive after three years with no government.

19 In considering the impact that the lack of
20 an Executive in Northern Ireland had, in the years
21 preceding this pandemic, we have identified several
22 disadvantages. Despite this, and from the department's
23 perspective, the exercise of civil contingencies and
24 pandemic planning functions was not affected by the
25 absence of ministers, and no policy matters arose during
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1 Finally, the department wishes again to convey our
2 deepest sympathies to those bereaved throughout the
3 course of the pandemic.

4 Those would be our submissions, my Lady.

5 **LADY HALLETT:** Thank you very much indeed, Ms Murnaghan.

6 Now I think it's Mr Ford.

7 **Submissions on behalf of the Association of Directors of
8 Public Health by MR FORD KC**

9 **MR FORD:** Thank you, my Lady.

10 My Lady, I appear on behalf of ADPH, the Association
11 of Directors of Public Health. Before I briefly explain
12 what the association is and what its position is in
13 respect of the issues with which this module of the
14 Inquiry is concerned, I want to read these words from
15 Professor Jim McManus, who is the president of the
16 association and who will be giving evidence in week 4:

17 "Over 225,000 people in the UK alone lost their
18 lives to this virus, with many people experiencing the
19 enduring pain of long Covid and, as we have heard, many
20 who have lost loved ones and colleagues and care and
21 health staff who have experienced significant trauma.
22 Our hearts are with them all. The scale of this loss
23 heightens considerably the fundamental moral obligation
24 on all of us to ensure that when the next pandemic
25 comes, as it will, we are absolutely prepared to respond

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1 in a way which delivers the minimum possible loss of
2 life and harms to people, keeping faith with those who
3 have been lost, bereaved or harmed entails that, above
4 all else, we lay seriously to heart this serious shared
5 obligation to articulate systems, structures, working
6 cultures and behaviours which will deliver that goal."

7 My Lady, the ADPH is the representative organisation
8 of the directors of public health across the UK. The
9 association is, along with the Local Government
10 Association and its equivalents in the devolved nations,
11 the only voice of localism that the Inquiry is going to
12 hear in this module.

13 The role of the directors of public health have been
14 likened to that of a local chief medical officer. Their
15 role is similar across the UK, although there are some
16 differences between the public health systems in which
17 they operate. As you've heard, I think from Mr Keith,
18 in England every local authority with public health
19 responsibility must employ a specialist DPH, they're
20 jointly employed by authorities in the DHSC.

21 Directors retain the primary responsibility for the
22 health of their communities and are accountable for the
23 delivery of their authority's public health duties. The
24 director is a statutory chief officer of their local
25 authority and the principal adviser on all health

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1 evidence base and what motivates behavioural change, and
2 helping develop local policy interventions.

3 Directors also have a deep knowledge of their local
4 populations and community organisations. While the
5 directors were working at a local level at the start of
6 the pandemic, they were repeatedly excluded from key
7 communications and guidance developed at a national
8 level. They should have been consulted earlier, and
9 more comprehensively, by national bodies with
10 responsibility for health protection from the outset.

11 There are some striking examples of this, as you
12 will hear in the evidence. Firstly, at the start of the
13 pandemic, the Department of Health and Social Care did
14 not hold an up-to-date contact list for the directors of
15 public health in the various local authorities.

16 Secondly, at the start of the pandemic, directors
17 were learning about new policies and guidance at the
18 same time as members of the public were, when the
19 televised 5 pm daily briefings began to be broadcast.
20 They were expected to implement these policies without
21 the necessary structures and support mechanisms having
22 been put in place. Along with several other
23 core participants, ADPH was asked by the Inquiry to
24 canvass the views of its members, which it did by means
25 of a survey, and the majority of its members felt that

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1 matters to elected members and officials.

2 In Scotland and Wales, directors are employed by NHS
3 health boards, while in Northern Ireland the sole DPH is
4 accountable to the Chief Medical Officer. Directors are
5 also present in Crown dependencies and overseas
6 territories, functioning as both directors of public
7 health and the chief medical officer for their
8 respective jurisdictions.

9 My Lady, the association wants to convey to
10 the Inquiry some key messages about resilience and
11 preparedness for pandemics at a local level. I'll
12 summarise those messages now, and they will be expanded
13 on by Professor McManus when he gives his evidence and
14 developed later in closing written and oral submissions.

15 The position of the association is that there was,
16 in the latter part of the period with which this module
17 of the Inquiry is concerned, an insufficient
18 understanding of the role, capabilities and
19 responsibilities of directors of public health at
20 a national level, and as a consequence they were largely
21 omitted from the systems, processes and plans that had
22 begun to be put in place at that point.

23 Directors of public health are trained in containing
24 infectious diseases, understanding and interpreting
25 data, recognising risk factors, understanding the

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1 initially there were very limited routes available to
2 them to engage with the national approach and that
3 during those initial stages of the pandemic it's widely
4 felt that the local voice was neither wanted nor heard.

5 Thirdly, directors of public health and their teams
6 have extensive experience of contact tracing, their
7 local communities and the wider health and social care
8 system. Within local government there were
9 environmental health officers and public health
10 specialists with the skills to support contact tracing
11 efforts in response to the virus. However, the
12 involvement of local councils and directors in the test
13 and trace service was, at the beginning of the pandemic,
14 very limited. Local capacity to carry out testing and
15 contact tracing was not recognised at a national level.

16 Returning, my Lady, to the survey, directors were
17 asked what were the top five factors which most
18 negatively impacted on their state of readiness, and
19 these were their responses.

20 One, national guidance relating to pandemic
21 preparedness did not anticipate the nature of the
22 challenges provided by Covid-19.

23 Two, full lockdown was never anticipated as
24 a reasonable worst-case scenario, so plans did not
25 reflect the challenges that such a lockdown would raise.

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1 Three, inadequate and unclear communication and
2 support from central government.

3 Four, inadequate capacity in the public health
4 workforce.

5 Five, inadequate funding. It is the view of the
6 association that across the public health system funding
7 and staffing levels have been run down to such an extent
8 at all levels that response to the Covid-19 pandemic was
9 severely hampered.

10 You will note, my Lady, that many of those five
11 points, if not all of them, have been raised by other
12 core participants already in their opening submissions.

13 Directors also identified the issue of data sharing.
14 This was a key challenge in the early stages of the
15 pandemic. The ability of directors to establish
16 effective data sharing protocols varied significantly
17 both across England and the devolved nations.

18 Statutory data protection requirements were rightly
19 or wrongly thought to be an obstacle to data sharing,
20 and different organisations had markedly different
21 interpretations of their data protection obligations.

22 Although beyond the remit of this module, it's right
23 to observe that, as the pandemic progressed, there was
24 increasing recognition of the value of local leadership
25 as a vital component of the pandemic response.

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1 the national response. There needs to be greater
2 recognition of the role of local public health and local
3 government in the planning of future pandemics. In the
4 association's view, a key lesson is that local-driven
5 processes and responses are more speedy and effective
6 than those prescribed centrally through top-down
7 approaches and enable improved co-ordination and
8 collaboration between agencies. It's important that the
9 UK Government understands the distinct role of directors
10 of public health when engaging locally.

11 My Lady, finally, returning to the survey, the
12 directors were asked to suggest ways for improved
13 preparedness and resilience, and these are the top ten
14 points which they raised.

15 Firstly, putting in place arrangements to enable
16 data and intelligence to flow more freely from national
17 agencies to local public health teams, organisations and
18 authorities.

19 Secondly, improved transparency and timeliness of
20 communications from national government.

21 Thirdly, national government should consider
22 developing a national strategy around communications
23 during an emergency and utilise the voice of trusted
24 local leaders and the voluntary sector.

25 Fourth, conducting regular tests of preparedness to

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1 Directors were brought in to provide a local perspective
2 and inform the design of the system. They worked at
3 pace to develop local outbreak plans, ensure the
4 challenges of Covid-19 were understood, and address the
5 impact on local communities, but there were, in the view
6 of the association, numerous missed opportunities early
7 on.

8 Overall, my Lady, the association's view is that the
9 UK was inadequately prepared for a pandemic of this
10 nature. At a local level, directors working in
11 partnership with local authorities, the NHS, voluntary
12 sectors and other emergency responders, had plans in
13 place for an influenza pandemic, for the reasons that
14 you've already heard, and did their best to adapt those
15 arrangements to meet the challenges presented by
16 Covid-19. In future, national and local plans will need
17 to be more flexible to respond to different types of
18 viruses and threats.

19 Looking forward, the association's view is that much
20 greater local involvement is needed in formulating
21 national policy. This means bringing bodies together
22 such as the ADHP, the Local Government Association, the
23 Association of Directors of Adult Social Services and
24 Association of Directors of Children's Services, along
25 with their devolved equivalents, to combine and inform

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1 better equip the workforce to respond to pandemics by
2 providing more training opportunities for relevant
3 staff, in health protection and pandemic preparedness.

4 Fifth, widening the scope of emergency planning to
5 be more inclusive of different emergencies and diseases
6 and developing a national testing strategy early on.

7 Sixth, maintaining the relationships they formed
8 during the pandemic with internal and external partners
9 through the local resilience forums.

10 Seventh, better harnessing of the voluntary and
11 community sectors and emergency planning strategy going
12 forward.

13 Eighth, greater clarity around the role of the
14 directors of public health and local authorities in
15 pandemic preparedness and emergency planning.

16 Ninth, greater certainty around the public health
17 grant and more funding for emergency planning and health
18 protection.

19 Tenth, expanding the public health workforce.

20 My Lady, the aim of the association is to provide
21 evidence to this Inquiry that informs better pandemic
22 planning and preparedness. In summary, lessons point to
23 three essential themes.

24 Firstly, improving the overall health of the UK,
25 including reducing health inequalities. Secondly,

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1 clarifying the roles and responsibilities of key
2 agencies and professionals at all levels. Thirdly,
3 ensuring sufficient powers, capacity and resources are
4 in place.

5 My Lady, we must learn these lessons from Covid and
6 we must do better next time. Thank you very much.

7 **LADY HALLETT:** Thank you very much indeed, Mr Ford.

8 I think it's now Mr Allen.

9 **Submissions on behalf of the Local Government Association
10 and Welsh Local Government Association by MR ALLEN KC**

11 **MR ALLEN:** My Lady, thank you very much.

12 It's my privilege to represent the interests of the
13 Local Government Association and the Welsh Local
14 Government Association in this so important process.

15 The two associations work very closely together and
16 welcome the opportunity to contribute as
17 core participants in this module.

18 Together they represent the collected voice of local
19 government, having 100% of the Welsh and over 99% of the
20 English principal local authorities as members, and
21 these are, of course, category 1 responders and core
22 members of local resilience fora.

23 They applied to become core participants because
24 local government and its officers played such a major
25 role in bringing these countries through the pandemic.

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1 necessary understanding of the role of local government
2 should and could play in the pandemic was sometimes
3 lacking within central government. So let me summarise
4 now what local government did and would do again.

5 In the very shortest of terms it can be said that
6 throughout the pandemic councils kept essential local
7 services going. But they did considerably more than
8 that. They stepped up to deliver a whole suite of new
9 functions crucial to the response.

10 Putting it rather more fully, local government
11 continued to have a major role in almost all of life's
12 big moments, as well as the everyday services people
13 rely on. Registering births, deaths, marriages and
14 partnerships, protecting consumers, providing social
15 housing, safeguarding children and young people,
16 collecting waste, maintaining transport and other local
17 infrastructure, providing open spaces for health and
18 recreation, managing adult social care for the elderly
19 and those who are otherwise clinically vulnerable, and,
20 of course, ensuring that there continued to be
21 mortuaries and cemeteries at end of life. Only very
22 temporarily were some of these functions, but by no
23 means all, suspended during the most restricted periods.

24 At the same time, they administered multimillion
25 pound national financial assistance schemes for

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1 There also can be no doubt that local government
2 would be called on to play this role again, should there
3 ever be another pandemic, and of course it would do so
4 with total commitment.

5 My Lady, you will recall that during lockdown we
6 were encouraged to go out and bang our saucepans to
7 celebrate and acknowledge the contribution of
8 key workers. The predominant media focus was on those
9 who worked in the NHS. But the phrase "key workers"
10 went much wider. Like the NHS, nearly all local
11 government officers were engaged in the pandemic
12 response. On average, only 1% of directly employed
13 council staff were furloughed during 2020. In numerical
14 terms, the role played by the local authority workforce
15 was comparable to that of the NHS; in our areas, in
16 full-time equivalent terms, about a million compared to
17 1.28 million.

18 It is, therefore, really important in this Inquiry
19 that you and the wider public and media appreciate just
20 how big a part local authorities had in bringing the
21 country through. Political leaders of all parties have
22 praised local authority officers for their dedication
23 and flexibility, and so have business leaders.

24 So it may be surprising to say, but in this module
25 it will, we believe, become clear that the fullest and

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1 business. They ensured that those made vulnerable by
2 the pandemic across the two countries were identified
3 and protected. They supported local schools to maintain
4 educational provision, and support for pupils. And they
5 co-delivered test and trace and vaccination programmes
6 to help control the spread of the virus.

7 And that is why such a very high proportion of local
8 authority officers were designated as key workers, with
9 many changing roles, to deal with the pandemic.

10 The associations emphasise, therefore, that in
11 planning for civil contingencies no other body
12 understands local areas better than their councils, and
13 this has to be taken fully into account. The highly
14 valued services they deliver were absolutely crucial to
15 the Covid-19 response, by protecting both lives and
16 livelihoods, and that would be so in another pandemic.
17 And yet, as I've already alluded, one concern
18 particularly affecting the LGA and the English local
19 authorities is that too often during the pandemic
20 central government did not fully understand the way
21 local government in England worked and what it could
22 contribute. On occasions, it has seemed as though there
23 was a lack of trust in local authorities, even perhaps
24 a misplaced confidence by central government as to what
25 it could achieve by itself.

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1 Now, I am glad to say that this was not evident in
2 the relationship between the devolved government in
3 Wales and the Welsh Local Government Association and
4 Welsh local authorities. Both associations urge this
5 Inquiry to conclude that in all planning for a future
6 pandemic there must be a full recognition of the risks
7 and responsibilities that local authorities will face
8 and the contributions that they can make, and that any
9 planning, whether on paper or in exercises to test
10 resilience, that fails fully to include local government
11 will always be incomplete.

12 We expect that by the end of your Inquiry, the huge
13 contribution of local government should be as well known
14 as that of the NHS, that the personal sacrifice, in some
15 cases the ultimate sacrifice, the constant stress,
16 danger to health, and many acts of great courage of
17 local authority officers should be fully understood and
18 better appreciated by you, central government, the media
19 and the public, and that it will be realised in the
20 future that more engagement by central government with
21 local government can only enhance the quality of both
22 contingency planning and emergency responses.

23 Now, this first module focuses on the steps taken in
24 the period between 2009 and 2020 to prepare for
25 a pandemic occurring at some time in the foreseeable

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1 Inevitably, this impacted the ability to plan, to
2 prepare and resource, and the overall resilience of
3 services.

4 Notwithstanding, my clients' witness statements set
5 out the steps councils have taken around risk assessment
6 and contingency planning, and testing and exercising, as
7 well as the engagement by the two associations
8 themselves, and councils consider that they well
9 prepared for what was expected of them.

10 You will already know that local government was not
11 in charge, though, of the process of pandemic planning.
12 Its engagement was in response to requests and
13 directions from central and devolved government, and it
14 is clear, in hindsight, that there were significant gaps
15 in the pandemic planning process by central government.

16 There was insufficient focus on the emerging
17 infectious diseases such as MERS and SARS relative to
18 the engagement on influenza. There was a failure to
19 learn from how Asian countries were responding to these
20 diseases. And in any event, the learning from previous
21 incidents and exercises was not consistently applied.

22 Perhaps most seriously of all, none of the pandemic
23 plans suggested non-pharmaceutical interventions such as
24 national lockdowns, international travel restrictions,
25 wholesale school and workplace closures, or compulsory

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1 future. In the view of both associations, the local
2 government was generally well prepared for what central
3 government had expected of councils in dealing with
4 an influenza pandemic. But that of course is not at the
5 heart of the Module 1 questions, and it is not to say
6 either the resilience of health protection systems
7 operated perfectly. On resilience matters, we expect
8 the Inquiry to find that some guidance was out of date,
9 that central government was not always willing to share
10 information with local partners in a timely way, and in
11 the run-up to 2020 attention was being diverted to other
12 resilience issues such as the no-deal EU exit.

13 On health protection issues, we expect the Inquiry
14 to find that central government policy making was
15 undermined by its lack of understanding of the public
16 health system which, at a national level, was complex
17 and, on occasion, fragmented, and we echo, therefore,
18 some of the points already made by the previous speaker.

19 Across these points, we expect the Inquiry to see
20 that all local government services had been impacted by
21 austerity. This, as we've heard, has gone on for
22 a decade. The reductions in funding saw councils lose
23 60p out of every pound of funding, and that must be seen
24 against rising demand in key services such as adult and
25 children's social care and homelessness support.

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1 quarantine. In no significant way was there any
2 preparation for these, meaning that when the pandemic
3 struck, new plans had to be developed from scratch.

4 It will be obvious in general terms -- and this will
5 no doubt be discussed later in Module 2 in more specific
6 terms -- that to make these NPIs work swiftly,
7 efficiently and effectively required close local
8 knowledge and support. The failure to think through
9 fully how the rate of infection would have to be
10 controlled during a pandemic was, therefore, a very
11 significant omission. It became a matter of political
12 dispute, when it ought to have been a matter of social
13 planning well in advance.

14 The associations say that if it had been considered
15 in advance, those difficult issues that had to be
16 considered in the pandemic, that is to say effective
17 subsidiarity, business continuity, human rights and the
18 disproportionate impacts on minorities, could have been
19 thought through and addressed in calmer times. When
20 these matters were addressed, the skills that already
21 resided within local government could have been engaged
22 much more quickly and dynamically.

23 The lack of planning for these measures was
24 subsequently compounded by an initial failure to
25 recognise the vital role local government should play

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1 when systems were designed.

2 For instance, instead of developing from scratch
3 a new test and trace system, the skills of the directors
4 of public health in England and the Directors of Public
5 Protection in Wales could have been harnessed at the
6 outset.

7 How all this could have been done better in advance
8 is, of course, the complex question for you in this
9 module. As the events of 2020 to 2022 have shown,
10 pandemics are complex social and behavioural challenges
11 and not just technocratic issues.

12 So I want it make it clear that the approach of the
13 two associations I represent is by no means a purely
14 negative and critical one. Local government does not
15 say that everything was wrong. It recognises that there
16 were also many positives about a system with the
17 capability and agility to quickly pivot from existing
18 plans to respond to the pandemic. But it also says that
19 these systems can and should be improved with local
20 government treated as an equal partner in this.

21 And the associations hope that this too will form
22 part of your conclusions.

23 My Lady, I want to move now to set out some summary
24 points that the local government associations will be
25 asking you to have in your recommendations, and I take

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1 9. Greater focus on local issues in risk
2 assessments.

3 10. More systematised account of protected
4 characteristics in emergency plans.

5 11. More work on public awareness campaigns.

6 12. Distinct data sharing plans to enable local
7 government to act effectively and swiftly, for instance
8 in identifying vulnerable persons.

9 13. More general planning for vulnerable persons.

10 Mr Chris Llewelyn, the chief executive of the Welsh
11 Local Government Association, mentions many of the same
12 issues, but I would add to the previous list from his
13 witness statement the following:

14 1. That there should be protocols and agreements
15 for consistent intergovernmental planning and
16 co-decision-making on a pan-UK scale as part of the
17 devolution settlement.

18 2. Advance planning is necessary for Welsh local
19 authorities having to manage different approaches being
20 taken by the devolved and central governments, so as to
21 avoid the confusion and tensions that can occur in
22 cross-border areas.

23 3. Linking closely with the LGA's third point,
24 there must be a much better and fuller direct
25 interaction between central government and Welsh local

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1 them first from the evidence to be given by the chief
2 executive of the Local Government Association,
3 Mark Lloyd.

4 1. Improved democratic engagement with local
5 resilience forums.

6 2. Amendment of the Civil Contingencies Act and
7 delegated legislation to ensure it's more aligned to the
8 issue of resilience.

9 3. Specific obligations on central government, on
10 sharing critical planning information with local
11 government.

12 4. Much greater emphasis on the importance of
13 preparing for the implications for social care in the
14 context of a pandemic.

15 5. Greater discussion of health protection in the
16 preparations of a pandemic, including all forms of NPI
17 and their different consequences for breaking infections
18 whilst maintaining business continuity and civil
19 society.

20 6. Greater understanding of the different roles of
21 health protection obligations of councils and the more
22 general role of local resilience fora.

23 7. A better collection of guidance information into
24 one place.

25 8. Less secrecy in risk assessments .

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1 authorities, where policy directions are UK-wide and not
2 devolved, so as to enable immediate and consistent
3 responsive action at the local level.

4 4. Contingency arrangements are needed for the
5 urgent deployment of pre-trained and appropriately
6 skilled officers into emergency command and advisory
7 roles, and this should include civil servants in the UK
8 and Welsh Government and also local government and
9 emergency officers within local resilience fora
10 partnerships and local government structures.

11 5. Contingency arrangements are also necessary for
12 the passing of immediate and comprehensive legislation
13 and guidance, with draft modular laws and statutory
14 instruments and guidance held in reserve at both the UK
15 and Welsh levels.

16 6. There is a need for reserve stocks at scale and
17 for robust supply chains for the provision of specialist
18 medical equipment and goods such as PPE, with
19 specifications reviewed regularly to ensure
20 compatibility for emerging viruses.

21 7. Resilient emergency planning is necessary for
22 the expansion of the NHS facilities and services, to be
23 able to co-manage the demands of a pandemic alongside
24 critical and life-saving NHS services not related to the
25 pandemic.

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1 8. Reserve capacity, public sector workforce
 2 redeployment plans and logistical support and call-on
 3 contracts are necessary to stand up key support services
 4 such as mass testing, test and trace, and mass
 5 vaccinations.
 6 9. There should be plans, resources and
 7 flexibilities for the full recovery of public services,
 8 which might not be able to resume in meeting their
 9 statutory performance standards and targets for some
 10 time post pandemic.
 11 10. Again, related to the above LGA point 11,
 12 communication plans are necessary where there are
 13 differences of legal or administrative approach, and
 14 these should be planned for in advance.
 15 11. Also like point 10 in the LGA, the Welsh Local
 16 Government Association emphasises the need for a more
 17 systematised approach to taking account of protected
 18 characteristics in emergency plans.
 19 12. The Welsh Government should have more freedom
 20 in deciding its reserve levels for local authorities and
 21 the overall provision for greater emergency funding is
 22 essential if other services are not to be cut back.
 23 And lastly:
 24 13. There should be specific planning undertaken
 25 for the procurement of medical equipment for use within
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1 Wales.
 2 My Lady, we thank you for this opportunity to make
 3 an opening statement, and the two associations will
 4 support you in your work in every way we possibly can.
 5 Thank you.
 6 **LADY HALLETT:** Thank you very much indeed, Mr Allen.
 7 We were meant to, I think, go to Mr Bowle now.
 8 Mr Bowle, where are you? I'm just wondering, are
 9 you here tomorrow in any event? Or would you prefer to
 10 go now?
 11 **MR BOWLE:** I don't mind, my Lady, I'm here tomorrow,
 12 whatever's easier.
 13 **MR KEITH:** We do have now, fortuitously, a certain degree of
 14 flexibility tomorrow morning, if my Lady wished to go
 15 now.
 16 **LADY HALLETT:** If you don't mind, Mr Bowle, I think it's
 17 been a long day for quite a lot of people, so if that's
 18 all right with you?
 19 **MR BOWLE:** Of course.
 20 **LADY HALLETT:** Very well, we'll start at 10 o'clock
 21 tomorrow, please, with Mr Bowle. And I hope that
 22 everyone has been okay today.
 23 **(4.26 pm)**
 24 **(The hearing adjourned until 10 am**
 25 **on Wednesday, 14 June 2023)**
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