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 TWO OPENING SUBMISSIONS

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INTRODUCTION

1. Boris Johnson asserts in his account to the Inquiry that the UK "*defied most of the gloomier predictions and has ended the pandemic…well down the global league tables for excess mortality*". In his account, he attempts to present a balance between things that might have been done better, and what he describes as "*a great many successes*".[1] Is this fact or fiction?

2. Is Mr Johnson correct that the UK was 'mid-table' in comparison to other nations? According to an analysis by the John Hopkins University of Medicine, the *per capita* mortality rate of the UK was number 20 out of 173 countries listed.[2] According to Professor Sir David Spiegelhalter (a statistician relied upon by Mr Johnson in the early days of the pandemic) while it will take time to draw definitive conclusions, *"we can confidently conclude that the UK has not done well."*[3]

3. Even if Mr Johnson were to be correct in his sweeping assertion, from the viewpoint of the bereaved families, we urge the Inquiry to avoid accepting that 'mid-table' would be some kind of positive outcome. Currently, the UK is the 6th biggest world economy by GDP.[4] Only one of the five countries with greater wealth fared worse.

4. The UK has mature scientific industries and academic research establishments. It has mature, if struggling, health systems. It has mature Government and administrative frameworks. Geographically, it should be well-placed to combat a pandemic threat because, together with the island of Ireland, it is spread over two main islands, or two epidemiological units, as opposed to being a part of a large continental landmass. On those metrics, the families do not view the international comparative position of the UK as any kind of collective positive.

5. From the point of view of the families, the official figure for the overall loss of life - 228,000 - is the real metric. By how much would that figure have been reduced if the health and social care sectors were in better shape – resilience – and there were proper plans in place? By how many would that figure have been reduced if the warning sounds from 1 January 2020 had been heeded and acted upon? At that stage, and at every stage, much more could have been done.

6. Adopting an apparent strategy of 'confession and avoidance', Mr Johnson accepts to some extent that more could have been done, but then caveats that by the book of excuses; not enough was known, there had been false alerts before, he and the Government were relying on expert scientific advice. If things went right, he takes the credit. If things went wrong, it was generally the responsibility of others, or the unique and unknown circumstances.

7. In Module 1 the Inquiry looked at resilience and planning – preparedness – as it was at the time the pandemic struck. Although we await the Inquiry's report, the Chair's findings on

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[1] Witness Statement of Boris Johnson INQ000255836/8§15, 11
[2] John Hopkins mortality analysis, available at: https://coronavirus.jhu.edu/data/mortality
[3] Spiegelhalter and Masters, 2021, *Covid by Numbers, Chapter 14 'How do we compare countries?', p.145*
[4] Forbes, 2023, available at: https://www.forbesindia.com/article/explainers/top-10-largest-economies-in-the-world/86159/1

preparedness are the starting point from which it must consider the UK and Government and devolved administration responses in Module 2.

8. For example, if there had been a Minister responsible for civil emergencies prior to January 2020, overseeing a department with responsibilities for managing and assuring a national system with properly funded local frameworks, clear structural links to the devolved administrations and to local authorities and public health bodies, and supported by a standing scientific committee on pandemics, it is far more likely that the UK Government would have had the mechanisms in place to hit the ground running when the pandemic came over the horizon.

9. If established mechanisms allowing for a process of genuine engagement with devolved administrations had been kept in use, then there may have been a truly coordinated, and therefore more effective, response across the four nations, rather than reliance on a variety of ad hoc mechanisms designed expressly to keep devolved actors outside the decision making process.

10. If there had been a 'whole system' plan for pandemics, rather than a decade-old single department flu plan, then all involved in the response would have had something to work from: a head start. If the health and social care sectors had been in good shape, with funding keeping pace with the evolving needs of an expanding and ageing population, and if local authority and devolved budgets had not been slashed through the years of austerity, then that mechanism, and that plan would have had a resilient basis upon which to operate. Unfortunately, none of that preparedness was in place, and the response of any Government or devolved administration started from that profound deficit.

11. It is the role of any competent Government or administration to react to whatever crises arise, with the resources available, to catch up and protect the population as far as is possible. However, the failures of preparedness combined with an indecisive Government response meant that on all levels there was failure: PPE procurement, planning and distribution; provision of mass testing; provision of effective contact tracing; availability and provision of data to decision-makers; effective infection control measures across health and social care and also at borders and in the community; and resilience capacity in key areas.

12. Below, we highlight particular areas of concern which the bereaved families we represent urge the Inquiry to investigate in Module 2.

SECTION 1: INERTIA AND COMPLACENCY - JANUARY TO MARCH 2020

The Prime Minister and Key Government Decision Makers

13. Boris Johnson accepts that in January and February 2020 "*we were far too complacent about what might happen, and about the state of our national preparedness*" and he had "*a basic confidence things would turn out alright*."[5] This complacency was evident through the top tier of Government, despite clear recognition across the UK and international scientific community about the danger of Covid-19. The Inquiry must consider why the

[5] Witness Statement of Boris Johnson INQ000255836/20§78

Government failed to recognise the scale of the emergency and structural problems early enough.

14. On 25 January 2020 the UK Government described the risk to the public from Covid-19 as 'low.' On the same date, in an email to Catherine Calderwood (Chief Medical Officer (CMO) for Scotland, which was circulated to the CMOs of England, Wales and Northern Ireland, Professor Mark Woolhouse warned the Government in stark terms:

> *"I have discussed what I am telling you here with: [Jeremy Farrar] Director of Wellcome Trust, and Neil Ferguson of the Who Collaborating Centre for Infectious Disease Modelling at Imperial College London. They have independently reached the same conclusions and have advised Chris Whitty accordingly.*
> *WHO reported 2 key numbers in their statement last week. The basic reproduction number (central estimate R0=2.0) and the case fatality rate (CF=4%)….*
> *If you were to put those numbers into an epidemiological model for Scotland (and many other countries)* ***you would likely predict that, over about a year, at least half the population will become infected, the gross mortality rate will triple (more at the epidemic peak) and the health system will become completely overwhelmed. … Please note that this is NOT a worst-case scenario, this is based on WHO's central estimates and currently available evidence. The worst-case scenario is considerably worse. …*** *Your reply to my earlier e-mail did not give any indication that here in Scotland we are preparing for a R0=2, CF=0.04 event. And I don't have the sense that we are from my networks here either. It is still possible that this outbreak can be contained and that Scotland and the rest of the UK escapes relatively lightly. But I, and others, consider this more of a hope than an expectation at this stage."*[6]

15. It is clear that these warnings about the potential scale of the pandemic registered on some level at the heart of Government: by 29 January 2020 COBR was briefed that it was "plausible" that within "weeks or months" the UK would be faced with a Reasonable Worst-Case Scenario (RWCS) similar to that for pandemic flu. As was covered in Module 1, this scenario predicted the deaths of 800,000 people.[7]

16. Mr Johnson was not present at COBR to hear this warning and did not attend COBR until March. It appears a deliberate decision was taken that COBR would not be chaired by the Prime Minister. The Inquiry should examine the reasons for this decision, what it signalled to Government departments about the seriousness of the crisis and the impact of this decision on the urgency with which Covid-19 was treated across Government. Was this because the pandemic was seen simply as a health issue and it was considered more appropriate that Mr Hancock took the lead? Or was it because Mr Johnson had other priorities such as leaving the EU, and dismissed reports of the virus as a false alarm, until it was too late? As the expert evidence will inform us, it is not always necessary for the PM to chair COBR, and it is sometimes better that the relevant Minister does so. It was

[6] Email Mark Woolhouse – Catherine Calderwood 25.01.20, INQ000047559
[7] COBR Meeting Minutes 29.01.20, INQ000056226/5

abundantly clear from January, however, that this was no ordinary health crisis but had the clear potential to develop into the worst civil emergency in living memory, threatening the lives of hundreds of thousands of people across the UK. It demanded leadership from the top.

17. Notably, the ex-PM's statement indicates that he was sceptical that there was a problem at all; he hoped for the best, and that led to dither, delay and ultimately a reactive rather than proactive response. He recounts telling Mr Hancock not to panic, that a Government medical officer had warned that the Creutzfeldt Jakob Disease crisis would lead to "*hospices on every corner*" when in reality its effect on humans was "*very small*". He refers to a "*bird flu scare*" when he was Mayor of London. Even the WHO declaration of Covid-19 as a PH Emergency of International Concern was belittled by him, because "*there had been several such declarations*" since 2009.

18. Other than wealth and economic power, we anticipate that the single biggest difference between countries which fared relatively well and those which did not, was a proactive rather than reactive response.

19. Apart from a 'wait and see', or more accurately a *de facto* belittle, dither and delay approach caused by the apparent insistence that this was a false alarm, Mr Johnson appears to have brushed aside the concerns of others or reduced the virus to a cause for humour. He acknowledges Mr Hancock's assertion that by 22 January he raised alarm directly with the PM in person on the phone, saying that there was a 50-50 chance the virus would 'escape' China. By this point Mr Hancock had been advised that if the virus got out of China it would "go global" and "a very large number of people would likely die". But Mr Johnson goes on to say that he does not recall that conversation. This is not a minor oversight. Is it credible that he has forgotten this?

20. Mr Hancock states that No 10 refused his request for a COBR meeting until 24 January, saying it was "*alarmis*t".[8] In a similar vein, Mr Johnson sweeps aside the suggestion coming from an unnamed adviser that he dismissed the emerging crisis as a "*scare story*" and flatly rejects the assertion that he "*volunteered to be injected with the virus on live TV*", saying he attaches "*little credence to the source of that account*". This is illuminating evidence because he is referencing Dominic Cummings without naming him. At the time of this catastrophic emergency, the PM's most influential adviser, his chief of staff no less, was a man to whom Mr Johnson now says little credence attaches.

21. Throughout his account of these early stages of the emergence of the virus Mr Johnson asserts that there was no evidence that there was asymptomatic transmission. He states that with hindsight "*we vastly underestimated the risks*",[9] because the Government did not understand how fast Covid-19 was spreading and the fact that it was spreading asymptomatically. He asserts that uncertainty as to the speed of transmission and whether it could be passed asymptomatically delayed stocking of PPE, the provision of diagnostic testing, the "*race for a vaccine*", and public messaging. How so? Given that this was a newly emerging disease, it is hardly surprising that there was sparse evidence as to asymptomatic transmission.

[8] Witness Statement of Boris Johnson INQ000255836/28-29§120, §124
[9] Witness Statement of Boris Johnson INQ000255836/15§46

22. Mr Hancock goes further, asserting that there was a global scientific consensus that the virus did not transmit asymptomatically, reflected in WHO guidance "*until April 2020*".[10] We anticipate that the evidence will show that to be a considerable exaggeration. In fact, Mr Hancock had been advised in the same 29 January COBR meeting that *"early indications imply"* that asymptomatic transmission **was** occurring.[11] As the evidence developed, these indications were fortified by a growing body of evidence, and the Government's Chief Scientific Adviser, Professor Sir Patrick Vallance, publicly opined that asymptomatic infection was a probability, four days prior to the disastrous decision to discharge 30,000 patients from the NHS into the care sector.[12]

23. The Inquiry should examine why Mr Hancock, Mr Johnson and other senior decision makers appear to have relied on a negative presumption when they were advised from January 2020 that the indications were that asymptomatic transmission was occurring. Common sense dictates that policy should have operated on the basis that asymptomatic transmission was entirely possible until proven otherwise.

24. The delays in responding were nothing to do with the lack of such evidence, but a dithering, uncertain, 'caught in the headlights' Government. Reactive rather than proactive. Mr Hancock asserts that he was uneasy that the Government was not doing more at borders by 21 January but he had been advised "it was not worth the cost".[13] He states that 'Enhanced Monitoring Arrangements' at Heathrow amounted to asking travellers alighting flights from Wuhan if they felt ok and giving them an advice leaflet.[14] PHE had advised that "*its contact tracing system was the best in the world, as rated by WHO*."[15] We anticipate that the evidence will show this was far from the truth.

25. In Module 1, Sir Oliver Letwin described the role that a Minister should play in asking the right questions and interrogating assurances provided by officials.[16] It is not sufficient for a competent Minister leading the UK's response to a mounting crisis to rely on vague reassurances. The first step for such a Minister would be to familiarise themselves with the detail of the plans and capabilities in place to handle such a crisis, to identify whether there are gaps between the existing preparedness and likely needs, and if so how to determine how these can be addressed or mitigated.

26. We anticipate that the evidence is likely to show that Matt Hancock failed to do this. On 25 January 2020, Matt Hancock was asked by Dominic Cummings to what extent he had investigated preparations for a pandemic. He responded that *"we have full plans up to & including pandemic levels regularly prepped and refreshed."*[17] Given the severe criticisms that Matt Hancock made about the very obvious flaws in pandemic planning in Module 1 which had not been refreshed since 2011, the Inquiry should investigate to what extent Matt Hancock had in fact read the 'full plans' upon which he placed such confidence and investigated whether they were 'prepped' and 'refreshed.'

[10] Witness Statement of Matt Hancock INQ000232194/9§37
[11] CRIP presented at COBR 29.01.20 INQ000056166/7
[12] The Spectator transcript of Today Programme interview 13 March 2020, available at: https://minhalexander.files.wordpress.com/2020/05/how-e28098herd-immunitye28099-can-help-fight-coronavirus.pdf
[13] Witness Statement of Matt Hancock INQ000232194/29§113
[14] Witness Statement of Matt Hancock INQ000232194/29§117
[15] Witness Statement of Matt Hancock INQ000232194/29§115
[16] Module 1 hearings Oliver Letwin D6:P13
[17] WhatsApp Matt Hancock—Dominic Cummings 25.01.20 INQ000129180

27. The buck did not stop with Matt Hancock. Despite his non-attendance at COBR, Boris Johnson also appears to have been advised of the potential impact of Covid-19 from January, with a briefing from the Cabinet Secretary ahead of the Cabinet meeting of 31 January that it was *"prudent to start preparing for the reasonable worst."* [18] Mr Johnson's account recognises this, repeatedly referring to briefings and meeting minutes from late January which assert that "*we should begin to prepare for the reasonable worst-case scenario*". Incredibly, he may not have understood what this meant. He himself accepts that on reading a briefing from Katherine Hammond on 28 February 2020 he and his advisers were unsure as to what a reasonable worst-case scenario was and meant.[19]

28. Why therefore, did minutes of his meetings in January refer to preparing for this eventuality? One of the few actions that was taken in preparation for the incoming pandemic was Exercise Nimbus, a Ministerial table-top exercise focusing on communicating the reality of a RWCS in preparation for Covid-19 and the decisions that Ministers might have to make. It does not appear that Boris Johnson, the leader and key decision-maker who would be grappling with these issues attended the table-top. Why not? At the very least these demonstrate grave errors of judgment, at worst they are evidence of negligence on the part of the former PM.

29. Mr Johnson notes that he knew that SAGE and COBR meetings had commenced before the end of January and that he was "*confident that steps were being taken across Government*" to prepare for the pandemic. As Mr Johnson himself told the Cabinet on 6 February 2020, in response to Matt Hancock's briefing to Cabinet that the spread of coronavirus was *"clearly very serious,"* that the virus spread easily and had a mortality rate of 2% and that a RWCS would impact almost every Government department, *"confidence is contagious."*[20] Did Mr Johnson ask any of the questions that would have been expected to be asked by a competent Prime Minister to ascertain whether this confidence had any basis in reality?

30. Email correspondence between the Cabinet Office and the Prime Minister's Private Secretary on 24 February 2020 suggests that instead Mr Johnson took a cursory approach to his role in managing the response to the Coronavirus crisis. Discussing the pandemic outbreak in Italy and local lockdowns, the Private Secretary contacted the Cabinet Office to enquire what the plans were in the event that a similar outbreak developed in the UK. *"At some point soon, I'd like to start exposing the PM to the potential decisions he might have to take in short order ... at the moment it's been fairly abstract with him I think."*[21]

31. As part of this 'abstract approach', it appears that by this time Boris Johnson had not even requested sight of the UK's plans. On 25 February Dominic Cummings *"made clear"* that No 10 *"should see all the plans for what the UK should do in a worst-case scenario"* and at that point the Health Secretary confirmed that *"all these plans would be shared."*[22]

32. One might expect that a competent Prime Minister facing a whole systems emergency of this nature would have grasped the situation in more than an 'abstract' sense.

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[18] Cabinet Secretary's briefing in advance of Cabinet meeting 31.01.20 INQ000056142/10
[19] Witness Statement of Boris Johnson INQ000255836/24§101
[20] Cabinet meeting minutes 06.02.20 INQ000056137/7
[21] Email Imran Shafi – Katharine Hammond 24.02.20 INQ000146563/1
[22] Email Tara Soomro – Katharine Hammond 25.02.20 INQ000146566/2

Scientific Advice to Government

33. The Inquiry should carefully scrutinise the role of the Government's Chief Scientific Adviser and the four nations' Chief Medical Officers as well as SAGE in January and February. Behind the scenes, the evidence may show that scientists external to the Government were pushing Professors Vallance and Whitty *"hard and in the same direction"* in emphasising the seriousness of the situation from late January, and yet the PHE risk rating was 'low' in January and remained 'moderate' through to March.[23]

34. Professor Woolhouse expresses the concern shared by a number of scientists that the minutes from SAGE and its subcommittees fail to communicate the urgency of the situation.[24] The Inquiry should examine whether these concerns are valid and in particular to what extent scientific advice was hampered by a focus on political and resource constraints as well as the 'consensus' SAGE approach. However, the narrative that the Government was *'following the science'* risks missing the point: from January to March 2020 senior Ministers possessed the information they needed to understand the gravity of the situation and it was their responsibility to ask the right questions and to make positive and proactive policy decisions.

The Prime Minister and Early Public Health Messaging

35. On 1 March, Mr Johnson visited the Royal Free Hospital, where he shook hands with staff and patients. It is of note that the Hammond briefing referred to above, which Mr Johnson says he read the night before the hospital visit, expressly refers to transmission of the virus by touching an infected person. Mr Johnson comments that with hindsight he would have been more cautious: *"But that is true of much (if by no means all) of this account."* In fact, media reports quote him as saying at the time: *"I think there were a few coronavirus patients and I shook hands with everybody, you will be pleased to know, and I continue to shake hands."*[25]

36. This was the day before he chose to chair his first COBR meeting, and two months after knowledge of the virus began to emerge. Public messaging at this point centred around handwashing. Were public assertions of his physical touching of Covid-19 patients consistent with his account that his Government was taking the pandemic seriously? Or were the actions on the hospital visit a deliberately cavalier act, to be followed by irresponsible messaging from a PM out of touch with or dismissive of the impending disaster and mass fatalities coming around the corner? Was this clear evidence of complacency and irresponsibility at the heart of Government?

37. By 2 March, apart from China, the Far East, SE Asia and Italy, there was sustained community transmission in Germany and France, and tracing of UK cases had failed. No doubt much work was going on amongst officials and scientists, but there was little or no decisive action, and very little positive political leadership. We are told that WHO and Government scientific advisers did not support travel restrictions, and there were cautions about implementing measures to delay the spread of the virus too early to ensure maximum effectiveness. But as at this date the extent of Government action appears to have been

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[23] Email Jeremy Farrar – Mark Woolhouse 26.01.20 INQ000103219/1
[24] Witness Statement of Mark Woolhouse INQ000250231/19§105
[25] Rahman K, Newsweek 03.03.20, available at: https://www.newsweek.com/boris-johnson-says-shaken-hands-coronavirus-patients-1490214

some limited guidance to health and social care settings, some limited public messaging regarding handwashing and self-isolation if symptomatic, preparation of pandemic legislation and regulations, and an action plan prepared by the DHSC which was put to the devolved health Ministers.[26] The Plan outlined four phases: contain, delay, research, and mitigate.

38. The Plan itself was completely lacking in detail, centred on vague assurances about the UK's readiness, and failed to provide any real guidance to inform decision making. Special Adviser at Number 10, Ben Warner, describes being provided with a draft of the plan on 2 March 2020 and leaving a printed version on the PM's Private Secretary's desk with a Post-it saying *"this is a comms plan, where is the real plan?"*[27]

39. No lockdowns, little in the way of border screening, low levels of testing and tracing, a lack of availability of PPE, no compulsory mask wearing, no restrictions on transport or movement or mass assembly and a failure to protect care homes and the vulnerable. The stable door was open, the virus was free to leave, to multiply and to spread, unhindered.

Following the Science

40. On 3 March, Mr Johnson gave his first major Covid-19 press conference flanked by Professors Whitty and Valance. We were told the virus was for most, mild and those infected would *"speedily and fully recover*". The plan was to follow the advice of *"our world leading scientific experts". "We already have a fantastic NHS, fantastic testing systems and fantastic surveillance",* and we were *"extremely well prepared."*[28] The mantra was 'wash your hands'.

41. On 5 March, Mr Johnson asserts that Professor Whitty reported that the UK was still in the 'contain' phase. Without meaningful action it is difficult to understand what that meant. The plan did not contemplate preventing or limiting the spread of the virus across our borders. Or indeed, within our borders. What significant action had been taken by 5 March to 'contain'?

42. By 9 March, there were 4 UK Covid-19 deaths and 270 known cases. The figures were worse in Germany and France, and most serious in Italy. According to Mr Johnson, the advice of Government scientists related to changing the shape of the virus curve rather than suppressing it. The perceived risk was said to be public compliance. Once again, we note this assertion will require careful consideration by the Inquiry. Indeed, this may well prove to be a key issue between the success of other countries in protecting their citizens and the much higher mortality in the UK. Delaying decisive action until the virus had a firm hold within our communities meant not only a far higher number of deaths but also that draconian measures such as lockdowns and the shutdown of many sectors of the economy would persist for far longer. If public acquiescence was a key concern, it would appear that decisive early measures would prevent rather than cause compliance fatigue. Decisive early measures to break the chain of infection and reduce the all-important R number to

[26] Witness Statement of Mark Drakeford INQ000273747/9§27
[27] Witness Statement of Ben Warner IN0000269182/19§61
[28] UK Government Transcript of Prime Minister's Statement 03.03.20
https://www.gov.uk/governmentGovernment/speeches/pm-statement-at-coronavirus-press-conference-3-march-2020

below one, would have protected the economy, limited effects on mental health, and reduced lost educational opportunity.

43. There is no doubt that public confidence was a key issue, and equally no doubt that some scientists were concerned about timing. However, were concerns regarding economic effects allowed to colour the water? Were vital measures delayed because of concerns regarding how financial markets would react? London Mayor, Sadiq Khan comments that he agreed with Mr Johnson and others to do a joint press conference at 5pm on Thursday 19 March 2020, regarding the closing of pubs and clubs the following day. However, he then received a follow-up call from Dominic Cummings indicating that No 10 had pressed pause because of concerns about the effect on markets.[29]

44. In March 2020, incredibly, mass gatherings continued. While this was presented as a decision 'following the science.' In truth, the scientific evidential base with regards to mass gatherings did not indicate that preventing mass gatherings would have no impact on transmission, merely that preventing mass gatherings would not be effective as a lone measure. Part of the reasoning for mass gatherings continuing was the assumption that those who were prevented from gathering would simply gather in indoor spaces such as pubs. [30] The Inquiry should investigate whether there was any evidential basis in behavioural science or otherwise to support this assumption, particularly for events where attendees travelled from around the country and from abroad, such as the Cheltenham races or the Champions League match between Liverpool and Atletico Madrid.

45. In reflecting on his role in providing scientific advice on the issue, the Government's Chief Scientific Adviser believes that large events should have been stopped earlier together with instructions about smaller indoor meetings and gatherings in pubs and clubs.[31] As late as 16 March 2020, the Government advice as to the risk of transmission at major sporting events remained that such risks were low. Given what we now know about the numbers who did contract Covid-19 after attending major events, and that transmission was asymptomatic, it is difficult to fathom why this advice was still given at this time.

46. Returning chronologically to the next press conference on 9 March, Mr Johnson again concentrated on handwashing, indicating that preparations were being made for the delay phase of the response. Professor Whitty told the same press conference that it was important to get the timing right. By the next day both case numbers and deaths had jumped exponentially in Northern Italy. The day after that, WHO declared Covid-19 a global pandemic.

47. According to Mr Johnson, at the 12 March COBR meeting a paper prepared by the Cabinet Secretariat considered three scenarios: firstly, if there were no interventions the virus would have a high impact by April and would peak by May 2020; secondly, some interventions may flatten the curve but increase the duration of the impact, and; thirdly, stringent interventions as operated in China could prevent a major epidemic in the short term, but risked it occurring when lifted. Meanwhile the Scottish First Minister was pressing for banning mass gatherings. Professor Vallance reported that SAGE considered that the UK was four weeks behind Italy *"and on a similar trajectory"*.[32] It is difficult to reach any

[29] Witness Statement of Sadiq Khan INQ000221436/21§92
[30] Witness Statement of Patrick Vallance INQ000238826/192§582-583
[31] Witness Statement of Patrick Vallance INQ000238826/195§597
[32] Readout from press conference 12.03.20 INQ000064707

conclusion other than that it was clear that the pandemic was heading rapidly towards the UK and decisive action was required.

48. Mr Johnson continually raises his assessment of the advice that was being given around this time: border measures might not be effective, low confidence that cancelling mass gatherings would make an effective difference, problems with implementing interventions too early. So, whilst the virus went out of control elsewhere in Europe, the UK Government prevaricated. Apart from the handwashing message, the 'action' announced at the press conference the same day, 12 March, amounted to requesting those with symptoms to stay at home for 7 days. Mr Johnson expressly clarified that this request did not extend to other members of the household, and that the Government were not stopping mass sporting events or closing schools. It is difficult to think of a less proactive response at this critical juncture. The press conference announced the move from the 'contain' to 'delay' stage. Once again, we ask: what action had been taken up to this point to contain the virus? To what extent was it likely that advising people to stay home if they had symptoms would delay it?

49. Mr Johnson rationalises this inaction by the advice he received, a fear of 'going too early' and the possibility of a second spike, later in the year. Although it is presented as the Government anxiously considering various options, the reality was a lack of decisive action when it had been expressly recognised that without response the objective effect was that the UK was heading the way of Italy. Mr Johnson asserts that the UK had no tools except public messaging for many months.[33] The families vehemently disagree, as did countries which applied urgent and effective countermeasures from the start.

Herd Immunity

50. The 12 March was a significant moment as was its daily press conference. Professor Whitty asserted that the intention was to flatten the curve so as to prevent the collapse of the NHS. Professor Vallance explained that this meant reducing the number of cases at any one time, but added that it was not possible to stop everybody being infected and indeed this was undesirable because of the need to build herd immunity. He repeated these comments about herd immunity the next day on the Today programme on Radio 4.[34] Mr Johnson recalls that around this time Cabinet Secretary Lord Mark Sedwill made a *"passing reference to chicken pox parties"* in the context of a discussion as to whether it was sensible to allow young people to get the disease and therefore become immune on recovery.[35]

51. A few days later, Mr Hancock was to confirm that herd immunity was not the policy. At around the same time, Mr Johnson had a phone call with the Italian PM, following which the Italian Health Minister says he was informed that Mr Johnson had indicated that he "wanted" herd immunity. This is disputed. Not only does Mr Johnson claim not to recall the Hancock conversation on 22 January and disputes the Cummings account of him saying he would be injected with Covid-19 on live TV, he now also rejects the account of the Italian Health Minister. There is plainly some confusion regarding Mr Johnson's

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[33] Witness Statement of Boris Johnson INQ000255836/37§156

[34] The Spectator transcript of Today Programme interview 13 March 2020, available at: https://minhalexander.files.wordpress.com/2020/05/how-e28098herd-immunitye28099-can-help-fight-coronavirus.pdf

[35] Witness Statement of Boris Johnson INQ000255836/43§178

communications and his recollection of conversations where the issue of herd immunity arises. Why is that?

52. The 12 March 2020 proved to be a busy day. Mr Johnson's daily update from his officials indicated to him the effectiveness of early decisive border restrictions and use of quarantine in Taiwan, and he comments that he was acutely aware of similar approaches being taken in China and Singapore. He deprecates what he terms authoritarian action as against *"science-led incrementalism."*[36]

53. From a human rights perspective, the preservation of life trumps other important freedoms in extreme circumstances, such as a deadly pandemic. It is not helpful to brand effective decisive action as 'authoritarian' whilst justifying doing nothing as science based. It can be assumed that if the methods employed by China, Taiwan and Singapore (and of course others such as NZ) worked, then science would support their efficacy, irrespective of the socio-political or ideological reasons why some measures may be more acceptable than others. Going back to the figures and Mr Johnson's reference to league tables, all of these countries ultimately had far lower mortality rates than the UK. That is not an observation on the efficacy of authoritarianism, it is evidence as to how life was actually preserved in some other countries, both authoritarian and liberal democracies.

The Lack of a Whole Government Response

54. On 13 March 2020, a note to Mr Johnson referred to the *"shift from a health response to a whole Government effort",* which is referred to as advice leading to so-called Ministerial Implementations Groups. The significance of this note is that two and a half months in, the response to the virus was still being treated as a health matter and cross-Government involvement was lacking. So too, involvement of the devolved Ministers. Although Mr Johnson indicates that he saw the devolved administrations as important, his concentration was on achieving agreement to what he wanted to do. He also comments that he did not want to see regular meetings with the devolved First Ministers as *"a kind of mini EU of four nations",* and he therefore delegated collaboration to Mr Gove. Did Mr Johnson and his Government seek, embrace and value the views of the other UK administrations? Or were those views side-lined as unwelcome or unfairly dismissed as unnecessarily divisive? The Inquiry will of course need to hear each side of this issue, as discussed below.

55. On Friday 13 March 2020, Mr Johnson recognises that the Deputy Cabinet Secretary Helen MacNamara expressed very serious concerns that the country was heading for a disaster for which "*we had failed to prepare*". He says that SAGE was simultaneously cautioning that UK infection numbers were surging, and over the ensuing days a number of measures were considered. If the response to this point had been lacking, surely this Friday the 13th was another moment in time which should have triggered immediate decisive action. Boris Johnson's response to those urging the Government away from their course of inaction may be reflected in the offhand rejection of the concerns raised by Jeremy Hunt on the 13th who Mr Johnson felt *"needs putting back in his box."* In the face of growing public alarm, rather than consider that their approach might not be the right one, he and Mr Hancock focussed on the need for *"more scientists out there backing us up."*[37]

[36] Witness Statement of Boris Johnson INQ000255836/41§174
[37] WhatsApp Matt Hancock – Boris Johnson 13.03.20 INQ000129233

56. At the 16 March COBR meeting, Mr Johnson says four proposed interventions were discussed: three related to advice to stay at home if any household member has symptoms, advice to encourage home working and avoid social mixing, advice to vulnerable groups which amounted to asking the 70+ age group to follow social distancing more rigorously, and shielding. Large gatherings were recommended not to go ahead but this was advisory only. There was still to be no travel ban. There was a divergence of opinion with the devolved administrations, particularly Scotland. The Republic of Ireland also had more stringent measures in place: which merited significant consideration given the land border with Northern Ireland and the need to consider the desirability of treating the island of Ireland as a single epidemiological unit.

57. Even in the face of clear concerns within its own administration, and from the Devolved Administrations, the UK Government continued to take a largely advisory and hands-off approach. The spread of the virus on the other hand, continued unabated and exponentially.

58. As SAGE advised that cases would soon double every 5-6 days, Mr Johnson held a press conference advising whole households to stay home where anyone had a high temperature or cough, and advised against non-essential travel. Whilst advising against non-essential contact, pubs, restaurants and schools remained open and mass gatherings continued.

Discharging Untested Hospital Patients to Care Homes

59. There were two important developments on 17 March 2020. Firstly, Dominic Raab advised against all non-essential international travel, whilst simultaneously making clear that there was no scientific basis for the travel bans imposed by the EU. This appears to have been mixed messaging, but was justified on the basis of disruption arising from the travel bans of other countries.

60. More importantly, it was noted at the Cabinet meeting of that day, that 30,000 patients were to be transferred from hospitals to social care "imminently" to free up beds. Whilst increasing NHS capacity was imperative, in particular given the absence of resilience as evidenced in Module 1, the Inquiry will learn of the catastrophic consequences that ensued. Alarmingly, Mr Johnson does not recall consideration of testing hospital patients discharged to care homes, and does not think nosocomial infection was mentioned to him. He comments that "*we were all still labouring under a general misapprehension about asymptomatic transmission*".[38] This is his repeated defence, but is it true?

61. A chronology of a multitude of scientific papers is set out in the Gardner judgment[39]. On 28 January 2020 a PHE paper entitled "Are asymptomatic people with 2019nCov infectious" said there was insufficient evidence to reach a conclusion, but on the same day minutes of a SAGE meeting noted "*there is limited evidence of asymptomatic transmission, but early indications imply some is occurring. PHE is developing a paper on this*". Subsequent SAGE minutes and various other reputable scientific studies suggested asymptomatic infection was likely.

62. On 6 March, Professor Ferguson indicated to a NERVTAG meeting that there was evidence that infectiousness could be detected just before as well as just after the onset of symptoms.

[38] Witness Statement of Boris Johnson INQ000255836/59§236
[39] Gardner & Harris v Secretary of State for Health and Social Care & Ors [2022] EWHC 967 (Admin), from §34

A report dated 8 March 2020, entitled "Estimating the Generation Interval for C19 Based on Symptom Onset Date" indicated that the proportion of pre-symptomatic transmission in Singapore was 48% and 52% for Tianjin, China. By 13 March Professor Vallance told the Today programme: "*It looks likely that there is some degree of asymptomatic transmission*". It is simply not true that there was a general misapprehension about asymptomatic transmission when, on 17 March, the disastrous decision was taken to transfer large numbers of older people from hospitals to care homes without testing.

63. We note that Mr Hancock raises three further points with respect to defending the 17 March discharge decision. Firstly, the lack of testing capacity, secondly that testing would not be effective for those who were asymptomatic and thirdly that there is evidence that agency staff brought infections into care homes. The lack of testing and laboratory capacity reflects the failure of planning and the initial response, to surge manufacturing and emergency supply, noting Mr Hancock's own evidence that a test had been developed by 14 January 2020.[40] Furthermore, we note that evidence which came to light during the Gardner case indicated serious concerns were raised at the time by the Minister for Social Care, Helen Whateley MP, regarding such untested discharges, but went unheeded.

64. Mr Hancock was repeatedly disabused of his apprehension that testing did not work for those who were asymptomatic by the Government Chief Scientific Adviser, Professor Vallance, who explains that he made clear to Mr Hancock that testing *did* work for those who were asymptomatic but that false negative tests are possible.[41]

65. The scandal of the movement of staff between care homes is not a mitigation for the problem of discharge of hospital patients into the care sector, it is an additional massive failure. Mr Hancock asserts that *"during the summer of 2020"* he was made aware of evidence suggesting that the movement of staff between care homes was *"the main source of transmission",* and *"acted to limit staff movement*".[42] Did he need evidence to identify this very obvious problem? Wasn't it a matter of common sense requiring to be anticipated and addressed well before this time?

Non-Pharmaceutical Interventions

66. On the morning of 18 March Prof Whitty indicated that there had been a 30% increase in Covid-19 cases and deaths since the data of the previous day. The Welsh and Scottish administrations had announced plans to close schools, which prompted the UK Government to convene an emergency COBR meeting and announced that the Easter holidays would be brought forward with the effect that all schools would be closed other than for the children of key workers, from 20 March. Although this appears to have been a sensible measure, it is further evidence of a shambolic approach by the UK Government, pushed to take the right course by devolved administrations.

67. By 19 March President Macron was insisting that the UK take similar community measures to France or he would close his border. The Inquiry will have to consider whether this represented mere political rivalry or genuine frustration with UK Government inaction. Through this period Mr Johnson appears to have been more interested in messaging than

[40] Witness Statement of Matt Hancock INQ000232194/27§105
[41] Witness Statement of Patrick Vallance INQ000238826/170-171
[42] Witness Statement of Matt Hancock INQ000232194/12§49

action, insisting that good news was highlighted in communications. At the daily press conference, Mr Johnson concentrated on the need to ramp-up testing. Given the comments from Mr Hancock that capacity was a factor in the discharge of patients from hospital to care homes without testing, the Inquiry may conclude the plans to increase supply, announced on 19 March, were too little too late.

68. The press conference on the next day, 20 March, announced that pubs, bars and restaurant should shut, bringing into application the stalled agreement to call on hospitality venues to close by the night before. By the following morning, the Government received further dire data, indicating that the infection rate was doubling every 5 days and heading the way of Italy.

69. At the 22 March press conference, the focus was on the public taking social distancing seriously, and to shield the most vulnerable. Once again, the Inquiry will need to consider whether this was effective and timely action and whether it was sufficient.

70. On the evening of 22 March, the CMO delivered "*a very gloomy prognosis*" to Mr Johnson. It referenced both herd immunity and asymptomatic infections. The following day Mr Johnson announced the first lockdown. It lasted for over 3 months.

71. We anticipate that much will be said about the efficacy of various NPIs and their timing. We note that much of the evidence will be called from witnesses who have a position to defend. Whereas there are undoubtedly reasonable disagreements to be had on the effect of individual measures, the families urge the Inquiry to focus on why there was not a suite of interventions deployed early. Travel restrictions from known Covid-19 hotspots, coupled with screening at borders, quarantine measures, compulsory mask wearing, early restrictions on mass assemblies and social gatherings, well-resourced contact tracing, and the early mass production of tests and laboratory capacity, are all features of those countries which fared the best.

72. Similarly, although there may be reasonable arguments about the timing of lockdowns, what actual evidence was there that the public would not comply if applied early? The experience of other countries suggests that early and comprehensive lockdowns saved lives and lasted for shorter periods because they rapidly reduced the infection rate.

73. The ending of the first lockdown did not of course signal the end of the pandemic, and was followed by two further lockdowns, the second for a period of 4 weeks from 31 October 2020, and the third from 6 January 2021.

74. In the lead up to the first pandemic, as well as NPIs to prevent the spread of Covid-19 in the general population, a golden window of opportunity was missed to strengthen core capacities in key areas:

    a. **Testing:** It is clear from SAGE discussions in early February that it was widely understood that while the UK had been able to develop diagnostic testing, there was a lack of capacity to scale up testing. As Boris Johnson would lament to Matt Hancock in June 2020, testing would continue to be an "Achilles heel" to the UK's response. By June, even he was questioning *"What is wrong with us as a country that we can't fix this? We have had months and months. I am going quietly crackers*

about this." [43] Crucially, there was a complete failure to establish testing as part of a system of test, trace, isolate and support. The need for such a system was obvious, both from international examples and to protect the vulnerable. Although we understand testing will be the subject of a future module, it will be important for the Inquiry to look at what plans and what capacity were in place throughout this period. In particular, at what point key decision makers became aware of the limited testing capacity and what they did to address this?

b. **Data**: Evidence from scientists and decision makers is unanimous on this point: the UK's early response to Covid-19 was severely hampered by the absence of basic data, including accurate and independent data from the Devolved Administrations. This absence of data must have been obvious from January, when modelling and monitoring began. It was not until 24 March 2020 that the Covid Dashboard, the method by which data was presented to Ministers, became live. Even that development failed to address the core deficiencies in data gathering and analysis. What could have been done by high level decision makers in the early stages of the pandemic to address these crucial gaps?

c. **PPE:** Mr Hancock now asserts, as was clear from his Module 1 evidence, that the problems with PPE were with its distribution, rather than its availability. We anticipate that the Inquiry will find that there were problems across all areas of PPE: understanding of demand, availability and distribution. Again, the Inquiry will consider this area in a dedicated module, but it is important that the knowledge and action or inaction of key decision makers is addressed in Module 2. Matt Hancock complained to Lord Mark Sedwill in April 2020 in relation to PPE that *"we have HMT issues that stop us buying stuff."* [44] The Inquiry will wish to explore this assertion and Rishi Sunak's denial.

d. **Health and social care capacity:**_The lockdown 'U-turn' appears to have come after it was recognised that the NHS would soon be overwhelmed. However, given the well-known problems with NHS capacity, which were explored by the Inquiry in Module 1, how can this have come as a surprise? In briefing Boris Johnson in May 2020, Lord Mark Sedwill highlighted the inherent weakness in capacity of the NHS, writing *"I am not aware of any other country that asked its citizens to protect the healthcare service rather than the other way around."* [45] But given that these structural problems were well known, should decision makers have been planning for this eventuality from the outset and taking a precautionary approach to NPIs? The Inquiry will consider whether instead, decision makers relied on untrue platitudes about the 'world class' state of the UK's preparedness and failed to base their assumptions about the response to the pandemic in these realities.

75. To summarise the position up to the first lockdown, the families urge the Inquiry to concentrate on the following points:

[43] WhatsApp Matt Hancock – Boris Johnson 04.06.20 INQ000129351
[44] WhatsApp Matt Hancock – Mark Sedwill 18.04.20 INQ000129259
[45] Briefing from Cabinet Secretary to the Prime Minister 10.05.20 INQ000136756

a. Did the UK administrations start their pandemic response from a particularly weak position, given the lack of preparedness – in terms of resilience and capacity, and planning – evidenced in Module 1?

b. Was the initial response of the UK Government up to 23 March timely and proactive, or was it erratic, indecisive and ineffectual? What decisions and action taken during this period made a significant difference in preventing or mitigating the spread and effect of the virus?

c. Was the initial response inhibited by the lack of an effective national civil emergency framework, and was it hampered by giving leadership to one department: the DHSC? Would a 'whole system' approach from the outset have led to a different proactive response?

d. Was the UK Government, and in particular the PM, distracted by other policy priorities, in particular exiting the EU? Was the PM's absence from COBR until March 2020 indicative of this?

e. Were vital weeks lost because the UK Government considered that reports of the virus were a false alarm or exaggerated? Was this a view promoted by the PM, or was it contributed to by scientific advisers?

f. What was done in January and February 2020 regarding: ramping up health and social care capacity, ensuring best possible infection control and isolation was in place; putting in place measures to surge manufacture and source supplies of tests, requisite laboratory facilities, and facilities to undertake targeted and mass testing; putting in place robust and comprehensive contact tracing facilities; ensuring existing PPE was in the right place and there was an effective distribution plan, and surge manufacturing and sourcing supplies of further and ongoing supplies?

g. What NPIs were put in place before the first lockdown? Were assertions that border controls and screening and restrictions on international travel would make little difference correct in light of evidence from other countries? Were similar assertions regarding restrictions on mass assemblies and social gatherings correct?

h. Are assertions by Mr Johnson and others that there was a misconception about asymptomatic transmission credible in light of the raft of scientific reports which indicated otherwise, and the public pronouncement of the Government's own CSA? Why was there too little emphasis on mask wearing, in light of learning from other countries' experience of SARS?

i. Are these claims by Mr Johnson merely self-justifying excuses for indecision and inaction?

j. Does the evidence of statements and comments made by Professor Vallance and Lord Mark Sedwill concerning herd immunity indicate a prevarication within Government as to whether to take a laissez-faire or proactive approach, which delayed interventions?

k. Were the delays in taking action really justified by getting the timing right, or is the reality that earlier interventions would have saved lives and lessened the collateral effect on other aspects of society such as the economy, education and mental health? Was there any reliable evidence that the public would not comply with interventions if they were applied early?

l. Is Mr Hancock really correct in his suggestion that the 17 March decision to discharge thousands of older patients from hospitals to care homes without testing, made little difference to mortality rates, and the real care home problem was the movement of staff between facilities, and visitation generally? Or does the evidence show that all of these were factors in care home outbreaks, and none of them had been properly addressed?[46]

SECTION 2: STRUCTURAL INEQUALITIES

76. The Inquiry will hear from six experts on structural inequalities in Module 2 who have reported on structural inequalities and race, disability, age, children, LGBTQ+, and gender. The Inquiry will hear evidence from these experts on pre-existing and structural inequalities and will examine whether due regard was had to pre-existing inequalities in the Government's response to the pandemic and the disproportionate outcomes for ethnic minority groups and the vulnerable. We also anticipate that the Inquiry will examine the intersectionality of disability, age, gender, ethnicity and sexual orientation and resultant poorer outcomes.

77. We have focused our discussion on the disproportionate deaths of Black and Asian people and people from ethnic minority groups, the disabled and older people given the disproportionate mortality rate of people from these groups and the impact on the bereaved.

Inequality and structural racism

78. Professors Bambra and Marmot concluded in their report on Health Inequalities[47] published during Module 1 that the UK Government and devolved administrations and relevant public health bodies did not systematically or comprehensively assess pre-existing social and economic inequalities and the vulnerabilities of different groups during a pandemic in their planning or risk assessment process. The sequential questions in Module 2 must therefore be, how did this impact on the Government's response to Covid-19 at the start of 2020 as well as the outcomes of people from ethnic minority groups and the vulnerable.

79. Ethnic inequalities in relation to Covid-19 were foreseeable because they mirror ethnic inequalities in health which are driven by social and economic inequalities and are often the result of racial discrimination. These inequalities reflect the increased risk of exposure to Covid-19 because of where people live, the type of accommodation they live in,

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[46] Consensus Statement on the association between discharge of patients from hospitals and COVID in care homes, available at: https://www.gov.uk/governmentGovernment/publications/the-association-between-the-discharge-of-patients-from-hospitals-and-covid-in-care-homes/consensus-statement-on-the-association-between-the-discharge-of-patients-from-hospitals-and-covid-in-care-homes ,
Expert report Nazroo, INQ000280058/21§88
[47] Expert Report Marmot & Bambra INQ000195843§149

household size, jobs, and the means of transport used to commute to work.[48] People from ethnic minority backgrounds are more likely to be employed as key workers in sectors that increase their risk of exposure to the virus such as transport, delivery, security, cleaning, as health care assistants, in social care and in nursing and medicine.[49]

80. By May 2020, within 4 months of the first reported case in England[50] an analysis of the ONS data showed a trend of a higher rate of Covid 19 related deaths among black and minority ethnic groups compared to the white population. The report noted that men and women in the black community were over 4 times (4.2 and 4.3 respectively) as likely to die from Covid-19, and men and women from Bangladeshi and Pakistani origin were 3.6 and 3.4 times respectively to die from the virus.

81. Black and Asian people make up a disproportionately high percentage of "high risk key workers", particularly in cities.[51] In London, for example, while Black and Asian workers constitute 34% of the general working population, they represent 54% of retail food workers, 48% of health and social care workers and 44% of transport workers, 37% of workers in key infrastructure and utility sectors, 30% of workers in childcare, support and teaching staff and 24% key public services which were all front facing jobs putting them in direct contact with people who were likely to be infected, often without PPE.

82. People who are poorly paid, in insecure work, often zero-hour contracts and in the gig economy were at a greater risk of contracting Covid-19 because they were forced to go out to work. They were less likely to be given Government financial assistance under the furlough scheme or to be eligible for statutory sick pay. Housing overcrowding was also a significant risk factor for Covid-19 as it meant limited room for self-isolating or social distancing.

83. The UK Government's failure to conduct any Equality Impact Assessments of the emergency measures rolled out in response to Covid-19 meant that the structural inequalities which faced ethnic minority groups were not properly considered in its decision making and response. The Runnymede Trust has identified this failure as a lost opportunity to understand and assess the impact of Government measures to mitigate the impact of Covid-19 on people with protected characteristics which resulted in many groups falling through the cracks without any social or financial support to buffer the impact of Covid-19.[52]

84. PHE's report on Disparities in the risk and outcomes of Covid-19,[53] commissioned in response to the disproportionate impact of Covid-19 on people from ethnic minority backgrounds, acknowledged the link between socio economic factors and the outcomes for

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[48] Ethnic Inequalities in Covid 19 Mortality: A consequence of persistent racism, James Nazroo and Laia Bécares, available at: https://pure.manchester.ac.uk/ws/portalfiles/portal/200461103/Runnymede_CoDE_COVID_mortality_briefing_FINAL.pdf

[49] Nazroo and Bécares *supra*

[50] 31 January 2020 first known cases of coronavirus are confirmed in England, Chronology INQ000255835

[51] The Health Foundation, Inequalities and discrimination likely to be playing a significant role in higher rate of black and minority ethnic COVID-19 deaths, available at: https://www.health.org.uk/news-and-comment/news/inequalities-and-discrimination-likely-playing-a-significant

[52] Response from The Runnymede Trust to the Covid-19 Inquiry's Modules 2-2C Impact Questionnaire INQ000099679/3

[53] Public Health England, Disparities in the risk and outcomes of Covid-19, June 2020 INQ000268359

people from ethnic minority backgrounds who contracted Covid-19 but failed to acknowledge the role of structural and institutional racism in perpetuating those inequalities. Arguably, symptomatic of institutional inertia, these findings have not, 3 years on, translated into policies ameliorating the effects of socio-economic disadvantage on ethnic minority communities. The Inquiry will hear evidence of the impact of the Covid-19 policies and NPIs on ethnic minority groups and the vulnerable which in failing to have due regard to structural inequality exacerbated pre-existing inequalities. By way of examples these policies could and should have included the provision of financial support for contract workers, people in the gig economy and those on zero hours contracts who risked losing their jobs if absent from work due to ill health, but they did not.

85. Racism is a poison which infects institutions and social structures across the UK and invariably everyday life. We expect the Inquiry to examine the role of institutional racism in the Government's response and its impact on the disproportionate outcomes for people of ethnic minority backgrounds in particular black and Asian people.

86. Examples of institutional racism include health care workers being provided with masks and face coverings which were designed for European facial structures and unsuited for African features, the failure to ensure that messaging was delivered in languages to meet the needs of the UK's diverse and multi-ethnic population, and the 111 advice on signs of Covid-19 being blue lips, blue finger tips and extremities. These directly impacted the disproportionate outcomes for black and Asian people. A graphic example from a bereaved family member illustrates the point. His father sadly died from Covid-19 after calling 111 for advice and being repeatedly told that his reported symptoms were not indicative of Covid-19 because his lips were not blue –he was a black man with dark not pink lips.

87. The unevidenced and reductionist approaches of advancing biological and/or genetic and cultural differences as the reasons for the disproportionate outcomes for Black and Asian people rather than structural inequalities is an example of scientific racism that can only be debunked through the Inquiry's examination of the role of structural racism on the disproportionate outcomes for black and brown communities. The persistent scientific focus on vitamin D deficiency among Black and ethnic minority groups compared to white British groups as accounting for the disproportionate outcomes, was an example of this problem.

Structural Inequality and disability

88. Disabled people were among the most affected by the virus, accounting for up to 59% or 6 out of 10 deaths from Covid-19 between November to December 2020. The data showed that people with intellectual disabilities had 5.6-fold higher mortality rates, and people with Down Syndrome having over 30-fold increased risk of dying from Covid-19. [54]

89. It was well established and known that disabled people had a much narrower margin of health, face significant health inequalities and are more likely to die prematurely than non-disabled people. It was also known that disabled adults and children across the UK enjoyed overall lower rates of good physical and mental health compared to their non-disabled peers, with many having comorbidities, such as hypertension, heart disease, respiratory disease, diabetes and depression which were identified as risk factors for poor outcomes from

[54] Expert Report Shakespeare INQ000280067 §39 - 40

Covid-19. Additionally, disabled people were more likely to live in care home facilities. This was reflected in the daily release of mortality figures, in the early stages of the pandemic which was usually accompanied by comments such as "*the vast majority of those who died had underlying conditions*."[55] The deceased recorded in those statistics are the wives, husbands, partners, mothers, fathers, sisters, brothers, aunts, uncles, cousins - cherished family members and dear friends of the bereaved.

90. The breakdown of the ONS data showed that disabled people accounted for 68% of deaths from Covid-19 in Wales. The Report "Locked out – Wales" outlines how discrimination, poor housing, poverty, employment status, institutionalisation, lack of PPE, poor and patchy services, inaccessible and confusing public information and personal circumstances contributed to his figure.[56]

91. Given the known clinical vulnerabilities which placed disabled people at a greater risk to poorer outcomes from Covid-19, its disproportionate impact on disabled people was entirely foreseeable.

92. The experiences of thousands of disabled people who participated in the BBC report "Disabled people forgotten during Covid-19"[57] sharing the devastating impact of the pandemic on their lives and their "forgotten" needs is, arguably symptomatic of the UK Government's persistent failure to protect the rights of disabled people. To date, the UK Government has failed to implement the 2016 United Nation's 11 recommendations[58] and the provisions of the Equality Act 2010 to protect the rights of disabled people. Disability UK notes that the latter includes regulations being made which have failed to take into account the need for reasonable adjustments for disabled people and Covid-19 related communications not being provided in accessible formats.[59]

93. We urge the Inquiry to examine the extent to which the UK Government's failure to implement the UN recommendations and the provisions of the Equality Act to protect and safeguard the rights of disabled people impacted on the experiences of disabled people during the pandemic, exacerbated pre-existing inequalities and contributed to the deaths of disabled people from Covid-19.

94. By the start of 2020, the UK had experienced 10 years of austerity measures which saw cuts to services and support for disabled people particularly in the social care sector. By 2020 budget cuts left adult social care in crisis and on its knees. Across the UK as a whole, public spending on adult social care fell by nearly 10% between 2009–10 and 2016–17. The Institute for Government estimated that between 2009/10 and 2014/15, local authorities in England cut spending on adult social care by nearly 9.3% in real terms and that by 2019 social care funding had been cut by 2% in real terms compared to 2008/09. The third sector, voluntary and community sector organisations were left to pick up the gap.

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[55] Expert Report Shakespeare INQ000280067 §1 – 6

[56] Response from Disability Wales to the Covid-19 Inquiry's Module 2 Impact Questionnaire, INQ000099697/3

[57] Clegg R BBC 'Disabled people forgotten during Covid, BBC research reveals' 30.06.21 available at: https://www.bbc.co.uk/news/uk-57652173

[58] Equality and Human Rights Commission 'UK Government failing to protect disabled people, warns equality watchdog report' 17.08.23 available at: https://www.equalityhumanrights.com/en/our-work/news/uk-governmentGovernment-failing-protect-disabled-people-warns-equality-watchdog-report

[59] Response from Disability Rights UK to the Covid-19 Inquiry's Modules 2-2C Impact Questionnaire INQ000099696/3

However, their budgets were also slashed by spending cuts which in turn limited their support capacity to tackle structural inequalities which faced disabled people.[60]

95. Given the identified link between the reduction of services and support and poor outcomes for disabled people from Covid-19, we expect that the Inquiry will examine the impact of austerity measures on the outcomes and mortality rate of disabled people from Covid-19.

96. A higher proportion of disabled people in the UK are from black and Asian ethnicities – 25% Black/African adults and 10% Asian adults. Their outcomes were exacerbated by pre-existing structural racism which placed them at an increased risk of becoming ill from Covid-19.[61]

97. The Inquiry will therefore need to examine the extent to which the Government's response had adequate regard to the pre-existing structural inequalities faced by disabled people and their risk to Covid-19 from associated co-morbidities and ill health, reduced support as a result of austerity measures and the cuts to adult social care, the voluntary and charity sectors, living in residential facilities and intersectional issues such as age, and race.

Structural Inequality and older people

98. The ONS has estimated that 92% of COVID-19 related deaths in England and Wales occurred among people aged 65 or over, and analysis from the Public Health England review showed that once infected, those aged 80 or over were seventy times more likely to die than those aged 40. Additionally, 75% of excess deaths over the period 20th March to 7th May occurred in the 75+ age group. [62] The increased vulnerability of older people to a pandemic caused by a respiratory virus has been thoroughly documented, and was obvious from the outset. Professor Nazroo notes that those aged 65 and over living in care or residential homes and those who are the main carer of an older or disabled person should receive an annual influenza vaccination because of the high risk of complications. Age was identified at the outset of the pandemic as a major risk factor for critical illness and mortality. It is known that with age, there is increased risk of pre-existing health conditions, disability and the need for care. The vulnerability of older people to complications and mortality from Covid19 infection was known and foreseeable and Government decisions and public health responses should have responded to this increased risk.

99. Older people living in care homes were likely to experience multimorbidity, have higher medical needs, and care givers' assistance increasing the risk of transmission from carers and complications and mortality from infection. The CQC recorded 39,350 deaths in care homes that were directly attributed to Covid-19 during the period April 2020 – March 2021 with deaths in care home settings accounting for 40% of deaths during the first wave.[63] Given the known risks of complications and mortality from Covid-19 which older people faced and the high number of care home deaths, particularly during the first wave, we expect the Inquiry to examine the impact of the Government's decision to transfer Covid-

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[60] Expert Report Shakespeare INQ000280067 §32 & 35
[61] European Disability Forum European Human Rights Report 2021 available https://mcusercontent.com/865a5bbea1086c57a41cc876d/files/08348aa3-85bc-46e5-aab4-cf8b976ad213/EDF_HR_report_2021_interactive_accessible.pdf
[62] Nazroo, GLA Rapid Evidence Review 2020 available at: https://data.london.gov.uk/dataset/rapid-evidence-review-inequalities-in-relation-to-covid-19-and-their-effects-on-london
[63] Expert Report Nazroo INQ000280058 §42

19 positive patients from hospitals to residential and care homes on the infection and mortality rate of care home residents. Additionally, given the disproportionate number of older people with disability and from ethnic minority backgrounds we invite the Inquiry to conduct its examination through the intersectional lens of age, disability and race.

100. The rise in "blanket polices" being applied to older people has been identified as an area of concern by Age UK. There are multiple reports of an apparent policy which saw DNACPR notices being placed on patient records without consultation as well as DNACPR decisions made on assumptions about specific conditions or disability[64], which are of particular concern to bereaved family members. Many of these decisions were applied to older people, in particular care home residents, and policies around hospital transfers and admissions.[65] They raise questions as to the role of ageism in Government policy and institutional policies which we would expect the Inquiry to examine.

101. We would also expect the Inquiry to examine the role of ageism in the application of NPIs which left older people isolated, struggling to manage essential tasks including personal care, without mitigation.

102. Professor Nazroo has identified the deprioritising of services for older people which has left the care home sector with chronic staff shortages and underfunding from years of austerity cuts as illustrative of ageism. As discussed above, by 2020, the adult social care sector had suffered over 10 years of austerity, impacting on services and support for older people. We expect Inquiry will examine the impact of austerity cuts on the outcomes for older people from Covid-19. We also expect the Inquiry to examine the impact of ageism on the provision of social, economic and health services for older people.

103. The mortality rate among older Black people from Covid-19 was disproportionately higher than white older people throughout the pandemic and a disproportionate number of Black and Asian older people were hospitalised and died in hospital from Covid-19. Accordingly, we urge the Inquiry to examine impact of Covid-19 on older people through the intersectional lens of age, disability and race.

SECTION 3: SOCIAL CARE

104. Against the backdrop of 'political neglect' about which the Inquiry received evidence in Module 1, the social care sector remained a 'Cinderella' or poor relation of the NHS and the relationship between the two remained misunderstood throughout the Covid-19 Pandemic. Although the Inquiry will examine the planning for and impact of the virus on the care sector in Module 6, an analysis of UK Government decision-making in regard to the care sector generally is plainly vital to Module 2.

105. In particular, the Inquiry should examine:

   a. The extent to which high level decision making considered targeted interventions for older people and those with underlying health conditions.

[64] DHSC internal document on DNACPR 24.09.20 INQ000058389/2
[65] Age UK briefing to Joint Committee on Human Rights May 2020 INQ000176646/4

b. The extent to which the known dangers of the spread of the virus in care homes (a term we use in this section to include other state run, private or charitable residential facilities such as nursing homes and hospices) was addressed in the lead up to March 2020.

c. The decision which was made to discharge hospital patients to care homes without testing.

d. The steps that should have been taken to prevent the spread of Covid-19 through care homes by workers and clinicians moving from facility to facility, and visitors more generally.

e. The steps that were or should have been taken to protect those receiving domiciliary care.

f. The steps that were or should have been taken to protect those working within the sector.

106. The potential impact of a pathogenic respiratory virus on care home residents was not news to central Government. In his expert report, Professor James Nazroo directs the Inquiry to a 2017 article co-authored by Professor Sir Jonathan Van-Tam which highlighted that, "*Outbreaks of influenza ... are well documented in LTCFs [care homes], and may be explosive ... with high mortality, highlighting the need for early recognition and prompt initiation of control measures*".[66] As explored in Module 1, this had been an area identified as one of particular concern in a pandemic context, through Exercise Cygnus and this was well known to Government scientific advisers, senior civil servants and should have been to politicians.

107. Despite this, the evidence shows that there was almost no action on the part of Government to protect those in care homes in the golden window of opportunity available from January through to March. Although advice was sought from the SPI-M modelling group on generalised NPIs on 28 January 2020, the possibility of shielding vulnerable adults and their essential contacts does not appear to have been considered at all prior to March The evidence so far suggests that at least one month's worth of preparation for the Adult Social Care sector ('ASC') and the vulnerable adults it serves was consequently and needlessly lost. The fact that modelling entirely neglected to consider care homes is staggering.

108. It appears from the evidence that Matt Hancock and Helen Whately (Minister for Social Care) only became live to the serious problems facing the social care sector in early March, at which point they discussed their concern and the need to *"put a rocket"*[67] under preparations for the sector. Helen Whately seems to have begun her investigations at this point, meeting Chief Social Workers on 4 March 2020 and at around the same time realising the lack of adequate plans in place for care homes. The lack of preparation meant that by April 2020, after the first lockdown was in place, Helen Whately was still trying to work out what the position was in relation to PPE for social care settings, remarking that "*there's only so long that I can keep saying to the social care sector 'we're working on it' without*

[66] Expert Report Nazroo INQ000280058/13§40
[67] WhatsApp Helen Whately— Matt Hancock 03.03.20 INQ000176785/4

losing all credibility."[68] It is within this context of chaos and lack of control of transmission within the social care setting that Matt Hancock's disastrous 17 March decision to discharge thousands of hospital patients into care homes (examined at paras 59-65 above) without testing occurred.

109. All the while, the evidence suggests that the ASC sector was vociferously raising the alarm. Cathie Williams of ADASS states, "*There was very limited experience of the operational delivery of social work and social care, within DHSC, and, indeed, NHSE. There was insufficient knowledge, capacity, and traction with decision makers*." On 9 April 2020, ADASS escalated their concerns to Jeremy Hunt as Chair of the Health and Social Care Select Committee raising issues of basic safety, testing and PPE "*as a result of our perception that social care issues (and the needs of people working in and drawing on it) were not getting sufficient attention*."[69]

110. At the point the decision was made to discharge hospital patients to care homes, there was no reliable data on the prevalence of Covid-19 among care home residents. The clear evidence of sustained human-to-human and recognised asymptomatic transmission should have led to alarm bells ringing. Despite this, a SAGE Social Care Working Group was only established in April 2020 "*when the impact on care homes was manifest*"[70] This is remarkable in itself but made more so by the published evidence from the Diamond Princess cruise ship, which confirmed that closed settings could cause superspreading events and was described as being "*conceptually similar*" to care homes and prisons.[71]

111. On the evidence available to us so far, it took until 23 March 2020 for the CQC to start routinely sharing data with DHSC on the deaths of service users in care homes and domiciliary services, even though there were established data sharing channels from EU Exit preparations.[72] It took until April 2020 for the exercise to be coordinated between CQC, PHE, ONS and DHSC[73] The data across different sources eventually confirmed that deaths in care homes were rising exponentially.[74]

112. On the hospital metrics produced by PHE on 17 April 2020, Professor Graham Medley told Sir Patrick Vallance, *"...my reading of the situation is that we have wide-spread on-going transmission in the health and social care systems. Hospital and community-health and social care appear to be driving transmission, and potentially at an increasing rate. In effect, this is the opposite of shielding – vulnerable* [people] *are being preferentially infected*."[75]

113. On 9 June 2020, a DHSC civil servant with responsibility for care homes described, "*a postbag of correspondence from care home managers who didn't know where to turn*."[76]

[68] WhatsApp Helen Whately— Matt Hancock 03.03.20 INQ000176785/4
[69] Witness Statement of Cathie Williams INQ000207511/4§9
[70] INQ000260643/11§3.4ix Statement of Professor Graham Medley
[71] INQ000215645/1§1 Hall, I. (06.04.20) [PHE] 'Modelling outbreaks in enclosed societies
[72] INQ000250230/56§214-216 Statement of Ian Trenholm
[73] INQ000250230/58§224
[74] INQ000220227 CQC spreadsheet on the number of deaths in care homes involving COVID-19 in England
[75] INQ000213054/1
[76] INQ000152211/2 Email from Ros Roughton to Jenny Harries, Eamonn O'Moore and Yvonne Doyle

114. Professor Alex Thomas opines, ‘*'Protecting the NHS' was articulated as the priority, even when that appeared at times in tension with saving lives, for example in relation to care home discharge decisions.’*[77]

115. The Inquiry must rigorously examine the question of whether structural discrimination caused care home residents to be so forgotten and to die in such high numbers. Ableism, racism, sexism, heterosexism and cisgenderism affect adults with care and support needs of all ages but the root of discrimination as it relates to care home residents is ageism and ableism. Were the deaths of these people more acceptable to decision-makers and scientists because they were older? Were they deemed less worthy of protection because of a physical or mental disability? It is submitted that these are essential questions within the scope of Module 2 and necessitates consideration of the detail of what was known to UK Government decision-makers at the time.

SECTION 4: LACK OF DIGNITY FOR THE DECEASED

116. It is an inherent tragedy of any pandemic that there will be 'excess deaths'. Therefore, in addition to measures to minimise the loss of life, there must be effective planning, capacity and co-ordination in place at a national and local level to manage these deaths in a dignified way and to support those who are bereaved. In particular there must be a clear recognition in policy and guidance of the recognition of cultural differences in post-death processes and funerals, and a minimum interference necessary approach. From the Module 1 evidence, it is apparent that there was a lack of consideration, capacity and planning in this regard. In Module 2 the Inquiry must consider what was done in response to make up this deficit, when that was done and whether it was sufficient.

117. The reality it seems, is that the Government sought to follow a "death management programme" which remained at Red or Amber Red throughout the pandemic. This programme was preoccupied with the disposal of bodies, rather that creating law and policy that offered the bereaved consistency, confidence and comfort in how their loved ones would be laid to rest, and it appears to have had little regard for religious rights or cultural traditions.

118. In Module 1, the Inquiry heard evidence regarding the recommendations of Exercise Cygnus. A key recommendation was Lesson 21 - that Government departments should develop policies and guidance on excess death planning. That lesson was kept secret and was not taken forward in any effective way at a national or a local planning level.

119. The Inquiry heard oral evidence in Module 1 from Mark Lloyd of the Local Government Association (LGA). Mr. Lloyd didn't know about the Cygnus recommendation until 2020. He told the Inquiry that he now knew that Exercise Cygnus had found uneven levels of resilience and limited capacity to surge resources into excess death management in some areas. He confirmed that Local Authorities and partners had been concerned about managing increased death rates in their communities for some time before the pandemic. There were also differences that Mr. Lloyd identified between local resilience fora in their planning. Some were focused just on mass fatalities incidents (such as a terrorist attack) and others were focused on pandemic planning.

[77] INQ000236243/30-1§101

120. We say what was required was a Government-led, people-centred holistic approach. Mr. Lloyd agreed that this needed to be produced collaboratively by Local Authorities, central Government, Hospital Trusts, funeral directors, and specific faith communities. The Inquiry should carefully examine whether any holistic and dignified framework was ever developed between these stakeholders, and go on to consider the extent to which the deficit was addressed in the response from January 2020.

121. Within key Government decision making fora it was known from the outset of the pandemic that there would be a significant shortfall in the capacity of local death capabilities to manage the increased number of deceased persons. Indications were that the local capacity to store bodies would be sufficiently short of the required capacity in most Local Resilience Forum areas. This was the same for the capacity for burial and cremation. There was no Government assessment of the local capacity to provide bereavement support.

122. It was known by the Cabinet Office in February 2020 that legal provisions in the proposed Coronavirus Legislation would not be sufficient to enable local areas to meet the requirements of a 0.5% mortality rate increase. There were known issues around the ability to have funeral services conducted and the limited number of faith and non-faith leaders available to undertake these roles.

123. By April 2020, mortality management remained a key issue but there was still limited data regarding the numbers of deaths and capacity at local level. In our submission, understanding the numbers of excess deaths was key to understanding capacity constraints.

124. In his evidence in Module 1, Mr. Lloyd also told the Inquiry that although Local Authorities were working with the Civil Contingencies Secretariat during the pandemic to try to understand the numbers of excess deaths for which capacity was required, that there was an absence of data being provided to them to facilitate this planning. This resulted in them having to act at a local level to commission extra capacity.

125. This lack of understanding led to a dearth in co-ordinated national management on the capacity of mortuaries, coroners and funeral homes, with Local Authorities and the private sector being expected to deploy their resources on an ad hoc basis in the face of increasing numbers of deaths. This in turn created an inconsistent understanding by those on the front line of how the deceased and the bereaved should be treated.

126. Families were told that their loved ones had been taken to temporary mortuaries, which for one family was a cold storage unit at the back of a supermarket. Families were told that the body of their loved ones had to be contained and then buried in a hazardous waste bag because of "contamination." Because of the use of these body bags, their loved ones could not be prepared or dressed for burial. The bereaved could not see their loved ones in chapels of rest, nor were they permitted to have open caskets at the funeral, which is traditional in many communities. The deceased were denied a burial with personal items. Many families reported that their loved one's belongings went missing or were mixed up with those of others in hospitals and care homes. If they were given personal items, families report that they were given to them in bin bags and told that they had to keep them outside the house for 2 weeks, again because of "contamination".

127. The inconsistent messaging around the number of people that could attend funerals also caused great anxiety to families. Some were initially told that they could not attend at all

before being given only days' notice that a few people could attend, but with strict social distancing in place. Other families report religious and cultural rituals being prohibited, and funerals being strictly time-limited.

128. The evidence suggests that rather than formulate a clear and holistic plan, the Government instead focused on the logistical practicalities of excess deaths as they escalated during the pandemic. Covid dashboards and Cabinet Office presentations focused on numbers and capacity, but there was scant regard for dignity and support for the bereaved.

129. As we set out in our closing written submissions for Module 1, prior to the pandemic there was draft guidance (of unclear provenance) on dealing with excess deaths. The draft paid scant regard to dignity and religious or cultural issues. The Inquiry should carefully examine whether the Governmental response ever provided any national or local guidance that was issued to Local Authorities, coroners and funeral directors that gave a clear person-centred framework for the dignified treatment of the deceased and the bereaved.

SECTION 5: THE PERIOD AFTER THE FIRST LOCKDOWN AND 'FOLLOWING THE SCIENCE'

130. Much of the Government's justification of the early months of inaction, as set out at Section 1 above, flowed from the assertion that the Government was 'following the science.' This was misleading, as it both oversimplified 'the science' and passed off responsibility for value judgments, which ought to have been inherently policy based, on to the shoulders of scientific advisers. Such claims should be assessed in light of the subsequent decision-making by politicians: an analysis of the periods between the first, second and third periods of lockdown appear to show that policies were adopted either purposefully without scientific advice or in contradiction to it.

131. Policy is for policy makers and not scientists. Expert advice is often a necessary, if not critical element, but it is not a sufficient basis for optimal decision-making. Was a feature of the response to the pandemic that some decisions were taken wholly on the basis of particular scientific advice, and others taken wholly in the absence of expert assistance? The Inquiry should investigate whether the result was a yo-yo of policy making absent any clear and consistent strategy. While some measures to minimise infections continued between lockdowns, these periods appear to have been marked by a combination of policies that actively encouraged social mixing. We anticipate the evidence will point to the conclusion that these policies contributed to the increase in the transmission of the virus which led to multiple lockdowns.

132. A key example of this is the ill-fated 'Eat Out to Help Out' scheme. Directly following from the closure of pubs and restaurants, the Inquiry may find that this scheme gave the public an entirely contradictory and false message: that Covid-19 was over, that it was time to relax all vigilance and there was an implied duty to support local bars, restaurants and cafes. It is important for the Inquiry to examine the evidential basis for the scheme in the context of the rate of transmission at the time and in the absence of a vaccine. A starting point will be what advice was sought before such a controversial measure. Professor Vallance, the Government Chief Scientific Adviser does not recall Rishi Sunak or any other decision maker seeking scientific advice as to the likely effect of this scheme. It does not appear that SAGE were consulted either. Professor Vallance points out this measure

increased the rate of infections in the lead up to the second lockdown and that it was entirely predictable that it would, and this is what he would have advised had he been consulted.[78]

133. Another example of this confusion in policy making can be found in sudden changes in public communications, which the Inquiry may find gave the public mixed messages about the dangers of the virus and about what actions they should take. In May 2020, the Government slogan changed from "Stay Home, Protect the NHS, Save Lives" to "Stay Alert, Control the Virus, Protect Lives," although formally Government advice remained at the time that the public should stay at home wherever possible. The Inquiry should consider the process which led to this change in messaging as well as its impact. We anticipate that the evidence will show that the change was driven by UK Central Government over the objections of Devolved Administrations. To what extent where their views considered and why were they overruled?

134. The Inquiry will also wish to consider the evidential basis for the change in messaging. It appears that SPI-B, SAGE's sub-committee on behavioural science was not consulted as to the impact of the change in messaging and its efficacy for maintaining social distancing behaviour. Upon becoming aware of the policy, concerns were raised by the scientific experts that this messaging was "*disastrous*" and would "*do damage in many ways*", "*missing an opportunity to provide behaviourally scientific and precise advice*"[79] thereby increasing transmission. By the time that the scientists became aware of the shift in public messaging and these concerns were raised, Boris Johnson had already announced the shift in policy. It appears from the evidence that we have seen so far, that there was also a failure to consult experts within central Government itself, with an official from the Government Communication Service writing that "*The messages in this instance are kept so elusive by a small group of mainly No10 advisers … My team was never consulted either and as soon as I heard the message I flagged our concerns which mirror those of the group - only to be told it was too late now (and "it tested well" which often means a shut down of discussion of any risks!) I think bottom line isn't [sic] they won't change the message now. … I am so sorry that despite being the behavioural scientists inside the Government communications service we don't have a handle on this either*."[80]

135. The Inquiry will have to consider the extent to which these measures caused a spike in the transmission of the virus, increased the need for further lockdowns and were ideologically driven, but packaged as balancing economic recovery against public protection. Many witness statements that have been disclosed so far have highlighted the lack of economic expertise and documented expert analysis of likely economic consequences of NPIs. That there were no transparent vehicles for economic advice should not be confused with the concept that economic factors were not considered. On the contrary, we anticipate that the evidence will show that key decision makers, and particularly Boris Johnson and Rishi Sunak prioritised what they considered to be short term economic gains over controlling the transmission of Covid-19.

136. The Inquiry will consider whether these economic arguments were in fact grounded in evidence-based analysis which properly considered different factors, such as the need to protect vulnerable populations and the importance of preserving life, as well as the economic and social impacts of increased transmission of the virus. We anticipate that the

[78] Witness Statement of Patrick Vallance INQ000238826/115-116§347-349
[79] Email chain between SPI-B members 06.05.20-10.05.20 INQ000197075/6-7
[80] Email Moilere-Rubin 10.05.20 INQ000197075/1

evidence will show that there was no such finely tuned analysis, but ideological and knee jerk decision making. This meant that the easing of regulations was not driven by scientific evidence but by the need, in the words of one senior civil servant, "*to balance realism with Johnsonian optimism*."[81]

137. One of the issues that the Inquiry should consider is whether structural discrimination contributed to an overly optimistic focus on how 'most' people would fare in the face of a pandemic which posed an extreme danger to known vulnerable sections of the population.

138. The Inquiry should consider not only the measures which increased the need for further lockdown, but the delays in imposing NPIs in the face of increasing rates of infection. This is particularly evident in the lead up to the second lockdown. We anticipate that the evidence will show that SAGE and the Government CSA advised with increasing concern from early September that there were measures needed to combat the increasing levels of infections. We anticipate the evidence will show that Boris Johnson and Rishi Sunak in particular were resistant to imposing measures. Boris Johnson appears to have been advised specifically that the 'Rule of 6' measures would not decrease the R rate sufficiently, but decided to impose those measures anyway. Again, insofar as the 'tier' system that was introduced is concerned, it appears from the evidence currently available that scientific advice was not sought.

139. The Inquiry should investigate the repeating pattern that led to the second and third lockdowns and the similarity to the first lockdown: a period of dithering, lack of action and 'Johnsonian optimism' during which infectivity rates grew, necessitating more stringent measures, rather than consistent policy direction and action. In a similar manner to early 2020, while concern raged around him by 30 October 2020, Boris Johnson remained even "*less convinced of need for action than Rishi! He was really kicking back.*"[82] The Inquiry should consider how much he had learned from the first lockdown and what consideration he gave to the large scale loss of life until that point.

SECTION 6: POOR GOVERNANCE AND CHAOS AT THE CENTRE OF GOVERNMENT

140. In examining high level decision-making, the Inquiry should examine the extent to which the UK's response was hampered by poor governance structures, a toxic and chaotic culture at the heart of Government and personal incompetence and lack of trustworthiness of key figures involved in the response. The bereaved families are particularly concerned that at no point during the pandemic did the UK establish a system of test, trace, isolate and support. It seems from the evidence so far that there was a failure to build upon existing local structures, for example Local Authorities' Directors of Public Health, and instead there was an insistence on establishing new national structures which never became adequately operational. The Inquiry should examine the reasons for this, especially in the context of a system apparently premised on subsidiarity.

[81] WhatsApp Simon Case – Matt Hancock 16.07.20 INQ000129427
[82] WhatsApp Simon Case – Matt Hancock 30.10.20 INQ000129555

Trust in Government

141. Partygate has become an emblem of the behaviour of senior figures at the heart of Government during this period of national crisis. The behaviour and trustworthiness of senior political figures should not be seen as a distraction from the Inquiry's aims, but as a critical element underpinning the response. As highlighted by the Inquiry's experts both for Module 1 and Module 2, public trust in Government and senior decision makers is a key element of resilience and an important driver of public behaviour during crisis. A lack of trust in key figures has real world consequences. As was recognised by one senior civil servant in discussing how to achieve public adherence to isolation measures "*We are losing this war because of behaviour - this is the thing we have to turn around (which probably also relies on people hearing about isolation from trusted local figures, not nationally distrusted figures like the PM, sadly).*" [83]

142. We anticipate that the 'Barnard Castle incident' will be a key event from the perspective of undermining public trust. Boris Johnson now undermines the trustworthiness of the figure at the centre of that scandal, describing Dominic Cummings as a source to which little credence should be attached. Why then, in May 2020 did the ex-PM stake so much on the credibility of that same individual? Was Boris Johnson so hoodwinked by Dominic Cummings that he believed his implausible account of driving to test his eyes? Or was this part of Johnson's governance style which prized perceived political ideology over trustworthiness and competence in selecting key decision makers? Similarly, proven accounts of suitcases full of alcohol being brought into Downing Street and parties at the heart of Government could only undermine collective responsibility across society.

143. We recognise that individual breaches of Covid-19 regulations are beyond the scope of the terms of reference. However, repeated scandals across headlines which in turn caused serious if not irreparable harm to public confidence in Government during the pandemic call for consideration. The Inquiry must examine the extent to which public trust was undermined by the behaviour of those within Government.

Competence in Government

144. A clear thread running through the evidence that we have seen so far both from scientists and political advisers is the perception that there was a lack of strategic direction and a dithering at the heart of Government. The Inquiry should examine the extent to which this was caused by Ministerial ineptitude, particularly on the part of the ex-Prime Minister himself, given the centrality of the role played by the Prime Minister in the UK's crisis response architecture. We set out at Section 1 the questions that arise in relation to Boris Johnson's understanding and management of his brief during the early stages of the pandemic.

145. Beyond this, his decision-making style appears to have been marked by a "*tendency to say different things to different people, reverse settled decisions and be heavily influenced by pressure from parts of the media*."[84] The Inquiry should consider whether these failures were contributed to by a lack of focus on the part of the ex-PM on the job at hand. Beyond competence at the top of Government, the Inquiry should consider the extent to which those

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[83] WhatsApp Simon Case – Matt Hancock 30.10.20 INQ000129555
[84] Expert Report Thomas INQ000236243/27§85

who were advising Government and carrying out policy work and implementation of Government decisions were equipped to do so. The view of the former Director of Communications, for example is that in the crucial area of public communications *"poor performance"* is "*routinely accepted*."[85]

Structures in Government

146. Expert witness Alex Thomas sets out the changing structures governing the response to the Covid-19 pandemic. As the pandemic progressed, structures changed time and again. Once more, Boris Johnson appears to have played a role in the confusion of governance structures and accountability, engendering what has been described as a 'chaotic' Number 10 with competing power sources and unclear lines of responsibility. However, the inadequacy of crisis response structures went beyond individual Ministers and the former Prime Minister himself.

147. We anticipate that the evidence will show the truth of criticisms that were levelled at the UK's decision-making structures in Module 1: a lack of central coordination and direction, a lack of structure to ensure common understanding of crisis levels, and crucially absolutely no formal structure to ensure consistency and cooperation between the four nations. On another level, for a system that relies on subsidiarity, the structures of liaison with local and regional Government appear to have been inadequate or non-existent with "*a lack of understanding of local Government in emergency responses. A missing link between central and local Government led to unhelpful and counter-productive centralization*."[86] The Inquiry should investigate whether the attempt to circumvent the COBR structure through informal decision-making mechanisms and limited meetings meant that policy decision-making was chaotic and failed to consider all the relevant evidence and perspectives.

Culture in Government

148. The Inquiry should examine whether the response was hampered by a toxic culture at the centre of Government which hampered decision-making, both across Government and in the Cabinet Office and Number 10 in particular. Rather than 'pulling together' to address the challenges facing the UK, it appears that there was a culture of "*unnecessary and unhelpful departmental turf wars*,"[87] with departments treated as separate "fiefdoms." The Inquiry should investigate whether, and to what extent, a fractured relationship between Number 10 officials and Cabinet Office officials hampered coordination of the Government's response.

149. In relation specifically to the Cabinet Office, the Inquiry should examine whether its culture and governance affected its response to Covid-19. The evidence indicates that there were severe and well-known problems within the culture of central Government, the Cabinet Office, and Number 10 in particular. As one senior official put it in April 2020 "*the Cabinet Office is a totally dysfunctional mess at present, so not a great place to be!"*[88] A draft internal review by Cabinet Office officials gathering views of civil servants mainly from the Cabinet Office and No 10 at around the same time paints an even more concerning

[85] Witness Statement of Lee Cain INQ000252711/14§58
[86] Expert Report Thomas INQ000236243/42§142.3
[87] Witness Statement of Lee Cain INQ000252711/15§59
[88] WhatsApp Simon Case – Matt Hancock 29.04.20 INQ000129289

view, observing that "*the culture isn't getting the best of people…not working as one team between the CO and No 10 – not one team in the Cabinet Office… lots of senior people negotiating with each other rather than doing stuff… no one listens to anyone else… bad behaviour from senior leaders tolerated… too much politics with a small 'p'… lots of people mentioned junior women being talked over (including those who had talked over junior women.)*" [89]

150. In its consideration of the culture within the civil service, the Inquiry should also consider the extent to which civil servants are open and honest with the Inquiry in Module 1 and in Module 2 about the known internal problems of culture and structure that the evidence from Module 2 brings to light. Does the approach of civil servants to the Inquiry reflect a culture of candour or a defensive closing of ranks?

SECTION 7: RELATIONSHIPS AND DECISION-MAKING INVOLVING DEVOLVED NATIONS/JURISDICTIONS

151. Consistent with, and in addition to, the concerns surrounding decision making, governance structures and culture identified above, are the families' concerns about the approach of Westminster Government to the devolved jurisdictions. The families consider that the following criticisms can be identified in these relationships (with particular focus on NI):

152. The Westminster Government considered devolved entities as an inconvenience or problem rather than partners in decision-making, according insufficient weight to the role of and contributions from elected representatives with regional responsibility:

- i. In approaching the devolved authorities as a political hurdle, they failed to identify and consider the scientific perspective relating to the different regions of the UK, (i.e. consideration of separate epidemiological units);
- ii. The lack of engagement with or involvement of devolved actors at outset ensured that NI, Scotland and Wales were an afterthought in determining policy;
- iii. Even when engagement was regular, it did not amount to consultation, merely notice.

153. These will be addressed in turn. We will also address particular features of the relationship which ensured that the response of the devolved administrations to the pandemic could not be seen in isolation from Westminster. That was particularly the case for NI.

154. Before doing so however, we consider it important to reiterate the significant regret on the part of those we represent that there will be no witnesses from the devolved administrations generally and from NI in particular in Module 2. An important aspect of this Module, and one addressed in this particular submission, requires the Inquiry to consider "*The central Government structures and bodies concerned with the UK response to the pandemic* ***and their relationships and communications with the devolved administrations*".** An informed assessment of this issue necessarily requires evidence from witnesses other than those associated with the UK Government. As a matter of logic the Inquiry would require

[89] Draft Report from Helen McNamara to the PM, approximate date derived from witness statement of Martin Reynolds INQ000136755/1

to hear from witnesses in the devolved administrations who can provide evidence about any such communication. It is already evident from the witness statements received to date that representatives of the devolved administrations have much to say. Hearing evidence from those witnesses in this module would, we contend, better enable the Chair to draw conclusions on these key matters within scope. It would ensure the Inquiry would be better placed to consider whether there were failures in proper communication with the devolved administrations including whether such failures arose from individual decisions or systemic failings.

155. The value of hearing that evidence now will, we say, be evident from the submission below, which is significantly informed by material and statements provided by a small number of witnesses from the devolved administrations. Moreover, the evidence of devolved witnesses is necessary not just to reach informed decisions on these issues at the conclusion of the evidence, but is required in order that the appropriate questions for relevant witnesses are identified in advance. We consequently reiterate our clients view that it is not possible to properly assess the evidence and come to informed conclusions on the primary issue in Module 2 if the evidence is heard from only one side of the equation.

156. With that concern and caveat in mind, it is appropriate to turn to the issues identified above, and, pertinently, the suggestion that the Westminster Government considered the devolved administrations as problems to be "managed" rather than partners in decision-making.

Devolved Administrations as Problems to be Managed

157. The *"occasionally divergent Four Nation approach became a growing presentational problem… there was always a risk that the DAs would diverge and choose a more restrictive measure, or one that was perhaps different for the sake of being different".*[90] This observation, from Boris Johnson, is a measure of the attitude towards the devolved administrations, held by the former PM and key actors in central Government. The fear that devolved nations would grow into an increasing political headache, be it because they were either no longer willing to wait for Westminster to act, or because they adopted measures that may have diverged from central Government policy, dictated attitudes from Westminster, at a time when it is evident that the UK Government sought little data and considered less about the impact of the pandemic across the four nations.

158. The concern that Westminster viewed the existence and jurisdiction of devolved administrations as a problem in itself in responding to the pandemic is not simply an inference or based on the observations of our clients, nor does it emanate solely from the comments of the former PM. It is based on explicit statements of multiple actors, including Secretaries of State.

159. The Statement of then Secretary of State for Health, Matt Hancock, effectively espoused this view[91]:

> "*in terms of the Government machine, I suspected that the hardest part may be dealing with the devolved Governments. I recall thinking that it was madness that the devolved Governments would be taking their own lead on domestic health*

[90] Witness Statement of Boris Johnson INQ000255836§153
[91] Witness Statement of Matt Hancock INQ000232194§128

policy; that kind of devolution is all very well for running the NHS and fighting obesity, but not for responding to a pandemic. Unfortunately, there was not much I could do about it..."

160. Consistent with this view, in September 2020 the First Minister of Wales made a request for more regular and focused Ministerial and COBR meetings between devolved Governments and central Government. A readout of a subsequent meeting to consider this request recorded that the SOSNI had stated: "*DAs are dispersed in wider UKG meetings; if we convene them in a smaller meeting, they may prove more difficult to handle.*"[92]

161. For the avoidance of doubt, the families reject the view that devolved Governments taking responsibility for decisions about healthcare for devolved jurisdictions in the course of a pandemic, is "*madness*". Indeed, such an attitude reveals a startling lack of understanding and respect for the principles of devolution, for the role of locally elected representatives and for the differences in the way in which Covid-19 impacted the individual jurisdictions. As observed by former First Minister Paul Givan at paragraph 18 of his first statement '*There was not a 'one size fits all' approach…Each jurisdiction has a right to take its own decisions which needs to be respected under devolution."*[93] And in his second statement at 3a "*the UK Government needs to be able to trust the devolved administrations and bring them in at a timely point in their consideration".*[94] Notably, Mr Givan assumed the role of First Minister in June 2021 but his experience echoes concerns raised by Executive colleagues who had been communicating with Westminster from a much earlier stage in the pandemic. In stark contrast with the assumption that divergent approaches in the DAs were, at least in part, motivated by making political capital within the crisis, Michelle O'Neill argues at §7 of her second statement:

> *"In my opinion, the reasons for divergences were three-fold. In the first instance, divergences reflected real policy differences between the UK Government and devolved administrations. I believe that there was a concern generally on the part of the devolved administrations, and certainly I was concerned, that the UK Government approach to the pandemic was flawed, in that, they were slow to react to the crisis and thereafter lifted restrictions prematurely, in a manner which I felt created risks to public health. There was a real concern that at times they were adopting a policy of 'herd-immunity'. I reject the suggestion that any divergences I advocated for were for the sake of being different. It was my sense that divergences adopted by the devolved administrations were motivated by the need to protect the health of citizens and to protect the health service."*[95]

162. This is plainly a conflict in evidence that the Inquiry will need to resolve. However, it may well be that rather than being 'madness' or 'a growing presentational problem' the ability of and indeed the necessity for individual administrations to take informed decisions on the part of their citizens is a feature of the importance of local accountability in the UK's constitutional settlement. During the course of the pandemic, the value of devolution called for a greater degree of trust, respect and positive consideration.

[92] Email chain from SoSNI Private Office to NIO Leadership team 22.04.20 INQ000091348/2
[93] Witness Statement of Paul Givan INQ000256605§18
[94] Witness Statement of Paul Givan INQ000274197§3a
[95] Second Witness Statement of Michelle O'Neill INQ000273782§7

Failure to Appreciate and Address Epidemiological Reality

163. One concern about this general attitude is that it appears to have been based on political concerns or considerations rather than an assessment of the features of the pandemic.

164. Responding to the pandemic in Northern Ireland had unique and complicating features. Most obviously as an entity it exists on a separate island and forms a separate epidemiological unit with a neighbouring state as a result of the open land border on the island (which land border was, of course, occupying a great deal of consideration as a result of Operation Yellowhammer). In the context of the pandemic however, it is important to emphasise that the island of Ireland was (and is) primarily an epidemiological reality rather than a political dilemma. That much ought to have been entirely foreseeable from a very early stage of the pandemic (and indeed before).

165. That point was made in the witness statement of Prof Graham Medley, Co-Chair of SPI-M-O[96], where he observes:

> "*(P)andemics do not respect national or sub-national boundaries. A global failure was not to have international co-operation and concerted strategies to agree a common approach. When faced with a pandemic individual nations' natural response is to try and gain advantage over other nations which leads to a sub-optimal response from a global perspective. ...*
>
> *The situation in Northern Ireland is particularly complicated and complex given the border with Eire means that a country outside of the United Kingdom has particular influence on the United Kingdom's epidemic. Having a co-ordinated and concerted approach to the next pandemic would improve strategy development."*

166. Expert to the Inquiry Professor Aisla Henderson in her report also addresses this issue:

> *"[114] Northern Ireland's geographic and institutional ties to the Republic meant it had an additional coordination role in managing the Coronavirus pandemic. As early as 2 March 2-2- plenary discussions in the Assembly...indicated that the Chief Medical Officer in NI and Ireland had engaged routinely for weeks.*
>
> *[116] by virtue of its geography the NI Executive was particularly attuned to advice that varied across borders. This included contradictory signals to international travellers offered by the FCO and Irish Department of Foreign Affairs. There were, however, ongoing efforts at co-ordination…"*[97]

167. We endorse that assessment of the difficulties in addressing the pandemic without a coordinated and concerted approach between different states and jurisdictions, to take into account epidemiological reality and international borders. It was therefore all the more important that Westminster shared what information it held in a timely manner, and that the concerns of devolved actors from this jurisdiction were taken into account in wider

[96] Witness Statement of Graham Medley INQ000260643§12.5

[97] INQ000269372 §114-116 Report of Professor Ailsa Henderson for the UK Covid-19 Inquiry titled 'Devolution and the UK's Response to Covid-19'

decision-making. In contrast, the approach of Westminster Government appears to be that the problem of devolved administrations was primarily political rather than science based.

168. While the view of the then Prime Minister as expressed above at [7], appeared to be that a UK wide approach was preferable and that decisions of Scotland and others to diverge were unhelpful[98], the reasoning by which he justifies this view appears not to be based on concerns at the impact of two separate approaches in one island and epidemiological unit, but rather were focused on political appearances.

169. The same attitude is expressed in a variety of other documents which have been provided to the Inquiry. By way of example, the Prime Minister's Briefing Note on Mass Gatherings suggested that the position in NI was "*complicated by the decision last week by the Irish Government to cancel all indoor events of over 100 people and all events outside of over 500 people…. This has created a significant degree of public pressure to justify the different approach taken in NI (and the rest of the UK).*"[99]

170. It is not clear why the decision in the Republic of Ireland was considered a complicating factor in circumstances where Westminster was considering making provision for such measures to be imposed in NI. It is difficult to see how restrictions on mass gatherings in NI could operate successfully in slowing the virus (as opposed to simply freeing up medical workers) if there were no similar restrictions in the south of Ireland. We also observe that the Briefing Note does not describe any engagement with the Irish Government to ensure coordination on these issues.

171. Similarly, the simple fact that Scotland had its own view of the need for a ban on such gatherings appears to be a considered a challenge by the same briefing note:

> *"33. Decisions on whether to restrict mass gatherings would ideally be made consistently across each of the four nations of the UK. It will create challenges with public messaging and appropriate behaviours if there are divergent directions and different measures being applied.*
>
> *34. The Scottish First Minister has already said publicly that she favours a restriction on mass gathering above 500 people. ... The Scottish Government does not have legal powers to effect such a restriction…"*

172. There consequently appears to have been a view adopted that a UK-wide approach was beneficial in itself. For example, Matt Hancock emphasised his view that it was "*vital that all parts of the UK moved in lockstep…*"[100] It is a particular concern that the former Health Secretary who, it is understood, was in frequent communication with his devolved counterparts should express such an apparently narrow political view. As explained in the second statement of Michelle O'Neill at §8:

> *"Divergences [in approach]… reflected real differences at a regional and local level which necessitated a flexible approach. Thus, the north of Ireland was around two weeks behind England in the trajectory of the virus and the R rate and a divergence in approach was a necessary response to that reality."*

[98] Boris Johnson witness statement INQ000255836§152-156
[99] 15 March 2020 PM Strategy Meeting, Mass Gathering Briefing Note, Paper from DCMS, INQ000106212§35
[100] Witness Statement of Matt Hancock INQ000232194§156

173. Ms O'Neill continues at §15:

> *"I believe that a rigid 'consistency' of approach would have constrained the devolved administrations when they needed to respond to local conditions or in circumstances where their policy approach differed from London."*[101]

174. Notably, Ms O'Neill's view finds support in that of Paul Givan who, in his first statement observed at§28 that:

> *"Each administration moved at its own pace, with each nation's response being tailored to its own social and political landscape."*

175. In his second statement, in response to a question that, we infer focused on UK wide decision making, at Q3c Mr Givan goes on to state:

> *"I do not agree that "greater streamlining of decisions and measures would have improved the UK-wide response to the pandemic". I have no doubt that it would have been easier and more straightforward for the UK Government to have been able to legislate on a UK-wide basis without involving the devolved administrations. However, I do not believe that this would have necessarily "improved the UK-wide response to the pandemic". First, this assumes that UK-wide decisions of the UK Government would have been the 'right' ones when applied in each of the four nations, and, secondly, it ignores the reality that failing to 'bring along' the devolved administrations in decision-making could lead to problems with implementation in areas resistant on a political basis to UK Government involvement."*[102]

176. Accordingly, whilst across the islands, communication was of the utmost importance and coordination of clinical advice was clearly appropriate, the need for movement in "lockstep" is less clear in circumstances where different nations were divided among separate epidemiological units. Indeed, that statement in itself belies a UK Government that was 'out of step' with the impact of the pandemic in regions across the UK and systemically 'out of step' with opinions of both local political leaders and epidemiologists including those experts from whom the Inquiry will hear.

Devolved Nations absent or an afterthought

177. It is not entirely clear to what extent NI actors were informed of the risks of Covid 19 at an early stage in January 2020, or in fact as the pandemic developed.

178. The Inquiry will be aware that the Executive was not reformed until 10th January 2020, and as a consequence the Assembly had not been sitting. This is a significant period at the outset of the pandemic, during which, we note that emails were exchanged between Jonathan Van Tam (Deputy CMO) and Chris Whitty and others about a novel coronavirus originating in Wuhan, China, with South Korea and Hong Kong having suspected cases, or expecting them (See e.g. emails of 2nd January INQ000047484, 9th January INQ

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[101] Second Witness Statement of Michelle O'Neill INQ000273782§8
[102] Witness Statement of Paul Givan INQ000274197§3a

000047486). The extent to which, in the absence of an Executive, NI individuals or entities were made aware of events at this stage is not entirely clear.

179. However, the concerns do not dissipate when the Executive was reformed and there remain concerns at how communication was conducted. Both Baroness Foster and Michelle O'Neill suggest that NI were represented at COBR from an "early stage", identifying that the Minister for Health had attended a COBR meeting on 29 January.[103] One issue that calls for consideration is whether it was appropriate that communication with NI and other devolved administrations appears at this stage to have been through the respective Ministers for Health. This appears to have been due to the fact that the then Prime Minister, Boris Johnson, was still not attending COBR meetings at this stage. As outlined above, that approach was inconsistent with the seriousness of the situation at that stage. As the First Minister of Wales notes, "*the reasons for Prime Ministerial engagement in early COBR meetings would include the signal this would have sent as to the seriousness of the emerging position; the greater force with which Prime Ministerial involvement communicates the need for cross-Government action and the fact that the Prime Minister himself would have been better prepared, through that direct engagement, for the decisions that lay ahead.*"[104] Furthermore, this absence goes hand in hand with an apparent policy of informing the devolved nations of decisions taken by the UK Government, rather than involving them in the decision-making process.

180. As observed by Mr Givan in his first statement at §9, in relation to a later stage of the pandemic, four nation '*calls were a means of communicating UK Government decisions after they were made, and, as a courtesy to the devolved administrations, shortly before the decision was announced".*

181. Again, his view, formed having taken up office in June 2021, reflects that of dFM Michelle O'Neill who had been in post since 10 January 2020. Ms O'Neill's view was "*that the meetings held between UK Government and the devolved administrations were little more that our being provided with information about decisions that had already been taken by the UK Government. There was little evidence of the UK Government working collaboratively with the devolved administrations. Decisions were communicated to the devolved administrations at the last minute, just prior to and sometimes just after, they had been communicated either to the public or to Westminster. There was no opportunity for the devolved administrations to have any meaningful input into decision-making nor was the UK Government minded to take on board the views of the devolved administrations. [second statement at §18]*

182. By way of clear example of the impact of such pronouncements, the deputy First Minister identified that she was unaware of what extent, if any, that the Coronavirus Action Plan circulated on 3rd March 2020[105] had benefitted from NI input.[106]

183. Although both Baroness Foster and Ms O'Neill consider that the COBR meeting in late January was an "early stage", the Inquiry may also wish to consider whether such a

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[103] Witness Statement of Baroness Foster INQ000255838§16, Witness Statement of Michelle O'Neill INQ000273783§11-12
[104] Witness Statement of Mark Drakeford INQ000273747§25
[105] Email Chain Chris Stewart TEO 03.03.20 INQ000232520
[106] Michelle O'Neill witness statement at INQ000255838§35

meeting should have occurred sooner, and, if so, whether NI was hindered in identifying the risk due to the absence of representatives at other UK meetings, including of SAGE.

184. Evidence identifies that representatives for the DAs were not present at a number of critical SAGE meetings. The Welsh representative did not attend until the thirteenth meeting on 5th March 2020 and the representative for Northern Ireland did not attend until the twenty-fourth meeting on 9th April 2020. Although a representative for Health Protection Scotland attended the first and second SAGE meetings, Scotland was not represented again until 3rd March 2020. [107] The inquiry will appreciate that the earliest date of NI presence at SAGE was therefore three months after the coronavirus had been identified, and was after lockdowns had been imposed, a decision which was informed by SAGE advice. According to Professor Henderson's report, most of the academic experts on SAGE were located in England, and more than half of the SAGE subgroups had no representation from a devolved administration.

185. This raises real concerns as to the extent to which SAGE was acting for all of the UK. As the First Minister of Wales observed: "*Unfortunately there was no reliable protocol which made it clear that SAGE worked for all Four Nations, not just England*." This meant that devolved regions could not ask SAGE to carry out bespoke research for it without prior agreement from COBR. In contrast to that position, "*it was becoming clearer that SAGE was considering the implications of options/scenarios for easing lockdown restrictions in England only,"* having apparently been asked to do this by the Cabinet Office.[108] This was a concern shared by the First Minister for Scotland Nicola Sturgeon.[109]

186. Expert to the Inquiry Professor Ailsa Henderson notes that SAGE concerned itself almost exclusively with England. The "*implicit frame of reference*" for SAGE throughout "*was an English one, with English-only data seen as good enough to enable decision-making"*.[110] She further notes that the deliberations of SAGE revealed a focus on return dates for schools and universities "*tied to the English calendar with no reflection that the Scottish schools were to return several weeks earlier*." [111] As a result, the UK Government acted predominantly on the basis of England-only information,[112] and on scientific advice tailored to the context in England. According to Professor Henderson "*a predominantly English frame of reference undoubtedly meant that advice to local populations at times did not meet local circumstances."*[113]

187. It appears that the UK Government's so-called "Four Nations" approach was in practice little more than an expectation that the DAs would adopt advice tailored to the conditions in England.

[107] INQ000269372 §95-97 Report of Professor Ailsa Henderson for the UK Covid-19 Inquiry titled 'Devolution and the UK's Response to Covid-19'
[108] Witness Statement of Mark Drakeford INQ000273747§86
[109] Witness Statement of Nicola Sturgeon INQ000235213§71
[110] INQ000269372/46§140 Report of Professor Ailsa Henderson for the UK Covid-19 Inquiry titled 'Devolution and the UK's Response to Covid-19'
[111] INQ000269372/46§140 Report of Professor Ailsa Henderson for the UK Covid-19 Inquiry titled 'Devolution and the UK's Response to Covid-19'
[112] INQ000269372/62§192 Report of Professor Ailsa Henderson for the UK Covid-19 Inquiry titled 'Devolution and the UK's Response to Covid-19'
[113] INQ000269372/48§149 Report of Professor Ailsa Henderson for the UK Covid-19 Inquiry titled 'Devolution and the UK's Response to Covid-19'

188. Whether the under-representation of the DAs in SAGE led to the scientific focus on England at the expense of NI, Scotland and Wales, will be an important question for the Inquiry to consider in Module 2.

189. Baroness Foster has emphasised the importance to NI of "*access to the wider pool of experts including SAGE than likely would have been available in NI"*[114] For this reason, the absence of NI representatives on SAGE for a significant period at the outset of the pandemic appears particularly unfortunate, as does its apparently England-centric role. The Inquiry may want to consider the extent to which this was a failing, particularly given the emphasis on the importance for NI of access to SAGE.

190. It is not disputed that there was some level of information sharing with NI even in early January 2020. We do note that representatives from NI were in attendance at an extraordinary meeting of "the 4 nations High Consequence Infectious Disease (HCID) and list group" on 10 January 2020 which recommended that the disease caused by Wuhan Novel Coronavirus be classified as an Airborne HCID.[115] However we would urge the Inquiry to consider whether the information sharing was adequate at this stage and with individuals in appropriate positions to ensure that the information could be used to inform independent decision-making on a response in NI.

191. Moreover, under this heading we consider that the Inquiry should be particularly concerned about the apparent trend in governing and decision making through WhatsApp chats, rather than formal decision-making structures, particularly when WhatsApp groups failed to include representatives from devolved nations. This practice made it all the more likely that decision-making would not just be England-centric but London-centric, to the exclusion of those representing regional cities as well as devolved administrations. We also note with concern that difficulties in establishing the extent to which WhatsApp was a feature of devolved decision-making, for NI at least, due to the fact that the First Minister in post for the majority of the pandemic appears to have routinely deleted her messages, preventing informed consideration of the information they contained.

192. In addition to concerns at the engagement with devolved actors as the risk posed by Coronavirus began to become apparent, there is also a concern at the manner in which devolved administrations were included in decision-making as the pandemic developed.

Failure to Use Established Structures for Liaison with Devolved Administrations

193. We have identified above concerns at the UK Government approach, with confusion at Government structures and the use of informal decision-making mechanisms. The approach of the Westminster Government to devolved administrations is perhaps consistent with those concerns. By way of example, Mark Drakeford comments "*Throughout the pandemic there was a sense that engagement with the devolved nations was ad hoc. Intergovernmental machinery was not used as it should and could have been.*"[116]

194. The Inquiry will want to examine why more use was not made of the already established mechanisms for communication between the devolved administrations and the UK

[114] Witness Statement of Baroness Foster INQ000255838§33
[115] Note on Outcome of HCID 4 Nations Meeting 10.01.20 INQ000223380
[116] Witness Statement of Mark Drakeford INQ000273747§85

Government, including the British Irish Council (BIC) and the Joint Ministerial Committee (JMC) and which provided the devolved actors with a defined role[117] This is particularly the case in view of evidence available to the Inquiry which suggests that these committees may not have been adequately set up to deal with a fast-moving pandemic. By way of example, evidence shows the First Minister and deputy First Minister had requested a summit of the British Irish Council in Summer 2020. This eventually took place only in November 2020, and rather than addressing the issues identified by the OFMDFM, was focused on "economic recovery" following the pandemic.[118]

195. Whilst DAs were briefly included in Ministerial Implementation Groups ("MIGs"), set up in March 2020, these were replaced by the Cabinet-O and Cabinet-S committees in June 2020, to which members of DAs were not invited.[119] Boris Johnson agreed to a proposal in April 2020 to "*manage the DAs*" through "*the usual Joint Ministerial Committee mechanisms*".[120] However, this failed to materialise and there were no meetings of the Joint Ministerial Committee ("JMC") in the relevant period.

196. The JMC was not used despite having a joint secretariat, being staffed by officials from the Cabinet Office and devolved administrations.[121] The failure to use the JMC, both before and during the pandemic, was also lamented by the Welsh First Minister.[122] Meanwhile weekly meetings with SOSNI, which were also a means of facilitating bilateral intergovernmental relations between Northern Ireland and UK Government appear to have taken place biannually, on 7 July 2021, 22 September 2021 and 26 January 2022.[123]

197. It is accepted that devolved representatives also attended at COBR meetings, however, in contrast to the BIC and JMC this was not a pre-existing mechanism with a specific role for devolved administrations, rather the inclusion of devolved representatives in COBR meetings was a novel step. Furthermore, the reorganisation and use of structures in Westminster had meant in practice that less reliance was placed on COBR and more on internal cabinet committees, making it more difficult to include DAs in decision-making. This appears to have been by design. The former PM has identified the advice he was following in adopting these processes recommended a daily, smaller meeting at 9:15 each morning, chaired by the PM, with a small group of Ministers and key advisers, scheduled to allow decisions to be taken at the meeting. It also recommended forming a series of subgroups so that the PM could task Ministers to solve specific problems. Instead of inviting the devolved administrations to meetings where decisions might be taken, the advice proposed:

> "*Instead of inviting them to your 9:15 meeting we propose continuing to include them in COBR as public service delivery is where their main challenges will be.*

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[117] See e.g. Witness Statement of Michelle O'Neill INQ000273783§71
[118] Witness Statement of Baroness Foster INQ000255838§80
[119] INQ000269372/31§88 Report of Professor Ailsa Henderson for the UK Covid-19 Inquiry titled 'Devolution and the UK's Response to Covid-19'
[120] INQ000137215/2§1 Exhibit SC/25: Document prepared by Helen MacNamara and Simon Case to the PM dated 22/05/2020 regarding Cabinet Structures. Produced in the witness statement of Simon Case, Cabinet Secretary and Head of the Home Civil Service at INQ000207294.
[121] Witness Statement of Michelle O'Neill INQ000273783§73
[122] Witness Statement of Mark Drakeford INQ000273747§186-187
[123] Paul Givan First Witness Statement PG/06 [INQ000232638] and PG/07 [INQ000232639]) §11

We would also recommend a regular meeting with First Ministers, either chaired by you or CDL, ***to update them on the response.***"[124]

198. The Prime Minister decided that Michael Gove should chair such meetings, apparently because he viewed himself as irredeemably toxic.[125] Therefore, instead of utilising established structures with provision for devolved actors, it appears that communications between the UK Government and the devolved administrations, including the NI Executive, took place primarily through meetings between representatives of the devolved administrations and Michael Gove, at first in his role as Chancellor of the Duchy of Lancaster, then as SOS for Levelling Up, Housing and Communities[126]. As is apparent from the advice quoted above, these meetings were not intended to allow for decision-making, but were intended to update devolved administrations about those decisions which had been taken. The Inquiry may want to consider whether this approach was a contributing factor to some of the criticisms of the relationships, and whether or not this was deliberate. As noted above, this approach may require to be considered against the context of comments suggesting that the devolved administrations were problems to be handled. This approach is also relevant to assessing the extent of consultation that was undertaken with devolved administrations in advance of key decisions.

Lack of Consultation with Devolved Administrations in Decision-Making

199. The Inquiry has identified it will examine whether key decisions were taken by the Westminster Government after a proper process of advice/consultation with the devolved administrations. On the basis of the evidence before the inquiry it does not appear that this is an open question.

200. Baroness Foster's view was that she did not expect to have access to "*all the advice and information to which Westminster had access*", and "*would not necessarily have expected to have a significant input into UK Government decision-making*."[127] Nevertheless, even she concluded that these meetings were focused on information-sharing rather than decision-making:

"*I consider that, generally, the purpose of these meetings was to communicate what was going on at Westminster, and the decisions that had been reached by UK Government, rather than seeking the opinion or input of the devolved administrations into those decisions before they were made.*"[128]

201. The result was that key decisions taken by Westminster during the pandemic did not benefit from input of devolved administrations. By way of example, Baroness Foster confirms she was "*unaware*" of the extent that NI had input into the Westminster decision to move the pandemic response from contain to delay, and noted the UK Government was considering such a move at the time she received the action plan.[129]

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[124] Boris Johnson witness statement INQ000255836§181-186
[125] Boris Johnson witness statement INQ000255836§186
[126] Witness Statement of Michelle O'Neill INQ000273783§70. See also Witness Statement of Mark Drakeford INQ000273747§100
[127] Witness Statement of Baroness Foster INQ000255838§62
[128] Witness Statement of Baroness Foster INQ000255838§106
[129] Witness Statement of Baroness Foster INQ000255838§35

202. The view that there was in fact no process of consultation is one issue on which the NI First Minister and deputy First Minister are in agreement. The deputy First Minister identifies in her witness statement a number of concerns with UK Govt communication[130], and goes on to observe:

> *"[69] ... It was my perception that the general approach of the UK Government at meetings was to give information to the devolved administrations, usually at the last minute, rather than provide information in a timely fashion so that the devolved administrations could make a meaningful contribution to meetings and to have a consultative and collaborative approach.*"

203. This evidence appears to provide a simple answer to the question being asked by the inquiry, as it dispels any suggestion that there was a process of consultation (as opposed to notification of decisions) and this was deliberate. Moreover, Baroness Foster's predecessor in the role of First Minister, Mr Givan proposes what might be thought an obvious possible solution:

> *"... I consider that, while respecting the differing constitutional positions of the UK Government and the devolved administrations, it is still possible for the Prime Minister to have regular engagement with the leaders of the devolved administrations, and this should not be regarded as demeaning in any way. Indeed, if there was more regular engagement in normal circumstances i.e. outwith an emergency scenario, and greater collaboration and cooperation between the devolved administrations and UK Government was a culture led by the Prime Minister, this would strengthen relationships and foster a greater level of trust, notwithstanding the different political perspectives involved.*"[131]

204. Should further confirmation be required, it is notable that this was not only the view of the NI Executive Office. Devolved Ministers from Scotland, Wales and NI all expressed frustration in different terms at the failure to consult on policies rather than simply inform those present of decisions that had been taken or, as on at least occasion, to have Devolved Ministers discover UK Government decisions from the media[132]. This was not simply an issue for NI, but was a view shared by the First Ministers of Scotland and Wales. Nicola Sturgeon identified that "*In practice, furlough decisions were taken in isolation by the UK Government and announced with little prior notice given to the devolved administrations to consider what any changes would mean.*"[133] She considered that this in fact "*hampered*" the co-ordination of decision-making on NPIs across the four nations.[134] Mark Drakeford raised concern "*about the lack of advance notice of UK Government announcements*", with examples cited repeatedly throughout his statement.[135] We have also noted above that he was moved to suggest different structures be adopted, prompting the problematic comments of the SOSNI highlighted above.

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[130] Witness Statement of Michelle O'Neill INQ000273783§58
[131] Second Witness Statement of Paul Givan INQ000274197/§2a
[132] See email discussing CDL call with DAs 29.06.20 INQ000091382/2
[133] Witness Statement of Nicola Sturgeon INQ000235213§63
[134] Ibid at [95]
[135] Witness Statement of Mark Drakeford INQ000273747§65. See also examples at §§ 82, 104, 143, 162, 191, 192, 197

205. We further note that the treatment of devolved administrations chimes with some observations of regional mayors. By way of example, the Mayor of Greater Manchester, Andy Burnham, identifies that "*the approach to the pandemic was overly top down and overly centralised. ... At all times, the national response was characterised by a lack of adequate consultation and poor communications.*"[136] Mayor of London, Sadiq Khan, observes "*The Approach taken by the Government was consistently characterised by three key things*" including *"absence of engagement with regional and local leaders on decision-making...*"[137]

206. Given the repeated complaints of inadequate engagement by the Government, of a dismissive, high handed or overly centralised approach that failed to properly consider the need to consider divergent views and approaches, the Inquiry must consider these were systemic problems in governance and what steps must be taken and lessons learned as a consequence. The Inquiry should also consider whether many of the problems related to the dominant political culture, rather than institutional obstacles. As Professor Henderson notes *"...it was the spirit in which actors approached inter-Governmental work that mattered. The existence of fora on paper matters little if they are not called into session, or have a limited approach to information sharing or where voices are excluded."*[138]

207. We contend that the Inquiry should be extremely cautious to accept Mr Johnson's apparent recommendation of a pan-UK Civil Contingencies Act so as to 'bind the UK together' [§153- 157]. That recommendation, we contend, may well be infected by the same apparent blindness to the individual needs of the DAs as appears to have afflicted Mr Johnson during the pandemic. Clearly it is unsupported, for what the Inquiry might find are sound epidemiological and political reasons, by NI political leaders from across the internal political divide. Similar it runs counter to the view of the First Minister of Scotland that "*the ability to make use of devolved powers to respond to the pandemic in Scotland made a significant, positive difference."*[139]

208. Effectively the same view was set out by the Welsh First Minister in his own conclusions:

> "*Once the determination was made to rely upon public health powers as the basis for responding to Covid-19, the responsibility for decision making was dispersed to each UK nation. I believe that this allowed the Welsh Government to calibrate a response which reflected our particular circumstances, and which sustained the broad support of Welsh citizens."*[140]

209. Perhaps unsurprisingly, the families we represent consider the lack of involvement of devolved actors in decision-making is concerning and consider the suggestion of a 'one size fits all' CCA hugely problematic. A concern observed by many families is that NI leaders at times appeared not to exercise their own judgment on how best to respond to the pandemic, but simply waited for and then followed the approach taken by Westminster. However, an approach by Westminster that prevented devolved actors from coming to

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[136] Witness Statement of Andy Burnham INQ000216991§23. See also examples to support these conclusions at §14-22
[137] Witness Statement of Sadiq Khan INQ000221436§350
[138] INQ000269372/42§129 Report of Professor Ailsa Henderson for the UK Covid-19 Inquiry titled 'Devolution and the UK's Response to Covid-19'
[139] Witness Statement of Nicola Sturgeon INQ000235213§92
[140]Witness Statement of Mark Drakeford INQ000273747§195

their own informed decisions about what actions to take in response to the pandemic may have precluded any other outcome. The concern that this is how decisions were taken appears consistent with the account of Baroness Foster, who appears to suggest that NI was not provided all necessary information to take informed decisions on its own, and that she was required to proceed on the assumption that the decisions of Westminster Government were properly informed and reasoned. In respect of whether the first lockdown was announced too soon her evidence is that:

> "*I did not receive all the advice and information provided to the UK Government throughout this period…From the engagement I did have it seemed to me that the UK Government was listening to, and acting on, the advice it was receiving.*"[141]

210. While the question of whether NI simply followed the UK Government's approach because it seemed that they were properly considering the evidence may be a matter which will require consideration in Module 2C, the extent to which the UK Government's approach to sharing information, or failing to engage devolved administrations in consultation, thus preventing NI and other devolved administrations from reaching informed decisions themselves is properly a matter to be considered in this Module. We consider that the evidence suggests that devolved administrations were hindered in taking decisions that focussed on the impact of the pandemic in their respective jurisdictions as a result of this approach. We consider that the Inquiry should identify this to have been a failing and to make recommendations that would prevent such an approach being adopted in future.

211. The lack of consultation is not merely important for optics. That is because decisions taken by Westminster had a very real impact on the ability of devolved administrations to take their own independent action.

Legal and Practical Difficulties for DAs adopting a different approach to Westminster

212. The lack of consultation on devolved issues in advance of key decisions is a significant concern for those we represent because for a number of reasons the decisions of the UK Government affected how devolved administrations could themselves take steps in response to the pandemic. That is perhaps self-evident over a wide range of issues, but we consider it appropriate to highlight two in particular:
    i. Access to funding
    ii. Control of borders and international relations.

213. These will be addressed in turn.

Access to Funding

214. As noted above, members of NICBFFJ consider that, particularly in the early stages, the NI response frequently gave the appearance of simply following the UK response without much if any independent exercise of discretion. In a general sense this appears to be accepted by the First Minister, who appears to suggest that, at least in relation to some key decisions, NI lacked sufficient information to exercise its own decision-making.

[141] Witness Statement of Baroness Foster INQ000255838§56

215. A further factor that prevented devolved administrations from departing too significantly from the approach of Westminster, even if they had sufficient information and desire to take a different course, was the restrictions on access to funding which may be necessary to take such steps or to ensure they were successful. Baroness Foster in her witness statement identifies that the Barnett formula effectively prevented NI from taking an approach that was significantly different to that taken by the Westminster Government.[142] Similar observations were made by the deputy first Minister.[143]

216. We note that the then chancellor, now Prime Minister, identifies that steps were taken to address devolved concerns on this issue, by providing an up-front funding guarantee which was uplifted on a number of occasions.[144] However it is notable that these funds were still apparently distributed according to the Barnett formula. It is also not clear that these steps were sufficient to resolve the concerns identified by the devolved regions.

217. In this respect we note the First Minister of Scotland describes making "*requests for additional budget flexibilities but these were not granted*", and noted that the inability to control resource to provide financial compensation, in contrast to England, became a significant issue during later stages of the pandemic[145]

218. The First Minister of Wales describes how Wales probably would have gone into lockdown sooner in October 2020 but delayed due to the absence of financial support from the UK Government. He notes that the then Chancellor of the Exchequer "*refused to fund the consequences of a public health decision taken in Wales*." This contrasted with the situation when a similar set of measures were adopted in England. At that stage England benefitted from funding, as did the other nations as a result of the operation of the Barnett formula, rather than due to their public health need at that stage. Mark Drakeford notes his view that HM Treasury "*was, in effect, acting as a Treasury for England, not a Treasury for the UK*."[146]

219. In assessing the question of whether this was a failing, and whether a different approach should be adopted in future, it is notable that Professor Hale has identified that, "*there is abundant evidence that NPIs that reduced physical contact and proximity reduced viral spread, particularly when implemented early during a period*"

220. Prof Hale further identified overriding principles, including that speed matters, strength matters and, significantly for this issue, that economic support bolsters compliance.

221. We note that the then chancellor, now Prime Minister, identifies that steps were taken to address devolved concerns on this issue, by providing an up-front funding guarantee which was uplifted on a number of occasions.[147] However it is notable that these funds were still distributed according to the Barnett formula about which representatives from the DAs complain.

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[142] Witness Statement of Baroness Foster INQ000255838§33
[143] Witness Statement of Michelle O'Neill INQ000273783§57
[144] Witness Statement of Rishi Sunak INQ000263374§566-569
[145] Witness Statement of Nicola Sturgeon INQ000235213§31
[146] Witness Statement of Mark Drakeford INQ000273747§136-139
[147] Rishi Sunak Witness statement, para 566-569

222. We respectfully suggest that it serves to undermine pandemic response where there is seen to be unfairness in access to funding, particularly where that unfairness manifests as a lack of equality in the ability of each nation to respond. On this basis, the Inquiry should consider whether the Barnett formula ensured an equitable and appropriate response across the UK. Steps should be taken to identify any unfairness that arose as a feature of the response, and to make recommendations that would prevent recurrence in the future.

223. We also note that the operation of some funding by HMT, including the replacement of EU funding for farmers, is provided outside the Barnett formula.[148] This appears to be based on the logic that different parts of the UK may suffer to different extremes due to the loss of this funding. That logic would also appear to apply to issues such as Coronavirus response. This may be an issue to be considered by the Inquiry in making recommendations for the future.

Lack of Control Over Borders and International Relations

224. It is also clear that NI lacked control over its relationship with other states, and over international travellers. As noted above, Prof Graham Medley, Co-Chair of SPI-M-O observed "*The situation in Northern Ireland is particularly complicated and complex given the border with Eire means that a country outside of the United Kingdom has particular influence on the United Kingdom's epidemic. Having a co-ordinated and concerted approach to the next pandemic would improve strategy development.*"[149]

225. Baroness Foster's statement makes repeated reference to issues of relevance to the devolved NI response and relationships with the Irish Government, including, for example, information sharing in relation to travellers to NI arriving in Dublin Airport, or information about infection figures and proposed NPIs more generally, and the lack of advanced notice before decisions were announced.[150] Baroness Foster identifies that one difficulty for NI actors addressing these issues was that liaison with the Irish Government was a matter for central Government and the Secretary of State for NI.[151] In passing we note that this provides further support for the views expressed at the outset of this submission, and the lack of devolved administration witnesses in this Module.

226. The Inquiry may scrutinise those suggestions, including in the context of the existence of cross border bodies established by the Good Friday Agreement. We further note that Michelle O'Neill describes taking part in a conference call with the First Minister and Health Minister together with the Taoiseach, the Minister for Health and the Chief Medical Office in the south of Ireland on 29 February, to try to ensure that protocols for travel were in place and were working.[152] This was before the First or deputy First Minister had been invited to attend a COBR meeting.

227. We further note that Prof Henderson identifies that a Memorandum of Understanding was signed between the authorities in NI and ROI in April 2020, following a joint statement in

[148] Ibid. 565
[149] Witness Statement of Prof Graham Medley INQ000260643§12.5
[150] Witness Statement of Baroness Foster INQ000255838§95-97
[151] Ibid. 95
[152] Witness Statement of Michelle O'Neill INQ000273783

March 2020 to the effect that "*everything possible would be done to facilitate coordination and cooperation between the administrations.*"[153]

228. Whilst acknowledging evidence of this nature, it does remain the case that central Government is ultimately responsible for border and international relations. The Inquiry may require to consider the extent to which the UK Government did in fact take steps to communicate with the Irish Government about such issues, or whether this provides a further example of NI interests being treated as an afterthought, or not properly placed in the context of a jurisdiction on a separate island and sharing an open land border with a neighbouring jurisdiction.

CONCLUSION

229. The Inquiry must keep well in mind that the people who died as a result of Covid-19 were not the numbers and statistics neatly represented in graphs, but individual people with their own unique stories. As Brenda Doherty powerfully told the Inquiry in Module 1 *"My mummy was not cannon fodder. My mummy was a wonderful wee woman who had the spirit of Goliath."*[154] The decision makers whose actions the Inquiry will be examining held the responsibility for decisions in which millions of lives were at risk. The evidence suggests that many of them failed in their responsibilities.

230. These decisions occurred within a context: as we have noted from the Module 1 evidence, undoubtedly the UK entered into the pandemic wholly unprepared to face the challenges presented by Covid-19. However, in January and February 2020 key decision makers had a 'golden hour' - a window of opportunity - to take swift and decisive action to address the UK's failings in pandemic preparedness and to catch-up and mitigate their impact on the response to Covid-19. The Inquiry will have to consider whether they did so, or whether high-level decision makers compounded pre-existing structural weaknesses through complacency, inertia, failures of judgement and their own rule-breaking. Did failures in decision making then persist far beyond the initial stages of the pandemic?

231. In analysing the underlying causes of such failures, the Inquiry will have to look at how much was down to systemic failure and how much poor leadership. To what degree was the UK impacted by a failure to consider and combat structural discrimination, and by a lack of partnership between the UK Government and the devolved administrations? These issues that are not limited to Covid-19 but paint a picture of the UK's ability to meet any whole systems emergency. It is imperative that, in the words of Matt Fowler in Module 1: "*We need to learn lessons, we need to learn about things that went wrong, and we need to put something in place to prevent those mistakes from being carried out again in the future."*[155]

26 September 2023

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[153]INQ000269372§71 Report of Professor Ailsa Henderson for the UK Covid-19 Inquiry titled 'Devolution and the UK's Response to Covid-19'
[154] M1 hearings D22:P73:L18-25
[155] M1 hearings D22:P22:L5-10

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