IN THE UK COVID-19 PUBLIC INQUIRY
BEFORE BARONESS HEATHER HALLETT
IN THE MATTER OF:
THE PUBLIC INQUIRY TO EXAMINE THE COVID-19 PANDEMIC IN THE UK

On behalf of Covid-19 Bereaved Families for Justice UK and NI Covid-19 Bereaved Families for Justice

MODULE ONE OPENING SUBMISSIONS

INTRODUCTION

1. The families want this Inquiry to discover whether the UK was fundamentally unprepared for a devastating pandemic such as Covid-19 resulting in a far greater loss of life than would otherwise have occurred. The UK is the 5th richest G20 nation. It has a mature political system, with advanced infrastructure and healthcare, and together with its neighbour, Ireland, it consists of islands. Those factors should have mitigated against the devastating impact that the pandemic was to have on the UK and given it a clear advantage. Instead, the UK is one of the top 20 countries in the world in terms of Covid-19 deaths per 100,000 people.[1] Technical disputes about how figures are recorded and methods of data collection should not detract from the basic truth: the UK could, and should, have fared much better.

2. Nor should the mistake be made of thinking that the UK's failure is measured in figures. It is measured in the lost years, love, happiness, potential and missed milestones of every person who did not survive to see the world 'return to normal.' It is 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. Bereaved family members who are part of the CBFFJ represent a large and diverse group of individuals. They come from all walks of life and, by dint of their occupations as well as personal circumstances, saw and felt this pandemic on many levels. They have different areas of interest, different experiences, and different questions. But they are united. Not only by grief, but by their determination that the legacy of this Inquiry, an Inquiry that they campaigned for, is one of justice, accountability, and most importantly, change.

3. We know that the next pandemic is coming. We do not know what characteristics the disease will have, save that it is unlikely to be identical to Covid-19. It may well be more deadly and more easily transmissible. Unless it finds in the UK an approach which has fundamentally changed, the impact of such a pandemic could be even more devastating. This Inquiry carries the heavy duty of making recommendations to prevent and to mitigate the next time. The lack of progress following previous inquiries shows that any change needs to be timely, sustained, effective and independently scrutinised and enforced.

4. The Inquiry begins to discharge this duty in Module 1, through a high-level examination of the UK's preparedness focusing on the 'Relevant Period' (11.06.09-21.01.20). The Inquiry has split preparedness over several modules. The actual preparedness of the health and social care systems,

[1] John Hopkins Coronavirus Resource Centre, *Mortality Analyses* (available at: https://coronavirus.jhu.edu/data/mortality; last accessed 12.06.23).

and many other areas such as PPE procurement, vaccines, test and trace, and the economy will be returned to in later modules. Because the Inquiry is beginning with a high-level examination, there will be a temptation for it to focus on frameworks, strategies and plans, removed from their real-world context and impact, sanitising the real human loss. This temptation must be resisted. Frameworks, policies, strategies and plans are formulated within the cultures, systems, approaches and principles which give rise to them. Were the UK frameworks for civil emergencies focused wholly on identifying threats and risks to life and the wellbeing of the country, and creating optimal resilience, preparedness and planning to meet those risks? Or did political or ideological issues get in the way, leading to a lack of central responsibility, a labyrinthine arrangement of secretariats, committees, and boards, which is difficult to unpick even in hindsight? Was that framework fit for purpose? Where was the Ministerial responsibility? Was it properly resourced?

I. KEY QUESTIONS

5. The CBFFJ families suggest that the fundamental topics within the scope of M1 are:

    a. At a UK level, who had overall responsibility for civil emergency resilience, preparedness and planning? Where did the buck stop?
    b. Who was responsible for assessing the risk of a pandemic such as Covid-19 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 the methodology and evidential basis in the public domain? Was it properly scrutinised and challenged?
    c. Was there a 'whole system' plan to prevent such a pandemic, or mitigate its effects? If so, who was responsible for it, 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?
    d. Was planning and preparedness optimal? Was it fatalistic and too focused on managing deaths rather than preventing them? Was there sufficient understanding of it amongst leading policy makers, 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?
    e. In terms of the civil emergencies' framework, were the responsibilities on Central Government clear? Indeed, were there any such responsibilities on Central Government or was the framework deficient in this 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 and devolved governments integrated their approaches? Was there a persistent failure across government to identify, learn and improve on responses to crises?
    f. 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 this gap exist?
    g. 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? Did a closed institutional culture reduce the opportunity for challenge to orthodoxies and reduce the autonomy of scientists to frame their own questions rather than be restricted

to answering the questions of policy makers? Did a closed culture promote or fail to counteract structural discrimination, or to consider health inequalities?

h. 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 emergencies may well not happen on your watch? Was former Chancellor and architect of austerity, George Osborne correct when he said those financial policies *"fixed the roof whilst the sun was shining",* or was Dr Jonathan Fluxman of Doctors in Unite right when he described non-NHS public health funding reductions as *"stripping the lead off the roof to make the buckets to catch the rain"*?

II. THE HUMAN IS MISSING

6. The purpose of the State should be to serve its people. Ultimately, the frameworks that the Inquiry is going to examine are there to protect and promote human life, safety and wellbeing. The Inquiry will need to examine whether this core principle has been lost and the human at the centre has been replaced by a technocratic focus on process and product.

7. Inquiry experts Bruce Mann and Professor David Alexander ('Mann and Alexander') describe the civil contingencies framework as "*process-orientated*," "*technocratic*" and "*antiseptic*"[2] rather than centred on people and their needs. This flows from the Civil Contingencies Act 2004 (CCA) itself which, the experts point out, does not "*talk explicitly about the care of people affected by the emergency."*[3] This antiseptic approach has been borne out time and again in the experiences of people on the ground, from the 7/7 bombings[4] to the Grenfell Tower Fire.[5] The Inquiry must examine whether, in reviewing their actions and learning lessons, there was any meaningful reflection within Central Government on the stories and experiences of the people affected by emergencies. The absence of reflection on real human experience is in itself indictive of this antiseptic culture.

8. The Inquiry must examine the impact of this culture on pandemic planning. The fatalistic approach to Covid-19 was characterised by the House of Commons Health and Social Care Committee as amounting *"in practice to accepting that herd immunity by infection was the inevitable outcome*."[6] The evidence so far disclosed in Module 1 suggests that this fatalistic approach was built in at the centre of the UK's pandemic planning. As accepted by Matt Hancock and other witnesses, the UK's pandemic doctrine was to contain very early cases but then to give up on controlling the pandemic and manage the consequences. *"Preparation was focused on coping with the consequences of the disease, for example how to deal with hundreds of thousands of excess bodies- rather than stopping those people from dying."*[7]

9. **This raises the question: was the scale of deaths the consequence of implementation of a long standing and flawed plan, which was designed only with respect to influenza? That plan being the 2011 Influenza Pandemic Preparedness Strategy, which assumed that the virus will inevitably spread and measures to disrupt or reduce its spread would inevitably fail, and**

[2] Expert Report Bruce Mann and David Alexander INQ000203349 §53.
[3] Expert Report Bruce Mann and David Alexander INQ000203349 §423.
[4] C.f.2
[5] Bereaved Survivors and Residents Closing submissions to M4 Grenfell Tower Inquiry (open source) p.2-3.
[6] Matt Hancock Witness Statement INQ000182686 §81.
[7] Witness Statement of Matt Hancock INQ000181825 §53.

thereby be a waste of public health resources[8]. And if so, how did such resignation, or perhaps unthinking disregard for the human consequences of planning assumptions, form the centrepiece of our pandemic planning even beyond flu?

10. Following the Covid-19 pandemic, the Department of Health and Social Care would reflect that the "*UK's risk appetite has moved on from the 2011 pandemic influenza strategy. A broader range of interventions, and thus response capabilities, are now within possible scope of a pandemic response and we need to prepare to intervene earlier and harder to reduce infection rates and prevent the modelled acute RWCS [Reasonable Worst Case Scenario] impacts on the health system from materialising."*[9] Given that the modelled RWCS predicted a possible 750,000 deaths, it is extraordinary that between 2011 and 2020 there remained an unspoken assumption that the UK's 'risk appetite' would accept such a catastrophic number of fatalities. It is even more extraordinary, given the predicted human impact, that throughout that time period there was no questioning of this doctrine by senior decision makers. In particular, it is extraordinary that this central assumption was not challenged with respect to non-influenza pandemics, given experience with Ebola and other diseases.

11. As Professor Neil Ferguson acknowledges, in modelling the RWCS, consideration of Non-Pharmaceutical Interventions was limited by an assumption of what was considered to be *"feasible."* Therefore, the potential for preventing hundreds of thousands of deaths through the use of more intense community-focused NPIs was never contemplated.[10] During the Relevant Period there does not appear to have been any explicit consideration of what 'feasibility' meant when the alternative could mean the deaths of hundreds of thousands of people.

12. The Inquiry must examine whether an over-emphasis on process and lack of emphasis on the real-life human impact of decision-making contributed to fatalistic planning which focused on managing, rather than preventing, hundreds of thousands of deaths. This should also be considered in the light of the absence of containment from the 2011 Pandemic Influenza Strategy and the apparent lack of challenge during the Relevant Period of this omission and its consequences (see paras 40-54 below).[11]

13. That these assumptions appear to have been widespread during the Relevant Period does not mean that they were sound. The concept of normalised deviance, coined by Dr Diane Vaughan, reflects the cultural phenomenon in which unsafe practice becomes considered normal if it does not immediately cause a catastrophe.[12] This phenomenon may go some way to explaining the 'groupthink' that enabled the focus of pandemic planning to move away from protecting life to managing the consequences of its loss.

III. RESPONSIBILITY AND ACCOUNTABILITY

[8] UK Influenza Pandemic Preparedness Strategy (10.11.11) INQ000022708 §28.
[9] Pandemic Diseases Capabilities Board (PDCB) Paper [10.05.22] INQ000087205 1§2.
[10] Witness Statement of Neil Ferguson INQ000185337 §81-83.
[11] Expert Report Bruce Mann and David Alexander INQ000203349 §472,475.
[12] Vaughan, Diane (January 4, 2016). The Challenger Launch Decision: Risky Technology, Culture, and Deviance at NASA, Enlarged Edition. University of Chicago Press. pp. 30–1.

14. **In examining preparedness, amongst the key questions, the Inquiry will need to ask: 1. During the Relevant Period and as of January 2020, with whom did the buck stop when it came to ensuring that the UK was prepared for Covid-19? 2. With whom does the buck stop now in ensuring that we are prepared for the next pandemic?**

15. These should be easy questions to answer. In the context of our labyrinthine structures of resilience, they are not. This reflects the fragmentation or absence of responsibilities, and thereby of accountability, oversight, assurance, and leadership that characterises the civil contingencies framework at every level of decision making.

Central Government: the 'ghost within the machine'

16. This flaw begins with the CCA. Across Scotland, England and Wales, the Act imposes legal duties of preparedness on organisations responsible for managing emergencies at the local level.[13] It imposes no duties on Central Government which is effectively the *"ghost in the machine,"*[14] its role in our civil contingencies framework in essence operating on the level of a gentleman's agreement. With no duties in respect of planning, oversight or assurance of local preparedness or information sharing, Central Government may do as much or as little as it deems appropriate to ensure that this country is adequately prepared for an emergency. The evidence disclosed so far in Module 1 suggests that Central Government has taken a de-minimis approach in the Relevant Period. Following on from Exercise Cygnus, there was a belated recognition that more needed to be done, but this resulted in a burgeoning of boards and committees which ultimately achieved little in terms of addressing shortcomings in preparedness. A post pandemic cross-government review rated 82% of Central Government department plans as being "*unable to meet the demands of any actual incident."*[15] This is unsurprising given that, as set out by Mann and Alexander, *"the temptation on UK government departments to ignore or pay lip service to responsibilities which are not captured in law can be strong, especially at a time when resources are tight."*[16]

17. Nor is this omission by error or oversight, but by design. In 2003, the Parliamentary Joint Committee on the Draft Civil Contingencies Bill recommended that duties be placed on Central Government, recognising that the CCA "*appears to be very 'bottom heavy', with all statutory duties being accorded to local providers and a cloak of invisibility being drawn over the regional and central tiers. It is entirely conceivable that a local emergency could turn into a regional one and then a national one. Given this potential, it is vital that the role of the regional and central tiers is clarified and codified, so that the chain of responsibilities is obvious to all."*[17] The Government decided not to act on that recommendation. In 2022, the National Preparedness Commission would recognise that *"experience since 2004, and especially over the past decade, has shown this decision to be fundamentally wrong. Effective resilience can only be achieved as a shared endeavour, with the UK Government working in full partnership with the Governments of the Devolved Administrations and with designated local bodies."*[18]

[13] The position is different in Northern Ireland and this is addressed in detail below.
[14] Walker and Broderick; *The Civil Contingencies Act 2004, Risk, Resilience and the Law of the United Kingdom* (Oxford 2006) p.295-297.
[15] [19.11.21] National Audit Office Report (19.11.21) INQ000146685 §17.
[16] Expert Report Bruce Mann and David Alexander INQ000203349 §276.
[17] Open Source [11.11.03] Report of the Joint Committee on the Draft Civil Contingencies Bill, p.27§102.
[18] Report from the National Preparedness Commission (1.3.22) INQ000187729 pp.123-124.

18. As predicted by the Committee in 2003, the system of duties on the local tier only has proven particularly inapposite in the face of a national emergency like Covid-19. As explained by one representative of a Local Resilience Forum, in the context of a nation-wide emergency, *"It feels like locals have been given the responsibility but are constantly over ridden by London who make decisions but don't take the hit if it doesn't work out."*[19]

19. In considering this issue, the Inquiry must not accept the false premise relied on by the Government: that the principle of subsidiarity justifies legal responsibilities being placed on the local tier only. Drawing a cloak of invisibility over the role and responsibilities of Central Government in national emergencies makes no contribution to empowering local communities. Indeed, the opposite is true. As recognised by the 93% of Local Resilience Forums surveyed by the Cabinet Office in 2021, placing duties on Central Government would assist and not hinder the local tier in ensuring its own resilience.[20] True subsidiarity would involve Central Government listening to the views of those it claims are at the centre of our civil contingencies framework. The Central Government approach to civil contingencies should be characterised by true partnership, not a spirit of *"do as we say, not as we do*."[21]

Local tier: 'flying blind'

20. Similarly, subsidiarity has served as a convenient excuse for the inaction of Central Government in failing to assure itself that the public are well protected in the face of an emergency. As set out by Mann and Alexander, *"senior leaders did not in the relevant period have a systematic, rigorous, evidence-based process which provided them with assurance on preparedness for identified potential major emergencies."* This led to government Ministers and senior officials "'*flying blind*'" throughout the period regarding the preparedness of the 'whole system' to provide an effective response to major emergencies. [22]

21. Nor is this a new issue. In 2016, Lord Harris, in reviewing London's preparedness for a terrorist attack, had recommended that an inspectorate be established to assure preparedness in the local tier warning that "*There is a mixed picture of provision. While some local authorities have full teams of specialist resilience officers, there are others who are taking a de-minimis approach. While MSLs [Minimum Standards for London] are meant to ensure that what is provided is at least adequate, the Standards themselves are monitored through self-assessment and peer review*."[23] His warning would prove prophetic when, just a year later, the Royal Borough of Kensington and Chelsea, considered to be a *"safe pair of hands"* by Central Government, would fail in its duties to the local community in the aftermath of the Grenfell Tower Fire.[24] This prompted a belated recognition by the Cabinet Office that *"It is not possible to predict with confidence, local areas which are likely to*

[19] Report from C19 National Foresight Group, titled Covid-19 Pandemic Third Interim Operational Review (26.10.20) INQ000075332 p.36.
[20] Cabinet Office Post Implementation Review of the CCA 2022 "Respondents to the Resilience Strategy Call for Evidence were in favour of duties being placed on central government with 78% (out of respondents who answered the question) and 93% of LRFs believing that the CCA should place specific duties on central government." (29.3.22) INQ000055883 §76.
[21] Expert Report Bruce Mann and David Alexander INQ000203349 §278.
[22] Expert Report Bruce Mann and David Alexander INQ000203349 §§245-246.
[23] Lord Harris Review of London's Preparedness to Respond to a Major Terrorist Incident (Oct 2016), Open Source, pp.36-7§9.8-9.
[24] Email from the Office of Melanie Dawes to the Office of Alok Sharma (14.6.17), Open Source.

be overwhelmed during an emergency."[25] Despite this, and an astonishing six years after Lord Harris' warning, the Government continues to "*consider the best way to develop a means of stronger assurance."*[26] The Inquiry should examine whether this inertia is symptomatic of a culture of complacency pervading the government's approach to emergency preparedness.

Fragmented leadership in the face of a whole systems emergency

22. It was obvious that a severe pandemic would be a 'whole systems emergency' which would impact on every area of our lives. Despite this, the government accept that the pandemic was treated as a health emergency which *"meant that there was little planning outside of the healthcare sector."*[27] For example, there was no planning for the economic consequences of a pandemic and it was not until March 2020 that the Treasury began to design economic support schemes.[28] Similarly the Government accepted internally that there had been no consideration of the demand which would be generated for PPE beyond the health and social care sector.[29] The Inquiry will consider in later modules the extent to which the demand for PPE from even the health and social care sectors was adequately considered, as well as the impact that this lack of planning would have on decisions such as the timing of lockdown and issues such as the availability and supply of PPE.

23. It is important for the Inquiry to examine not just the failure to plan outside of the healthcare sector, but the cause of this failure. It appears that there was appreciation within Central Government that a pandemic was a whole systems risk, but planning did not reflect that appreciation.[30] Nor is the lack of coherent cross-government planning limited to preparedness for a pandemic. A 2022 cross-government Crisis Capabilities Review found that there were "*no common assumptions as to the likely crises CG may be required to face," "no sense of an overall plan as to the breadth or capacity of the capabilities which may be required"* and *"relatively little routine coordination."*[31]

24. The Inquiry will examine whether the cause for this rests in the fragmented 'Lead Government Department' ('LGD') system. The LGD system allocates responsibility for managing each risk facing the UK to the department most relevant to the subject matter. In the case of a pandemic, the LGD was (and remains) the Department for Health and Social Care. However, the LGD does not take responsibility for assurance and management of risk beyond the policy areas for which they are responsible. Whereas this might seem sensible at first blush, and whilst the LGD will doubtless play a substantial part, preparedness and planning for many civil emergencies will involve interoperability across many different sectors. As we have seen, preparedness and response for a pandemic involves border, community, policing and security, education, equalities, transport, food supply, procurement, essential services, and economic measures, as well as public health, healthcare and social care. While the Cabinet Office plays a role in coordination, they are not responsible or

[25] Cabinet Office Briefing Paper by Zonia Cavanagh (28.9.17) Open Source, p.1.
[26] Resilience Framework 2022 (1.12.22) INQ000097685 §73.
[27] Resilience Framework 2022 (1.12.22) INQ000097685 §25.
[28] HOC Public Affairs Committee 13th Report (23.7.20) INQ000087193, p.5.
[29] INQ000087205 [10.05.22] Pandemic Diseases Capabilities Board (PDCB) Paper [3§11] *"The historical PFRB workplan did not consider PPE supply arrangements for non-health sectors and current DHSC-led PPE preparedness planning is modelled on demand generated by the health and social care sector only."*; INQ000105539 [14.04.20] Presentation from the Covid-19 Healthcare Secretariat (Cabinet Office) 'PPE Deep-Dive - Proposition for No10' [p.5] *"Despite repeated requests for clarity from CO, DHSC unable to explain how non-health sectors lodge needs and can get assurance about whether/when they will receive PPE."*
[30] Witness Statement of Oliver Letwin INQ000177810/2§6
[31] INQ000056240 [16.02.22] Crisis Capabilities Review [p.10§9, p.11§18]

accountable for assurance and leadership in planning for, or responding to a whole system emergency. This results in *"no single unifying vision but a range of different departmental agendas. Leadership is diffuse and confusing, with the ready potential to be conflicting."*[32]

25. There is no single point of *accountability* for ensuring that planning across government for any whole system emergency is adequate or coordinated. This state of affairs has persisted for many years[33] and its effects are felt across many of the most vital areas of preparedness facing the UK today, for example in relation to the impacts of climate change, where the lack of Ministerial responsibility has left *"an extreme weakness"* in our preparedness.[34] The Inquiry's work in addressing this weakness at the core of our resilience is urgent in the extreme, not only in preparation for the next pandemic, but for the next whole system emergency whatever that may be.

26. The Inquiry's examination of pandemic preparedness will also involve the consideration of an alphabet soup of different committees, advisory groups, boards and reviews.[35] This Inquiry has already become an acronym fest. It is striking that despite the advice and input of so many committees, key documents such as the 2011 UK Influenza Pandemic Preparedness Strategy would remain stagnant and would not be updated during the relevant period. The Inquiry must consider the coordination, information-sharing, autonomy and contribution of each as well as whether the profusion of committees gave the impression of action without leading to implementation.

27. When considering 'where the buck stops?' the Inquiry will be mindful of the evidence. Where there is buck passing, denial of responsibility and avoidance of accountability, there is no leadership. A system which allows fragmentation of responsibility and accountability is unlikely to lead to proper preparedness and planning, or produce strong and competent leadership in the face of a whole system emergency. A system which lacks clarity in its moving parts is unlikely to be understood by those vital to its operation. As with JESIP, this is an area which requires that everyone involved has a clear understanding not only of what they have to do, but the role of others.

Devolved government in Northern Ireland

28. If leadership and accountability was fragmented at a central government level, it was atomised at, and between, devolved governments. In Northern Ireland, for instance, a large part (Part 1) of the Cabinet Office Civil Contingencies Act 2004 containing important obligations on the public authorities (excluding most of the emergency services from being Cat 1 responders) do not apply.[36] The problem is not the devolution scheme. It seems that the main reason for this disapplication was because at the time the 2004 Act came into force, the Northern Ireland Executive and Assembly were in suspension with Northern Ireland under 'direct rule' of Westminster Ministers. The 2004

[32] Expert Report by Professor David Alexander and Bruce Mann INQ000203349/112§318
[33] Open Source [**2013**] All-Party Parliamentary Group on Homeland Security report [p.16]
"*Lead Government Departments are not held to account for their contingency planning. This fundamental weakness was illustrated during the Prison Service strike in 2011: although the Prison Service and Ministry of Justice said they had appropriate contingency plans to continue levels of service, the military had to be put on standby quickly. The military support was unplanned and reactive. While the departments had claimed that their plans were adequate, in reality the plans were not assured and were developed in isolation from other government departments"*
[34] *Open Source [17.10.22] Joint Committee on National Security Strategy, Readiness for Storms Ahead? Critical National Infrastructure in an Age of Climate Change. [p.3]*
[35] The organogram provided by the Inquiry Legal Team provides ample illustration of this.
[36] Expert Report by Professor David Alexander and Bruce Mann INQ000203349/45§126

Act did not to confer duties upon Westminster Ministers including those with direct rule powers in Northern Ireland at the time.[37] However, the 2004 Act has not been amended even after the (intermittent) restoration of devolved government. Moreover, no equivalent devolved legislation has ever been introduced despite the introduction of which was a key recommendation of the Cygnus Report[38] and despite the Secretary of State for Northern Ireland's expectation in 2005 that Northern Ireland would have a 'similar level of protection for its citizens as is experienced elsewhere.'[39] Rather, statutory obligations that pertain in the rest of the UK are mere guidance in Northern Ireland. The lack of cohesiveness at a local government level in Northern Ireland is plain from the witness statement of Alison Allen of The Association of Local Authorities of Northern Ireland (ALANI).[40] It conveys a sense that in the absence of statutory obligations being placed upon local authorities, there was relative inaction by councils in Northern Ireland when it came to planning/preparedness with little if any formulation of preparedness policies due to focus being on securing funding for emergency planning[41] and a lack of planning co-ordination as between autonomous councils. This absence of statutory duties leaves the people of Northern Ireland at distinct disadvantage with less statutory protection compared with other citizens in the UK.[42] We look to the Inquiry to examine the reasons for this and to make recommendations to address any gaps identified.

29. As to coordination between the devolved nations and central government in the event of a pandemic flu, each of the devolved governments were required to produce its own pandemic flu plan to be read in conjunction with a UK wide framework.[43] Although this changed with the 2011 national flu plan, as will be seen in the paragraph below, there remained a silo-approach to NI in relation to sharing of scientific evidence and attendance at SAGE and other bodies. This silo-approach may account for the disjuncture of approach to the Covid-19 pandemic as between the devolved governments and central government. This caused much confusion and mixed messages to the people of Northern Ireland in particular who were also aware of sometimes contrary information being given to their friends, family and neighbours by the Government of Ireland. In fact, the importance of co-ordination as between Northern Ireland government departments and their counterparts in Ireland during a pandemic was flagged by the Cabinet Office as long ago as 2007.[44] However, there is no evidence before this Inquiry that this occurred effectively or at all during Covid-19. This comes as no surprise to NI CBFFJ who lived through this obvious lack of co-ordination.

30. The disjuncture between central and devolved government in NI is demonstrated starkly by the revelation of Professor Ian Young, part time/consultant chief scientific advisor to the NI Department of Health, that his request to join the Chief Scientific Adviser UK Network was *"declined by the UK Government CSA, on the basis that only one representative for each Devolved Administration*

[37] See Walker and Broderick, *The Civil Contingencies Act 2004: Risk, Resillience, and the Law in the United Kingdom* (OUP, 2006), [4.108].
[38] JH/105 PHE report on Cygnus (20.10.16) INQ000090434.
[39] Office of First Minister and Deputy First Minister. The Northern Ireland Civil Contingencies Framework INQ000087965.
[40] Statement of Alison Allen, The Association of Local Authorities of Northern Ireland INQ000177812.
[41] Ibid, para 2.11
[42] See statement of Brendan Doherty, INQ000148480 §19-23.
[43] Cabinet Office. Pandemic Flu. A National Framework for Responding to an Influenza Pandemic (11.1.7) INQ000030563.
[44] Ibid

was allowed."[45] Further, Prof Young states[46] that there is no record of Northern Irish participation in SAGE prior to 29 March 2020. In his witness statement, Professor Sir Michael McBride, Chief Medical Officer for NI, confirms this and further says that between 2009 and 2015, the senior medical officer ('SMO') had observer status only with no speaking rights at Joint Committee on Vaccination and Immunisation ('JCVI') meetings, still only has observer status only at the Advisory Committee on Dangerous Pathogens ('ACDP') and NI had no automatic representation at SAGE meaning *that "policy makers in NI may have had more limited awareness of the extent to which uncertainty and a range of opinion is expressed in scientific discussion."*[47] We also know from Arlene Foster that Northern Ireland did not attend COBR meetings on Covid-19 until 2 March 2020.[48] This Inquiry must examine the circumstances in which this exclusion of Northern Ireland occurred, and in particular whether due regard was given to the inclusion of Northern Ireland in response and advice structures, as well as the consequential impact this had more broadly on preparedness and response in NI. This Inquiry should consider recommendations to ensure that in the future NI CSAs become part of the UK Network and SAGE and to ensure NI attendance at appropriate COBR meetings.

31. The Inquiry should also examine the apparent lack of knowledge of political leaders in Northern Ireland in relation to central government planning and preparedness and the reasons for it. Despite NI being involved in Exercise Cygnus,[49] Michelle O'Neill, First Minister of NI Designate and NI Minister for Health between May 2016-March 2017, in her witness statement to this Inquiry[50] remarkably admits to a lack of knowledge or, at best, is unable to recall details of the Cygnus Exercise despite it occurring during her tenure as NI Minister for Health. She avers pithily: *"I have asked for the Department of Health to provide relevant documentation. On receipt I would hope to provide more detail."* Ms O'Neill further admits to a worrying lack of knowledge about a UK wide influenza pandemic strategy that came into existence just 5 years before she became Health Minister, seemingly only learning of it during the course of preparation of her witness statement: *"I am now aware that there was a "UK wide influenza pandemic preparedness strategy" in existence from 2011. However, I do not recall the manner in which it was integrated in systems in this jurisdiction."*[51] Likewise, Arlene Foster, former First Minister, despite being First Minister during the relevant time of Exercise Cygnus and the pandemic and therefore responsible and accountable for civil contingencies, does not recall being briefed *"as to the recommendations made on foot of Exercise Cygnus, or any steps TEO intended to take to improve pandemic preparedness prior to the Assembly collapsing in January 2017."*[52] Nor does she recall *"any steps taken in relation to pandemic preparedness…between January 2017 and January 2020*."[53] All of this shows a worryingly very low level of interest or impact Cygnus had on decision making in Northern Ireland.

32. Ms O'Neill's successor as NI Health Minister during the pandemic, Robin Swann, does recall Cygnus and states his belief that his flu plan *"provided a good foundation for action during the Covid-19 pandemic."*[54] The Inquiry should examine this assertion in light of the adequacy and

[45] Statement of Prof Ian Young INQ000185346/2.
[46] Ibid, para 15
[47] INQ000187306_1, para 70, 74, 84
[48] Statement of Arlene Foster INQ000205274/2 §17.
[49] For example see INQ000006210 [undated] Exercise Cygnus CCS Roundtable with devolved administrations.
[50] Statement of Michelle O'Neill INQ000183409.
[51] Ibid §16.
[52] Statement of Arlene Foster INQ00020527 4/2.
[53] Ibid para 12
[54] Statement of Robin Swann INQ000192270/1 §7.

appropriateness of its exclusive focus on influenza pandemic. In any event, it is clear that the NI devolved government failed to implement a coherent response to the pandemic. The Inquiry may well find, in light of the issues set out below, that the devolved government was incapable of providing a coherent response.

33. The requirement for cross-border co-operation on the island of Ireland in the event of emergencies or disasters was well known to decision-makers, including the development of a Joint Disaster Planning Protocol between PSNI and An Garda Síochána.[55] An important executive body set up under the Good Friday/Belfast Agreement, the North South Ministerial Council (currently suspended due to an unlawful boycott by the DUP[56]) even identified the need to establish a Cross Border Emergency Management Group.[57] This was established in 2014. However, it is not clear if it had any or any significant role during the pandemic. It is also clear from Arlene Foster that she considered that the All-Island Institute of Public Health Ireland had 'very limited' input into pandemic response.[58] This is despite the Institute having statutory responsibility for public health in Northern Ireland. Was it a lack of preparation by the Institute? Were there political reasons? The Inquiry must consider why the Institute did not play a meaningful role in the pandemic response. Professor Young[59] describes in vague terms 'lines of communication' between scientific advisers in NI and Ireland. We submit that this ought to be a more formalised arrangement in future and ask the Inquiry to consider what steps might be done in this regard.

34. For the people of Northern Ireland, a common theme runs throughout the lack of statutory protection, lack of pandemic co-ordination and general pandemic unpreparedness: decades of political dysfunction. Whatever the causes of that political dysfunction – and there are many – neither local nor national politicians can be absolved from responsibility. As Brenda Doherty observes adroitly: *"The vacuum in governance 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 the 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."*[60] In her statement,[61] Arlene Foster highlights the constitutional difficulty that arises where civil servants cannot take significant or cross-cutting decisions in the absence of NI Ministers and must *"only operate within the context of existing policy directions set by Northern Ireland ministers while still in post.*"[62] Even during times when the NI government was ostensibly functioning, the dysfunction and infighting along constitutional allegiances within government is evident from the statement of Michelle O'Neill.[63]

35. An example of how all of this led to the poor state of preparedness in Northern Ireland is illustrated by the generalised nature of the OFMDFM guidance for pandemic preparedness[64] which has,

[55] Notes of a meeting between the Emergency Planning Officers Forum, regarding the Cross Border Activation Protocols (12.12.16) INQ000092730.
[56] *Re Napier's Application*, [2021] NIQB 86.
[57] Cross Border Emergency Management Group Terms of Reference (Dec 2018) INQ000092731.
[58] Statement of Arlene Foster INQ00020527, §30.
[59] C.f 45, §13.
[60] Statement of Brenda Doherty INQ000148480 §24 and her observations that follow to §29.
[61] Statement of Arlene Foster INQ00020527.
[62] Ibid, §8.
[63] Statement of Michelle O'Neill INQ000183409 §§23-28.
[64] Draft Guidance titled Influenza Pandemic: Northern Ireland Non-Health Preparedness and Response Guidance 2012 INQ000092700.

although has laudable overarching objectives (minimize potential health impact, minimize impact on society and economy, instil and maintain trust and confidence) and key principles (precautionary, proportionality and flexibility), it lacks detail. This lack of planning meant that the objective and principles were very obviously absent during the Covid-19 pandemic leading to many unnecessary deaths and suffering.

36. Another example of how not only was Northern Ireland under-prepared, but also was an outlier within the UK, can be found at the very cusp of the pandemic where on 22 January 2020 the Pandemic Flu Sub-Group itself acknowledged that due to the lack of work done and impact on staff resources due to EU exit preparations, '*in Northern Ireland being more than 18 months behind the rest of the UK in terms of ensuring sector resilience to any Pandemic flu outbreak*.'[65] Yet we learn from Professor Ian Young, part time/consultant chief scientific advisor to the NI Department of Health, that although he provides advice upon request by the NI Health Department, *"there were no requests for me to provide scientific advice to the NI Executive in the period following my appointment (in 2015) up to the beginning of the pandemic."* In other words, in at least the 5 years prior to the pandemic, the NI government received no scientific health advice to inform their decision making. It seems that Prof Young's role was merely to fill a box in an elaborate organogram. As he admits at §10: *"in my CSA role I had no role and limited awareness in relation to pandemic preparation and planning prior to COVID-19."* Professor Young's statement in this regard is supported by the statement of Professor Sir Michael McBride, CMO for NI.[66] It is little wonder that NI preparations were 18 months behind the rest of the UK.

37. The worrying impact of managing Brexit on preparedness was also highlighted in a report by the NI Department of Finance for the benefit of the NI Hub and CCG (NI) dated 23 October 2019.[67] It appears from the report that there was a sense of panic and that almost everything else was pushed to the side, or 'stripped back' including preparedness with reference to round-the-clock working 6 weeks prior to and 24 weeks after EU Exit Day to deal with the scale of the impacts of EU exit. Arlene Foster speaks of the *"significant focus"* on Brexit, particularly a 'No-Deal Brexit' in the months before the pandemic and that NI civil servants might have had to focus on No Deal more than their devolved counterparts elsewhere.[68]

38. Even the inadequate mechanisms and structures for civil contingencies that were in place did not function as the people of Northern Ireland should expect. We learn from Tony Simpson of the Department of Finance NI that in the 3 years prior to the pandemic that there were no instances of the activation of the NI Central Crisis Management Arrangements and that the CCG (NI) met only once in response to Storm Ophelia in 2017. Although Mr Simpson declines to provide a definitive answer to this Inquiry's question whether there would have been a difference in preparation for Covid-19 had there been a functioning Executive in place, the Inquiry must critically analyse this issue in light of the evidence outlined above. The Inquiry should also examine why the CCG(NI) does not include the CMO or CSA as medical/scientific experts and if it should.[69]

[65] Letter from TEO to Chris Stewart and others (22.1.20) INQ000092712.
[66] INQ000187306, §§25 and 16.
[67] Department of Finance, 'NI Command, Control and Coordination (C3)' (23.10.19) INQ000108611.
[68] Statement of Arlene Foster, INQ000205274/2§10.
[69] See Prof Sir Michael McBride INQ000187306, §137.

39. The political dysfunction and lack of properly funded and functioning civil contingency structures meant that the NI devolved government were simply incapable of providing an adequate response to the Covid-19 pandemic when it arrived.

IV. FORESEEABILITY AND PLANNING

40. The Inquiry will hear that the COVID-19 pandemic could not have been predicted and there was a focus on influenza.[70] It will be told that the response to pandemic influenza is necessarily different from the response to a novel coronavirus or other respiratory infection, and that there was a *'gap in strategy for emerging infectious diseases.'*[71] We profoundly disagree that a high impact newly-emergent disease could not have been foreseen, indeed there is evidence that it was.[72] We agree that there was a substantial gap in planning for such, and the apparent reliance on a 2011 Pandemic Flu plan was inadequate.

41. The Inquiry will hear that the UK was ranked second highest in overall preparedness in the 2019 Global Health Security Index behind the United States of America,[73] but in the evidence received so far, there has been markedly less emphasis on the following facts:

    a. That in 2002, the then Chief Medical Officer called for an effective strategy for combatting infectious diseases that "*must address the ever-present threat arising from new diseases, newly discovered diseases or old diseases posing a new or different threat"*[74] and found that, *"Although this country is respected internationally for its work on infectious disease surveillance, the present system falls short of what is necessary fully to protect the public health."*[75]
    b. That the UK had been told by the World Health Organisation in 2017 and 2018[76] of an urgent need for accelerated research into a priority list of diseases, including SARS, MERS and highly pathogenic coronaviral diseases, because of their potential to cause a public health emergency and the absence of efficacious drugs or vaccines; and that UK scientists were on those prioritization committees[77].
    c. That, in relation to an outbreak of a high-impact respiratory pathogen, the UK had been warned in 2019 that, "*the combined possibilities of short incubation periods and asymptomatic spread can result in very small windows for interrupting transmission, making such an outbreak difficult to contain";* and that senior UK scientific advisors were informants to this report, including the Deputy Chief Medical Officer.[78]
    d. That the key message from the 2019 Global Health Security Index was that "*National health security is fundamentally weak around the world. No country is fully prepared for epidemics or pandemics, and every country has important gaps to address."*[79]

[70] Third statement of Professor Sir Christopher Whitty, INQ000184639 §§4.17-4.18.
[71] Statement of Professor Dame Jenny Harries INQ000148429 §106.
[72] INQ000146555 [07.06.15] Report regarding G7 Speech [2]
[73] Third statement of Professor Sir Christopher Whitty, INQ000184639 §§4.17-4.18.
[74] RH/54: Getting Ahead of the Curve (2002) INQ000097690 p.55.
[75] RH/54: Getting Ahead of the Curve (2002) INQ000097690 p.12.
[76] MW/351: WHO Research & Development Blueprint (2017) INQ000149108 and (2018) Open source
[77] Professor Sir Peter Horby of NERVTAG and Dr Miles Carroll of PHE.
[78] Johns Hopkins Center for Health Security, 'Preparedness for a High-Impact Respiratory Pathogen Pandemic' (Sept 2019), Open source p.6
[79] Johns Hopkins Global Health Security Index 2019 INQ000023063, pp.9 and 12.

42. The 2011 UK Influenza Pandemic Preparedness Strategy was formed in the wake of the 2009 pandemic. Although a flu strategy, it *"could be adapted and deployed for… an outbreak of another infectious disease, such as SARS… with an altogether different pattern of infectivity"*.[80] However, there was no consideration within the plan of what parts would need adaption, on what basis or how decisions should be made regarding adaption, or of the consequences in terms of planning assumptions.

43. In considering the difference between planning for a pandemic in the context of an Emerging Infectious Disease and a novel Influenza pandemic, it is important to consider similarities in the early stages of responding to each disease. In the case of *any* novel disease, its impact and transmissibility cannot be measured until it arrives; so effective surveillance, and infection prevention, containment and control is key.[81]

44. The failure to have a plan in place for an Emerging Infectious Disease will be an important consideration for the Inquiry. However, the Inquiry should also examine the extent to which the planning assumptions which underlay the 2011 Strategy were valid even in the context of pandemic influenza.

45. In relation to mass gatherings, the 2011 Strategy adopted a working presumption '*that Government will not impose any such restrictions'* because the evidence apparently did not support it[82], but the scientific evidence base which underpinned the 2011 Strategy did not actually say that these measures would not work.[83] It said that evidence was sparse but that it was possible to draw three possible conclusions:

> *"Firstly, mass gatherings are very varied and the type, size, duration and setting of such events may play a role in the risk of influenza transmission. Secondly, there is some evidence that influenza may be transmitted at certain kinds of mass gatherings. Thirdly, limited - and mainly historical - evidence indicates that restrictions of mass gatherings can reduce transmission when part of a package of other public health interventions including isolation and school closures."*

46. By 2018, that conclusion had become stronger[84] and it was opined that "*The combined effects of various social distancing measures (including closing schools, cancelling large public events, closing places of entertainment, and home isolation) if started very early on in a locality affected by influenza may have a significant impact on reducing transmission…however such measures would need to be maintained until sufficient quantities of pandemic specific vaccine became available."* Yet the working presumption remained unchanged.

47. In relation to travel restrictions, the 2011 Strategy states that "*imposing a 90% restriction on all air travel to the UK at the point a pandemic emerges would only delay the peak of a pandemic wave by one to two weeks. Even a 99.9% travel restriction might delay a pandemic wave by only two*

[80] CW/3: 'UK Influenza Pandemic Preparedness Strategy' (10.11.11) INQ000022708 p.15.
[81] CW/3: 'UK Influenza Pandemic Preparedness Strategy' (10.11.11) INQ000022708 pp.6-7.
[82] CW/3: 'UK Influenza Pandemic Preparedness Strategy' (10.11.11) INQ000022708 p.39.
[83] Department of Health, 'Impact of Mass Gatherings on an Influenza Pandemic: Scientific Evidence Base Review' (2014), Open source, p.6
[84] JE/02: 'SPI-M Modelling Summary' (November 2018) INQ000147220, p.20.

months."[85] The same research from 2006 was cited for the same assumption in a modelling summary in 2018.[86] Two of the authors of the 2006 reports sat on the scientific advisory group that produced the summary.[87] This begs the question of whether and why research on travel restrictions had not been conducted between 2006 and 2018; and whether the scientific advisory groups were too insular to guard against groupthink.

48. In relation to border screening, the 2011 Strategy concluded that *"such measures are largely ineffective, impractical to implement and highly resource intensive"*[88] but by 2015, during the Ebola outbreak, there was a recognised need to improve capacity for border health and to formulate plans that were generic enough to be used in other incidents.[89] Despite this, the authors of the 2018 modelling summary concluded that, "*Screening on entry to the UK poses considerable policy questions (e.g. whether potential cases are quarantined) and planning (i.e. it requires considerable resources) and is not recommended"* based on evidence from 2005.

49. Whatever the validity of the assumptions during the relevant period in relation to pandemic influenza, there was no basis for extending reliance on these assumptions in relation to planning for an emerging infectious disease.

50. The economic, political and social consequences of these restrictions had been considered and embedded before a pandemic even occurred[90]. The lack of research into non-pharmaceutical countermeasures from 2015 onwards and the failure to implement an updated framework limited the position of the officials who inherited the 2011 Strategy.

51. The Inquiry will also have to consider whether during the Relevant Period there was adequate preparation to implement the measures that *were* envisaged in the 2011 Strategy. The 2011 Strategy was clear that large-scale testing, contact tracing and identification of at-risk groups were essential during the outbreak of <u>any</u> infectious disease.[91] Despite this, there appears to have been a complacency in planning for the implementation of these measures, with the seeming acceptance in 2017 that "*there may be lab capacity issues in future, depending on the nature of any outbreak"* without consideration of the consequences of this.[92]

52. In the decades before the onset of the pandemic, the UK government officials had repeatedly been warned not to be complacent about the risks of emerging infectious diseases that know and respect no international boundaries.[93] The NSRA assumption that such a disease would cause 100 deaths had no basis in science. There was no evidence to suggest that transmissibility and fatality were inversely related. Indeed the 2011 Plan had expressly asserted as much.[94] When questioned about the basis for this assumption, the Cabinet Office *"stated that, based on scientific and expert advice,*

[85] CW/3: 'UK Influenza Pandemic Preparedness Strategy' (10.11.11) <u>INQ000022708</u> p.38.
[86] JE/02: 'SPI-M Modelling Summary' (November 2018) <u>INQ000147220</u>, p.8.
[87] Professors Neil Ferguson and John Edmunds.
[88] CW/3: 'UK Influenza Pandemic Preparedness Strategy' (10.11.11) <u>INQ000022708</u> p.38
[89] Emergency Preparedness Resilience and Response Oversight Group meeting (14.1.15) <u>INQ000090487</u>, p.6.
[90] CW/3: 'UK Influenza Pandemic Preparedness Strategy' (10.11.11) <u>INQ000022708</u> p.38
[91] CW/3: 'UK Influenza Pandemic Preparedness Strategy' (10.11.11) <u>INQ000022708</u> pp.35-36.
[92] INQ000187748/2-3§5 [20.01.17] SPI-M meeting minutes
[93] RH/54: Getting Ahead of the Curve (2002) <u>INQ000097690</u> p.10; JH/045 PHE Global Health strategy 2014-2019 <u>INQ000090353</u> p.7; KG/28 UK Biological Security Strategy 2018 <u>INQ000104375</u> p.5; Johns Hopkins Global Health Security Index 2019 <u>INQ000023063</u> p.5.
[94] §2.10

diseases such as Ebola were expected to burn themselves out quickly, as had been the case on previous occasions."[95] This assumption does not appear to have been based upon any scientific advice, but on a complacent belief based on a non sequitur. Ebola had 'burned out' so the next dangerous disease would too.

53. The Inquiry should also consider the extent to which international learning from countries which successfully contained SARS and MERS was considered and incorporated into UK pandemic planning. Exercise Alice had identified a need to understand South Korea's response to MERS and consider its direct application to the UK, it appears that this learning was never in fact implemented.[96] This omission is striking and points once more to an insular and complacent culture.

V. A CULTURE OF SECRECY

54. **We invite the Inquiry to ask two important questions: 1. Was there a pervasive culture of secrecy regarding civil emergency preparedness during the relevant period, and if so, was this due to genuine national security concerns or an institutional mindset which avoided scrutiny and criticism? 2. What impact did this have on the UK's preparedness?**

55. These questions are posed against the backdrop of the current Judicial Review claim against the Chair, which seeks to establish that Ministers, or indeed any other material holder, should be the arbiter of relevance with respect to what the Inquiry can see. The government claims that these actions are consistent with 'full co-operation' with this Inquiry.[97] The families disagree. Control over what the Inquiry sees not only attacks its independence, but represents an attempt to avoid scrutiny. Apart from this Inquiry, is there generally a similar culture to avoid scrutiny of national civil emergency preparedness and planning which would highlight absence of responsibility?

56. There was much public concern over the secrecy that shrouded the involvement and advice of SAGE in the response to the Covid-19 pandemic.[98] Scientists working on SAGE were later interviewed by the Institute for Government about the decision not to reveal SAGE membership and said they: *"saw no overwhelming reason for the secrecy and felt it created unnecessary distrust and undermined the authority of their advice."* The IFG report noted that, "*Not being transparent was a political decision and SAGE members pushed for transparency earlier."* It also commented that, *"Further problems have been caused by the government's repeated reluctance to set out broader evidence and reasoning for its decisions."*[99]

57. The unnecessary secrecy regarding SAGE was not a novel issue, but one which had been raised as far back as 2011, in relation to the response to the volcanic ash crisis. The House of Commons

[95] National Audit Office Report (19.11.21) INQ000146685.
[96] Exhibit CW/416: Report from Public Health England titled 'Exercise Alice Middle East Respiratory Syndrome Coronavirus (MERS-CoV)' (15.2.16) INQ000022732 11§5.
[97] 'Government to take legal action against Covid Inquiry over Johnson WhatsApps', The Guardian (2.6.23) Open Source.
[98] The Guardian: 'Secrecy has harmed UK government's response to Covid-19 crisis, says top scientist' (02.08.20) - https://www.theguardian.com/world/2020/aug/02/secrecy-has-harmed-uk-governments-response-to-covid-19-crisis-says-top-scientist
[99] Institute for Government, 'Science Advice in a Crisis' (1.12.20) INQ000063070 pp.40-42.

Science and Technology Committee recorded their concern that, *"the SAGE mechanism operates under a presumption of secrecy rather than transparency and openness, and this was particularly and unnecessarily so during the volcanic ash emergency."*[100]

58. Internal Cabinet Office emails in relation to SAGE meetings held during the Ebola response shed light on similar issues of unnecessary secrecy. The SAGE meeting minutes were not published at the time of the response (October-December 2014) but almost a year later in September 2015. In discussing the publication of the minutes in September 2015, a senior Cabinet Office official remarked: *"the minutes themselves are largely innocuous but the Ebola ones in particular are likely to generate questions over why SAGE first met so late on and reopen debate on the speed of the UK response. I assume they have defensive lines in place."*[101]

59. A similar cloak of secrecy was drawn around the publication of pandemic preparedness exercises. The reports relating to Exercise Cygnus and Exercise Alice were eventually published as a result of FOI requests. They contain no information that is prejudicial to national security. They do, however, contain information that posed a reputational risk to the government. Internal government communications around the publication of Exercise Cygnus show that it was this risk that publication might provoke criticism and scrutiny of the Government's preparedness for Covid-19, that preoccupied government officials and not legitimate public interest concerns.

60. This is reflected in a submission dated 26.06.20 from a Government official to Matt Hancock and his Permanent Secretary, Chris Wormald, regarding the publication of Exercise Cygnus. Following the FOI requests, Parliamentary Questions in both houses, negative media coverage regarding the refusal to publish the report and an application for judicial review, the official stated: *"On 14 May you received a submission recommending that…you should seek collective agreement to release the full Exercise Cygnus report. After reviewing the submission, you asked for further work to be done so that… the balance of public interest could be shifted in favour of publishing the report by mitigating the risks from publication."* It continued: *"the release of the report will likely lead to increased scrutiny of our preparedness activity and plans in recent years…parallels will be drawn to our Covid-19 response. Publication could lead to a number of new FOIs, PQs and questions from parliamentarians, with potential criticism of our preparedness in a number of areas…many of the questions relating to the report will likely be similar to those being asked about the Government's response to the current Covid-19 pandemic, such as PPE supply, adult social care…"* Substantial work had been undertaken to mitigate the risk of *"significant media interest and negative coverage", "including by developing a positive narrative on our preparedness activity since Cygnus and preparing rebuttals for any areas of potential criticism."* [102] The government would not publish the report until 20.10.20, as part of *"a wider update"* on pandemic preparedness launched on a new gov.uk website.[103] The risks identified relate solely to the potential for increased scrutiny and criticism of pandemic preparedness.

[100] House of Commons Science and Technology Committee Report on Scientific Advice and Evidence in Emergencies INQ000101594 §164 and 168.
[101] Email Tallantire-Wainwright (14.09.15) INQ000017775.
[102] Submission from Callum McCarthy (UK Health Security) to individuals including Secretary of State, regarding Publication of the Report into Exercise Cygnus and Legal Challenges (26.06.20) INQ000057543/3§12.
[103] Submission from Callum McCarthy (UK Health Security) to individuals including Secretary of State, regarding Publication of the Report into Exercise Cygnus (12.10.20) INQ000057544/2§9.

61. A fear of criticism and a culture of secrecy on the part of the Government in relation to risk assessment and planning was identified by a House of Lords Select Committee in 2021. In finding that the UK Government *"defaults to secrecy too readily"* resulting in a risk management system that is: *"veiled in an unacceptable and unnecessary level of secrecy,*" the Select Committee pointed out that *"fear of criticism can drive unnecessary reliance on secrecy.*"[104]

62. This culture is not without consequence. As identified by the Select Committee, *"the UK's risk plans need to be shared widely to maximise their efficacy. Only through transparency and a healthy culture of challenge can we provide society with a reliable foundation to respond to emerging risks."*[105] The government had been given a similar warning by the House of Commons Select Committee 2011 in relation to the volcanic ash incident which highlighted that the consequence of the unnecessary secrecy around SAGE had been that *"During the course of our inquiry, we found it difficult to source information… More worryingly, it appears that the secrecy of SAGE's membership and operations posed a barrier to external scientists who wanted to contribute but were left outside the loop."*[106]

63. Local responders were also to feel the consequences of this culture. Mark Lloyd of the Local Government Association described difficulties experienced by his members in risk planning due to the secrecy which shrouds the National Security Risk Assessment (NSRA),[107] and these concerns about "*secrecy issues*" preventing the communication of important information were echoed by local responders who input into the Emergency Planning Society's call for evidence.[108]

64. In our view, the Inquiry should not separate its analysis of issues of 'groupthink', failure to learn lessons, insular decision making and the lack of external or red team challenge from its examination of this culture of secrecy and fear of scrutiny. One leads to the other and they both reinforce one another. An insular and secretive culture within government is also likely to contribute to structural racism and the failure to tackle inequalities engendered in its decision making. Without external input, blind spots are amplified and assumptions are not challenged.

VI. AUSTERITY

65. In considering the impact of austerity during the relevant period, the Inquiry is likely to find itself presented with witness evidence which falls into two diametrically opposing camps. The politicians and senior civil servants who oversaw austerity consider that it had little, if any, impact on preparedness and put the country in good stead to withstand the economic shock of Covid-19. Those who were on the receiving end of austerity, for example those who represent community groups, doctors, nurses and local authorities consider it had a huge and damaging impact on preparedness and made communities and our social and health infrastructure vulnerable, worsening the impact of Covid-19.

[104] Report by Select Committee on Risk Assessment and Risk Planning, titled 'Preparing for Extreme Risks: Building a Resilient Society' (03.12.21) INQ000055881/7.
[105] Ibid.
[106] House of Commons Science and Technology Committee Report on Scientific Advice and Evidence in Emergencies INQ000101594 §164.
[107] Statement of Mark Lloyd INQ000177803/40§148-150.
[108] Statement of Jeannie Barr, Emergency Planning Society INQ000183407/20 §(ii).

66. George Osborne, one of the architects of austerity, describes his financial policies as having *"fixed the roof while the sun was shining."*[109] Dr Jonathan Fluxman, of Doctors in Unite, describes the cuts to non-NHS public health funding as *"stripping the lead off the roof to make buckets to catch the rain, since failure to prevent created the workload crisis which overwhelms general practice and hospitals."*[110]

67. Rosemary Gallagher, on behalf of the Royal College of Nurses, explains that the *"effectiveness and sustainability of this vital system has been undermined by chronic underfunding and diminishing resources… this historic underfunding of public health undermined the capacity of local public health teams to effectively improve health and reduce inequalities and respond to the Covid-19 pandemic."*[111]

68. Then there is the evidence of the experts. Professors Bambra and Marmot point out that "*The UK fell from being ranked 26th globally in terms of life expectancy in 2010 to 36th globally by 2020. Life expectancy growth started to stall across the UK in 2011… Something had changed in the UK in 2010/11. It coincided with a new government, whose stated ambition was austerity."* In considering whether austerity had an impact on this, they draw from *"a large body of international public health research [which] has found that the austerity period was accompanied by adverse health changes.*" They cite the Marmot review 2020 which "*concluded that changes in the social determinants of health associated with UK-wide austerity policies since 2010, were likely to be the causes of the adverse changes in health and health inequalities across the countries of the UK."* [112]

69. Mann and Alexander likewise acknowledge the role that under-resourcing and austerity had to play in the UK's preparedness. At the local tier, the funding of local authorities fell by 35% in real terms and *"levels of resourcing for their resilience and preparedness activities which were unsustainable, with significant impacts on staffing, skills development, and training and exercising, which were causing real damage to their operational effectiveness*."[113] On the national tier, austerity contributed to a reduced commitment to pandemic planning between 2012 and 2016 with *"damaging effects."*[114]

70. Austerity was particularly damaging in the context of a civil contingencies framework based on subsidiarity as it relies on strength and capability of the local tier. As the local tier became increasingly under-resourced, by 2015 the Cabinet Office appears to have recognised internally that there had been a *decline* in capability in local resilience.[115] This was contributed to by austerity, with 69% of Local Resilience Forums (LRFs) citing funding as a 'top three' challenge in their response to the National Capabilities Survey 2014.[116] *"Given the growing evidence base of diminished resources affecting the ability of some LRFs to undertake collaborative work"* it was considered *"prudent"* by the Cabinet Office at that point (in 2015) to consider *"options for LRF funding arrangements."*[117] A year later, Lord Harris would come to the same conclusion, recommending

[109] Statement of George Osborne INQ000187308/6§15.
[110] Statement of Dr Jonathan Fluxman (Doctors in Unite) INQ000148403/26§57.
[111] Professors Bambra and Marmot INQ000195843, p.26 §47.
[112] University College London, 'The Marmot Review: national and local policies to redress social inequalities in health' (16.12.14) https://www.ucl.ac.uk/impact/case-studies/2014/dec/marmot-review-national-and-local-policies-redress-social-inequalities-health.
[113] Expert Report Alexander and Mann INQ000203349/119§343.
[114] Expert Report Alexander and Mann INQ000203349/164§484, 168§494.
[115] Draft Cabinet Office briefing on the role of the local tier in civil contingencies (Jan 2015) Open Source p.1.
[116] Ibid, p.10.
[117] Draft Cabinet Office briefing on the role of the local tier in civil contingencies (Jan 2015) Open Source p.1.

ring fenced budgets for LRFs.[118] This was not implemented. Following the Grenfell Tower fire in 2017, Katharine Hammond, director of CCS at the Cabinet Office, considered that *"cash strapped local authorities" "would happily deprioritise resilience"* if they could rely on a national taskforce to assist with disasters such as Grenfell.[119] In truth, the de-prioritisation had already taken place, the logical consequence of austerity coupled with a lack of oversight.

71. Nor was the impact of austerity on other sectors unknown. The House of Commons Health Committee warned in 2016 that *"cuts to public health and the services they deliver are a false economy as they not only add to the future costs of health and social care but risk widening health inequalities."* [120] By 2017, the position in relation to social care was dire, and the Government were well aware of this, with a Department of Health Resilience Plan recognising that:

> *"Significant reductions in Adult Social Care budgets over the previous spending review and the need for further reductions will lead to delivery risks. The financial constraint on councils is leading to increased pressure on provision across the system, which is largely delivered by the independent sector. … There are also significant constraints in the social care workforce across the whole of the sector. The level of risk varies across the country, but DH's assessment is that the sector has limited capacity to absorb further pressures which may be put on the system from a prolonged emergency period. Furthermore, the ability of providers to absorb further cost pressures associated with preparing for an emergency, including the vaccination of the workforce, is very limited and we would expect low levels of compliance if specific funding is not identified."*[121]

72. Jeremy Hunt would later come to regret the failure to *"secure a long term funding settlement"* for social care during his time as Health Secretary.[122]

73. This Inquiry is not here to decide the rights and wrongs of economic policy, but the impact of such policies is central to its work. Resourcing, and changes to resourcing brought about by policy are key issues. Austerity had a particular impact on four areas which were central to pandemic preparedness: public health, local authorities, social care and the NHS. The Inquiry does not have to choose between the two narratives, however, in determining whether austerity affected preparedness and planning, and indeed adversely affected inequalities, the evidence so far points all in one direction. Whether austerity really did leave the UK in a better financial state to mitigate the effects on the economy, is for a later module, but the proposition that it did is more assertion than evidenced so far.

74. Austerity has also had a very real impact at a devolved level in Northern Ireland. The lack of resources impacting upon preparedness has even been acknowledged expressly at NI Executive level. Director of the Northern Ireland Executive office, Bernie Rooney, said in a letter marked 'sensitive' just a couple of weeks before the confirmation of Covid-19 as a novel virus, warned that:

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[118] Lord Harris Review of London's preparedness to respond to a major terrorist incident (Oct 2016) Open Source pp.36-7§9.8-9.
[119] Email from Katharine Hammond to Paddy McGuinness, disclosed as part of the Grenfell Inquiry (21.06.17) Open source.
[120] House of Commons Health Committee (01.09.16) INQ000103569/7.
[121] Department of Health Security and Resilience Plan 2017/18 INQ000105273, p.16.
[122] Statement of Jeremy Hunt INQ000177796/12§56.

"The reduction in resources in civil contingencies in The Executive Office over a number of years had impacted on capacity with a very limited number of individuals having the knowledge, vital skills and experience necessary to the extent that this had become a significant risk for NICS, in being able to respond to a major event".[123]

75. A few weeks previous to Ms Rooney's letter, the poor state of the Civil Contingencies Policy Branch ('CCPB') was highlighted in a report dated 28 November 2019.124 The report concludes that the CCPB, which is the only NI team dedicated to civil contingency planning and meant to serve as a focal point for co-ordinating civil contingency response in Northern Ireland, *"is not currently structured or staffed to deliver this...In addition, the core skills and experience are only held in the key posts with no resilience, which is a risk against the branch's ability to plan and run operations in the future."* This paints a picture of the most important civil contingencies organisation in NI depleted and on its knees weeks before a major pandemic.

76. Even the NI Health Minister during the pandemic, Robin Swann, states his belief that *"collective past political/Governmental failings left health and social care vulnerable to the pandemic"* and is critical of the fact that *"vital services were underfunded"* and that "*social care was particularly neglected with a lack of proper pay and career structures, leaving our care homes exposed*."[125]

77. The significant contribution that austerity had on preparedness in Northern Ireland is very well set out in the witness statement of Gerry Murphy, Assistant General Secretary of ICTU.[126]

VII. HEALTH INEQUALITIES AND STRUCTURAL RACISM

78. An important measure of whether we successfully function as a society, is how the most vulnerable and marginalised communities and individuals are treated. In times of emergency and crisis, this is even more keenly observed; as it is those communities and individuals who will be at the forefront of the fall out and impact of these emergencies.

79. The Health and Social Care Act 2012 was described as a response to Professor Sir Michael Marmot's *Fair Society, Healthy Lives* and reflective of the government's commitment to tackling *"the wider social determinants"* of health.[127] Yet, the expert evidence shows, by January 2020 health inequalities had increased not decreased. Preparedness for a pandemic had wholly failed to consider health inequalities or structural racism, or indeed other forms of structural discrimination. The 2022 Resilience Framework, while committing to substantial work *"on vulnerabilities and needs based planning"*, itself reflects a lack of consideration for those same issues.[128]

80. According to Professors Marmot and Bambra, "*Pre-existing health inequalities were only considered in a minimal way in the UK's and devolved administrations' pandemic planning and then largely in relation only to age and clinical risk factors. Wider issues of vulnerability (such as*

[123] Letter from Bernie Rooney to the Deputy Secretary (10.12.19) INQ000092722.
[124] Draft Report 'NI Civil Contingencies Future Recommendations Report' (28.11.19) INQ000092723.
[125] Statement of Robin Swann INQ00019227.
[126] Gerry Murphy INQ000177806.
[127] JH/015: White Paper by 'Healthy Lives, Healthy People: Our strategy for public health in England' (November 2010) INQ000090323 Executive Summary, §2.
[128] Expert Report Alexander and Mann INQ000203349/28§56

socio-economic status or ethnicity) were seldom considered in the UK and devolved administrations planning documents that we reviewed [with some noted exceptions]. *"*[129]

81. They conclude:

> *"The UK entered the pandemic with increasing health inequalities and health among the poorest people in a state of decline. We knew from previous pandemics and research into lower respiratory tract infections that people from lower socio-economic backgrounds, people living in areas or regions with higher rates of deprivation, and people from minority ethnic groups and people with disabilities, are much more likely to be severely impacted by a respiratory pandemic. lack of consideration of pre-existing social and ethnic inequalities in health in our pandemic plans may have meant that our responses were unable to mitigate the disproportionate impact experienced by minority ethnic, low socio-economic status and other socially excluded communities. Whilst it is difficult to be definitive, it may have mattered that pre-pandemic government policies failed to have adequate regard to pre-existing health inequalities in terms of: the timing and delivery of our non-pharmaceutical interventions; our plans for surge control and NHS demand; the make-up of the Shielded Patient list; occupational health guidance and workforce deployment; how the COVID-19 testing and vaccine was rolled out; and potentially the mortality and morbidity resulting from COVID-19 in the UK.*"[130]

82. Professors Marmot and Bambra set out *how* health inequalities and structural racism came to be not only neglected but entrenched by and within our systems of resilience and pandemic preparedness. **The Inquiry will have to examine *why* it came to be that there was such a failure to consider the types of people who might be impacted by the pandemic and their needs.**

83. The Inquiry has evidence from witnesses who represent groups who were excluded and marginalised. Their evidence paints a picture of neglect and omission which meant that the planning and preparedness systems which did exist, failed to address never mind prioritise equality. This evidence chimes with the experience of many black and brown bereaved family members.

<u>*Structural racism*</u>

84. Ade Adeyemi on behalf of the Federation of Ethnic Minority Healthcare Organisations[131] describes how structural racism and multiple layers of inequality resulted in "*the first alarming sub-plot of the Covid-19 pandemic in the UK in 2020 … the disproportionate death rates among our numbers. This created the motivation for focused advocacy, to literally, save our own lives."* He highlights the absence of mitigation of health inequality and structural racism which should have been a critical component of UK emergency planning and building of pandemic resilience.

85. Witness evidence also sheds light on policies during the relevant period which actively promoted health inequalities and structural racism. Anna Miller of Doctors of the World UK[132] and James Skinner of Medact[133] highlight that policies such as NHS charging for overseas visitors and data

[129] Professors Marmot and Bambra INQ000195843 §146.
[130] Professors Marmot and Bambra INQ000195843 §189.
[131] Witness Statement of Ade Adeyemi INQ000174832/6§18.
[132] Witness Statement of Anna Miller INQ000148404/4§11.
[133] Witness Statement of James Skinner INQ000148410/3§10.

sharing between the NHS and Home Office reduced access to healthcare and deterred people from accessing the NHS during the relevant period. Selma Taha of Southall Black Sisters[134] highlights the impact of Asylum Support and No Recourse to Public Funds policies on health inequalities. In exacerbating inequality, these policies played a key role in decreasing resilience among already marginalised groups.

86. Of course, the pandemic also exacerbated other pre-existing health inequalities.

Structural ableism

87. Disabled people make up one fifth of the UK population; yet Disability Rights UK does not know of any Disabled person who was invited to provide their knowledge or expertise on pandemic planning before January 2020.[135]

88. Disabled people disproportionately suffered poorer health outcomes before and during the pandemic[136]. Before the pandemic, people with learning disabilities were significantly more likely to die before the age of 50, with respiratory and heart diseases the leading cause of death.[137] According to the 2019 Learning Disabilities Mortality Review (LeDeR) Programme Annual Report, "*People with learning disabilities died from an avoidable medical cause of death twice as frequently as people in the general population.*"[138]

89. As outlined by Disability Rights UK, ***This level of disproportionality [in mortality rates] in itself calls into question whether there was adequate pre-planning for the pandemic's potential impact on Disabled people, particularly where a large number of Disabled people died in residential care settings***.'[139] We agree with Disability Rights UK and the many other Disabled persons' organisations that have given evidence to the Inquiry and raised similar concerns.

Structural ageism

90. There was ample evidence during the relevant period that older people would be among those most likely to be severely impacted by a pandemic causing a whole system shock (despite the fact that this pandemic is often remembered for the spike in young people who died because of cytokine storm):

    a. the Independent Review into H1N1 acknowledged that children under the age of 5 and over 65 were at-risk groups;[140]
    b. the very young and older people were at higher risk of flood-related deaths;[141]
    c. older people were significantly overrepresented among fatalities in Hurricane Katrina;[142]

[134] Witness Statement of Selma Taha INQ000108571/4§16.
[135] Kamran Mallick INQ000185333 §§4-5.
[136] See for example, Statement of Nuala Toman (Disability Action Northern Ireland) INQ000148464; and Disability Action, 'COVID-19 Updates from Disability Action Northern Ireland' (11.4.23) INQ000148337.
[137] (Heslop et al, 2014: 889), referenced by Marmot and Bambra INQ000195843 §35.
[138] University of Bristol (2019), Open source, p.8.
[139] Kamran Mallick INQ000185333 §10.
[140] Professors Marmot and Bambra report INQ000195843 §185.
[141] Professors Marmot and Bambra INQ000195843 §163.
[142] Professors Marmot and Bambra INQ000195843 §165.

d. during the 1918 pandemic, death was particularly high in young children and older people;[143] and
e. older people suffered significant inequalities in heatwaves.[144]

91. Despite being fixed with this knowledge, Paul Farmer, CEO of Age UK explains *"Age UK does not believe that older people and their needs were adequately considered or understood when decisions about emergency planning, preparedness and resilience were taken by the UK Government" and "Government priorities appeared to reflect embedded ageist and ableist attitudes towards older and disabled people."*[145]

Intersectional experience

92. As outlined by Professors Marmot and Bambra, social inequalities in health are experienced intersectionally.[146] This aligns with the evidence of Disability Rights UK[147] and others.

93. The disproportionate impact of a pandemic on all these groups, and more, should have been something the governments of the four nations at least *imagined* was possible. Instead, there is extremely limited evidence of consideration or consultation.

94. The suffering of older people and Disabled people was not just about fatalities; it manifested itself in other ways as well. Many people suffered the distress of not having close personal contact with their loved ones, not only in clinical settings but in the community also; the indignity of being cut off from their loved ones in their final hours and moments; the isolation.[148] These inequalities affected individuals as well as their families.

95. The denial of the ritual of wakes and/or burials (which although important in every part of the UK, has a particular cultural significance for all communities in Northern Ireland) resulted in some families querying whether their loved ones were actually dead, or whether it was their loved one's body in a sealed coffin.[149] The importance of these rituals was acknowledged expressly by the Northern Ireland Government when it made *'the respect for the deceased and bereaved'* a key principle of anticipated mass fatalities arrangements[150] and that "*caring for deceased victims in a dignified and respectful way, paying due regard to cultural and faith issues."*[151] Yet, the lack of preparedness in this respect had the effect of denying, delaying or worsening the grieving process of the bereaved.

[143] Professors Marmot and Bambra INQ000195843 §168.
[144] Professors Marmot and Bambra INQ000195843 §164.
[145] Paul Farmer INQ000106031 §§4 and 7.
[146] Professors Marmot and Bambra INQ000195843 §6.
[147] Kamran Mallick INQ000185333 §9.
[148] MA/8: British Red Cross, 'Lonely and left behind: tackling loneliness at a time of crisis' (1.10.20) INQ000102731.
[149] See Statement of Brenda Doherty INQ000148480 §88-90, 111, 114(viii).
[150] Presentation from NI Department of Justice 'Mass Fatalities Arrangements in Northern Ireland' (4.10.18) INQ000097494.
[151] Draft Plan from Emergency Preparedness Group 'Mass Fatalities Plan' (Sept 2017) INQ000092702; See also, the anticipated *'significant burden on funeral directors'*: 'Excess Deaths Illustrative Example Using Modelling Data' (undated) INQ000092728.

96. This failure to act arose from deep seated fatalism embedded among State actors and decision makers that some people would die disproportionately in a pandemic and nothing could be done about it. Ultimately, this failure arose from systemic State ageism, ableism and racism. Many people died unnecessarily as a result.

VIII. FAILURE TO LEARN LESSONS

97. One of the fundamental and urgent issues for any inquiry, is to consider what lessons can and should be learnt. Sadly, we have seen all too often that government at all levels and organisations repeatedly fail to learn lessons or enact recommendations.

98. Throughout the Relevant Period, there was a persistent failure across government to learn lessons, and to action change from lessons which have been identified. This failure was highlighted repeatedly and nevertheless continued. **A key aim of the Inquiry is to achieve change through its recommendations. In doing so we urge it to consider the root causes of the failure to learn or action change.**

99. In 2013, the Cabinet Office commissioned Dr Kevin Pollock to examine the lessons learned by the State over 32 incidents spanning from 1986 to 2010. His review found that *"the consistency with which the same or similar issues have been raised by each of the inquiries is a cause for concern. It suggests that lessons identified from the events are not being learned to the extent that there is sufficient change in both policy and practice to prevent their repetition."*[152] By 2017 these problems persisted, with the Chair of the Manchester Arena Inquiry finding that *"On 6th May 2011, Lady Justice Hallett issued her Prevention of Future Deaths report following the… the 7/7 attack. The report sets out what went wrong with the emergency response to that atrocity… those who have followed this inquiry will immediately recognise that these same things went wrong again… published in October 2013 was [the Pollock review] … the evidence heard in this Inquiry shows that those same issues recurred on the night of 22nd May 2017.*"[153]

100. Dr Pollock would once again examine lesson learning in the context of the Covid-19 pandemic. He found that the issues which have emerged in the context of Covid-19 *"mirror the lessons which emerged from Exercise Cygnus."*[154] The analysis of the response to Covid-19 by the House of Commons Public Accounts Committee chimed with Dr Pollock's reviews. It highlighted that *"the Government's response to the pandemic has been least effective in areas that we have repeatedly reported on, including data quality and data sharing, co-ordination between central and local government, and staffing and resilience in the health and social care sectors."*[155] Mann and Alexander reach the same conclusion: *"there was a repeated failure to learn lessons identified in successive 'lessons learned' reports and the reports of independent inquiries so that weaknesses were repeated and gaps left unaddressed."*[156]

[152] Pollock K, Emergency Planning College, 'Review of Persistent Lessons Identified Relating to Interoperability from Emergencies and Major Incidents since 1986' (October 2013), p.7.
[153] Manchester Arena Inquiry, Volume II Report (03.11.22), pp.86-87§11.13-11.18.
[154] Pollock K, Coles E, Vol. 19 No. 7 Special Issue on COVID-19 #2 (01.10.21) p.8, p.12.
[155] House of Commons Committee of Public Accounts Committee (15.07.21) Open Source p.3.
[156] Mann and Alexander report INQ000203349/26§51.

101. The internal government Crisis Capabilities Review 2022 highlighted that *"The Cabinet Office is failing to consistently identify, learn and improve on its own response to crises in any systemic way... the current Cabinet Office approach to learning lessons is "haphazard."*[157] It may be tempting to assess this failure as the result of an absence of process and mechanisms, but its persistence suggests a more systemic problem with culture and attitude. Mann and Alexander highlight the findings of the 2022 Independent Review of the CCA, which found "*Limited evidence in England of a learning and continuous improvement culture. This was sometimes portrayed as being due to a lack of time and resources. More worryingly, this was also sometimes attributed to a fundamental lack of desire to disturb the status quo, or to a perception that there was nothing to learn from others."*[158]

102. Attachment to the status quo and complacency appear to be a cultural problem for the Cabinet Office in particular. Its assessment within this process of its own performance and the performance of the civil contingencies framework over which it presides stand in stark contrast to some of its own internal documents, the views of this Inquiry's independent experts and to the views of Parliamentary select committees who have examined preparedness and response to Covid-19.

103. By 2015, internally the Cabinet Office was examining the role of the local tier in civil contingencies, and warning that "*Although the Act has changed little in the last 10 years, the operating environment has changed significantly*," including due to austerity and a decline in capability in local resilience, leading to a conclusion that *"out to 2020, the current model may not be fit for purpose."*[159] The 'current model' would continue undisturbed. By October 2016, the Cabinet Office had received a warning from Lord Harris that under the current model *"resource is so denuded"* in some areas of London *"as to be unfit to respond to a major [terrorism] disaster."*[160]

104. In March 2017, the Cabinet Office put before Parliament a post-implementation review of the CCA. In that review, it assured parliament that "*there is no specific evidence, anecdotal or from the RCS to suggest that major legislative change is required… CCS and the Department for Communities and Local Government's Resilience and Emergencies Division (DCLG RED) have a well-developed knowledge of the practice of local resilience through working with both local resilience forums, and with local responders planning for and responding to emergencies. This knowledge, which includes learning from emergencies and exercises, indicates that although there may be a need to consider the way in which the CCA, Regulations and guidance are being interpreted by central government and responders, there is no clear case for reviewing the regulatory framework itself."*[161]

105. What the Cabinet Office omitted to make clear to Parliament was that there was no specific evidence to suggest that change was required because it had not yet started to gather any evidence for that 2017 review. In an internal government meeting on 21.03.17 *"The Cabinet Office said that a report of the Post Implementation Review of the Regulations would be laid before parliament at the end of March 2017 to meet the statutory deadline, but this would be only the preliminary part of the process."* In that meeting, an action point for the Cabinet Office was to *"identify opportunities to examine whether the legislative basis for civil contingencies planning is fit for purpose and start*

[157] Crisis Capabilities Review (16.02.22) INQ000056240, p.25 §61.
[158] Expert Report Bruce Mann and David Alexander INQ000203349, p.140§403.
[159] Draft report titled Civil Contingencies: Role of the Local Tier – GT INQ000198951.
[160] Lord Harris Review of London's preparedness to respond to a terrorist incident pp.36-7§9.8-9.
[161] Post Implementation Review 2017 INQ000056230, p.8 §§19-20.

gathering evidence."[162] The reality appears to be that the Cabinet Office was in no position to reassure Parliament because it had not yet begun to gather the evidence.

106. The Cabinet Office assertion that it had a "*well-developed knowledge*" of the practice of local resilience must be viewed in the context of the disastrous handling of the aftermath of the Grenfell Fire, for which Theresa May issued an apology on behalf of the Government.[163]

107. One of the key learning points to emerge from the response to the Grenfell Tower Fire was the need to engage with voluntary organisations in preparedness and response. Michael Adamson of the British Red Cross described his attempts to engage with the Cabinet Office:

> *"The BRC has long believed that increased engagement between the CCS and the voluntary sector would be beneficial for the UK's emergency preparedness. It is in that context that, in 2019, the BRC and other voluntary organisations sought to engage with the CCS. Our focus was on seeking to develop a strategy with the government for the voluntary sector to react to a range of emergencies based on the lessons learned from responding to the multiple emergency events of 2017. The experience was somewhat dispiriting and there appeared to be a lack of curiosity on the part of the CCS regarding what the voluntary sector could provide."*[164]

108. The witness statements submitted from representatives of voluntary sector organisations reflect a similar lack of engagement from Central Government.

109. The failure to learn lessons during the relevant period was not limited to a failure to learn from incidents and exercises in the UK. While the UK was involved in international structures, it failed to implement learning from international best practice. For example, Mann and Alexander point particularly to the failure to implement the Hyogo and Sendai Framework, which Mann and Alexander as illustrating the UK's failure to keep pace with developing good practice during the Relevant Period.[165]

110. A commitment to learn must have a foundation in both introspection and candour. We urge the Inquiry to take close account of this in considering evidence regarding lessons learned and changes made as a result of the pandemic. Too frequently, institutional defensiveness and protection of reputation trumps real change.

CONCLUSION

111. The precise characteristics, timing, and the place at which Covid-19 emerged were all unknowns, but the probability of a pandemic caused by a respiratory disease such as Covid-19 was approaching one: it was highly likely to happen. The UK, together with its constituent parts, was under an obligation to do everything reasonably practicable to prevent such a disease from emerging within or entering the UK, or to mitigate its effects if it did. The evidence clearly shows that it did not do

[162] NSC THRC Meeting Minutes (21.03.17) INQ000020315.
[163] 'Grenfell Tower: May apologises for failures of state, local and national' [21.07.17] Open source.
[164] Witness statement of Michael John Adamson INQ000182613/10§43.
[165] Expert Report Bruce Mann and David Alexander INQ000203349/96§255.

so: reaching instead a point where its preparedness as of January 2020 was "wholly inadequate."[166] The Inquiry needs to ask why.

112. Module 1 may be about high-level frameworks and structures, but high-level structures obscure deep-seated cultures, attitudes and assumptions. At the beginning of January 2020, the State shared a common assumption: it considered itself a world leader in preparedness and resilience. The pandemic exposed this as false complacency which had persisted for years. The repeated failures to learn from previous emergencies constitute a fundamentally flawed mindset at the heart of government, which spread to other public bodies. Now that have moved to a phase of 'living with Covid-19' there is a temptation to return to the same complacency. Our clients made clear in a petition calling for this Inquiry, which gained almost 300,000 signatures, that this cannot be allowed to happen. As they said:

> *"The government continues to refer to its 'apparent success' and being 'proud' of its record. Not only is this deeply hurtful for bereaved families who have already gone through a traumatic loss to hear, but this reluctance to engage honestly with what has gone wrong is a barrier to learning. Our greatest fear is that more families will needlessly go through the loss and trauma we are experiencing."*[167]

113. This Inquiry came about as the result of this search for truth and learning. If it is to succeed in its task, rather than repeat the mistakes it is examining, the Inquiry will need to put ordinary people, their stories and their needs at the heart of its work.

12 June 2023

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[166] Expert Report Bruce Mann and David Alexander INQ000203349/181§527.
[167] Change.Org petition 'Hold a public inquiry into the government's handling of the Covid-19 pandemic' Open source.

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