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

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

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.

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

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

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

(Pause)

LADY HALLETT: Could we play the film, please.

(Video played)

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

(Pause)

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

Mr Keith.

Statement by LEAD COUNSEL TO THE INQUIRY

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

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

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

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

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

No inquiry, however large or however long, could

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

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

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

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

On 10 January, in the United Kingdom, the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

the contain phase to the delay phase.

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

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

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

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

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

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

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

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

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

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

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

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

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

But how developed were those plans for school closures?

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

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

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

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

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

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

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

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

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

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

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

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

I mention, my Lady, the various regulatory

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

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

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

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

Health and social care workers, the police and the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

bureaucracy or prescriptive overmanagement or jargon.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

has to await those later modules.

May I now then turn to the system for preparedness.

It is obvious, my Lady, that the degree to which Covid-19 could be prevented from laying waste to society was a matter within the control of government and the systems for EPRR which existed. Those systems may not be able to stop a pandemic in its tracks, but they ought to be able to put in place measures of understanding a virus, understanding and forecasting how it might develop, tracking it, limiting transmission and coping with the consequences of large scale transmission.

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

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

My Lady, this is a document which the Inquiry team

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

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

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

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

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

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

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

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

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

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

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

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

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

at the top of the screen.

Towards the top right of the screen, you will see a reference to the National Security Risk Assessment.

The National Security Risk Assessment is the United Kingdom Government's classified assessment of the top national level risks facing the United Kingdom. The assessment focuses on both the likelihood of the risk occurring and the impact it would have were it to happen. And it has a public-facing document, the National Risk Register, which provides information for those who have contingency planning responsibilities at a national, regional and local level.

My Lady, we know, of course, what the broad nature of future emergencies might be. Natural hazards include global health challenges, animal and plant diseases, growing antimicrobial resistance, space weather events, extreme weather, climate change, infrastructure collapse, or perhaps the unintended consequence of human endeavour in artificial intelligence. The world is an uncertain place and risks seem set only to grow.

Though the exact nature of those major risks cannot, of course, be identified in advance, and because it's not possible to know in advance with certainty which risks will crystallise, and how, and because it's not practical to plan for every major risk, there will

always be uncertainty.

So the government draws up policies, and those policies are, by their nature, of more general application. But both the policies and the planned operational responses must build in the ability to respond to the unknown and provide for contingencies. Government planning must be flexible.

Were the governments of the four countries flexible enough with their policy making? Was the consideration of what those risks might be and how they could be prepared for sufficiently imaginative?

My Lady, you will hear evidence that for many years an influenza pandemic was assessed as being one of the most likely risks to the United Kingdom. But what about other risks that, whilst they might be less likely, could be just as, if not more, deadly? Did planning sufficiently address the risk not only of the known but the unknown, a new pathogen, a new disease, a disease X, as it's known, with pandemic potential?

Did planners pay sufficient focus on potential impact as opposed to likelihood?

With Covid, the evidence will demonstrate that the government thought that the greater risk was an influenza pandemic and, therefore, devoted more time and resources to that possibility. In the event, we

were hit, of course, by a coronavirus. That might suggest a lack of flexibility or proper foresight. Or perhaps the policies, plans and structures were so flexible and broad, so as to a cover any reasonable possibility, that this prevented us from focusing enough on those particular risks which, as I say, whilst being perhaps less likely, could cause us more harm.

So a core question in Module 1 will be: to what extent was thought given to and planning devoted to the risk of a new emerging infectious disease that was not influenza? Did the system of planning become self-validating or complacent so that that question was not asked, or if it was asked by individuals was not listened to?

To what extent were the likely consequences of either influenza or a new and emerging infectious disease reassessed?

My Lady, the evidence may show that there was a degree of assumption in the process, that if there was to be an influenza pandemic, it would be bound to lead to hundreds of thousands of deaths. This was because planners positively planned on what was known as the reasonable worst case scenario, the RWCS, planning for the worst case that could realistically happen.

The good sense of planning for the worst case that

could realistically happen is obvious: you need to prepare everyone to respond to that possibility, to have enough resources, enough surge capacity, enough room for manoeuvre in the healthcare and social care systems, enough PPE and so on. But not at the expense of pausing and asking: what more can we do to ensure we don't get to that stage at all?

The evidence may show, simply and terribly, that not enough people thought to ask, because everybody started to assume it would be flu. And if it was flu, diagnostic testing, case detection and isolation are less effective on account of the shorter incubation period, and, as I've said, there would always be antiviral medicine and vaccines and a national pandemic flu service.

So, my Lady, to what extent did the UK Government and the devolved administrations have a strategy for preventing a pandemic from having disastrous effects, as opposed to dealing with the disastrous effects of the pandemic and the reasonable worst case scenario which was assumed to follow?

LADY HALLETT: Mr Keith, I have been encouraged to take regular breaks, as you know, for the purposes of the stenographer and others. Would that be a convenient moment? I apologise for interrupting.

MR KEITH: It's a very convenient moment.
LADY HALLETT: Thank you. I shall be back at 11.30.
(11.15 am)
(A short break)
(11.32 am)
LADY HALLETT: Yes, Mr Keith.
MR KEITH: My Lady, I was addressing you in relation to whether or not the United Kingdom Government and the devolved administrations had a strategy at all for preventing a pandemic from having disastrous effects, as opposed to dealing with the disastrous effects of the pandemic.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank you.

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

So part 1 of the Civil Contingencies Act 2004

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

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

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

But there are no comparable duties on central

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

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

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

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

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

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

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

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

Another important area concerns the Resilience

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

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

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

Is that really the best way of doing it?

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

countries.

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

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

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

the devolved administration level.

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

Page 14, similarly in relation to Northern Ireland.

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

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

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

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

groups.

My Lady, there are a profusion of bodies.

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

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

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

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

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

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

What was the state of pandemic readiness and preparedness for each of those bodies?

There had also been significant reforms to the national and local systems for public health. The Health and Social Care Act 2012 transferred most public health functions from NHS bodies in England and Wales to local authorities. At the same time, local authorities with public health responsibilities were required to employ a specialist director of public health. Were directors of public health utilised effectively within their local authorities? Did those public health reforms make our public health structures more or less resilient and able to respond to a pandemic?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

the reality to that question.

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

LADY HALLETT: Thank you very much indeed, Mr Keith.

Mr Weatherby.

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

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

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

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

if a better approach is not put in place."

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

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

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

storm.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

prevention and mitigation?

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

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

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

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

They want to save lives.

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

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

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

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

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

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

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

has had any such training in PPE.

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

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

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

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

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

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

against disabled people.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

emergencies may well not happen on their watch?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

But a whole system plan should also recognise that

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

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

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

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

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

In conclusion, you will be told by some politicians that austerity put the UK in a good place to respond to the pandemic, but experts will point to its effect on public health and local authority resilience funding. The Inquiry will learn also of what happened to health inequalities concurrently with these cuts, and reasons why the widening of such inequalities might have occurred as a result.

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

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

lost at that time.

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

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

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

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

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

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

Mr Lavery.

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

MR LAVERY: Good afternoon, my Lady.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Policymakers in Northern Ireland may have had more

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

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

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

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

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

and January 2020.

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

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

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

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

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

is quoting from her statement:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank you very much for listening to us today.

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

I shall break now and return at 2.10.

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

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

(12.53 pm)

(The short adjournment)

(2.00 pm)

LADY HALLETT: Right, Ms Heaven.

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

MS HEAVEN: Good afternoon, my Lady.

LADY HALLETT: Good afternoon.

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

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

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

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

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

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

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

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

Many members of the Cymru group have professional

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

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

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

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

First Minister for Wales, Mark Drakeford, and the Welsh Government that they were committed to fully engaging with this Inquiry. It is against this background that Mark Drakeford, as First Minister, maintained and continues to maintain that there is no need for Wales to hold its own public inquiry.

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

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

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

documentary evidence.

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

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

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

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

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

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

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

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

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

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

Now, the Cymru group consider that the critical

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

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

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

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

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

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

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

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

However, one of the most significant failures on the

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

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

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

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

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

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

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

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

The Welsh Government knew that they needed to

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

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

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

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

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

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

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

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

For example, did the Welsh Government consistently

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

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

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

Inquiry that:

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

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

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

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

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

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

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

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

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

However, risk in Wales ought to have been properly

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

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

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

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

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

of course was after devolution in 1999.

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

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

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

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

Thank you.

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

Dr Mitchell KC.

Submissions on behalf of Scottish Covid Bereaved by DR MITCHELL KC

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

In writing on the "great flu", the influenza

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Were our social care services properly staffed and resourced?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

These are the submissions for the Scottish Covid Bereaved.

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

Right, I think it's Mr Stanton next.

Submissions on behalf of the British Medical Association by MR STANTON

MR STANTON: Good afternoon, my Lady.

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

(Pause)

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

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

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

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

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

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

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

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

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

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

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

For doctors and other healthcare workers, the

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

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

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

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

This same 2008 report also predicted the crisis of

PPE supply, including the following statement:

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

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

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

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

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

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

While the UK did carry out a planning exercise based on a coronavirus, Exercise Alice in 2016, this exercise did not sufficiently prepare from a wider range of infectious disease threats and, crucially, key lessons from this exercise, as well as transferable learning from pandemic influenza exercises, were not implemented.

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

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

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

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

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

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

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

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

A doctor in England recalled how they "made our own

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

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

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

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

both strategies need full consideration.

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

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

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

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

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

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

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

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

The reforms introduced in England by the 2012 Health

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

One public health doctor told the BMA that:

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

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

Northern Ireland.

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

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

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

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

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

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

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

As one consultant in England told the BMA:

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

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

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

Thank you, my Lady.

LADY HALLETT: Thank you very much indeed, Mr Stanton.

Mr Jacobs.

Submissions on behalf of the Trades Union Congress by MR JACOBS

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

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

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

My Lady, I start with three points of context.

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

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

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

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

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

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

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

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

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

The third point of context is a less positive one.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

By early June 2020 the HSE had already received over

6,000 additional concerns from workers about social distancing and other pandemic-related matters, but those concerns resulted in the sum total of 47 physical inspections of workplaces and one prohibition notice. It was a regulator utterly bereft of any teeth.

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

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

It is a crisis which continues to develop, with NHS waiting lists reaching 7.33 million in March of this

year, a workforce burnt out by the demands of the preceding years and vacancies at a five-year high.

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

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

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

On behalf of the British Medical Association,

fragmentation in healthcare has just been described, but it is also an acute problem in the social care sector. In social care, the problem has not been so much one of repeated restructuring and reorganisation, but one of neglect. There has been no attempt to structure at all.

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

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

Co-ordinating a national effort across a hotch potch of private organisations is quite obviously impossible. In terms of data, the Inquiry will hear that records in relation to the care sector are vitally lacking. At the beginning of the pandemic, no single national database existed and local authority records were incapable of providing a clear picture of the number of people needing social care or working in the care sector, nor their demographic characteristics.

It was not known and is in fact still not known with any level of precision how many residential care homes were in operation across the UK.

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

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

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

Many of the highest risk occupations were outside of

healthcare and were in the elementary occupations. In any pandemic, there will be a need for food to be produced, for parcels to be delivered, for transport to operate and so on. Preparedness for these sorts of sectors is crucial. It is where the virus can spread if not managed appropriately; it is where the death rate was at its highest; and it is where much of the unequal impact of a pandemic is felt.

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

There also needs to be effective mechanisms for joint working between government and the relevant industries, including unions. The Inquiry in this module, and certainly in Module 2, will hear of

differences in these respects between the devolved nations.

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

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

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

For many, self-isolation would be a choice between

not self-isolating or self-isolating but not having the money to live and eat.

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

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

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

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

LADY HALLETT: Thank you very much, Mr Jacobs.

On the basis of resilience, I think we all need

a break, so I shall be back just after half past, 15 minutes from now, please.

(3.17 pm)

(A short break)

(3.30 pm)

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

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

MS MURNAGHAN: That is correct, my Lady.

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

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

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

The department extends its sincere condolences to

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

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

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

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

The department's key statutory responsibilities arise on foot of the Health and Social Care (Reform) Act (Northern Ireland) 2009. These core responsibilities are to promote an integrated system of health and social

care so as to ensure improvement in the physical and mental health of people in Northern Ireland, in the prevention, the diagnosis and the treatment of illness, and in the social wellbeing of people in Northern Ireland.

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

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

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

department and its arm's length bodies are often referred to by the umbrella term of health and social care", or HSC, and similarly reference is made to arm's length bodies as being HSC bodies.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

that it is better prepared for the future.

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

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

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

a timely way.

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

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

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

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

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

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

This also had the benefit of meaning that the

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

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

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

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

In considering the impact that the lack of an Executive in Northern Ireland had, in the years preceding this pandemic, we have identified several disadvantages. Despite this, and from the department's perspective, the exercise of civil contingencies and pandemic planning functions was not affected by the absence of ministers, and no policy matters arose during

the three-year period that required specific consideration by the Executive.

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

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

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

Finally, the department wishes again to convey our deepest sympathies to those bereaved throughout the course of the pandemic.

Those would be our submissions, my Lady.

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

Now I think it's Mr Ford.

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

MR FORD: Thank you, my Lady.

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

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

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

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

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

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

matters to elected members and officials.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Four, inadequate capacity in the public health workforce.

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

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

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

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

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

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

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

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

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

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

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

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

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

Fourth, conducting regular tests of preparedness to

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

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

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

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

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

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

Tenth, expanding the public health workforce.

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

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

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

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

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

I think it's now Mr Allen.

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

MR ALLEN: My Lady, thank you very much.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

when systems were designed.

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

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

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

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

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

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

1. Improved democratic engagement with local resilience forums.

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

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

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

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

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

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

8. Less secrecy in risk assessments .

9. Greater focus on local issues in risk assessments.

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

11. More work on public awareness campaigns.

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

13. More general planning for vulnerable persons.

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

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

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

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

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

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

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

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

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

8. Reserve capacity, public sector workforce redeployment plans and logistical support and call-on contracts are necessary to stand up key support services such as mass testing, test and trace, and mass vaccinations.

9. There should be plans, resources and flexibilities for the full recovery of public services, which might not be able to resume in meeting their statutory performance standards and targets for some time post pandemic.

10. Again, related to the above LGA point 11, communication plans are necessary where there are differences of legal or administrative approach, and these should be planned for in advance.

11. Also like point 10 in the LGA, the Welsh Local Government Association emphasises the need for a more systematised approach to taking account of protected characteristics in emergency plans.

12. The Welsh Government should have more freedom in deciding its reserve levels for local authorities and the overall provision for greater emergency funding is essential if other services are not to be cut back.

And lastly:

13. There should be specific planning undertaken for the procurement of medical equipment for use within

Wales.

My Lady, we thank you for this opportunity to make an opening statement, and the two associations will support you in your work in every way we possibly can. Thank you.

LADY HALLETT: Thank you very much indeed, Mr Allen.

We were meant to, I think, go to Mr Bowle now.

Mr Bowle, where are you? I'm just wondering, are you here tomorrow in any event? Or would you prefer to go now?

MR BOWLE: I don't mind, my Lady, I'm here tomorrow, whatever's easier.

MR KEITH: We do have now, fortuitously, a certain degree of flexibility tomorrow morning, if my Lady wished to go now.

LADY HALLETT: If you don't mind, Mr Bowle, I think it's been a long day for quite a lot of people, so if that's all right with you?

MR BOWLE: Of course.

LADY HALLETT: Very well, we'll start at 10 o'clock tomorrow, please, with Mr Bowle. And I hope that everyone has been okay today.

(4.26 pm)

(The hearing adjourned until 10 am on Wednesday, 14 June 2023)

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