Tuesday, 3 October 2023

(10.30 am)

Opening remarks by THE CHAIR

LADY HALLETT: Good morning to all those present in the hearing room, and to those following us online.

Today marks another important milestone for the Covid-19 Public Inquiry United Kingdom. We begin the public hearings into the response to the pandemic. The focus of Module 2 will be on governance and key decision-making at a high level in the United Kingdom, during the time when the pandemic was at its worst and when it caused so much suffering.

Some of those who suffered and who continue to suffer maintained a dignified presence outside the hearing centre this morning to remind us of why we are all here. We will be hearing from some of them during the course of this module.

We will be calling many witnesses, advisers, experts, scientists, politicians and civil servants, but I'll also hear from about 15 witnesses who will describe the suffering and the problems faced by various groups during the pandemic.

First, I will hear from four representatives of bereaved families. They will be followed by experts on ethnicity, later life, children and young people,

frontline and key workers, sex and gender, disabled people, LGBTQ+ and long Covid.

Their evidence will enable us to put the decision-making into context and to help us establish the extent to which decision-makers took into account the interests of such groups and the impact on them when making their decisions.

I know that some of the bereaved have campaigned for me to call more bereaved as witnesses during this Inquiry. I understand their concerns. However, we simply do not have the time to call more witnesses. The need for me to reach conclusions and make recommendations to reduce suffering in the future, when the next pandemic hits the UK, is pressing. I say "when the next pandemic hits the UK" because the evidence in Module 1 suggested it is not if another pandemic will hit us, but when.

The more witnesses we call in any module and the longer the hearing takes, the greater the delay in making recommendations and the greater the delay in hearing other important modules investigating, for example, care homes and children and young people.

I have therefore had to find other ways, with the Inquiry team, to make sure the voices of those who suffered during the pandemic are heard. The Inquiry is

not ignoring the bereaved or any other group who suffered; far from it. They may be called as witnesses in later modules where there will be a greater focus on the impact of the pandemic or where they can assist me on the subject of systemic failings. They can contribute to the listening exercise, Every Story Matters, the reports from which I will consider very carefully and which will inform my conclusions and recommendations. Some of them may contribute to the impact films, one of which we are about to see.

14 people from across the United Kingdom have been recorded talking about the devastating impact the pandemic has had on their lives and the lives of their families. The film includes references to bereavement, to grief, to care homes, hospital wards, funerals, feelings of guilt, feelings of anger, loneliness and isolation, long Covid in adults, long Covid in children, mental health, physical disability, and to lockdown rule breaking. I am extremely grateful to all those who have agreed to participate. I know how difficult it must have been for them to recount their experiences on camera.

As with the impact film we showed at the beginning of Module 1, this film too is extremely moving, and there will be those who will find it too distressing to

watch. I will pause in a moment to allow those who are in the hearing room who wish to do so to leave for a few minutes. They will be taken to a part of the building where the film will not be shown. The film lasts just over 20 minutes. Those who are following online should press mute or pause the streaming if they do not wish to watch it.

After the film has been played, we shall reassemble, and Mr Keith KC, Counsel to the Inquiry, will begin his opening submissions. He will explain in far more detail than I have done what we shall be examining in this module and what the issues are that I need to resolve, with the help of Counsel to the Inquiry and of course all the core participants.

So would those who would like to leave the hearing room or switch off the streaming online please do so now.

(Pause)

(Video played)

LADY HALLETT: We shall now reassemble to hear Mr Keith's opening submissions.

(Pause)

Mr Keith.

Statement by LEAD COUNSEL TO THE INQUIRY

MR KEITH: My Lady, we turn today to the Inquiry's

1 consideration of how the highest levels of government,
2 senior ministers, civil servants, advisers and
3 scientists, responded strategically to the crisis that
4 enveloped the nation.
5 In Module 1, the Inquiry considered the state of the
6 United Kingdom's emergency preparedness, response and
7 resilience structures at the time just before SARS-CoV-2
8 commenced its deadly work.
9 Module 1 asked in essence: were those structures and
10 systems ready for what befell us? The prior question of
11 whether the right groundwork had been laid and
12 the extent to which the civil contingencies framework
13 anticipated a pandemic of this nature was a necessary
14 one, because it provided the vital context for the
15 decisions that the government had to make as the
16 pandemic began to unfold. And so the Inquiry now
17 examines how well the government discharged those
18 decisions, that decision-making process, the essential
19 burden that is placed on all governments of safeguarding
20 the life and health of its citizens.
21 In the momentous decisions that the government took
22 concerning the control of the virus, the lockdowns, the
23 social restrictions, the shutting of businesses and
24 schools, did the government serve the people well, or
25 did it fail them?

1 How is this to be measured? The virus left in its
2 wake, of course, not just death but injury, incalculable
3 hardship and misery, as those heartfelt and terrible
4 recollections of a few moments ago remind us.
5 However, if the protection of life is the
6 pre-eminent duty which every government owes to the
7 people, the numbers of those who died is the marker
8 against which the government's response must be judged.
9 This is the stark metric which matters most. Death,
10 my Lady, was the inevitable consequence of a runaway
11 high-consequence infectious disease, and the prevention
12 of death should arguably have been the government's
13 primary obligation.
14 The number of deaths across the United Kingdom
15 calculated by whether Covid-19 is mentioned on the death
16 certificate is now over 230,000. By the measure of
17 excess deaths or excess mortality, the figures are
18 likely to be similar.
19 That is, by any measure, a shocking figure, and
20 a terrible loss of life. It is almost one too large to
21 comprehend, and the testimonies which you've heard
22 remind us that each death represents the loss of
23 an individual, often in circumstances which makes their
24 death even harder to bear for their families and
25 friends, and which multiplied their grief many times

1 over.
2 So standing back and in the broadest possible terms,
3 such loss of life demands the question: did it have to
4 be that way? That question must be inquired into and
5 answered by your Inquiry. The bereaved and those who
6 otherwise suffered, of whom there are very many in
7 number, are absolutely entitled to nothing less.
8 The consequences of the lockdowns were, of course,
9 grievous too. In societal terms, there was an explosion
10 of mental health disorder, an entire generation of
11 educational prospects was harmed, pre-existing
12 inequalities were seriously exacerbated. Non-Covid
13 health conditions went untreated and undiagnosed. In
14 economic terms, there was a 10% fall in GDP in 2020.
15 Public finances were seriously damaged, and massive
16 debts were incurred. Were those appalling consequences
17 avoidable?
18 A related vital issue in this module is the position
19 of the vulnerable and at-risk groups, and the extent to
20 which the government assessed the likely impacts upon
21 them of its contemplated non-pharmaceutical
22 interventions, that is to say the interventions that
23 the government imposed that were non-drug or vaccine
24 related.
25 Given the importance of this issue, and because it

1 runs throughout the module, I introduce it now. How was
2 the danger to health posed by the virus weighed up
3 against the risk of societal and economic damage to
4 vulnerable and at-risk groups? To what extent was the
5 possibility of serious long-term health consequences
6 arising from the NPIs foreseen and addressed?
7 Tomorrow you'll start to hear from representative
8 witnesses from the bereaved groups. Later this week you
9 will hear evidence relating to the impact of the
10 pandemic on certain vulnerable and other demographic
11 groups in society. That evidence will address the
12 pre-existing structural inequalities that those groups
13 faced before 2020 and the exacerbation of the
14 inequalities caused by the pandemic and the measures
15 taken to combat it, in particular the lockdowns.
16 So, in the course of this module, we'll be exploring
17 whether the interests of all those groups were properly
18 considered. Later in the module, we'll be hearing from
19 Dame Priti Patel, the then Home Secretary,
20 Kemi Badenoch MP, then Minister for Equalities, and
21 Justin Tomlinson MP, then Minister for Disabled People.
22 Also amongst those who suffered, and indeed continue
23 to suffer from Covid, are the victims of the post viral
24 syndrome that is known as long Covid. In March this
25 year, the Office for National Statistics, the ONS,

1 estimated that 1.9 million people were suffering from
2 self-reported long Covid. Long Covid gives rise to
3 other questions, in particular whether developing
4 understanding of the condition during the pandemic was
5 taken on board and acted upon appropriately by
6 decision-makers, questions we shall explore in the
7 course of the hearings.
8 My Lady, I've referred to the government's core
9 highest level decision-making, and I must emphasise that
10 the focus of Module 2 is on the most important strategic
11 decisions that were taken.
12 Past public inquiries have attempted to give
13 definitive accounts of relevant events, decisions,
14 consequences, and of the entirety of the relevant
15 technical or scientific hinterland. It is simply not
16 possible to do so here. No Inquiry, however large,
17 however long, could possibly enquire into all aspects of
18 the government's decision-making on Covid, because
19 of course the pandemic and the government's response
20 impacted on virtually every area of public and private
21 life. It would be an impossibly complex task.
22 You have instead determined that the module will
23 focus on those aspects of the central government's core
24 response, in essence the Westminster decision-making,
25 that had the potential for the widest effect, had the

1 greatest impact, and which caused the most public
2 concern.
3 Modules 2A, B and C will look at the analogous
4 position in Scotland, Wales and Northern Ireland. So
5 this Inquiry will enquire into, probe and challenge
6 those core decisions to see if they were made on the
7 best information, after proper consideration, as part of
8 a well-ordered process and without undue delay or
9 unnecessary prevarication.
10 There will also necessarily be a greater
11 concentration on the events of January to March 2020,
12 because to some extent the events of those extraordinary
13 days and the government's response charted the course of
14 what was to come.
15 The virus became established, and this inalienable
16 fact dictated all that followed. In responding to the
17 virus by way of the imposition of the lockdown in late
18 March, the government took the profound step of
19 essentially shutting down society, and it set in motion
20 a host of other consequences, the effects of which are
21 still being felt today.
22 An essential part of the Inquiry's work is therefore
23 to understand whether the proper strategic objectives
24 were identified. Why were the major strategic decisions
25 taken as they were? Did the systems for reaching them

1 work? How can we improve the crisis response machinery?
2 It is absolutely essential to know before we have to
3 face the next national crisis.
4 This module is therefore no less than a rigorous
5 examination of how strategically the Prime Minister,
6 Number 10, the Cabinet, senior ministers and their
7 scientific and political advisers grappled with the
8 crisis.
9 So, to this end, the module will be hearing from
10 a range of scientists and academics both from within the
11 many government committees that were constituted to give
12 the government advice and from outside.
13 It will hear from many of the relevant
14 secretaries of state and the then Chancellor of the
15 Duchy of Lancaster, Michael Gove MP.
16 It will also be hearing from senior civil servants
17 in Number 10, the Cabinet Office and the DHSC, past and
18 current Cabinet secretaries, relevant
19 permanent secretaries, and some of the former
20 Prime Minister's principal private secretaries.
21 We will hear from his chief of staff, his director
22 of communications and certain of his special political
23 and other advisers.
24 Lastly, we'll be hearing from the then
25 Prime Minister, Boris Johnson, himself, and the current

1 Prime Minister, Rishi Sunak MP.
2 It is, of course, impossible to call every witness
3 who can give evidence relating to the core high-level
4 decision-making. Your Inquiry has neither the time nor
5 the resource for this, and the general public would not
6 wish it to be so.
7 I emphasise the focus on the core decision-making
8 because it is that decision-making that affected
9 the whole country. The more detailed scrutiny of
10 the NHS response, the care sector, shielding, vaccines,
11 PPE, procurement, test and trace, financial and business
12 support, children and education, and many other areas,
13 are for later modules, and you've referred to them
14 already in your opening this morning.
15 So with that introduction, may I now introduce
16 the stark reality of the pandemic.
17 Could we have, please, INQ000283367 on the screen.
18 This chart, entitled "Daily deaths with COVID-19 on
19 the death certificate by date of death", shows the
20 number of deaths where Covid-19 was mentioned on the
21 death certificate for the whole of the United Kingdom.
22 We can see from that chart that the peak of
23 the first wave was 8 April, with 1,461 deaths occurring
24 on that day. The peak of the second wave was
25 19 January, with 1,490 deaths. Similar waves occurred

1 from late 2021 onwards, the highest peaking on
2 15 January 2022, with 260 deaths.
3 The following chart is a chart concerned with what
4 is called "All-cause deaths in the [United Kingdom] -
5 weekly". This chart, taken in fact from public media --
6 and we're grateful to the organisation in question for
7 its production -- shows all the deaths that occurred in
8 the United Kingdom, not just those caused by Covid, but
9 all the deaths reported by all the official statistical
10 agencies.
11 The expected number of deaths per week, based on
12 an average from recent years, is denoted by the dashed
13 black line. The red shaded area shows the actual number
14 of deaths above, therefore, what was expected. The grey
15 shading under the dashed line shows actual deaths at or
16 below expected levels. Obviously, in those places and
17 at those times where we can see the red shading, the
18 deaths were above those grey expected levels.
19 The sharp dips are due to fewer deaths being
20 reported on bank holidays rather than a real decline or,
21 on one occasion, because there was a recalibration or
22 calculation of the chart.
23 The peak of the deaths in the first wave, we can
24 see, was considerably higher, reaching almost 25,000 in
25 that week, double the usual number.

1 The peak was not as high in the second wave, but
2 the second wave lasted over a longer period, the extent
3 of the red shaded part, leading to a similar number of
4 excess deaths in both waves.
5 The third chart shows hospitalisations across the
6 United Kingdom. This chart shows the daily count of how
7 many Covid patients were in hospital across the
8 United Kingdom from 1 April 2020. The peak of the wave
9 was, as we can see, around 12 April, with over 21,000
10 persons, patients in hospital. The peak of the second
11 wave was around late January, with nearly 39,000
12 patients in hospital.
13 Up to September 2022, around 986,000 people had been
14 admitted to hospital with Covid, and that figure is now
15 well over 1 million. We can see a reference to
16 the September 2022 figure in the bottom right-hand
17 corner of that chart.
18 Could we now then move to chart 5, please, the
19 reported cases of infections. This is entitled "Cases
20 by specimen date", but it actually shows the cases of
21 infection in the United Kingdom following their
22 reporting. It shows the number of infections per day
23 over the whole of the United Kingdom.
24 The peak of the first wave was, as we know,
25 of course, April 2020, but it doesn't show on this

1 chart, because it's a chart that shows the reported
2 cases, and there was, at that stage, very little by way
3 of reporting. The under-reporting of cases was, as you
4 know, particularly severe in the first wave.
5 The Alpha variant first emerged in Kent, around
6 September 2020, and by the time of the peak of
7 the second wave, 29 December, it was responsible for
8 the vast majority of infections nationally. We can
9 see -- by way of reported cases, again I emphasise --
10 the numbers going up in October 2020 and peaking in
11 January 2021.
12 The next wave, primarily of the Delta variant,
13 peaked on 15 July with around 62,000 confirmed cases.
14 Then, and by this time of course the degree of reporting
15 had become a great deal better, the huge Omicron wave,
16 which peaked in January 2022 with over 275,000 confirmed
17 cases.
18 The next chart, chart 6, is the ONS infection
19 survey. It shows the results of a survey carried out by
20 the Office of National Statistics for England, Wales,
21 Scotland and Northern Ireland, and it gives a more
22 accurate estimate of the true proportion of
23 the population who were infected with the virus at any
24 one time, because it works on the basis of
25 a representative sample being taken across

1 the United Kingdom and then extrapolated into these
2 figures.
3 It also identifies patients or persons who had no
4 symptoms, and they of course account for a very large
5 minority of the persons, overall number of persons who
6 were infected.
7 It didn't in fact start reporting data until after
8 the first wave was over, and that is why you will see
9 very little by way of figures, estimated percentage, in
10 the first few months up to September 2020.
11 But antibody surveillance, that is to say testing of
12 the presence of antibodies in blood, shows that
13 approximately 6% of the population had been infected by
14 July 2020, ten-fold higher than the reported positive
15 tests.
16 The arrows in the bottom left-hand corner of the
17 chart show when results first became available, in blue
18 for England, green in Wales -- I think Wales in July,
19 Northern Ireland in September, the red arrow, and
20 Scotland in October, indicated by the yellow arrow.
21 Despite what we saw on the previous graph, at
22 the peak of the second wave there were probably over
23 1 million people, therefore, infected across
24 the United Kingdom, and at the peak of the Omicron wave,
25 in 2022, there were perhaps as many as 5 million people

1 infected, a very large percentage of the overall
2 population.
3 The final chart, my Lady, chart 7, shows
4 a comparison of official excess deaths statistics from
5 a handful of other countries. We've selected them for
6 illustrative purposes, and this isn't intended to be
7 a comprehensive ranking. There are obviously many more
8 countries in the world than are demonstrated on this
9 chart.
10 It shows, adjusted for population size, because
11 of course each country has different sizes of
12 population, the cumulative, the running total, excess of
13 all-cause deaths that has built up over the pandemic,
14 rather than taking a snapshot of the weekly figures.
15 It's vital to understand that there are, of course,
16 differences between these countries, and excess deaths,
17 which is the genesis of this chart, are not solely
18 affected by government decisions but depend on
19 the proportion of elderly people, household composition,
20 single or multigenerational, trust in government, travel
21 connections, pre-pandemic resilience, and a host of
22 other factors.
23 But a broad comparison is still useful. It shows,
24 for example, here that the United Kingdom had a lower
25 burden of excess mortality than indeed many countries.

1 The example that we've chosen here is Italy, which had
2 a greater degree of excess death than
3 the United Kingdom. So we were by no means the hardest
4 hit, but we did have a higher burden in terms of the
5 calculation of excess deaths than many other countries,
6 and we've put on this chart France, South Korea, Sweden
7 and Denmark.
8 Some other figures, my Lady, are of no less
9 importance. The direct impact of severe disease and
10 death due to Covid did not fall equally. Older people
11 were, as we all know, at particular risk. The median
12 age at death in the United Kingdom at the beginning of
13 the pandemic was 83. The median age of persons who died
14 was 82.
15 In the first wave more than 80% of the approximately
16 50,000 deaths occurred in those over 70. Those over 70
17 had a 10,000 times greater risk of dying as those
18 under 15.
19 Years of life lost is one way of estimating how long
20 someone would have lived had they not died. On average,
21 each person who died with Covid lost over ten years of
22 life. Of course age is not the only factor that led to
23 stark inequalities and deaths from Covid, although no
24 other individual factor has a stronger effect.
25 Mortality was 2.6 times higher in the most deprived than

1 the least deprived tenth of areas. People from some
2 ethnic minority groups had a significantly higher risk
3 of being infected by Covid and dying from it. Covid-19
4 mortality during the pandemic has been highest in people
5 from the Bangladeshi, Pakistani and black Caribbean
6 communities. Mortality rates were higher amongst people
7 with disabilities, in particular those with a learning
8 disability.
9 While women can expect to live longer than men, so
10 would lose, theoretically, more years of life if they
11 died at the same age, men have been up to twice as
12 likely to die from Covid as women of the same age.
13 Finally, my Lady, the issue of flu. Covid has been
14 compared by some to seasonal flu in its effect. In
15 a bad flu year, around 30,000 people in the
16 United Kingdom die from flu and pneumonia, with a loss
17 of around 250,000 life years, and that's in a context,
18 of course, in which there are few or no social
19 restrictions or non-pharmaceutical interventions put
20 into place to control transmission.
21 That figure is one sixth of the 1.5 million life
22 years lost to Covid in the first year of the pandemic,
23 despite the extensive non-pharmaceutical interventions
24 which were, as we know, put into place.
25 Those figures expose the underlying reality. Once

1 infected, death was, for that desperate minority,
2 inevitable. But infection was not inevitable. The
3 figures show a massive difference in mortality rates
4 between the United Kingdom and, for example,
5 South Korea. The overarching question for you in this
6 module will be whether the massive casualties of
7 the first and second waves were the direct result of
8 a plain and obvious failure to put in place proper
9 infection control across the country. Why was that so,
10 if that is what you conclude?
11 The Covid-19 Bereaved Families for Justice and the
12 Northern Ireland Covid-19 Bereaved Families for Justice
13 point out in their submissions that the United Kingdom
14 is a wealthy country, with mature scientific, academic
15 and administrative frameworks and a very substantial
16 health system, if struggling somewhat of late.
17 The government knew, just as well as other
18 countries, that the virus was coming. In fact it had
19 greater notice than some, by virtue of our island status
20 and being on the western edges of Europe. So why did so
21 many deaths occur?
22 To start answering that question, I need to turn to
23 the early days of the pandemic and set out the history
24 for your examination. Nothing, of course, that I say is
25 evidence. You have reached no view on the evidence one

way or the other. We haven't even heard it. But I need to set it out simply to provide the context for the identification of the issues. You will, of course, be identifying the right and the correct events and the issues in your report.

January 2020.

Two of the most important issues for the Inquiry's focus in Module 2 will be whether, putting it in the broadest terms, the government reacted with sufficient speed in the early months of 2020 on learning of the emergence of the virus in China, and whether it was provided with the right information to enable it to react with sufficient speed.

This is of central importance to your Inquiry, because some argue that had the government reacted with greater urgency and to greater effect in January and February, it might not have been forced into making the extraordinary far-reaching decisions that it later felt itself obliged to take.

So the chronology. On 9 January, the World Health Organisation issued a statement concerning a cluster of pneumonia cases in Wuhan, China. The first formal note went to ministers. The risk to the UK population was assessed by Public Health England to be very low at that point in time, but the risk on the UK basis, on the

UK level, is a risk not of what might happen in due course or what events might inure, but what the risk is that is posed at that very point in time.

The risk was assessed to be very low, although officials and ministers correctly gauged that there were a number of countries with very high volume links to Wuhan which had themselves already introduced some form of port of entry screening.

Public Health England's assessment was that port of entry screening was, however, neither efficient nor effective in the case of the United Kingdom. On 11 January Chinese media reported the first deaths from the novel coronavirus. On 13 January, the Ministry of Public Health in Thailand reported the first imported case of novel coronavirus from Wuhan.

On the same day, NERVTAG, the New and Emerging Respiratory Virus Threats Advisory Group, a UK scientific committee, met for the first time. It noted that the last official report from China had stated that there had been no significant human-to-human transmission, and that implied to NERVTAG that there may be some evidence of limited human-to-human transmission which had not yet been made available.

The issue of human-to-human transmission is vital, of course, because it means that humans and persons may

become infected from other people, rather than directly from a carrier of the virus, a bat or some other form of wild animal.

As for port of entry screening, NERVTAG said:

"... the body of scientific evidence and previous experiences indicate that port of entry screening, whilst not having zero effect, has very low efficacy and the benefit is very unlikely to outweigh the substantial effort, cost and disruption."

On 14 January the World Health Organisation announced that:

"Preliminary investigations conducted by the Chinese authorities have found no clear evidence of human-to-human transmission ..."

On 16 and 20 January, cases were reported in Japan and the Republic of Korea.

On 16 January, the novel coronavirus was classified as a high-consequence infectious disease, requiring in the United Kingdom barrier care, steps to be taken to protect healthcare workers from infection from patients, and the use of specialist units.

Professor Neil Ferguson, an epidemiologist, and his colleagues at Imperial College calculate on that day that Wuhan was likely to have been harbouring more than a thousand cases by 6 January, so more than ten times

the official figure, and they distribute their findings in their estimate to officials in the government, including the Chief Scientific Adviser, then Sir Patrick Vallance, the Chief Medical Officer, then and now Sir Chris Whitty, and the Deputy Chief Medical Officer, then Professor Sir Jonathan Van-Tam.

On 19 January, the World Health Organisation Western Pacific Regional Office tweeted that, according to its latest information, there was now evidence of some limited human-to-human transmission.

By 20 January, 282 confirmed cases had been reported from four countries including China. Officials, in particular the CMO (the Chief Medical Officer), the DCMO (the Deputy Chief Medical Officer), and the CSA (the Chief Scientific Adviser), become increasingly concerned about the risk. They speak to Public Health England, and Public Health England agree the risk assessment requires revisiting. The first meeting in the DHSC at Permanent Secretary level takes place, and it's agreed that the situation is developing rapidly, but that entry screening was currently neither effective nor efficient.

On 21 January, the issue of Covid is raised with the Cabinet Secretary in London for the first time.

NERVTAG meets again, but agrees that, although there is clear evidence of person-to-person transmission, the

1 degree of transmissibility was not clear.
2 On 22 January for the first time a group known as
3 the Scientific Advisory Group for Emergencies, SAGE,
4 met, activated in fact on a precautionary basis, that is
5 to say in advance of formal activation. It is the
6 primary body in the United Kingdom for the giving of
7 scientific advice to government.
8 The minutes, my Lady, are lengthy, and each SAGE
9 meeting, of which there were subsequently over 100,
10 produces reams of records of the conclusions that it
11 reaches. The minutes on this occasion record,
12 therefore, only in very small part the following words:
13 "There is evidence of person-to-person transmission.
14 It is unknown whether transmission is sustainable ...
15 There is no evidence yet on whether individuals are
16 infectious prior to showing symptoms."
17 The minutes record that the United Kingdom did have
18 a good centralised diagnostic capacity, that is to say
19 a testing capacity, and "is days away from a specific
20 test, which is scalable across the [United Kingdom]
21 in weeks".
22 Public Health England raised the current threat
23 level to the United Kingdom from very low to low, and
24 a report from Imperial College estimates again about
25 the numbers of figures in Wuhan. It concludes that

1 there were probably around 4,000 infected persons in
2 Wuhan, and it advises that self-sustaining
3 human-to-human transmission should not be ruled out.
4 On 23 January, public transport is suspended in
5 Wuhan. The World Health Organisation issues a statement
6 announcing that its emergency committee had been unable
7 to agree that a public health emergency of international
8 concern was warranted.
9 A central alert system is sent round
10 the United Kingdom, or rather at least in England, from
11 the NHS England National Medical Director and the PHE,
12 the Public Health England National Infection Service
13 Director, and the Chief Medical Officer, asking for
14 clinicians to identify possible cases.
15 Imperial College issue a third report, shared with
16 the United Kingdom government, which estimates that
17 the basic reproduction number was above 1 -- I'll come
18 back to the meaning of that in a moment -- and that it
19 indicates self-sustaining human-to-human transmission.
20 If the virus was spreading in such a way that one
21 infected person could infect more than one other
22 uninfected person, it could only mean that there was
23 human-to-human transmission.
24 Their conclusion, although it was difficult to say
25 at that stage, was that the reproduction number could

1 even be in the range of 2 to 3, that is to say one
2 infected person could infect two to three other
3 uninfected persons.
4 On 24 January, COBR (Cabinet Office Briefing Room)
5 crisis committee, meets for the first time. It's
6 chaired, my Lady, by Mr Hancock, who was then the
7 Secretary of State for the Department of Health and
8 Social Care, which was, as we know from Module 1, the
9 lead government department.
10 COBR agrees a series of actions to be put in place,
11 but only when certain trigger points are reached,
12 which -- they have not yet been so reached.
13 The Chief Medical Officer publishes a statement
14 which reads in part:
15 "We all agree that the risk to the [United Kingdom]
16 public remains low, but there may well be cases in the
17 UK at some stage. We have tried and tested measures in
18 place to respond. The UK is well prepared for these
19 types of incidents, with excellent readiness against
20 infectious diseases.
21 "We have global experts monitoring the situation
22 around the clock and have a strong track record of
23 managing new forms of infectious disease. [The UK has]
24 access to some of the best infectious disease and public
25 health experts in the world ...

1 "There are no confirmed cases in the
2 [United Kingdom] to date."
3 France, however, that day reports the first
4 confirmed Covid case in the European region. In London,
5 *The Lancet*, a well known medical journal, publishes
6 an article entitled "A novel coronavirus outbreak of
7 global health concern", and it reports that
8 the detection of infection in China shows at least one
9 household cluster and multiple infections in healthcare
10 workers caring for patients infected with Covid.
11 Professor Woolhouse, who is a professor of
12 infectious disease epidemiology at the Usher Institute
13 at the University of Edinburgh in Scotland writes to the
14 Chief Medical Officer for Scotland.
15 Could we please perhaps have his email on
16 the screen. INQ00047559, page 2.
17 He writes to the Chief Medical Officer of Scotland,
18 Catherine Calderwood.
19 I apologise, yes, it's all on this first page. If
20 you could just scroll in, please, to the middle of the
21 page and the start of the sentence:
22 "If you were to put those numbers into
23 an epidemiological model for Scotland (and many other
24 countries) you would likely predict that, over about
25 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. We can formalise those predictions (and there are many caveats to them) but those are the ballpark numbers based on information from [the World Health Organisation]. 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.

"There are very good reasons to suppose it might not be as bad as that, but we need additional evidence ... to move the dial on those predictions."

That email is dated 25 January. Two days later, the WHO reports 80 deaths in China.

On 28 January, SAGE meets again and it's informed that 50% of new cases in China are now occurring outside Wuhan. It has given evidence that there is a specific test ready for the United Kingdom, that it should be ready by the end of that week, with a capacity to run 400 to 500 tests per day.

The Chief Medical Officer emails a health special adviser in Number 10, copying in the Chief Scientific Adviser and others, to inform him of the possible scenarios.

On 29 January there is a further article, this time

in the *New England Journal of Medicine*. It publishes an article from a field epidemiology investigation team in China, but the heart of the article provides their estimate that, based on their research of the first 425 cases, the basic reproductive number is 2.2, and it states in clear terms that there is evidence that human-to-human transmission has occurred amongst close contacts since the middle of December.

On 30 January, the World Health Organisation declares a public health emergency of international concern, the declaration that it had declined to do a week or so before. A level 4 national incident is declared in England, and the UK current risk level is raised from low to moderate.

The paperwork that we've seen, however, my Lady, shows that at the time that the risk level is raised, the reasonable worst-case scenario, the genesis, the font of the planning that was done pre-pandemic, was still judged by officials in the Civil Contingencies Secretariat to have only a 10% probability of occurring.

On this day, 30 January, the first case in the United Kingdom was confirmed. It was a 23-year old Chinese student who had travelled back to York from their family home in the Hubei region in China.

On 31 January the novel coronavirus is discussed in

Cabinet, and the briefing for the Prime Minister, which sets out in advance of the meeting information for his use, and also possible conclusions that may be drawn from it, advises that preparations should begin to prepare for that reasonable worst-case scenario.

Could we have, please, INQ00056142.

This is an extract from Cabinet minutes, hence the words "Official, Sensitive" at the top. Item 3 was the coronavirus item, and the summary -- I said minutes, I apologise, this is an extract from a document prepared for the meeting. The document provides introductory points for the Prime Minister in relation to coronavirus, so that he can "update ... Cabinet on the Government's understanding of the outbreak and how it may progress", and you can see there there's a reference to the information that it's a "new and rapidly evolving situation".

COBR had been chaired. The reasonable worst-case scenario should be begun to be prepared for. The Chief Medical Officer agreed, with support from his colleagues, the risk assessment should be changed from low to moderate and that note is taken of the World Health Organisation declaration of a public health emergency of international concern. And the debate then changes to a debate over the repatriation of

UK nationals from Hubei Province.

That same day, my Lady, the Chief Medical Officer publicly confirmed that two patients in the United Kingdom, members of the same family, had tested positive. It was also Brexit day.

There was, of course, an obvious need to understand and quantify the nature of the risk posed by the new virus. The range of the severity of the symptoms, the case fatality rates, that is to say the proportion of confirmed cases which would lead to death, let alone the infection fatality rates, the proportion of infected cases, infected persons, that would lead to death, were not at all clear.

It's a matter for you, and it will be a matter for you at the conclusion of all the evidence, but it may seem that by the end of January it was clear that a fatal respiratory disease was inevitably spreading across the world, transmitted person-to-person, possibly asymptomatically. The clinical consequences of that virus included, without any doubt, organ failure and death. There was and there didn't remain for some time any antiviral drug to alleviate the disease, and there was, of course, no vaccine.

The only possibility of escape for other countries was if China managed to contain the virus and the

outbreak. But since it was estimated that over 4 million people had left Wuhan between January 11 and the start of the travel ban on Wuhan on 23 January, and because China had not closed its borders, although it did introduce screening procedures, such an outcome must have appeared, you may think, unlikely.

So a number of questions arise immediately: was the fact that the virus would spread to the United Kingdom and start its insidious work properly appreciated in government? Were the consequences of the likely lack of any control adequately understood? Was there perhaps an undue degree of caution?

As for testing, to what extent was it suspected that any new diagnostic testing process that was forthcoming would be inadequate to control an outbreak once it had spread beyond the initial 20 or 30 cases?

The United Kingdom led the world in the speed and scope of its genetic sequencing, and it continued to do so, as it did in a number of other scientific fields. But testing capacity is not simply the number of tests but the ability to process them at scale, in a quality-assured manner, and to inform people of the results.

Why were there no such arrangements in place, and if they were not in place, why were they not called for in

January?

What was the impact of the World Health Organisation not declaring a public health emergency until 30 January? Did it lead to an unwarranted degree of optimism on the part of countries, including the United Kingdom, that things wouldn't turn out quite as badly as might be suggested?

Should consideration have been given, even at this relatively early stage, not just to the gearing up of NHS preparedness, but to the introduction of widespread public health measures in the United Kingdom?

February.

On 2 February, a public information campaign was launched by the DHSC advising the population to adopt respiratory and hand hygiene behaviours. The Prime Minister receives an update on the evacuation of UK nationals and at SAGE, two days later, the CMO, the DCMO and the Chief Scientific Adviser and a number of other scientists from universities, from research institutes such as Imperial and the London School of Hygiene & Tropical Medicine agreed that United Kingdom-only China-focused measures would likely only achieve minor delays in slowing United Kingdom transmission, but that transmission could be slowed if multiple countries took concerted action. But of course

as is well known no such concerted action took place.

A "consensus statement" -- I've referred already to the process by which the scientific committees produced a statement concluding and summarising their views -- a "consensus statement" from the modelling scientific committee, SPI-M-O, dated 3 February concludes:

"The number of confirmed cases of [Covid] in China is estimated to be at least 10 times higher than the number currently confirmed ... It is unclear whether outbreaks can be contained by isolation and contact tracing."

And it said this:

"[Our] view was that the impact of any intervention would be highly dependent on the patterns of transmissibility ... As this is poorly understood ... the impact of interventions is hard to determine ... the impact of any individual interventions would be expected to be relatively small, and none would be expected to delay a UK epidemic by a month."

"Little direct evidence is available on the effects of cancelling large public events."

And then elsewhere in the minutes:

"The wearing of facemasks by the general population is unlikely to meaningfully reduce transmission."

On 3 February the Prime Minister receives a briefing

from the Chief Medical Officer as part of a wider NHS briefing on the potential risks of Covid. Sir Chris Whitty expresses the view that if Covid-19 spreads internationally and becomes a pandemic, there was a reasonable chance there would be between 100,000 and 300,000 deaths in the United Kingdom. The minutes of the SAGE meeting on 4 February record:

"12. Lack of data sharing is seriously hampering understanding of [the new coronavirus] ... Case ascertainment in China appears to be low: possibly [only] 1 in 15 [cases] being identified ... Case ascertainment outside China potentially [only] 1 in 4 ... Asymptomatic transmission [that is to say the transmission by a person of the virus where they display no symptoms] cannot be ruled out and transmission from mildly symptomatic individuals is likely ..."

On 6 February it is announced that the first UK national had caught Covid in Asia, and had travelled back to UK via the Alps.

Public Health England announced the development of a new coronavirus diagnostic test. The Chief Scientific Adviser presses the Prime Minister's chief adviser, Dominic Cummings, to arrange a meeting with the Prime Minister at which levels of concern could be impressed upon him. That meeting takes place on

1 10 February.
2 Also on 10 February, the team of epidemiologists at
3 Imperial provide a first estimate of the severity of the
4 virus. They give an overall estimate of a case fatality
5 rate in all infections, symptomatic or asymptomatic,
6 that is to say the proportion of death from amongst
7 confirmed cases of Covid as around 1%.
8 SPI-M-O, the modelling committee, estimates on the
9 same day the number of confirmed cases in China is
10 likely to be ten times higher than the number of cases
11 confirmed. The minutes say this:
12 "It is a realistic probability that outbreaks
13 outside China cannot be contained by isolation and
14 contact tracing. If a high proportion of asymptomatic
15 cases are infectious, then containment is unlikely via
16 these policies ... It is a realistic probability that
17 there is already sustained transmission in the UK, or
18 that it will become established in the coming weeks."
19 On 13 February, the seventh meeting of SAGE takes
20 place. It debates, in the context of a discussion of
21 how to delay the peak of the epidemic, as opposed to
22 trying to suppress its spread entirely, the impact of
23 mass school closures, restricting mass gatherings, and
24 mask wearing. The minutes state:
25 "SAGE and wider [government] should continue to work

1 on the assumption China will be unable to contain the
2 epidemic ... SAGE concluded that travel restrictions
3 within the UK, unless draconian and fully adhered to,
4 would not be effective in limiting transmission. They
5 would also be ineffective if Covid-19 cases were already
6 established in the UK ... There is no current evidence
7 to suggest prevention of mass gatherings is effective in
8 limiting transmission. Public actions in the absence of
9 a mass gathering could have comparable impacts
10 (eg watching a football match in a pub instead of
11 a stadium as [being equally] likely to spread the
12 disease)."
13 **LADY HALLETT:** Is that a convenient moment?
14 **MR KEITH:** My Lady, it is.
15 **LADY HALLETT:** Just so everybody understands, because we
16 have so much to get through today and tomorrow -- well,
17 throughout this module -- the plan is to break now for
18 15 minutes, return at 12, and then go through to 1.15.
19 I'm afraid just 45 minutes for lunch thereafter.
20 Thank you.
21 **(11.46 am)**
22 **(A short break)**
23 **(12.00 pm)**
24 **LADY HALLETT:** Yes, Mr Keith.
25 **MR KEITH:** My Lady, picking up the chronology on

1 21 February, news emerges that day of a cluster of
2 locally transmitted cases in Lombardy in Italy.
3 A lockdown begins there covering ten municipalities of
4 the province of Lodi in Lombardy, and one in the
5 province of Padua.
6 On 22 February, UK passengers from the cruise ship
7 the Diamond Princess arrive back in the United Kingdom.
8 Now, the Diamond Princess had been quarantined on
9 3 February by the Japanese Government after a passenger
10 from Hong Kong, who had been on board, tested positive
11 for Covid after having earlier left the ship on
12 25 January. Of the some 2,600 passengers and the
13 1,000 crew, over 500 people became infected, but the
14 significance of the Diamond Princess for these purposes
15 is that early reports showed that around 18% of the
16 people who had become infected had showed no symptoms.
17 On 23 February, the DHSC reports 13 cases in the
18 United Kingdom.
19 At the COBR meeting on the 26th, the Deputy Chief
20 Medical Officer reports that official data from China
21 showed that case numbers were continuing to increase
22 internationally, case numbers outside China were going
23 up, and that this highlighted clear person-to-person
24 transmission, and particularly sustained human-to-human
25 transmission in Italy, which received a high number of

1 travellers to and from the United Kingdom.
2 On the 27th the Prime Minister calls for activity to
3 be stepped up, the Civil Contingencies Secretariat of
4 the Cabinet Office circulates a report on the most
5 significant choices that the government might have to
6 take, but it asserts that the global pandemic is not yet
7 certain.
8 On the same day, the Deputy Chief Medical Officer
9 and others advised the Secretary of State for
10 the Department for Culture, Media and Sport, that the
11 epidemiological data did not support the cancellation of
12 the Six Nations England and Italy game in Rome.
13 COBR meets again on the 28th. The United Kingdom
14 reports publicly its first case of confirmed community
15 transmission.
16 A day later, the total number of confirmed cases has
17 risen to 23, after over 10,500 people had by that stage
18 been tested.
19 On Sunday 1 March Professor Whitty announces
20 the total number of confirmed cases in England is 33.
21 Later estimates, taken not long afterwards, suggest
22 that several hundred infections had probably already
23 occurred by that date.
24 Most significantly of all, on 2 March the committee,
25 the modelling committee to which I have made reference,

SPI-M-O, reports it is highly likely that there is sustained transmission of Covid-19 in the United Kingdom. 2 March.

You will need to consider the extent to which the end of February was therefore a pivotal time, because it showed that community transmission might by then have been well established in the United Kingdom. If so, only the extent would have remained unclear, and that would have to remain unclear in the absence of a sufficiently clear surveillance system. Unless all contacts were traced and quarantined, if the virus had taken hold and there was sustained transmission human to human, then the risk of the epidemic becoming inevitable had gone up dramatically. If so, each person infected would inevitably infect two to three other people, and of the total number of people infected a proportion would die, as the very reasonable worst-case scenario planned for influenza pandemic envisaged they would.

But by that time, all that were in place were travel advisories or restrictions, that's to say compulsory self-isolation (not state quarantine) for travellers. There was enhanced surveillance of travellers from identified high-risk regions and limited contact tracing around index cases. That's where the majority of the limited available testing was focused.

So a major question for the Inquiry is whether it was then clear by 2 March that the epidemic could not now be controlled by test, trace and quarantine alone. If so, why were other stringent restrictions not being considered more seriously and considered early, especially as there was evidence that restrictions had been seen to work in Wuhan? Had the opportunity to reduce social mixing in a way that would keep some sort of brake on the virus already been lost?

Subsequently, extremely sensitive genetic tests showed that there were 1356 different strains of Covid in the approximately 16,000 people who had tested positive in the first half of 2020.

So over a thousand different strains amongst the 16,000 people or so who tested positive.

Those strains were compared genomically to sequences from Covid in Europe. More than a thousand of those 16 and a half thousand people had brought coronavirus in from Western Europe. In February they had mostly come from Italy, in March mostly from France and Spain. 70% of all cases from the first half of the year that were traced -- and of course many couldn't be traced -- could be tracked back to those three countries.

My Lady, I've spoken a lot about SAGE and its subcommittees, given the importance of their role and

the crucial contribution that they make. Before I turn to March 2020, it's therefore necessary to look at them in a little more detail.

There were a number of committees and procedures in place for providing the government with scientific advice. The main body for our purposes, SAGE, was a standing committee -- it wasn't a standing committee, I apologise, but was convened from time to time when it was needed. And it does what it says on the tin: it provides scientific advice during emergencies. It's the main conduit in the United Kingdom for scientific input in the event of a major emergency. It has no standing membership other than the Government Chief Scientific Adviser, Professor Sir Patrick Vallance at that time, and it's constituted with relevant experts from within and outside government for any particular emergency that requires scientific advice.

It played a crucial role during the pandemic because it brought together scientific advice and summarised it, through its minutes and through the conduit that the CMO (the Chief Medical Officer) and the Chief Scientific Adviser themselves constituted to Number 10 and the Cabinet Office. They relayed the advice from SAGE to government.

Advice given in SAGE meetings was minuted and those

minutes formed the official record of advice. All SAGE minutes are now published and made publicly available, but that process of publication didn't in fact commence until May 2020, when SAGE published the first of its 34 meetings.

SAGE was, of course, asked to advise on extremely complex issues. Scientific advice is always uncertain, but one of the difficult matters that it confronted was -- and the one of the matters that you will have to judge upon -- the limits on its role.

SAGE is a scientific advisory committee, its members during the pandemic were scientists, and largely epidemiologists, modellers and behavioural scientists. Politicians and civil servants did not have their expertise, and of course they required SAGE's assistance to provide them with information.

But SAGE was not designed to make policy recommendations, let alone operational decisions, and so a matter for you is whether there was a disconnect between SAGE, operating as it did under its quite limited advisory limits, and the government, which had no body or group of people, certainly at this early stage, who could draw together all the complex strands and present it with clear options.

The limitation on the role of SAGE provides

1 the foundation for the argument, which we're all
2 familiar with, that it was perhaps inaccurate or wrong
3 for the government to claim that it was "following the
4 science". Many witnesses stressed the need in a crisis
5 for government to set clear strategies and objectives.
6 By publicly stating it was "following the science", to
7 what extent if any did the government undermine its own
8 role?
9 Professor Vallance, the Government's Chief
10 Scientific Adviser, wrote evening notes every night or
11 most nights during the pandemic in which he set down his
12 thoughts from those extremely difficult and troubling
13 days. He's provided a copy of those notes, his diary,
14 quite properly to this Inquiry.
15 In his notes for 7 May 2020, he makes this
16 observation:
17 "Ministers try to make the science give the answers
18 rather than them making decisions."
19 It's an issue that you will need to look at.
20 In practice, there was also an issue as to how well
21 the system worked, because government didn't give SAGE
22 any clear idea of its own objectives or directives, and
23 so there may have been a vacuum that SAGE did not feel
24 able to fill with its own suggestions. It's a matter
25 for you, but this may be why lockdowns were not even

1 openly debated by SAGE until mid-March. Perhaps they
2 had simply not been debated because they had not been
3 put on the agenda by the government.
4 The body the Institute for Government reported on
5 these matters and noted in its own report that in
6 the initial months ministers put too much weight on
7 SAGE, relying on it to fill the gap in government
8 strategy and decision-making that was not its role to
9 fill.
10 That didn't mean, of course, that SAGE was immune
11 from political attack from its own side, the government.
12 A diary entry from 10 June 2020 from Professor Vallance
13 records:
14 "I am [worried] that a 'SAGE is trouble' vibe is
15 appearing in No 10."
16 It may even be the government selected on occasion
17 from SAGE what it wanted.
18 There is a:
19 "Paper from No 10/[Cabinet Office] for
20 1[metre]/2[metre] review. Some person has completely
21 rewritten the science advice as though it is
22 the definitive version. They have just cherry picked.
23 Quite extraordinary ..."
24 SAGE's advice was routed through to decision-makers
25 through the CMO and the CSA. The Inquiry will want to

1 examine the efficacy of this. That was a relatively
2 narrow conduit and one that was, more often than not,
3 not recorded.
4 Did and were the CMO and the CSA able to reflect the
5 extent to which there was any divergence of opinion
6 within SAGE when they gave their advice to
7 the government?
8 There was no opportunity for SAGE or the subgroup
9 members to understand, moreover, how politicians were
10 interpreting their advice or translating it into policy,
11 and therefore there was never any meaningful engagement
12 at which the politicians, the civil servants and
13 the scientists could engage in discussions about
14 the appropriateness of policies or areas where policies
15 might be needed.
16 As for the composition of SAGE, this is something
17 you'll also want to consider. Was there a lack of
18 diversity? Too great a focus on biomedical and
19 mathematical expertise? Although PHE was always
20 represented and senior officials of NHS always attended,
21 was SAGE weighted too much towards academia rather than
22 those with extensive experience of public health,
23 pandemic management, experience of infection control and
24 community mobilisation?
25 You will also be considering in due course no doubt

1 the issue of the members themselves. SAGE was never
2 designed to be run at such speed, with such heat or for
3 so long. It sat for over 100 meetings. In past crises
4 it's met generally on no more than five occasions. Its
5 members worked around the clock unceasingly in the
6 public interest and pro bono. And as you know, they
7 were placed under sustained and also unfair media
8 scrutiny and, increasingly, attacked.
9 The diaries of Sir Professor Vallance speak of SAGE
10 and the CMO and the CSA being positioned as human
11 shields.
12 My Lady, these issues are of central importance.
13 Not only is it vital to guarantee the supply of high
14 quality external scientific advice, but the transparency
15 and speedy communication of such advice, and an
16 understanding of the worth of its source, is scarcely
17 less important.
18 Then lastly there is the issue of SAGE's scope. The
19 national crisis required at its heart the bringing
20 together and resolution of intensely complex public
21 health, pandemic management, societal and economic
22 issues. SAGE was a scientific advisory body. It
23 produced the science. It couldn't integrate the
24 economic and societal considerations. So who did?
25 The government, of course.

1 But when did and how did the Cabinet Office and
2 Number 10 bring together those different strands of
3 scientific, economic and societal analyses into coherent
4 advice for the Prime Minister and his Cabinet? There
5 was no transparency or equivalent process as there was
6 with SAGE.
7 So all this gives rise to the question of whether
8 there should have been a permanent pandemic management
9 body above SAGE that could draw together all these
10 issues, but in particular the societal and economic
11 issues, and produce operational suggestions for
12 politicians, then, in the light of other considerations,
13 to decide to take forward and to act upon, or not, as
14 they best see fit.
15 My Lady, there were a number of other subcommittees,
16 the most important one probably being SPI-M, the
17 Scientific Pandemic Infections group on Modelling, which
18 reported formally to SAGE on the dynamics of infectious
19 disease transmission.
20 My Lady, little or no work had ever been done on the
21 effectiveness of non-pharmaceutical interventions such
22 as closing schools and lockdowns, not least because
23 there hadn't been a respiratory pandemic recently, and
24 no such societal measures had been applied in
25 the United Kingdom for over 100 years. But this field

1 of mathematical and statistical models in public health
2 is an extraordinarily complex one, and there was a basic
3 difference between forecasting and the construction of
4 model-based scenarios, both processes engaged in by this
5 committee.
6 Forecasting essentially concerns asking
7 the question: what do we think will happen? Model-based
8 scenario construction basically asks the question: what
9 might happen if we do X or Y? How effective will
10 closing schools be on reducing the spread of the virus?
11 That difference between forecasting and model-based
12 scenarios was crucial, because scenarios were often
13 wrongly treated by many as forecasts, so that when
14 a particular scenario didn't come to pass, for example
15 the number of deaths that were estimated in that
16 scenario did not come, and, for example, the number of
17 deaths did not go up to the particular levels estimated
18 on the closing of schools, or one of the other social
19 restrictions that was imposed or could be imposed, this
20 was treated as a failure of modelling or as the
21 deliberate propagation of a climate of fear. It wasn't.
22 The models were extremely complex, because there
23 were a significant number of measures that had to be
24 considered, mask wearing, hand hygiene, social
25 distancing, closing schools, stay at home orders and so

1 on, and it was simply no possible to know how society
2 might react to such measures.
3 So for you, my Lady, in this Inquiry a number of
4 related questions arise: were the limitations of that
5 modelling properly understood by decision-makers,
6 particularly at the beginning, when many of the
7 assumptions upon which the models were based were not
8 yet supported by data?
9 Professors Whitty and Vallance, together with teams
10 of scientists, produced a technical report following the
11 pandemic. In chapter 5, which deals with, amongst other
12 issues, behavioural modelling, they say:
13 "The craving for certainty of what is to come,
14 particularly in the early stages of a pandemic, may mean
15 that model outputs are seen as 'the answer', which they
16 can never be ..."
17 So was there an over-reliance on epidemiological
18 modelling? Was too much time spent analysing even
19 the differences between the various types of models?
20 Could more attention have been paid to tracking the
21 policy responses of other countries, as well as, as I've
22 indicated, the likely economic and social impacts of the
23 lockdowns?
24 A second committee was the Independent Scientific
25 Pandemic Insights Group on Behaviours, SPI-B, chaired by

1 Professor James Rubin and Professor Lucy Yardley.
2 Again, it does what it says on the tin: it examines and
3 reports on behavioural patterns.
4 A key question for you is: how effective was the
5 advice that SPI-B gave to SAGE and, through SAGE, to the
6 government? It is that committee which engaged in
7 an argument with the CMO as to where the notion of
8 behavioural fatigue first originated.
9 SPI-B has been criticised by some in the public for
10 seeking to orchestrate a culture of fear, and SPI-B
11 itself complained that the communication of its advice
12 was not sufficiently open to scrutiny. Professor Rubin,
13 its co-chair, noted that after advice had left SPI-B it
14 often appeared to disappear into a black hole.
15 Another important team that worked alongside SPI-B,
16 but from within the Cabinet Office, was the government's
17 Behavioural Insights Team. This was established in 2010
18 by the Cabinet Office to provide the government with
19 a better understanding of human behaviour when dealing
20 with policy challenges and issues.
21 The director of this team, the Behavioural Insights
22 Team, became increasingly concerned regarding SAGE and
23 the readiness of the United Kingdom government: SAGE at
24 the absence of clear operational advice or suggestions,
25 a role of course that it was not permitted to perform;

1 and the government because of the apparent failure to
2 take clear proactive steps.
3 At a meeting on 13 March, at a meeting of SAGE, in
4 fact, at the offices of the Department for Business,
5 Energy and Industrial Strategy, the director of BIT
6 wrote in his notebook:
7 "WE ARE NOT READY."
8 A Number 10 adviser, equally concerned, leaned over,
9 crossed out "NOT READY" and wrote "Fucked!".
10 The issue for you will be whether, using different
11 terminology, that was a fair reflection of
12 the government's position.
13 There were, indeed, a number of extremely difficult
14 issues facing the government, and it was upon its
15 ability to resolve them that much of the decision-making
16 turned thereafter.
17 Data.
18 An issue for you will be whether there was a lack of
19 basic data concerning the virus's characteristics.
20 A proper understanding of those characteristics is vital
21 to be able to determine, in terms of pandemic
22 management, the speed at which the virus spreads, what
23 is the risk of hospitalisation, what is the risk of
24 death, who needs protection, what measures are required
25 to be put in place.

1 We're all familiar with the notion of the basic
2 reproduction number. The basic reproduction number for
3 Covid-19, how many people will a single person infect in
4 an unimmunised population, was of crucial importance.
5 To control an epidemic, the reproduction number
6 needs to be maintained at or below 1. But it's not at
7 all easy to calculate how many people are ill, how many
8 people are infected, how many people are hospitalised,
9 and you need those figures in order to be able to work
10 out the basic reproduction number. You can add up the
11 number of hospital cases and deaths, but it takes time
12 to get those figures back from GPs and hospitals and the
13 like.
14 Hospitalisation and death only becomes apparent,
15 moreover, around a week or respectively two weeks
16 following infection. So if you wait for those figures
17 before deciding what to do, it's already too late, the
18 infection has gone on in the meantime to grow
19 exponentially, with further hospitalisation and death
20 inevitable. And not every infection leads to
21 hospitalisation or death.
22 You can test those with symptoms, but not everyone
23 who is infected will or can be tested, and there is,
24 again, a time lag. You can test the index cases under
25 the scheme known as the First Few 100, but at the

1 beginning of the pandemic the limited PCR testing, which
2 is all that there was, took time, and reports of tests
3 wouldn't, in any event, reflect the number of infections
4 that day but perhaps days earlier.
5 You can finally test large numbers of the populace
6 to see what proportion is infected, but only if there is
7 a process for mass testing, which there wasn't, or you
8 can do surveys asking people if they've got the virus,
9 but those surveys only really got going in March and
10 April.
11 There are a number of other important issues. Will
12 an infected person show symptoms before they become
13 infectious to others, pre-symptomatic, or never show
14 symptoms at all, asymptomatic. And it's of vital
15 importance, because if you're pre-symptomatic or
16 asymptomatic, you may infect hundreds of people without
17 knowing and there is -- in the absence of mass testing,
18 which there wasn't -- there is no way of calculating the
19 virus' spread. If you don't show symptoms, how do you
20 know how to self-isolate? Contact isolation will only
21 work if there's little or no transmission before the
22 virus causes symptoms. People can, in that situation,
23 be isolated immediately once they show symptoms and
24 before they infect others. But what if the virus
25 transmits, as Covid did, before you show symptoms?

1 What's the incubation period? The latent period, the
2 generation period?
3 So ready access to accurate data was crucial and, as
4 the minutes from COBR, SAGE and SPI-M-O, to which I've
5 already referred, arguably show, there was a critical
6 lack of data.
7 So you'll need to consider the state prior to early
8 March 2020 of the surveillance system in place.
9 The first detailed data was provided from around
10 about 6 March in what is known as the First Few 100
11 dataset. It consisted of a spreadsheet with relatively
12 detailed information about each case. As at 6 March, it
13 listed 116 cumulative cases, but 164 cases had already
14 been reported in the United Kingdom, so there was
15 a divergence between the information on the dataset and
16 the information that came from an alternative system,
17 the Covid-19 Hospitalisation in England (Surveillance)
18 System, CHESS, and also cases which were publicly
19 reported. Moreover, the dataset gave up at 416 cases
20 around the middle of March.
21 The general lack of a sophisticated, effective and
22 up-to-date data system was particularly noticeable in
23 Downing Street, according to Mr Cummings. He complains
24 in his witness statement of there still being
25 an analogue system, no secure Cloud access. He says

1 officials argued over whether Google Docs or Teams
2 should be used.
3 The government, nevertheless, pulled together the
4 data that it had and, of course, day by day, week by
5 week the surveillance systems became ever more
6 sophisticated, and they issued a digital dashboard
7 released for the first time on 24 March. By 5 may it
8 ran to 85 pages. Here's one example from 3 May, on that
9 day, comprising, I think, 88 pages.
10 If you would be good enough just to scroll the first
11 seven or eight pages, we'll get some idea of the sort of
12 information which was provided, daily average deaths of
13 people, expected supply of PPE, the number of UK tests
14 carried out, the leading indicator of GDP, people in
15 hospital with Covid by location and then, finally, beds,
16 critical care beds with Covid-19 patients.
17 There were also large-scale randomised control
18 trials carried out. The UK took a leading role in the
19 establishment of a very large number of highly
20 sophisticated, large-scale epidemiological studies, the
21 SIREN cohort study in healthcare workers, the Vivaldi
22 study in care home workers, the ONS Coronavirus
23 Infection Survey, the REACT study, the Covid-19 Clinical
24 Information Network and some others.
25 There were gaps, however, and you will need to

1 consider from the evidence whether, for example, data
2 from care homes was not clearly or regularly provided.
3 Were there delays in the transfer of required data
4 between the DHSC, which subsumed the Joint Biosecurity
5 Centre, and NHS track and trace?
6 Mr Hancock told the Chief Scientific Adviser:
7 "... the pre-pandemic data flow between [the] NHS
8 and the rest of government [was] the worst in all
9 government."
10 My Lady, the lack of a full surveillance system had
11 severe consequences, because, as at 6 March,
12 for example, whilst there were only eight non-travel
13 related cases on the First Few 100 line list, that had
14 risen to 43 by 11 March, but the NHS Covid sitrep,
15 situation report, from around that time, showed
16 350 Covid patients in hospital.
17 By 21 March it showed 2,156 people. So
18 the surveillance data was missing more than 90% of
19 hospitalisation cases. That was equivalent to
20 approximately two weeks of epidemic growth, so the
21 decisions were being made on the basis of a position
22 which had been passed two weeks before.
23 A massive data system was, in the event, created.
24 A vital task for this Inquiry is to enquire whether
25 those data systems have been maintained and recalibrated

1 to meet any future exigency.
2 I now turn to strategy.
3 Along with proper data, the Government also needed
4 to have a clear strategy or aim on how to deal with any
5 virus that managed to infect our shores. As SAGE
6 commented, it was essential to understand the objectives
7 behind seeking to manage the epidemiological curve.
8 Once there was clarity on those issues, SAGE could then
9 review all the methods that might be needed to limit the
10 spread. The Government strategy was based, as you heard
11 in Module 1, on influenza pandemic -- on an influenza
12 pandemic, and it published a book, an article or
13 a publication -- an article on 3 March, in which that
14 presumption was built in. This was the "Contain, Delay,
15 Mitigate, Research" strategy, INQ000237322. This is the
16 Coronavirus Action Plan of, we can see, 3 March.
17 The heart of it was contained at paragraph 3.9,
18 page 10, please. I think that's 16. Thank you very
19 much. Page 10:
20 "The overall phases of our plan to respond ... are:
21 "Contain: detect early cases, follow up close
22 contacts, and prevent the disease taking hold in this
23 country for as long is reasonably possible.
24 "Delay: slow the spread in this country, if it does
25 take hold, lowering the peak impact and pushing it away

1 from the winter season."
2 But, my Lady, how strong was that conditional if,
3 "if it does take hold?" By 3 March, you will recall
4 SPI-M-O had already reported sustained community
5 transmission in the United Kingdom, so a matter for you
6 will be whether containment had already failed, and why
7 is there no reference in that publication to trying to
8 control the spread of the virus once it had escaped the
9 detection/containment of early index cases?
10 We all recall the expressions "flattening the
11 curve", "reducing the peak", "squashing the sombrero",
12 a phrase used by Mr Johnson on 12 March, but they all
13 meant the same thing: trying to reduce the very worst
14 ravages of the virus, as opposed to trying to retain or
15 get back control. Was this publication a reflection of
16 that attempt just to manage the virus, as opposed to
17 trying to achieve a rapid reduction of the reproduction
18 rate to suppressing the virus?
19 A second, related presumption in this document, you
20 may think, appears to have been that if attempts were
21 made to suppress completely and not just mitigate the
22 virus, and then the wave were to be completely
23 unsuppressed later, the virus would reemerge like
24 an uncoiled spring upon an unimmunised and vulnerable
25 population. Of course, in the event, because a lockdown

was imposed in March to save the NHS from being overwhelmed and the virus was suppressed in March to June, it did reemerge like an uncoiled spring in October 2020.

So an issue for you to consider is what would have been the alternative impact if there had been an earlier suppression of the virus, rather than the suppression that took place in March, by stringent methods falling short of a lockdown? Would the virus have reemerged with less venom in the winter of 2020 or perhaps been kept under control without the need for a national lockdown at all?

A third linked issue is the highly emotionally charged matter of herd immunity. What is herd immunity? Herd immunity, also known as population immunity, is the indirect protection from an infectious disease that happens when a population is immune, either through vaccination or immunity developed through previous infection.

Herd immunity through vaccination, rather than by deliberately allowing a disease to spread through any segment of the population is seen, of course, as a good thing. Herd immunity of the latter type may be thought to be very different, because it may result in unnecessary cases and deaths, hence the emotionally

charged nature of the issue.

However stringently a government intervenes, it is of course not possible to stop everyone getting infected. Some will inevitably be infected and thus be immune, but that is a long way from deliberately exposing them to a virus that might kill them. There are a number of extremely problematic issues surrounding this issue. What proportion of the population might be required to become infected and therefore immune to ensure the epidemic dies out? What if lots of people accidentally, coincidentally become sick and then die? What if not enough people get infected and immunised to mean the epidemic dies out alongside that appalling vista. What if so many people fall ill and die regardless, that the health system becomes overwhelmed, or if the immunity they acquire doesn't last?

So the issue of partial management or mitigation of a virus is an extremely problematic one. My Lady, you will need to consider the issue of whether it was possible to identify and separate those who are vulnerable from those who are not. Can parts of society be hermetically sealed? Care homes have to have carers come in from outside; someone has to deliver food and medicine.

A number of politicians and scientists referred

publicly to this issue in March. Mr Johnson referred to "taking it on the chin" and to "allowing the disease, as it were, to move through the population". At a 12 March press conference, putting it significantly differently, the Government's Scientific Chief Adviser, Sir Patrick Vallance, said:

"It's not possible to stop everyone getting it and it's also not desirable because you want some immunity in the population. We need to have immunity to protect ourselves ..."

He wasn't, of course, advocating the deliberate spread of a fatal virus throughout the population. But you will need to decide whether herd immunity was a goal. Was it an aim in itself or was it just the inevitable consequence of not suppressing the virus completely in the initial response?

Why does this matter? Mr Cummings will say, we understand, in his evidence that the Government had a deliberate strategy, a goal, of herd immunity.

March.

On Sunday, 1 March the EFL Cup Final was played at Wembley and 82,000 people attended. On 2 March, the Prime Minister chaired a COBR meeting for the first time. The World Health Organisation raised its alert to "very high". The total number of cases in England is

37.

Mr Cummings texts Lee Cain, the Director of Communications in Number 10. The text reads:

"The PM doesn't think it's a big deal; [he] doesn't think anything can be done, and his focus is elsewhere; he thinks it will be like swine flu and thinks his main danger is taking the economy into a slump."

My Lady, is that simply an egregious piece of opinion hearsay or was it, albeit through the distorted lens of a text, a fair reflection of the Government's thinking at that time?

On 3 March, the report -- the publication to which I've referred you -- was published. An adviser in Number 10, Ben Warner, who was provided with a draft, asked:

"This is a comms plan, where is the real plan?"

A member of the DHSC press group sent a WhatsApp saying:

"What are we doing to contain, what are we doing to delay, what are we doing to research, what are we doing to mitigate?"

On 5 March, the first death of a patient with Covid in England is announced. 25 further cases in England are announced, bringing the total to 115. SAGE recommends measures, such as individual home isolation,

whole family isolation. The issue of mass gatherings is debated, again, and SAGE concludes there was still no evidence that banning large gatherings would reduce transmission.

By 7 March cases in Italy had risen five fold to 5,800 and deaths had risen eight fold in six days to 233.

Further proposed measures to combat the spread of Covid are announced. In Italy, there is a quarantine. It's extended to all of Lombardy and 14 other northern provinces and the next day, 9 March, to all of Italy. On 8 March, Scotland played France at Murrayfield.

On Monday, 9 March, the eighth meeting of COBR takes place. It's chaired by the Prime Minister. A report is circulated that NHS demand would greatly exceed capacity by, in fact, 240,000 beds, if the Government were to implement the measures then only under consideration, social isolation, and so on.

Professor Steven Riley, a Professor of Infectious Disease Dynamics at Imperial, sends an email to the SPI-M mailbox with reasons for the United Kingdom not to delay closing schools, to move to working from home, to implement any other possible social distancing. He warns that the mitigation strategy to Covid-19 will lead to critical care facilities in the UK being overrun.

On 10 March, the Cheltenham Festival commences. Public Health England is informed of the first Covid outbreak in a care home. Public Health England data suggests the true number of cases is not 5,000 to 10,000 infections but may be around 30,000.

Professor Ferguson emails a set of graphs to a Number 10 adviser, that he expressly asks the Prime Minister to see and understand. The graph showed that bed capacity will be outstripped by demand in the absence of a lockdown, that under mitigation strategies then being considered, that is to say not a lockdown, daily deaths are still likely to peak at 4,000 to 6,000 per day. The reasonable worst-case scenario in the Government's plans was now Imperial College's best estimate of what would happen.

On 11 March, Liverpool played Atletico Madrid at Anfield, 52,000 supporters were in attendance. According to Mr Johnson, in his witness statement, the Secretary of State for the Department of Health and Social Care, Mr Hancock, briefed Cabinet that:

"... without symptoms [it was] highly unlikely someone was suffering from coronavirus."

My Lady, you will need to consider what was known in Government at that stage about the figures derived from the Diamond Princess incident, to which I made reference

earlier.

On 12 March the WHO declared a pandemic. In the United Kingdom stay-at-home guidance is published for people with symptoms of possible Covid-19 infection, telling them to stay at home for seven days. The Government announces it's moving from that "contain" phase to the "delay" phase and the UK risk level changes from "moderate" to "high".

Initial contact tracing processes in community testing are ended, as they simply couldn't cope and such supplies as there were were needed for hospitals. From 25 January to 11 March, 27,000-odd tests had been carried out in the United Kingdom. South Korea had carried out over 20,000 tests a day since late February.

Downing Street was, according to Mr Cummings, distracted by reports in the press concerning Mr Johnson's personal life.

At a tense and heated 13th meeting of SAGE on Friday, 13 March, National Health Service England representatives are asked whether there is any way the NHS could cope with the number of hospitalisations being envisaged under any of the mitigation scenarios falling short of a lockdown, previously reviewed by SAGE.

There's division as to whether suppression is viable because, as soon as lockdown is lifted the virus will

come back like the uncoiled spring. But the minutes record SAGE's view that owing to a five to seven-day lag in data provision for modelling, it now believes there are more cases in the United Kingdom than it previously expected at this point and we may, therefore, be further forward on the epidemic curve.

A senior Cabinet official comes through to Number 10 from the Cabinet Office to tell officials:

"... I think this country's [headed] for a disaster, I think we're going to kill thousands of people."

That evening a discussion takes place between a number of Number 10 officials and advisers. One of them, Ben Warner, argues that the strategy is required to be changed from one of mitigation to one of suppression, because the modelling shows that, unless the Government changes course urgently, the NHS will be overwhelmed. On a whiteboard, the Prime Minister's Chief Adviser, Mr Cummings, writes:

"Must avoid NHS collapse. To stop NHS collapse, we will probably have to lock down."

That meeting agrees that the Government has to be advised to introduce a national lockdown as a matter of urgency.

On the Saturday, a national lockdown is announced in Spain. In Downing Street, a meeting takes place in

1 Number 10 at 9.00 am between the Prime Minister and his
2 advisers. There is then a meeting between the
3 Prime Minister and his Health Secretary, the Chancellor
4 of the Duchy of Lancaster, the CMO, the CSA and other
5 senior officials. The Chief Scientific Adviser tells
6 the Prime Minister that scientists had previously
7 thought the UK was three to four weeks behind Italy but
8 now it's only two to three weeks. The Prime Minister
9 asks for a package of measures to be drawn up, but no
10 decision is taken then. A further meeting takes place
11 afterwards and the advisers press for firmer action.
12 The Prime Minister asks for the CMO and the CSA, who are
13 not present at that last discussion, to validate the
14 agreement for further action.
15 Professor Ferguson is asked to provide a slide deck
16 illustrating the potential healthcare demand resulting
17 from mitigation versus suppression policy options.
18 On Sunday, 15 March the Prime Minister discusses the
19 matter with the Chief Medical Officer, the Chief
20 Scientific Adviser and there is another wider
21 ministerial meeting. He agrees that stricter measures
22 should be taken to COBR the following day, including
23 individual isolation and voluntary social distancing.
24 On Monday, the DHSC announces 1,543 confirmed cases,
25 up 181 in 24 hours. Estimates show the number of

1 infections, the true number, was between 35,000 and
2 50,000.
3 Imperial College publishes its report 9, which
4 models the potential impact of stringent conditions and
5 concludes that epidemic suppression is the only viable
6 strategy.
7 On Monday, as we all recall, the Prime Minister made
8 an announcement asking people to work from home and to
9 stop all non-essential contact and travel. The
10 government advises mass gatherings should not take place
11 and that those in the same household as a symptomatic
12 case should isolate for 14 days.
13 The Cabinet Office emails Mr Cummings to the effect
14 that the Cabinet Office and the Civil Contingencies
15 Secretariat had still not seen any departmental plans
16 for a pandemic, let alone evaluated them. There were no
17 NHS plans and no real-time data, he believes.
18 On Tuesday, there were national lockdowns announced
19 in France and the Netherlands. In London, the
20 Government advises against international travel. On
21 Wednesday, 18 March, SAGE 17 convenes and there is
22 a discussion over the locking down of London. SAGE
23 advises immediate school closure. The PM announces
24 an indefinite closure straightaway. On Thursday,
25 19 March, the NHSE/I publishes guidance for discharging

1 patients from hospital, that is the discharge service
2 requirements order.
3 On Friday, the 20th, it is decided that pubs,
4 restaurants and gyms will be ordered to close. The
5 Number 10 Behavioural Insights Team recommends , however,
6 London should be locked down immediately. On Saturday,
7 Public Health England publishes guidance on shielding.
8 But over the weekend, the weekend of 21 and 22 March,
9 the Prime Minister and his advisers become concerned by
10 reports of continued social mixing. SPI-B produces two
11 urgent papers on the degree to which the UK population
12 was adhering to restrictions.
13 On Monday, that evidence is produced, it shows that
14 compliance is not exceeding 75%. Even more importantly,
15 intensive care patient numbers show that they're
16 doubling every three to five days and the hospitals in
17 London will be overrun in a week.
18 By 23 March, my Lady, the number of cases verified
19 by test was 6,650. Estimates from the First Few 100
20 study and CHESS showed the true number to be in the
21 region of 500,000, with over 100,000 of those infections
22 occurring on the day the lockdown began.
23 Lockdowns.
24 What are they? The rates of contact between people
25 can be suppressed through voluntary behaviour or

1 mandatory social restrictions. A lockdown basically
2 means a mandatory social restriction designed to
3 suppress the spread of virus. Lockdowns are a blunt
4 instrument, however, and, on account of the obvious and
5 severe damage they cause, they may be said to be an act
6 of last resort.
7 Another feature of lockdowns is that they are not
8 a long-term solution: a country cannot lock down
9 forever. They only buy time, alongside immediate
10 reduction in the spread of the virus and, unless the
11 virus is eradicated ready indicated completely, as I've
12 suggested, or brought under firm and continuing control,
13 it will reappear with devastating effect.
14 Once the virus is established, it may, however, be
15 very hard to eradicate it. An issue for you is whether,
16 even had a complete elimination or zero Covid policy
17 been pursued in the United Kingdom, as it was in some
18 other countries, would general elimination have been
19 possible? New Zealand and Australia, in particular,
20 achieved near Covid from time to time, because the virus
21 was never allowed to become completely established.
22 They took control before there was widespread community
23 transmission and, of course, they applied harsh and
24 early travel restrictions, but they also have relative
25 geographical isolation, lower levels of international

1 travel, less crowded cities and lower population
2 density.
3 So there are a number of issues which you will need
4 to enquire into. First, would the early imposition of
5 more stringent social restrictions short of a lockdown,
6 perhaps in late February/early March, have avoided the
7 need for a lockdown subsequently? Would any of those
8 arrangements, of the type that South Korea imposed, have
9 been possible here? Would it have been viable?
10 Secondly, whether to impose a lockdown at all. The
11 main lockdown debate is a reflection of the agonising
12 judgement call that the Government itself had to make.
13 Did it suppress less, thereby undoubtedly allowing
14 a greater loss of life and risking the collapse of the
15 NHS, in order to prevent the even greater, by other
16 terms, societal and economic damage that would be
17 wrought by the lockdown?
18 My Lady, that is an extremely difficult issue to
19 resolve. There is the complexity of the picture that
20 faced the Government, because the outcome would depend
21 on a number of immutable and difficult to identify
22 features -- population age, comorbidities, the state of
23 the Health System and resilience -- and no society wide
24 intervention, even one short of a lockdown, comes
25 without terrible cost and it is impossible almost to say

1 in advance what the cost and operational challenges of
2 an intervention falling short of a lockdown would be.
3 Then there was the issue of the delay between
4 changes of behaviour and cases emerging. Some parts of
5 the population had already started to protect themselves
6 in advance of 23 March.
7 Fourth, there was the absence of data to which I've
8 already referred. How could the Government decide the
9 benefits of lockdown against alternative NPIs?
10 Fifth, what was the Government strategy? If the
11 main objective was to ensure that as few lives as
12 possible would be lost, then, logically, the only route
13 is a full lockdown. Did the Government consider and
14 decide what level of loss of life was, however,
15 acceptable? If it had been a loss of life at the level
16 of SARS or MERS, which have infection fatality rates of
17 11 and 35%, there would have been no question that the
18 Government would have to fully suppress. No government
19 could tolerate such a loss of life. But no government,
20 on the other hand, suppresses flu by imposing a
21 lockdown, even though there may be as many as 30,000
22 deaths in a bad year. No government would ever
23 contemplate imposing a 5-mile an hour speed limit to
24 stop the 30,000 persons killed or injured every year
25 from being killed or injured. So what was the

1 government strategy?
2 There are intense moral and societal balances to be
3 struck at the heart of this debate, which will not be
4 easy for the Inquiry to resolve. But some, of course
5 perhaps a significant amount, of consideration must be
6 given to the fact that the primary decisions were taken
7 by our elected representatives.
8 What may, however, be clear is that there is
9 evidence from Imperial College in June 2020 that, had
10 a lockdown not been imposed at all, ie had just the
11 earlier measures of 13 March, 16 March, 18 March and
12 20 March been imposed, the virus would probably --
13 probably -- have continued to grow exponentially. The
14 evidence may also show -- and it's a matter absolutely
15 for you -- that achieving suppression, short of
16 lockdown, would still have required a reduction in
17 contact rates similar to lockdown and, therefore,
18 brought terrible cost to the country.
19 A final issue in relation to lockdown is whether it
20 should have been imposed earlier. Evidence of the
21 possible collapse in the NHS appears to have started
22 becoming available from around 9 March, but lockdown
23 wasn't imposed until the 23rd, allowing for the
24 necessary time to put appropriate arrangements into
25 place. The issue for you is whether there was avoidable

1 delay.
2 On 12 March a text from Mr Cummings read:
3 "We've got big problems coming. The
4 [Cabinet Office] is terrifyingly shit. No plans.
5 Totally behind the pace. We must announce today, not
6 next week 'if you feel ill with cold or flu, stay home'.
7 Some around the system want to delay because they
8 haven't done the work. We must force the pace. We're
9 looking at 100 to 500,000 deaths between optimistic and
10 pessimistic scenarios."
11 The then Cabinet Secretary wondered on 12 March
12 whether the Prime Minister should "go on [television]
13 tomorrow and explain to people the herd immunity plan
14 and that it's like old chickenpox parties". The then
15 Prime Minister was heard to wonder whether the virus
16 should just be allowed to "let rip". This is a matter
17 for you on the evidence and I emphasise we have heard no
18 evidence yet.
19 Ultimately, the immediate goal or objective of
20 preventing the collapse of the NHS drove the Government
21 to impose the lockdown. But if the emergency that drove
22 the lockdown, the need to avoid the NHS, was only
23 appreciate in mid-March, had the Government acted with
24 the speed that was required? To what degree should it
25 have seen that potential collapse coming? Was there too

1 great a focus also on the NHS? What about the no less
2 vital need of stopping the spread of the virus through
3 the care home sector?
4 Professor Hale, who is an expert in social
5 restrictions, in non-pharmaceutical interventions, will
6 give evidence that the country followed a rollercoaster
7 pattern. As a new wave arose, restrictive measures were
8 often introduced, only when it became apparent that the
9 health system as a whole would be at risk, not earlier
10 when there still might have been potential to prevent a
11 wave from rising in the first place.
12 Moreover, because restrictions only came in once
13 Covid was highly prevalent, it became necessary to keep
14 them in place for a longer period of time to bring
15 transmission back down, in turn, perhaps because the
16 difficulty of enduring long periods of restrictions,
17 measures were relaxed, but relaxed whilst Covid remained
18 prevalent, thereby allowing the conditions for a new
19 wave to arise.
20 I emphasise that that is just his evidence, whether
21 you accept it is another matter. But the issue for this
22 Inquiry will be: did countries that waited have overly
23 complicated and layered decision-making processes and,
24 which were late to react, have worse outcomes? It will
25 be a matter for you.

1 I now turn to set out some of the evidence relating
2 to the way in which the core decision-making of the
3 Government but, more particularly, the Cabinet Office,
4 Number 10 and the Prime Minister, operated.
5 Before I do so, I need to say something about the
6 issue of the many WhatsApp groups and threads and also
7 diaries and notebooks which have been disclosed to
8 the Inquiry. This material provides, of course,
9 a window, perhaps a somewhat distorted one, into the
10 workings of government.
11 My Lady, we requested, or rather you requested
12 through us, from decision-makers and advisers WhatsApps
13 relevant to Government decision-making. We've received
14 approximately 250 separate WhatsApp groups from over 24
15 custodians, in addition to thousands of pages of
16 one-to-one WhatsApp threads. In light of the press
17 reporting this morning, I should say that that material
18 includes copies of WhatsApp groups to which
19 Rishi Sunak MP was a participant. We also have multiple
20 one-to-one threads of WhatsApps with him. We have the
21 material extracted from an old phone belonging to
22 Mr Johnson, so rather more than the press in other
23 quarters has received from various other people.
24 It's right to say we have not received everyone's
25 WhatsApps, texts or iMessages. A lot were not retained

1 and were got rid of in accordance with what their owners
2 believed was Government policy, long before the Inquiry
3 came calling. Some were apparently deleted accidentally
4 and we'll be asking why that happened.
5 However, in light of the very large number of
6 messages and diary entries that we have received, we
7 have, we believe, a very good picture of what happened.
8 Given the multitude of people who were party to or privy
9 to the core decision-making, and who took decisions in
10 the presence of other people, and the range of WhatsApp
11 and diary material that we have -- which of course
12 necessarily engages more than one person, because
13 they're conversations -- there are unlikely to be any
14 hidden corners that have escaped the Inquiry's
15 examination.
16 You will, of course, exercise considerable caution
17 when assessing the worth of the WhatsApps. They were
18 often sent in speed, were largely informal and
19 spontaneous, and were sometimes ill considered. They
20 were always short, naturally, and could never be
21 a reflection of any nuances of any particular debate.
22 They often reflected irritation or even vitriol.
23 Mr Cummings' WhatsApps, in particular, contained
24 a certain degree of brusqueness.
25 The diary entries must too be treated with some

1 caution. Although highly relevant to the private
2 thoughts and opinions of their authors and, by
3 extension, retrospectively their opinions of the
4 decision-making skills of others, they're rather less
5 relevant as a tool by which the core policy making and
6 decisions can themselves be scrutinised. It's also
7 impossible to gauge the extent to which they accurately
8 reflected the authors' contemporaneous and actual views
9 of the merits of any given decision, as opposed to being
10 crafted for a later audience.
11 However, that material shows that many of the
12 important decisions were taken by the Prime Minister
13 and, to a significantly lesser degree, the Cabinet.
14 Below them, as you will recall from Module 1, the
15 complex and diffuse government structure was split
16 between Number 10, the Cabinet Office, the lead
17 government department, the DHSC and a host of other
18 departments and bodies, including the NHS and PHE.
19 The disharmony between Number 10 and the Department
20 of Health and Social Care is apparent from the WhatsApps
21 and diary entries.
22 A core question for you is whether, regardless of
23 the unceasing toil by individual politicians, civil
24 servants and advisers, there were just too many
25 disparate and moving parts and an insufficiently firm

1 control at the centre. Mr Cummings suggests that the
2 lead government department, the DHSC, just did not have
3 the systems or authority to orchestrate all the things
4 that needed to be done, which meant that it was too much
5 for the Cabinet Office and Number 10 to do.
6 There was no minister responsible exclusively for
7 civil contingencies overseeing a department with the job
8 of ensuring that there was an effective and
9 well-maintained civil contingencies structure in place.
10 There was no standard manual for pandemics, no practical
11 framework. You will want to enquire into how
12 effectively in the early days the Government machinery
13 worked.
14 There were also a number of other underlying
15 structural issues that may have had a bearing on how
16 efficient the machinery was. Witnesses speak of the
17 perennial difficulties associated with the division of
18 functions between the advisory role of the civil service
19 and the executive power of, and I emphasise in crisis
20 management terms only, the more amateur ministers.
21 There was an overload on existing personnel and
22 perhaps a lack of a straightforward mechanism for the
23 rapid scaling-up of administrators. Was there a lack of
24 general experience in crisis, let alone pandemic
25 management? Such institutional memory and experience as

1 there had been may have been lost through the
2 ever-present rotation of ministers and senior civil
3 servants and, perhaps, a mismatch between ministers and
4 the demanding requirements of their posts.
5 What about Cabinet? Mr Cummings -- and his general
6 level of objectivity will be a matter that you'll have
7 to determine -- observed that it was not the place for
8 serious discussion or decisions. It was a rubber-stamp,
9 the main function of which was to function as political
10 theatre. Perhaps more importantly, he says Cabinet
11 committees were scripted. Ministers were given scripts
12 to read out and conclusions were drafted in advance so
13 problems were simply not grappled with.
14 Ironically, you may conclude that Mr Cummings was
15 himself a source of instability and contributed to the
16 undermining of that very same Cabinet. After he left,
17 one regular attendee at Cabinet, though not a minister,
18 observed:
19 "Cabinet is more effective post [Dominic Cummings]."
20 You will have to assess the truth of these claims.
21 You will want to assess the degree, in fact, to
22 which Mr Johnson did take decisions alone, having no
23 doubt received advice from his advisers but in the
24 absence of fellow ministers.
25 My Lady, having seen the debate through WhatsApp

1 messages and texts and the diary entries that took place
2 in Cabinet, you may conclude, as they say in diplomatic
3 circles, that it was more often than not frank and
4 constructive. So it would seem that Cabinet itself
5 undoubtedly believed it was contributing appropriately
6 to the decision-making.
7 The psychology of central government and, in
8 particular, Downing Street is also an issue. Was there
9 an unwarranted degree of optimism on the part of
10 Government advisers and officials that things wouldn't
11 turn out as badly as was being suggested by the
12 scientists? There may have been a complacency that the
13 UK's plans were the best there were, along with
14 a misplaced and arrogant belief that other countries'
15 experiences were of little assistance.
16 The primary authority, however, and responsibility
17 for the major decisions with which this module is
18 concerned appear to have remained throughout with the
19 Prime Minister. He also had the overarching discretion
20 of deciding the extent to which matters were debated
21 within Cabinet. Number 10 doesn't exercise exclusive
22 executive power, however; it must ask in lock-step with
23 the Cabinet Office. They are to a very large extent
24 part of the same organisation.
25 Was there a lack of confidence in the Cabinet Office

1 and with its head, the then Cabinet Secretary?
2 Mr Cummings suggests in his written statement that the
3 Cabinet Office was bloated at senior levels with poor
4 lines of responsibility, huge numbers of comms and
5 engagement staff but too few civil servants who could
6 drive priorities.
7 The Cabinet Office, he says, was effectively
8 replaced by the 8.15 am meeting between officials and
9 Special Political Advisers in Number 10. At the same
10 time, he says, the private office of Number 10 was too
11 small to compensate for the shortcomings of the DHSC and
12 the Cabinet Office. He says the Cabinet Office was
13 a failure. But perhaps he would say that, as the Chief
14 Adviser to the Prime Minister.
15 In any event, the WhatsApp messages between
16 Messrs Johnson, Cummings and others portray a depressing
17 picture of a toxic atmosphere, factional infighting and
18 internecine attacks on colleagues.
19 A text from Simon Case, then a senior civil servant,
20 yet to become Cabinet Secretary, to Matt Hancock on
21 29 April reads:
22 "The Cabinet Office is a totally dysfunctional mess
23 at present, so not a great place to be!"
24 Mr Cummings' emails on the 13 July:
25 "The current [Cabinet Office] doesn't work for

1 anyone -- it's high friction, low trust, and [obviously]
2 many good parts but overall low performance ... friction
3 is [built] into the system including institutional
4 friction between [Number 10] and the [Cabinet Office]."
5 Sir Patrick Vallance notes in his evening notes:
6 "[Number 10] chaos as usual.
7 "On Friday the [2-metre] rule meeting made it
8 abundantly clear that no one in [Number 10] or [the
9 Cabinet Office] had really read or taken time to
10 understand the science advice on [2 metres]. Quite
11 extraordinary."
12 On 11 November, reporting in his diary something
13 said by the then Cabinet Secretary, he says:
14 "... Number 10 is at war with itself -- a Carrie
15 faction (with Gove) & another with SPADs downstairs. PM
16 is caught in the middle. He [the Cabinet Secretary] has
17 spoken to all his predecessors as [Cabinet Secretary]
18 and no one has seen anything like it."
19 Debate, perhaps even ferocious argument between
20 officials and advisers is to be expected, but the issue
21 for you is whether the internal machinations hindered
22 the good working of government. A significant number of
23 WhatsApp and diary entries refer to Mr Hancock. It
24 appears to be the case that the Prime Minister and
25 a number of officials and advisers held him in low

1 regard, in particular on account of an apparent
2 tendency, to use their words, to get overexcited and
3 then "make stuff up". The WhatsApps and diary entries
4 contained multiple references to Mr Johnson's loss of
5 confidence in Mr Hancock and to a general belief that he
6 was less than candid when informing Number 10 and the
7 Cabinet of progress that he and his department were
8 apparently making.
9 You will have to assess the truth of the claim of
10 this certain lack of candour on his part and, if you
11 accept the claim, whether this trait was deleterious to
12 good decision-making. Did it actually matter? That is
13 a matter entirely for you.
14 What of the Department of Health and Social Care?
15 It was the lead government department. Was it equipped
16 for such a role in the far-reaching crisis that Covid
17 presented? Was there adequate leadership? Did it try
18 to hold onto too many responsibilities. Was the
19 department, as Dominic Cummings has suggested publicly,
20 a "smoking ruin" and in crisis itself?
21 The attitude within Government towards a public
22 inquiry may also be of relevance. Sir Patrick
23 Vallance's diary records the Cabinet Secretary as saying
24 that any:
25 "Inquiry should go on for a decade or more [he]

1 wants someone like Saville to chair it and keep it going
2 forever", a reference obviously to the duration of the
3 Bloody Sunday Inquiry.
4 You, of course, have already said that you will not
5 allow this Inquiry to drag on and we're already at
6 Module 2 just 18 months after the end of Covid
7 restrictions.
8 Was this apparently divisive and dysfunctional
9 system the reality?
10 You will need to explore the role of the Chancellor
11 of the Exchequer and the Treasury in relation to
12 decision-making. Did it carry out and share sufficient
13 economic analyses? Did it balance its approach with
14 other trade-offs? How far, to what extent, did it push
15 Downing Street beyond that which the analysis would
16 support?
17 You will also need to consider the issue of
18 leadership. The evidence of some witnesses may show
19 that the character and operating style of Mr Johnson and
20 his team created instability and exacerbated some of the
21 pre-existing structural and cultural issues and
22 tensions. Some of this may have been deliberate,
23 perhaps even beneficial. But some of it, it's a matter
24 entirely for you, stemmed perhaps from Mr Johnson's own
25 character. Was his decision-making style antithetic to

1 effective and speedy decision-making?
2 He has already in the press, notoriously, been
3 described as a trolley, liable to career off in
4 unexpected directions. Witnesses and texts and
5 WhatsApps and diary entries speak repeatedly of
6 flip-flopping, of him ignoring problems then U-turning,
7 of poor and delayed decision making and of oscillation.
8 Some witnesses will say he had a tendency to say
9 different things to different people, to reverse settled
10 decisions and to be heavily influenced by pressure from
11 parts of the media.
12 These are perhaps, my Lady, undesirable traits to
13 have when dealing with the demands of a viral pandemic.
14 They are matters for you.
15 Sir Patrick's diary contains entries such as:
16 "This flip-flopping is impossible, one minute do
17 more, next do nothing.
18 "He doesn't seem to push actions or resolutions.
19 "Morning PM meeting, wants everything normal by
20 September and only deal with things locally and
21 regionally. He is now completely bullish about opening
22 everything -- as [another person] said it is so
23 inconsistent. It is like 'bipolar decision-making'."
24 Then this, on 19 September, the crux or the time
25 when the argument over circuit breakers was raging:

"He is all over the place and completely inconsistent. You can see why it was so difficult to get agreement to lock down first time.

His ability to manage those around him may also be an issue. Could he build -- did he build a high performance team? Did he take the role in which he was placed seriously enough? Witnesses cite his ignoring of advice not to shake hands, his failure, due perhaps to his libertarian tendencies, to restrict mass gatherings and the obvious continuation of Government business in person. Was he in those terrible early days overly dismissive of the threat faced by the United Kingdom?

Public trust in government and its leaders is of vital importance, as it's a key part of promoting resilience and ensuring compliance. Although he was not obliged to chair COBR, which was and was just as easily chaired by Matt Hancock MP as the Secretary of State to the lead government department, the Prime Minister did not chair the COBR meetings of 24 and 29 January and 4 and 12 and 18 February. Was an opportunity to demonstrate leadership lost? He first chaired COBR on Monday, 2 March, just three weeks before the national lockdown was imposed.

Moreover, there's the difficult issue of whether, as one witness suggests, his attention in February, that

most crucial of events, was diverted elsewhere. Brexit Day, the resignation of Sajid Javid MP and the reshuffle that followed, Storm Dennis, his personal issues concerning half-term holiday, the finalisation of his divorce, the announcement of Carrie Symonds' pregnancy on 29 February, and the IOPC investigation into allegations made against him by another have all already been publicly ventilated. To what extent, if at all, is any of that relevant to his leadership of our country in those weeks?

Turning to, finally, some of the other important Government bodies, what of the Public Health England agency? It's been described by witnesses as leaderless and totally dysfunctional. A 3 June entry by Sir Patrick records:

"Quad call [that's a ministerial quad call] exposed the massive internal operational mess inside DHSC and PHE. Getting something done is almost impossible."

My Lady, how is the Inquiry to approach such matters? The Inquiry is, of course, completely politically agnostic in its approach. It has no personal or political inclination or disinclination towards any of the primary actors in the appalling tale of this pandemic. There has been enough politicisation and polarisation of the public discourse in any event

but, in any event, you may conclude that this is not an exercise in apportioning blame. It is and can only be an inquiry into what actually happened so that the vital lessons may be learned for the future. But these decisions were, at their heart, not political decisions, they were matters of public health, although the Prime Minister plainly came under intense pressure from certain elements in the press and his own backbenchers to open up whenever possible and not to reimpose the lockdowns, which had, of course, such terrible consequences. The Inquiry has no interest in the political position or views of the primary actors. It is interested only in how they discharged their functions.

So it's not a personal attack. Those at the heart of the Government's decision-making undoubtedly tried their best and they worked night and day, like many others, in the face of unprecedented crisis. But politicians, although members of a party, owe their governmental responsibilities to the country as a whole, and those civil servants who exercise this level of power and authority are accountable to those over whom they exercise it.

My Lady, is that a convenient moment?

LADY HALLETT: It is. We shall return at 2 o'clock, please.

I apologise to all of those who were distracted by the noise. I suspect probably people over that side of the room are most distracted. I certainly find it most distracting. It's coming from next door. We will do what we can. Whether we have any power is another matter.

Thank you.

(1.15 pm)

(The short adjournment)

(2.00 pm)

LADY HALLETT: Mr Keith.

MR KEITH: My Lady.

My Lady, the list of issues for Module 2 pose a number of questions in relation to how Westminster engaged with the devolved administrations, the regional and local authorities as well. There are some key questions relating to the degree of liaison and whether the key decisions taken by the United Kingdom government were taken after a proper process of advice or consultation with the devolved administrations and regional and local authorities.

The starting point is that the United Kingdom could not readily exercise direct control over pandemic management throughout the United Kingdom, because health is a devolved matter, and once the United Kingdom

1 government used public health legislation and
2 the Coronavirus Act to respond to the pandemic rather
3 than the Civil Contingencies Act, the Rubicon had been
4 crossed.
5 But as the pandemic progressed, the DAs, devolved
6 administrations, started to go their own way in terms of
7 the imposition of non-pharmaceutical interventions,
8 starting with mass gatherings and, later, the Welsh
9 circuit breaker. They obviously also took differing
10 approaches to tier systems and local lockdowns.
11 Mr Johnson suggests in his statement that this
12 divergence represented a regrettable failure to ensure
13 consistency of approach, but the ministers of the
14 devolved governments insist the divergence was
15 the inevitable consequence of the way in which the virus
16 spread across the various nations of the United Kingdom
17 and that in implementing policies that diverged from
18 Westminster, they were simply exercising their proper
19 devolved powers.
20 There are a number of evidential conflicts for you
21 to determine. Written evidence suggests that
22 the devolved administrations were not updated on some UK
23 decisions. They did attend COBR, but the material
24 suggests that concerns about the briefing of the media
25 afterwards led apparently to a general disinclination

1 for the Westminster officials to want to thrash issues
2 out in COBR, and meetings became more scripted and
3 formulaic.
4 One attendee at COBR describes:
5 "COBR [was] not really a COBR at all but more of
6 a talk to the DAs and then a series of 'give us more
7 money' questions."
8 The DAs were not invited to Covid-S, but they did
9 attend Covid-O. They weren't, of course, present at the
10 9.15 in the morning Prime Ministerial meetings, and
11 although the Joint Ministerial Committee existed to
12 provide a formal historical forum for meetings between
13 UK ministers and the First Ministers, after May 2020 it
14 doesn't appear, following a submission to the
15 Prime Minister, that the Joint Ministerial Committee
16 ever met.
17 Four-nation COBR calls and meetings were held and
18 chaired by Michael Gove, the Chancellor of the Duchy of
19 Lancaster, but the DAs say in their written material
20 that they had insufficient meaningful input into
21 decision-making. There was, however, ample
22 communication between the United Kingdom government and
23 the devolved administrations at the health minister and
24 chief medical officer level, and, of course, as I say,
25 in the Covid-O meetings.

1 As for the local and regional government,
2 the evidence appears to suggest that the United Kingdom
3 government was characterised by an absence of engagement
4 with regional and local leaders in decision-making, or
5 at least there was plenty of engagement but, from the
6 viewpoint of the regional authorities, there were
7 repeated failures to inform and involve them
8 sufficiently.
9 Turning to schools, which is another important area
10 on our list of issues, the issue of school closures and
11 the obvious impact on schools and educational prospects
12 of the lockdowns will be addressed in detail in a later
13 module, but it's necessary to look briefly at how
14 the decision on schools came to be considered and
15 decided by Number 10.
16 This is because, from a relatively early stage, the
17 possibility of closing schools was discussed by SAGE and
18 civil servants. It was discussed repeatedly at SAGE and
19 SPI-M-O meetings in February, and the possibility of
20 shutting schools was contained in the "Contain, Delay,
21 Mitigate" plan of 3 March. The Department of Education
22 had been represented at the SAGE meetings and had had
23 access to the papers. It's a matter for you whether
24 proper plans or impact assessments were drawn up.
25 Very late in the day, however, around 16 March,

1 the Department of Education was asked to consider
2 closure and to write an advice overnight for the
3 Prime Minister. Gavin Williamson MP, in his written
4 statement, describes that process as discombobulating.
5 He did agree with closing schools but disagreed when
6 the date for introducing attendance restrictions was
7 brought forward to 23 March instead of from the end of
8 the Easter holidays.
9 There is an issue for you as to the extent to which
10 guidance was properly prepared and published. That, as
11 I say, is for a later module. But why was there
12 a sudden change in Downing Street around 16 March, and
13 why was more advance thought not given to this
14 possibility?
15 Schools were not closed during the second lockdown.
16 The Department of Education was, it seems, very
17 resistant in mid-December to letting schools close early
18 for the holidays. Mr Williamson advised that schools
19 should remain open, which increased testing, and the
20 issue was vigorously debated, but in the very early days
21 of January there was what was described by him as
22 "a panic decision". There was a very late decision, as
23 you'll recall, to close schools. Some pupils returned
24 for the first day of term and were then sent home.
25 So in this module, what was the thinking in

Number 10? The material shows that some officials sought to dress up the change of position between 29 December and 1 January as being the result of new evidence and data, despite the fact that the two decisions, diametrically opposed as they were, had been taken just two days apart.

The care sector is, again, for a later module, but it's convenient to examine, in part, one of the major decisions affecting the care sector in this module, given the debate over the extent to which core decision-makers were aware of it and, of course, of the catastrophic consequences. It was, notoriously, the decision of 17 March 2020 to discharge hospital patients into social care.

There is an issue as to the extent to which Number 10 were advised or understood that clinical or scientific advice was to the effect that testing wouldn't work. Was there a lack of capacity? Did a greater number of infections come from staff who worked for more than one care home? Was isolation the proper route?

The final resolution of those issues from the viewpoint of DHSC and those in the care sector must be for the later module, but evidence will be called in this module as to the extent to which Number 10 was

aware of the decision and, of course, of the terrible consequences which arguably ensued.

Turning to the exit from lockdown 1 and back to the chronology and Eat Out to Help Out, restrictions were eased over late spring and the early summer of 2020, but there was a growing political and press pressure for a complete lifting of restriction, and the order and timing of the lifting of restrictions became ever more a political decision.

A divide opened up between the advice from SAGE and the preparedness of government to keep restrictions in place. On 21 March Sir Patrick's diary recorded:

"SAGE position maintained and clear but [Chancellor of the Exchequer] really pushing for more ... Simon Case [who was then still a very senior civil servant not yet Cabinet Secretary] commented it was like children pushing their parents to see how far they could go without being smacked. Totally inappropriate way for the politicians to go on and puts SAGE in a terrible position."

The final package of restrictions was lifted on 4 July. Cases started to increase immediately afterwards, but this wasn't immediately apparent as case numbers were low and there were significant variations in the reporting because of differences in testing and

also because of differences on different days of the week. But the consistent trend was upwards.

Sir Patrick's diaries reflect a growing level of concern at the government's approach. 9 July:

"PM cancelled the big announcement and has gone more cautious ... PM is simply not consistent. (as he wasn't at the beginning)."

13 July:

"The ridiculous flip flopping is getting worse ..."

28 July:

"[The Chief Medical Officer] and I are both worried about the extreme inconsistency from [the Prime Minister]. Lurching from open everything to panic."

Then on 3 August the government introduced the Eat Out to Help Out scheme, designed and driven by the Chancellor of the Exchequer and Her Majesty's Treasury. The scheme gave a 50% discount on meals up to £10 per person, but didn't apply to takeaways.

The policy objectives were obvious: to support the economic recovery by stimulating consumption in the hospitality sector, but it didn't appear to have been discussed with the Chief Medical Officer or the Chief Scientific Adviser, and it was not the subject of advice from SAGE, SPI-M-O or SPI-B. Professor Whitty and

Professor Vallance's written evidence is that had they been consulted they would have advised it was highly likely to increase transmission.

The Inquiry will be hearing from the then Chancellor of the Exchequer, Mr Sunak MP, on this. Treasury advance a number of arguments. Plainly the scheme was devised and implemented in the context that hospitality venues had already been opened safely and were operating Covid-secure guidelines. That was the premise upon which the scheme was introduced. It was also supported by the Prime Minister and recommended by industry and think tanks and a significant number of other countries has also used similar stimulus vouchers.

A second wave, they say, was always anticipated and it is unfair and wrong to attribute blame for that second wave from Eat Out to Help Out.

Most importantly, perhaps, the Treasury argues that the scheme and the re-opening of the hospitality sector did not have any noticeable impact on the rates of infection. The evidence on this is not clear. Some other evidence suggests there was an increase. But the conflict may not be easier to resolve and we don't invite you to do so. The lack of clear evidence one way or the other means that you'd only ever have quite a weak foundation from which to draw any conclusions and

recommendations. But there is a wider important point: did the scheme send out the wrong message to the public, with the consequence that other ongoing measures were indirectly weakened?

On 24 August Mr Hancock sent a WhatsApp message to Mr Case, still then the Second Permanent Secretary in the Cabinet Office:

"Just want to let you know directly that we have had lots of feedback that Eat Out to Help Out is causing problems in our intervention areas. I've kept it out of the news but it's serious. So please please let's not allow the economic success of the scheme to lead to its extension."

So in relation to the aftermath of the first national lockdown, was the lockdown lifted in the most appropriate way? How effective were the local restrictions that were introduced in England? Were the local restrictions and differences between them the most effective way of managing the virus? What was the impact in terms of messaging of the Eat Out to Help Out scheme?

Then the second lockdown. At the beginning of September, on 1 September, a Cabinet briefing to the Prime Minister noted:

"Since reopening hospitality seven weeks ago, we

haven't seen a widespread resurgence in transmission. Clusters of high transmission have largely been driven by social interactions between households, not formerly closed sectors."

At a Cabinet meeting on 8 September there was a robust debate over segmentation, that's to say shielding for segments of the population and allowing the virus to move through the population otherwise, also the merits of the rule of group of six and red teaming and herd immunity. Some ministers stated that things should be opened up, in particular the Chancellor of the Exchequer.

The Chief Medical Officer noted that if the government waited for deaths to increase before it took action, that would inevitably result in a substantial number of deaths.

The Prime Minister's view was that the government had known for a long time that a second peak was coming and was as well placed as it could be.

The rule of six was introduced on 9 September. It's unclear to what extent SAGE was sighted on the merits of that proposal. Professor Vallance noted:

"What a week - feels like Feb/March…strikes me that the delay in introducing the new rules until Monday is exactly what they did in March. Why delay??"

There was then a debate in government over the introduction of a tiered system. A modelling team at the University of Warwick published a paper on 14 September which concluded that a well timed and strong lockdown for a two-week period could have a very notable impact.

By the 16th it was noted that infections were doubling and admissions to hospital had gone up by 100% since the beginning of September. The Prime Minister indicated he wanted to explore, however, a range of views from different scientists before final decisions were taken. A meeting was set up for the following Sunday, 20 September.

On 18 September, Mr Case told Mr Hancock "the firebreak idea is gaining traction" with the Prime Minister, but later in the day he advised:

"[The Prime Minister] wants to double down [instead] on present strategy ... tougher local lockdown/enforcement, warning [measures] about what happens if people don't follow the rules."

On Sunday 20 September the meeting to which I've referred took place, chaired by Mr Case and attended by the Prime Minister, the CMO, the CSA, and Professors Edmunds, Gupta and Heneghan, Dr Anders Tegnell, from Sweden, and Professor

Dame Angela McLean, the Deputy Government Chief Scientific Adviser, also attended.

The Chancellor also attended, but he says in his written statement he doesn't have strong recollections of that precise discussion.

Professor Edmunds' evidence is that he tried to point out that the epidemic was increasing exponentially and harsh measures would have to be introduced soon to stop the NHS from being overwhelmed. He says for him the decision was not not to lock down or not, but to lock down now or be forced into locking down later. His arguments were not accepted.

Mr Johnson says in his own written statement that whilst he greatly respected Professor Edmunds' views, he had always put him at the gloomier end of the spectrum and he had wanted to give the Rule of Six a chance to work and to hear some alternative views.

At a presentation on 21 September, the CMO and CSA warned that at the current estimated rate of doubling, there could be 50,000 cases a day by mid-October.

The 58th SAGE meeting on that day considered a paper addressing the effectiveness and harms of different non-pharmaceutical interventions. It noted that the incidence of Covid was increasing across all the country and that the effect of opening schools had

1 only just begun to affect that increase. A package of
2 stringent interventions would be needed to be adopted.
3 In his written statement, the Prime Minister suggests
4 that the advice in that meeting was "not pushed on me
5 very hard".
6 In a statement to Parliament on 22 September, he
7 instead set out new national restrictions, including
8 working from home, table service extensions in pubs,
9 bars and restaurants, a closure of hospitality venues at
10 10 pm, extended requirements on face coverings and
11 a maximum of 15 at wedding ceremonies and receptions.
12 There is a debate about the extent to which SAGE would
13 ever have recommended a 10 pm curfew, because it was of
14 the view that it would be likely to have, in any event,
15 only a marginal impact.
16 On 30 September SPI-M-O indicated that, according to
17 medium-term projections from five models, the epidemic
18 was likely to breach the agreed reasonable worst-case
19 scenario of the next two weeks.
20 On 8 October, the Prime Minister gave a press
21 conference at which the three tier system was announced,
22 and one issue for this module is the practical wisdom of
23 those measures. They were complex, politically
24 divisive, and they led to considerable public confusion.
25 The existence of different control measures in

1 different places at different times also, you may
2 conclude, made it difficult to establish a clear
3 national message. A WhatsApp from Mr Cummings read:
4 "This is a shitshow. We should have gone a month
5 ago as we said."
6 At a meeting on 25 October, an argument began before
7 the Prime Minister, to use the words of the proponents
8 of one side of the argument, "let it rip - they have had
9 a good innings", and the contrary argument was put that
10 a democratically elected government's primary obligation
11 was to save lives. The Prime Minister acknowledged that
12 it was "a complete shambles" but that he really didn't
13 want to have to enter another national lockdown. He was
14 told that if he went down the route of not imposing
15 a lockdown, he would need to tell people that he was
16 going to allow them to die.
17 On 30 October, Sir Simon Stevens, head of the NHS,
18 reported that hospitals would be overrun in every part
19 of England. The decision to lock down was made but the
20 decision leaked and the announcement was brought
21 forward. There would be a lockdown from 5 November.
22 The third lockdown revolves largely around the
23 emergence of the Alpha variant, which first emerged in
24 Kent in late November and early December, which was up
25 to 70% more transmissible. The winter plan of

1 23 November set out a return from the second lockdown to
2 a three tier system.
3 Unlike the earlier three tier system, there was no
4 negotiation this time with local authorities. On
5 2 December, the last day of the lockdown, the Medicines
6 and Healthcare products Regulatory Agency gave approval
7 for the use of the first Covid-19 vaccines; the
8 Pfizer-BioNTech vaccine. The miraculous availability of
9 a vaccine turned the course of the pandemic, but it
10 would naturally be some time before vaccines could be
11 made widely available.
12 Debate again raged in government in late November
13 and early December as to whether it would be possible
14 for the majority of the country not even to be in
15 tiers 2 and 3. Would testing enable control to be
16 maintained? The figures showed that cases were going up
17 faster and faster. And then the genomic testing
18 revealed the new variant on the loose.
19 As a result of that new Alpha variant -- laboratory
20 studies in relation to which it was not likely to be
21 more severe or pathogenic but that it was, as I've said,
22 highly transmissible -- was that the hospitalisations
23 and deaths would result in even greater number, despite
24 the current measures and the start of the immunisation
25 programme.

1 At an extraordinary meeting of NERVTAG and SPI-M-O
2 on 21 December, the debate began as to whether or not
3 a lockdown was required.
4 A number of areas across England, including London
5 and the south east, and then across Scotland, Wales and
6 Northern Ireland went into blanket tier 4 effective
7 lockdowns. On 30 December MHRA approval was given for
8 AstraZeneca-Oxford.
9 In the first few days of January the Prime Minister
10 announced that children should return to school after
11 the Christmas break, but that restrictions in England
12 would get tighter, but in the event a third national
13 lockdown was announced on 4 January.
14 Hospitalisations peaked in mid-January, though by
15 this time roughly 70% of all ICU beds available in the
16 NHS were taken up by Covid patients. Deaths increased
17 from 82,000 or so by 11 December to 152,000-odd by
18 1 April. Roughly 70,000 people died in the wave despite
19 the start of the vaccination programme and the
20 imposition of severe restrictions.
21 Was a third national lockdown necessary? To what
22 extent were lessons learned from the first two? Should
23 the decision to impose a lockdown have been taken before
24 4 January?
25 My Lady, there's no need, I think, to address you on

1 the detail of the roadmap, the emergence of the Omicron
2 virus, because, of course, no fourth lockdown ensued
3 from the emergence of that particularly prevalent
4 variant. You've seen from the charts earlier,
5 of course, today the incredible number of infections
6 that ensued from the emergence of that virus in
7 November 2021.
8 The growth rate was alarming: it doubled every three
9 to four days, despite the UK's high level of immunity.
10 In late December there was a Cabinet meeting held to
11 discuss whether to introduce further restrictions before
12 the Christmas break. No further restrictions were put
13 in place, and after Christmas the Prime Minister decided
14 that the plan B restrictions which had been announced
15 should be scrapped on the basis that things had indeed,
16 on this occasion, turned out more favourably than had
17 been feared.
18 There are two remaining issues before I conclude.
19 They are public messaging, public confidence and
20 legislation enforcement.
21 The Inquiry is enjoined by the list of issues to
22 seek to ask how effective the public health
23 communication steps were that were taken to control the
24 spread of the virus. What did the move from "stay at
25 home, save lives" to "stay alert" actually mean? Were

1 the rules on group of six unwieldy
2 and counterproductive?
3 The Inquiry will hear evidence from government
4 officials as to the performance of the Government
5 Communication Service and the Covid communications hub.
6 What also was the impact of alleged or proved
7 breaches of rules and standards by ministers, officials
8 and advisers?
9 The link between public trust and compliance is
10 well known, and the evidence suggests that, over the
11 three weeks after the breaking of the story that
12 Mr Cummings had driven to Durham with his wife and child
13 during the lockdown and had been seen and had then
14 driven to Barnard Castle on Easter Sunday and then
15 of course had held a press conference on 25 May, that
16 willingness on the part of the public to comply with
17 the regulations dropped sharply.
18 Confidence in the government was badly damaged. The
19 impact of emerging stories in December 2021 of parties
20 in breach of lockdowns, regulations and guidance was no
21 less dramatic. So the Inquiry will need to explore the
22 critical need in a crisis for government to maintain
23 public confidence through leadership.
24 Legislation and enforcement.
25 The Inquiry will ask how proportionate were

1 the health and coronavirus legislation regulations
2 proposed and enforced. To what extent were equality
3 impact assessments carried out? Were their conclusions
4 taken into account when passing laws and regulations?
5 The lack of clarity, it may be thought, in
6 the legislation and regulations may have made it
7 difficult for the public to know what was criminalised.
8 How was the balance struck between incentivising people
9 to adhere to social restrictions and punishing them?
10 Were the rules enforced fairly?
11 There is some evidence that the majority of fixed
12 penalty notices were given to men. Three-quarters of
13 them were issued to white people, but proportionately
14 people from ethnic minorities were 2.3 times more likely
15 than white people to receive one in England and 2.8
16 times more likely to receive one in Wales.
17 Fines were also issued more frequently to people
18 living in disadvantaged communities. Fixed penalty
19 notice recipients were 7.2 times more likely to be
20 living in one of the most economically deprived areas of
21 England and Wales than one of the least disadvantaged
22 areas during the first lockdown. So an issue for you
23 is: how fairly were the rules enforced?
24 My Lady, in light of that identification of the
25 issues, I now make some concluding points about the way

1 in which your Inquiry may wish to approach its task.
2 At the outset, the legal team which has prepared
3 this material recognises that there were no easy
4 decisions. The government, in common with other
5 governments, was required to make extremely serious and
6 far-reaching decisions about how it would respond. Its
7 decisions were literally matters of life and death.
8 Equally, no government is expected to be or can be
9 perfect in its response. No amount of skill, resource
10 or judgement guarantees that mistakes will not be made.
11 Was there a limit -- it will be a matter for you -- to
12 what this government, any government, could do in the
13 face of an organism, a virus, that exists only to
14 infect, spread, maim and kill?
15 This was doubly so when one considers the evidence
16 that you've heard in Module 1 as to the lack of
17 preparedness. Different elected leaders may also have
18 drawn different conclusions as to how to balance the
19 extremely complex ethical, public health, social and
20 economic challenges posed by a lethal pandemic.
21 Some countries comparable to the United Kingdom
22 imposed lockdowns yet suffered lower levels of death.
23 Other countries fared worse. So comparison may
24 therefore only be drawn with caution. Some may say the
25 United Kingdom was probably in the middle of the pack.

But that brings no solace to the bereaved.

In any event, your task is surely to ensure that the government does better next time. The Inquiry also does not intend to enquire through the distorted lens of hindsight. As Anthony Hidden Queen's Counsel, later Mr Justice Hidden, remarked in the Inquiry into the Clapham rail disaster inquiry:

"There is almost no human action or decision that cannot be made to look more flawed and less sensible in the misleading light of hindsight."

So, of course, in the particular context of the lockdown decision-making, counterfactual scenarios must be treated with particular caution.

The evidence may show, but the degree will be a matter for you, that the odds may always have been stacked against the United Kingdom because of the deadly spread of the virus, that's what viruses do, because it was exacerbated and made more difficult to deal with by the UK's international integration, deep travel and trade links to the wider world. The impact of the virus may also have been exacerbated by the relatively poor health and age of the UK's population, by its lifestyle, relatively congested cities and population density.

But the evidence may also show, we will have to see, that there was a failure of technical insight. Was the

inevitable spread of the virus properly appreciated by government? Was there a failure to appreciate the early reports from China, of the Diamond Princess, of the medical journal reports? Were the consequences of the likely lack of any control adequately understood? Was there a failure to direct the putting into place on a crisis basis of mass testing and surveillance systems? Was there a general failure on the part of government to appreciate until 13 and 16 March the true nature of the likely explosion in cases and deaths and that this would lead to the collapse of the NHS? Was there a mistaken assumption that delaying and suppressing the peak would have the collateral benefit of bringing about herd immunity?

Was there, as a result, no early consideration given to how to suppress the virus and to try to keep or regain control? Was there a failure of process? Ministers claimed to be following the science, but did they probe and analyse it sufficiently? Did they allow themselves to believe that the pandemic could be withstood and contained without more urgent action? Was there a failure to obtain and consider specialist non-scientific advice along with the advice from SAGE? Was there a sufficiently effective and robust system for decision-making? Was a proactive strategy adopted and

pursued?

Finally, was there a failure of leadership and decision-making? Was there an absence of leadership?

The Inquiry will enquire into whether the government demonstrated sufficient leadership when it came to the events of March 2020, the first lockdown, the reemergence of the virus in September to October, and the second lockdown in November 2020.

The question for you will be whether any of those lockdowns became necessary as a result of any earlier failures, if you find them to be established. And also you will need to examine the timings of those lockdowns. Were they the result of prevarication by government? If so, another issue will arise, which is whether the system by which our leaders prepare themselves for, are advised upon and respond to, events of such magnitude, requires itself radical reform.

Ultimately, the United Kingdom was spared worse. It was spared worse by: the individual efforts and heroism of civil servants and public servants, and health and social care workers who battled the pandemic; the scientists, medics and commercial companies who researched valiantly to come up with the miracle of life saving treatments and ultimately vaccines; the local authority workers and volunteers who shielded and

delivered food and medicine to the elderly and vulnerable, and who vaccinated the population; the emergency services, transport workers, teachers, food and medicinal industry workers and other key workers who kept the country going.

But we must find out why so many died. Never again can a virus be allowed to lead to so many deaths and so much suffering. Unless we learn the lessons and implement change, all that effort and heroism will all have been in vain when it comes to the next national emergency. There must be, as we turn to the witnesses, accountability and ownership of what went wrong, if anything, and by whom.

LADY HALLETT: Thank you very much indeed, Mr Keith, I'm extremely grateful. We're now going to hear from core participants.

I think 18 core participants wish to make oral submissions, so we have a great deal to get through before we begin hearing evidence, we have therefore had to limit the amount of time available to the core partipants. I'm sorry about that, but it's because of the tight table that we have imposed on us, by me. I will therefore have to be strict with people to ensure they stick to the allotted time. If I intervene, please accept my apology, but rest assured I will read

1 carefully everything that is contained in the written
2 submissions that people have very kindly already sent.
3 Mr Weatherby KC, I think you're starting off.
4 **Submissions on behalf of Covid-19 Bereaved Families for**
5 **Justice UK by MR WEATHERBY KC**
6 **MR WEATHERBY:** Good afternoon, my Lady, and thank you for
7 that.
8 Can I start by welcoming the opening comments by
9 Mr Keith, which were comprehensive, and we will assist
10 to the best that we can to assist in answering the
11 questions that he's posed.
12 I take your encouragement to stick to the time
13 limit, and I will endeavour to do so. I might just go
14 slightly over, but I hope you'll stay with me.
15 In January 2020 Lord Bethell was the government
16 health whip in the House of Lords, and in March 2020 he
17 became a minister in the Department of Health and Social
18 Care. This is what he said in a recent interview with
19 the Institute for Government, which was widely reported:
20 "By mid-January, we in the top floor of the DHSC had
21 a pretty clear idea of what the train was looking like
22 coming down the tracks."
23 He then said this:
24 "No 10 didn't want to prioritise the pandemic in
25 early 2020, even though the evidence was mounting --

1 there was a post-election, ostrich head-in-the-sand
2 mentality ... its priority, and what we were told many
3 times, was Brexit and levelling-up. 'We have to deliver
4 Brexit, so could your pandemic quietly go and mind your
5 own business, please', we were told. After that, we got
6 a lot of erratic dipping-in -- in Yiddish, it's called
7 'kibbitzing', erratic and ill-informed interference."
8 What you made of the Module 1 evidence remains
9 of course to be seen, but in our submission it showed
10 a shocking lack of preparedness, little resilience with
11 a chronically underfunded health sector, and the absence
12 of a functioning social care system, compounded by
13 a lack of any proper pandemic planning.
14 We pose the following questions: how many lives
15 would have been saved if there had been a whole-system
16 pandemic plan, proper resilience within the health and
17 social care systems, a minister responsible for civil
18 emergencies, a standing scientific committee on
19 pandemics, a proper collaborative framework for working
20 with the Scottish, Welsh and Northern Ireland devolved
21 administrations, and also with local authorities? Many
22 lives would have been saved, is the answer that we would
23 provide.
24 So, most relevant to present purposes, the Module 1
25 evidence has highlighted that the United Kingdom had

1 a standing start, in our submission, from January 2020,
2 and it's the role of any competent government or
3 administration to react swiftly to whatever crises
4 arise, with the resources that are available to catch
5 up, and to protect the population so far as is possible.
6 What was needed, then, was a dynamic and proactive
7 government response to lead and galvanise the country.
8 But instead we got what Lord Bethell has starkly stated,
9 in what amounts to a pretty devastating series of
10 admissions from within the centre of government: ostrich
11 syndrome, fixation on Brexit to the exclusion of
12 anything else, and erratic ill-informed interference
13 from Number 10.
14 His words, not mine.
15 It amounts to dither, delay, indecision, denial,
16 bluster and, above all, a lack of leadership.
17 And the views of Lord Bethell will come as no
18 surprise, given the views of others as set out by
19 Mr Keith this morning and which I don't need to repeat.
20 Mr Johnson himself appears set to paint
21 a rose-tinted account to this Inquiry, and recently he
22 asserted that the United Kingdom "defied most of the
23 gloomier predictions and has ended the pandemic ... well
24 down the league tables for excess mortality".
25 Is that really so? Well, according to an analysis

1 by the John Moores University of Medicine cited in our
2 written submissions, per head of population the
3 United Kingdom was the number 20 worst of 173 countries
4 in terms of the number of deaths.
5 Was the outcome really as good as Mr Johnson
6 pretends? It will not surprise you that the
7 7,000 bereaved family members we represent will beg to
8 differ.
9 The bereaved families want vital questions answered.
10 They want candour from public representatives and public
11 servants, not self-serving justifications, bluster and
12 downright fiction. They present 230,000 reasons why
13 Mr Johnson's "we didn't do too badly" opening gambit
14 should be rejected. I'll return to the bereaved
15 families in a little while, because of their real life
16 experience, some of which you heard this morning.
17 If it's correct that the UK Government started with
18 no plan and no real health or social care resilience,
19 how quickly did the government mitigate those deficits?
20 Well, it appears that the starting point was that
21 Mr Johnson failed to take the emerging threat seriously.
22 Initially he will tell us that he thought it was just
23 a scare, and in his statement he says that the impact of
24 the Creutzfeld Jakob disease was initially overstated.
25 He refers to a "bird flu scare" when he was

1 Mayor of London, and he remarks that the 30 January WHO
2 declaration of Covid as a public health emergency of
3 international concern was just one of a number
4 since 2009.
5 His government approached the emerging crisis as
6 a health issue to be dealt with by the DHSC rather than
7 the real whole-system threat that it actually posed.
8 I've already mentioned Lord Bethell's views by
9 mid-January that it was clear to him and others at the
10 DHSC what was coming down the track. But Deputy Chief
11 Medical Officer Jonathan Van-Tam will tell us that as
12 early as 16 January he was "certain that the UK would be
13 struck by a severe pandemic".
14 Mr Hancock will tell us that by 22 January he was
15 warning Mr Johnson directly in a phone call that there
16 was a 50% chance that the virus would escape China and,
17 in his words, "go global", and that a "very large number
18 of people would likely die".
19 Mr Johnson says he doesn't recall this conversation,
20 a somewhat surprising assertion, given its content.
21 Mr Hancock will also tell us that Number 10 refused his
22 request for COBR, the central government emergency
23 committee, to be stood up until 24 January, calling him
24 "alarmist".
25 Although this evidence would suggest at least

1 Mr Hancock was taking the crisis seriously at this time,
2 other evidence indicates complacency on his part too.
3 In a WhatsApp exchange on 25 January, Dominic Cummings
4 asked him about the extent of preparedness for
5 a pandemic. Mr Hancock replied, "We have full plans up
6 to and including pandemic level regularly prepped and
7 refreshed". It will be interesting to see how he
8 squares that assertion with his Module 1 assessment that
9 the UK level of preparedness was "woefully inadequate".
10 Of course, Mr Cummings was the PM's Chief of Staff
11 at this time. For reasons which are unclear to us, his
12 statement and documents have yet to be disclosed, as
13 indeed has the content of Mr Johnson's phone from this
14 period, so I'm unable to take this part of the story too
15 much further, as to what was behind this request of
16 Mr Hancock.
17 Whilst I am on the subject, Mr Johnson claims that
18 although he's downloaded the phone, the WhatsApp
19 messaging from the crucial period of 31 January to
20 7 June 2020 are unrecoverable, a remarkable and
21 unfortunate coincidence, we would say.
22 In line with your forthright warnings earlier in the
23 process around the integrity of evidence, we would urge
24 the Inquiry to commission experts to see why those
25 messages can't be retrieved, and whether they may have

1 been deleted.
2 In considering whether, as Mr Keith says,
3 Mr Cummings was part of the problem and Mr Hancock was
4 less than competent, as some would have it, you'll no
5 doubt take account of the fact that they were in
6 positions at the appointment of Mr Johnson himself.
7 Mr Keith has set out the chronology in some detail.
8 The Inquiry will have to consider whether vital time to
9 form a contingency plan and to act was squandered.
10 Urgent continencies were certainly needed: to do what
11 was possible to mitigate the lack of resources and
12 resilience in hospitals and care homes, increase bed
13 capacity, find ways of increasing staffing availability,
14 provision of isolation and quarantine units, extra
15 intensive care provision, ventilators, PPE, guidance and
16 planning for infection control. Vital time was lost
17 which should have been used to ramp up the manufacture
18 of tests, which had been devised, we're told, by
19 mid-January. Facilities to roll them out, laboratory
20 capacity, PPE procurement and distribution, facilities
21 to vigorously pursue test and trace, similar to contact
22 tracing successfully operated in other countries.
23 None of this would be done, because part of the
24 government was in denial and others had a false view of
25 its own preparedness.

1 None of these failings, in our submission, can be
2 explained by scientific advice.
3 We'll be told, of course, as Mr Keith has indicated,
4 that some will say that they were following the science.
5 Is that really the case?
6 Mr Keith has helpfully referred to an email from
7 Professor Woolhouse on 25 January warning about
8 the urgent threat of the pandemic, the risk of the NHS
9 being overwhelmed. That email copied to all four UK
10 Chief Medical Officers. It was one of a series of
11 emails in fact sent between 21 and 31 January by
12 Professor Woolhouse, and it's important to note that
13 this key one referred to by Mr Keith begins with
14 an apology for when it was sent, on a Saturday.
15 That, we would say, is a clear measure of its
16 urgency. And he was at pains to set out that
17 the tripling of the excess death rate and overwhelming
18 of the NHS was not a worst-case scenario and that he'd
19 conferred with other leading lights in the scientific
20 world, Jeremy Farrar and Professor Ferguson in
21 particular.
22 If the government was following the science, what
23 happened as a result of that dire warning from such
24 eminent experts? And we would say we can identify
25 precious little over the following two months that

1 followed from those warnings. And in fact, of course,
2 those warnings, Mr Keith has said, are not isolated. By
3 29 January COBR was being briefed that the UK faced
4 a possible reasonable worst-case scenario similar to
5 pandemic flu. The importance of that is, of course,
6 that the reasonable worst-case scenario was 800,000
7 deaths.
8 We've heard Mr Johnson wasn't at COBR to hear this,
9 and he wasn't at COBR for more than another month after,
10 until March. He'll tell us that he properly left things
11 to others, but the reality is there was a leadership
12 void.
13 As we set out in the written opening, as Mr Keith
14 has graphically outlined this morning, during this
15 period there was a daily trail of warnings and evidence
16 of the pandemic going global.
17 In April, The Sunday Times ran an article headlined
18 "38 days when Britain sleepwalked into disaster". The
19 thrust of the article was that the UK sleepwalked into
20 widespread community infection, with little action to
21 slow it or prepare for the worst that was to come.
22 It struck a chord at the DHSC, which, unusually, put
23 out a detailed rebuttal, asserting in the strongest of
24 language that "the article contains a series of
25 falsehoods and errors and actively misrepresents".

1 Now, I'm not here to defend The Sunday Times. I'll
2 leave that to the government's Chief Scientific Adviser,
3 Patrick Vallance. His contemporary notes say:
4 "The [Sunday Times] got it about right. We warned
5 of pandemic flu level deaths in January. [Matt Hancock]
6 kept too much in DHSC and didn't move fast enough. [The
7 Civil Contingencies Secretariat] was slow as well."
8 He continued that The Sunday Times had "basically
9 ... got it right". So, again, was the government
10 following the science?
11 In a different entry, in April, Professor Vallance
12 quotes Matt Hancock admonishing him:
13 "Science advice we can't do because of supplies, is
14 worse than useless."
15 The clear inference is that certain ministers were
16 not so much following the science as wanting cover from
17 scientific advisers for shortcomings in provisions.
18 Here it was masks.
19 The theme continued with the change of designation
20 of Covid as being a high-consequence infectious disease;
21 as we know it was designated as such on 16 January,
22 given that it had the potential to spread widely and
23 with large scale fatal consequences.
24 But on 19 March as the UK slid into the first
25 devastating wave, the UK downgraded the designation of

1 the virus, no longer categorising it as an HCID. As we
2 understand it, without advice or consulting SAGE.
3 The effect of downgrading was to reduce
4 the standards of PPE required by healthcare guidance.
5 Or moving the goalposts to avoid criticism might be
6 a way that we would put it.
7 We'll hear from Mr Johnson that scientific advice is
8 also responsible for poor decisions. He will suggest
9 that there was no evidence of asymptomatic transmission,
10 and that explains why the risks were underestimated in
11 the early months.
12 We'll hear from Mr Hancock that there was a global
13 scientific consensus until April 2020 that the virus did
14 not transmit asymptomatically. That is completely
15 untrue. The High Court unpicked this issue in its
16 judgment in the Gardner case. The 29 January COBR
17 meeting already referred to was briefed that there were
18 early indications of asymptomatic transmission. The
19 Professor Woolhouse emails referred to earlier noted
20 that by 31 January there was growing evidence of
21 asymptomatic transmission. By mid-March
22 Patrick Vallance was publicly saying on the Today
23 programme that asymptomatic transmission was
24 a probability.
25 It's important to note that this very public

1 acknowledgement by Professor Vallance came just
2 four days before the decision on 17 March 2020 to
3 discharge 30,000 patients from hospitals without
4 testing, many to care homes. I'll return to that
5 a little later.
6 Mr Keith has already referred to the fact it was
7 two months into the emergency before Mr Johnson attended
8 his first COBR meeting, 2 March. The day before he
9 engaged in what can only be described as cavalier and
10 incredibly unhelpful public messaging when he visited
11 the Royal Free Hospital, telling the media, "I think
12 there were a few coronavirus patients and I shook hands
13 with everybody, you will be pleased to know, and
14 I continue to shake hands".
15 We now know he received a briefing the night before
16 his hospital visit expressly referring to transmission
17 by touching an infected person. It's difficult to see
18 his actions and media comments as other than dismissive
19 of a disaster which had been looming for two months and
20 was now just around the corner.
21 By 2 March the pandemic had not only struck China,
22 the Far East, South East Asia and Italy, but there was
23 sustained community transmission in Germany and France.
24 The contact tracing in the UK had failed.
25 Mr Keith has gone through what did and didn't happen

1 in March, and we've set it out in our written opening,
2 but in overview, until 23 March the approach was largely
3 messaging, advice rather than action. Pubs, clubs and
4 restaurants remained open until 20 March. A particular
5 issue, as we've heard, was mass assemblies.
6 By early March, Madrid had become a hot spot, yet
7 thousands of fans would travel to the Champions League
8 match in Liverpool on 11 March because the UK government
9 not only did not have travel restrictions but did not
10 curb mass assemblies and encouraged the match to go
11 ahead. Other major events went ahead around the same
12 time as we've heard: rugby internationals, incidentally
13 attended by Mr Johnson himself; the Cheltenham Festival
14 between 10 and 13 March, with international travellers.
15 Only on 16 March was there even advice against
16 gatherings.
17 Joan Lally picked up two close relatives from
18 the Liverpool v Atletico Madrid match. They all
19 contracted Covid, and Joan died. Her husband John
20 believes her death would have been prevented had
21 the government acted to stop mass sporting events at
22 a time when it should have been obvious to them that
23 they would become superspreading events, resulting in
24 mass infection and death.
25 John comments that his wife's death was not only his

1 loss, because for decades she had run a girl guides
2 group in a disadvantaged area which had to close as
3 a result of her untimely death.
4 Likewise, Richard Mawson developed symptoms a few
5 days after attending the same match. He died on
6 17 April, his son Jamie believes, again, the result of
7 the failure to stop mass sporting events.
8 Inaction had consequences.
9 No doubt the government did receive differing
10 advice, some against taking certain measures. It seized
11 upon that to explain its indecision, its dithering and
12 its delay. The families I represent count that
13 decision, that incompetence, in the numbers of their
14 loved ones who died, and their stories show how these
15 failures really impacted.
16 Jo Goodman's dad Stuart died on 2 April. You will
17 hear from her tomorrow as the Covid Bereaved Families
18 for Justice UK group witness. She believes that Stuart
19 contracted Covid in a crowded hospital waiting room at
20 an outpatient appointment on 18 March a week before
21 lockdown. He was vulnerable as he was due to begin
22 cancer treatment and had taken his own sensible
23 precautions. But without lockdown, without apparent
24 infection control in public spaces, without general
25 mask wearing, restrictions on transport and mass

1 assemblies, he was left extremely vulnerable when he had
2 to travel and attend the hospital appointment.
3 The early decisions, the lack of action, are
4 therefore of acute concern to Jo. Indeed, Jo was in
5 India in early March, and she was present there when
6 many of the events of the important religious festival
7 of Holi on 10 March were cancelled. She comments, in
8 contrast at that time the UK was allowing large sporting
9 events to continue and, worse, thereby promoting mass
10 international travel from hotspots such as Madrid.
11 Alison Saunders' partner James Yates died on
12 8 April. He had an impaired immune system and Alison
13 believes he contracted Covid at a factory in Livingston,
14 in Scotland, where he worked, or possibly as a result of
15 a trip to Glasgow prior to lockdown, where he visited
16 a number of pubs which had been allowed to stay open.
17 Alison believes that the lateness of the lockdown,
18 the failure to take other important decisions early
19 enough, the lack of safeguards provided to vulnerable
20 people such as James, increased the probability of him
21 and others succumbing. She comments that many such
22 deaths were preventable had there been earlier action by
23 the UK and the Scottish governments. In this regard she
24 particularly notes the apparent differences between
25 the Scottish and UK governments about restrictions on

1 mass assemblies at the time which she believes added to
2 the delay.
3 In this regard the families are concerned that
4 the Inquiry fully considers how the UK Government and
5 devolved administrations co-operated and collaborated or
6 the extent to which they did or didn't.
7 Mr Johnson would have it that his government
8 involved the devolved administrations, including in COBR
9 and through the CMOs. We don't doubt there was
10 co-operation at some levels. What we urge the Inquiry
11 to look at, however, is whether the UK Government was
12 really interested in the compliance of the devolved
13 administrations, persuading them to go along with UK
14 policy such as it was, or whether they actually valued
15 the devolved relationships and differing opinions, in
16 particular in meeting different challenges.
17 Mr Johnson has commented that he put Mr Gove in
18 charge of the relationship with the devolved
19 administrations because he didn't want there to be
20 a "mini EU" of four nations. That will be an issue
21 which will need some explaining and unpicking.
22 Ranjith Chandrapala was a London bus driver on the
23 No 92 route, which started at Ealing Hospital, where
24 subsequently he sadly died. His family believe he
25 contracted Covid at work around 20 April. A number of

1 his colleagues had Covid at the time. There was no
2 testing for drivers. He had not been provided with PPE.
3 There were no Covid safeguards on the buses and those
4 being carried were not required to wear masks.
5 The family comment that Ranjith was a frontline
6 worker left without proper protection, and his death
7 illustrates not only the likely effects of delay and
8 lack of early measures, but also the disproportionate
9 impact of the pandemic on transport workers generally,
10 and black and brown emergency and key workers in
11 particular, given that a third of Transport for London
12 employees are from minority ethnic communities.
13 Disproportionate effect was a factor particularly
14 evidenced in sectors with high percentages of black and
15 brown workers, including health and social care,
16 transport and the gig economy. The Inquiry has
17 instructed experts on structural discrimination issues
18 and it will be vital that it looks at how such issues
19 were considered -- if at all -- from the outset, and
20 throughout the pandemic.
21 Structural racial discrimination, other forms of
22 structural discrimination, in particular regarding
23 disability and age, and with respect to gender and
24 sexual orientation, had a real impact. It's not
25 suggested that an emergency response to any civil

1 disaster can solve such issues, but it is emphasised
2 that the reality of structural discrimination should
3 have been a consideration of central importance to
4 policymakers in mitigating that disproportionate impact.
5 It's simply not correct that the pandemic affected us
6 all equally. So far as we can see, as with the
7 preparedness evidence in Module 1, structural
8 discrimination was an elephant in the emergency response
9 room. There's scant evidence that it was considered at
10 all.
11 It's important to acknowledge that disproportionate
12 impacts persisted throughout the pandemic.
13 Winston Jones, for example, was a 53-year old transport
14 worker. He died on 6 January 2021. His wife Wendy and
15 his three children believe that he and his fellow
16 workers were impacted by mixed messaging after the first
17 lockdown -- which I'll turn to in a moment -- poor
18 guidance, and a lack of supervision of those measures
19 that were in place by the time of his death.
20 When the government ended the first lockdown, it
21 appears that its decision-making got no less erratic.
22 Mr Keith has mentioned the Eat Out to Help Out policy,
23 which involved subsidising people who were coming out of
24 a lockdown designed to minimise social gatherings to
25 gather with others in enclosed spaces. Explained as

1 an economic recovery measure, it appears that it was
2 rolled out without any scientific advice. We anticipate
3 that scientists will say their advice would have been
4 strongly against such a hare-brained scheme.
5 The Inquiry will have to consider whether
6 the government really was following the science, or
7 whether Mr Sunak's flagship policy hastened the next
8 wave of infections.
9 Furthermore, did Mr Johnson, as in March, unduly
10 delay the second lockdown leading to greater loss of
11 life and longer economic and social disruption? What is
12 clear, in our submission, is that lessons were not being
13 learned as the government went along.
14 Christina Fulop died of Covid on 8 January 2021.
15 She lived at home and was assisted by domiciliary care
16 workers. Her daughter Naomi, herself a professor of
17 health care organisation and management, notes that
18 the care workers were provided with no masks during
19 March and April 2020. At the beginning of May 2020 her
20 mother was sent 21 masks for one week to give each carer
21 when they visited her. She had three per day. At the
22 end of that week, Christina received a letter from the
23 care agency saying that the policy as set out by Public
24 Health England had changed and that carers would have
25 one mask per eight-hour shift.

1 Although Christina survived the first wave, she
2 contracted Covid during the winter and died during the
3 subsequent lockdown. Naomi believes that insufficient
4 PPE for care workers, the late imposition of the second
5 lockdown, and the ineffectiveness of NHS Test and Trace
6 led to her mother's death. She further notes that she
7 had been unable to see her mother for some weeks because
8 of the lockdown, was unable to visit her in hospital
9 when she was dying, and could only have a very
10 restricted funeral. This hugely distressing experience
11 was greatly exacerbated as it coincided with some of
12 the illegal drinks parties at Number 10.
13 The families have real concerns that the ongoing
14 failures of policy and erratic response firstly led to
15 mass discharges of mainly older patients from hospitals
16 to care facilities without testing, causing greater
17 transmission into the most vulnerable settings, and then
18 led to the under-admission of older people who needed
19 hospital treatment and the triaging of patients
20 resulting in the restriction of critical care for older
21 and vulnerable people and the inappropriate use of
22 DNACPRs. The families raise issues about dignity too,
23 the treatment of the deceased and of the bereaved in
24 terms of cultural norms and funerals, as you saw
25 powerfully in the impact films this morning.

1 Finally, the families raise the obvious points that
2 Mr Keith mentioned about public figures, Mr Johnson,
3 Mr Sunak, Mr Cummings and Mr Hancock amongst them,
4 breaking their own regulations, reports of suitcases of
5 drink being taken into Downing Street during lockdown,
6 illegal partying. These are already established facts,
7 they're not for the Inquiry to determine, but
8 the families urge the Inquiry not to ignore the
9 undermining of public messaging that these crass and
10 disgraceful events caused. Whilst the vast majority of
11 the country buckled down, complied, and came together,
12 some did not.
13 Thank you.
14 **LADY HALLETT:** Thank you very much indeed, Mr Weatherby.
15 And thank you too for the written submissions that you
16 sent. I found them all extremely helpful. Thank you.
17 **MR WEATHERBY:** Thank you.
18 **LADY HALLETT:** I think the suggestion is that we should
19 carry on. I'm not getting a nod from our lovely
20 stenographer. I think we'll take a break now.
21 We'll have a ten-minute break now and then, if
22 necessary, have another break later.
23 So Ms Campbell KC, after the break, please.
24 **(3.05 pm)**
25 **(A short break)**

1 **(3.15 pm)**
2 **LADY HALLETT:** Yes, Ms Campbell.
3 **Submissions on behalf of Northern Ireland Covid-19 Bereaved**
4 **Families for Justice by MS CAMPBELL KC**
5 **MS CAMPBELL:** Thank you, my Lady.
6 My Lady, on behalf of the Northern Irish Covid
7 Bereaved Families for Justice, together with
8 Peter Wilcock King's Counsel, our junior counsel
9 including Mr McGowan, who's here today, and our
10 instructing solicitors, PA Duffy & Co, we welcome both
11 the opening address from Mr Keith King's Counsel and
12 also this opportunity to address you further today on
13 behalf of the devolved administrations and
14 Northern Ireland in particular.
15 This module of course focuses on central government
16 and later modules, we know, are to examine in greater
17 detail the response of the devolved administrations, or
18 DAs as I might call them.
19 In the case of Northern Ireland, that examination
20 will come in Module 2C in April into May next year, but
21 it's important that I emphasise at this stage that this
22 module is of critical importance to the Northern Ireland
23 Covid Bereaved, because this is a starting point for
24 examining and assessing the pandemic response in
25 Northern Ireland, and there are a number of reasons for

1 that.
2 The most obvious is that Westminster was taking
3 decisions which were not or at least ought not to have
4 been just for England but were of UK-wide significance.
5 At the early stages of the pandemic and at many
6 stages throughout, all eyes, including those of the
7 devolved representatives, were on Westminster.
8 Initially eyes were strained waiting and willing
9 the UK Government to act, and to act with purpose, the
10 purpose being, we hoped, to protect lives. And
11 thereafter, eyes were open in horror and distrust as
12 stories of disarray at the heart of government and
13 parties at the height of the pandemic gripped the
14 headlines, rubbing salt into the wounds of the bereaved.
15 The action and inaction in Westminster had
16 consequences far beyond its postcode.
17 Of course in this module at its core we examine
18 the communication between the UK Government and the
19 devolved administrations. Communication that we observe
20 could have been conducted via well-established
21 mechanisms, could and should have been based on
22 consultation and transparent decision-making, could and
23 should have recognised the need to make decisions based
24 on the particular needs of the devolved nations, could
25 and should have respected the insight to be gained from

1 our local representatives, and should have been driven
2 by a desire to protect our populations rather than to
3 protect any perceived political hierarchy.
4 My Lady, from the material received and considered
5 to date, the Northern Irish Covid Bereaved fear that at
6 almost every level there were failings in that
7 communication.
8 In order to properly assess where the failings may
9 lie and the consequences of such failings, it will be
10 important to closely scrutinise all sides of the story.
11 Were the apparent fears of the Westminster government
12 justified that the devolved administrations would
13 diverge from Whitehall for "the sake of being
14 different", as the former Prime Minister suggests, or
15 does that suggest a belittling of the decision-making of
16 our elected representatives?
17 Is there evidence before this Inquiry from all
18 quarters, from the DAs, and from regional mayors, that
19 there are systemic problems with the governance emerging
20 from Westminster in that it failed to recognise or even
21 adequately attempt to recognise the need for a localised
22 approach to this global pandemic?
23 You're aware, my Lady, of our previously voiced
24 concerns at the decision you took not to hear from
25 devolved witnesses in this module, and those concerns

persist. But in order to go some way to assuage them as this module progresses, we do ask that you keep under close scrutiny the approach of Westminster to how the pandemic gripped the devolved administrations in areas that include scientific analysis, political response, international relations, and financial constraints, because the decisions or indecisions by Westminster were of wider impact. They directly affected our lives in Northern Ireland.

By way of just two examples, both that we've heard of today, the Cheltenham Festival and the Liverpool football match attract significant support from across the island of Ireland. The Cheltenham Festival invited many thousands of Northern Ireland to travel, to mingle, and to spread the virus across three full days in mid-March 2020, and in the same week football fans flocked to watch Liverpool play Atletico Madrid, flying and sailing to the northwest of England, many returning home with the virus.

Our clients strongly believe that these decisions allowed the disease to flourish on the island of Ireland, and considered that it was obvious at the time that this would happen. Their belief appears to be supported by the evidence that you will receive in this module. Your expert witness, Professor Thomas Hale,

identifies numerous studies that support that conclusion. He observes that the rapid banning of public events played a crucial role in explaining decreases in death rates across European countries during the first wave the pandemic. According to studies, a single day of delay in implementing a mass gathering ban or a school closure meant, respectively, a 6.97% and a 4.37% decrease in cumulative deaths. Every day mattered.

There is no doubt that people in Northern Ireland, including those in authority, looked to and relied on the UK to inform our own response. While many of those whom we represent would criticise our own Northern Irish responses, little more than the UK response with a two-week delay, it is important in the context of this module to consider the extent to which Northern Ireland was hindered in its ability to reach informed decisions either despite or because of the reliance on the United Kingdom response.

My Lady, I'll touch briefly on science, because one aspect of concern was access to information and scientific advice.

Baroness Foster, from whom you heard in Module 1, will emphasise the importance to Northern Ireland of access to the wider pool of experts, including SAGE,

greater access than would have ordinarily been available in Northern Ireland. And given this reliance, the make-up of SAGE, therefore, is a matter of importance to us. Despite this being a public health emergency, in fact the public health emergency of our time, and despite the large pool of experts available in the United Kingdom, evidence suggests that there was not a single public health expert or coronavirus expert on SAGE in the early stages of the pandemic.

Did that failure to ensure that appropriate experts were contributing from the outset result in early but significant errors in approach?

Our concerns don't stop there. The devolved authorities may have been denied the opportunity to identify critical omissions given the lack of a devolved representation on SAGE, as you heard in Module 1. This absence was in fact most glaring in Northern Ireland. The earliest date of any Northern Ireland representative at a SAGE meeting was on 9 April. That was the 24th SAGE meeting, coming weeks after a nationwide lockdown had been imposed. Did this inequality of access inhibit the devolved nations' ability to implement an informed response? It's difficult to see, we submit, how it could be said to be otherwise.

The Inquiry will also see and hear evidence that

more than half of the SAGE sub-groups had no representation at all from a devolved administration. According to Professor Henderson, from whom you will hear, a predominantly English frame of reference undoubtedly meant that advice to local populations at times did not meet local circumstances. So, in following the science, was the science just for England? And if that is correct, given the influence of SAGE recommendations on the political response, to what extent did that response make decisions in the best interests of the devolved regions and Northern Ireland in particular?

You know, my Lady, only too well that the Northern Ireland Executive did not function before 10 January 2020, and by that stage we know that there were already important developments in what was known about this new coronavirus and assessing what the potential risk was.

Key questions for the Inquiry in this period are: who was watching out for Northern Ireland in the absence of an Assembly? Was the situation in Northern Ireland, a part of UK without a functioning government, considered at all? It doesn't appear to have been. And what was told to relevant officials in Northern Ireland at that very early stage? Questions that of course are

1 all the more important now, given that our Assembly is
2 once again in a state of collapse.
3 The Inquiry will hear evidence that, following
4 the reinstatement of the Assembly in January 2020, the
5 Northern Irish First Minister and deputy First Minister
6 were not invited to attend a COBR meeting until
7 2 March 2020. Could this Assembly, in its infancy,
8 properly begin to respond to the pandemic that was
9 taking hold if it didn't have full access to the science
10 about what was to come and to the political
11 decision-making in response to it?
12 Sir Jeremy Farrar, formerly of SAGE, writes that
13 knowledge must be shared within hours and days and
14 not weeks, and knowledge must lead to action. The world
15 had all the information it needed by 24 January 2020:
16 a potentially fatal novel respiratory disease that could
17 spread between people without symptoms, with no vaccines
18 or treatment, that had already ravaged a huge highly
19 connected Chinese city. Early scientific papers were
20 spelling out its grim clinical consequences in patients.
21 The world may have had all the information it
22 needed, but did the UK Government consider it and share
23 it appropriately with the devolved nations? And
24 of course how did they, when they began to communicate,
25 do so?

1 The evidence that you will hear suggests that
2 mechanisms which should have been well placed to allow
3 for a co-ordinated response and communication across
4 these islands and amongst the devolved administrations
5 had fallen into disuse and were not resurrected.
6 You will know of the observation of
7 Professor Henderson that "pre-existing organisations to
8 facilitate intergovernmental working were notably not
9 pressed into service during the coronavirus pandemic",
10 and she references the use of the JMC and the
11 British-Irish Council.
12 In April 2020 the former Prime Minister agreed to
13 a proposal to "manage the devolved administrations".
14 That language is repeated and, we submit, it's telling.
15 But his proposal to "manage the devolved
16 administrations" was through the usual Joint Ministerial
17 Committee mechanisms. But despite the JMC having
18 a joint secretariat and being staffed by officials from
19 the Cabinet Office and from devolved administrations, it
20 didn't materialise, and there were no meetings of the
21 JMC in the relevant period.
22 Instead, as with other responses of central
23 government to the pandemic, the approach to devolved
24 administrations was to use ad hoc meetings without any
25 meaningful defined role for devolved actors.

1 My Lady, the Inquiry may find it illuminating that
2 the very same advice to Boris Johnson which suggested
3 his daily 9.15s, his 9.15 meeting, to "allow for
4 decisions to be taken at that meeting", also expressly
5 advised that the devolved administrations should not be
6 invited. Rather, they were going to be updated on
7 the response via a separate process established with
8 the Chancellor of the Duchy of Lancaster.
9 Notably absent from this advice was the suggestion
10 of any advance consultation or co-operation between
11 Westminster and the devolved administrations. The logic
12 underpinning it was that decisions would be taken
13 without them in the room and meetings with devolved
14 administrations became opportunities to convey those
15 decisions and the details of decisions already taken.
16 It's important to recognise that these decisions to
17 exclude devolved actors from decision-making were
18 deliberate. They were not as a result of urgency, or as
19 a consequence of oversight. The approach appears to
20 reflect the views of those in government at the time,
21 such as those expressed by the then Secretary of State
22 for Health, Mr Hancock, who recalls thinking that it was
23 "madness that the devolved government will be taking
24 their own lead on domestic health policy".
25 This view, we suggest, led to flawed

1 decision-making. It undermined co-operation across the
2 islands. It reinforced the appearance of the response
3 as England-centric. It failed to treat the people of
4 Northern Ireland with the respect or afford them the
5 protection to which they were entitled, and in due
6 course we anticipate we will invite you to make such
7 recommendations as to ensure that that does not happen
8 again.
9 My Lady, a brief word on the Treasury.
10 Significantly, the devolved response can't properly be
11 analysed and assessed without considering that
12 Westminster was at all stages controlling the purse
13 strings. It was not reasonably possible to implement
14 effective public health measures without financial
15 support, and we know that. As Professor Hale notes, and
16 is common sense, economic support bolsters compliance.
17 But did the Treasury provide economic support where and
18 when individual jurisdictions needed it? Was there
19 financial scope for Northern Ireland to diverge where
20 necessary from the approach being taken in England? Or
21 was it simply a matter of how soon the same measures
22 were imposed and lifted in England dictated how soon
23 they would apply in Ireland?
24 The First Minister of Wales, Mark Drakeford,
25 describes the Treasury refusing his request for funds to

1 allow Wales to implement a circuit breaker until such
2 time as it was necessary to take those actions in
3 England.
4 What of our nearest neighbour, the south or
5 Republic of Ireland? Northern Ireland sits on
6 a different island and epidemiological unit to
7 Great Britain. What approach did Westminster take to
8 address the unique geographical and epidemiological
9 circumstances of Northern Ireland? Was there any
10 consideration or adequate consideration of communication
11 with the Irish Government in the best interests of the
12 citizens of the north?
13 My Lady, one insight into the interface between the
14 UK government response and the need to co-ordinate with
15 the devolved administrations comes from the outcome of
16 a meeting of 14 March 2020. You heard about it briefly
17 this morning. It was between the Prime Minister,
18 the Chancellor of the Duchy of Lancaster, the Secretary
19 of State for Health, the CMO and the CSA. It was, by
20 this stage, mid-March. As Mr Gove will put it, there
21 was pressure on the Prime Minister to "shift gears and
22 accelerate plans" at this time. No official from
23 the devolved administrations was present or represented
24 at this meeting, but the outcome bears some attention.
25 It says this:

1 "We require a cross-governmental package on
2 shielding the vulnerable and elderly by Wednesday
3 lunchtime ..."
4 I add, that being 18 March 2020.
5 "... for review by the Prime Minister the following
6 morning [ie 19 March 2020], to be in sufficient depth to
7 be ready for implementation. The advice should include
8 'how to handle the devolved administrations'."
9 We were then in mid-March, and the government was
10 calling for a package to shield the elderly and
11 vulnerable against a background in which, on
12 21 January 2020, Professor Woolhouse and his colleagues,
13 Professor Ferguson and Farrar, loudly sounded the alarm
14 that they expected a pandemic fuelled by mild cases but
15 with significant mortality in the vulnerable groups.
16 Seven weeks on, seven weeks of the Prime Minister
17 expressing concern not to scare the financial markets,
18 belittling the risks of contracting Covid, dithering and
19 delay, he calls, for what appears to be the first time,
20 for a package to protect the elderly and the vulnerable,
21 and to "handle the devolved administrations".
22 That package was too late for many. It was too late
23 to provide any protection for Ruth Burke, the
24 indomitable mother of Brenda Doherty from whom you heard
25 powerful evidence at the end of Module 1. You will

1 recall that Mrs Burke was amongst the first to die from
2 Covid-19 in Northern Ireland, passing away on
3 24 March 2020.
4 That package provided no protection for
5 Mary Magdalene Mitchell, nor any consolation to her five
6 daughters who grieve her loss. Mrs Mitchell fell ill on
7 18 March 2020, the very day that cross-governmental
8 package was to be ready for consideration. She had
9 until then lived in her care home in Belfast, to which
10 access was unrestricted.
11 On 19 March 2020 while the then Prime Minister was,
12 we dare to hope, considering how he might protect the
13 elderly and vulnerable, she tested positive for Covid-19
14 and was admitted to hospital.
15 When it quickly became clear that she was not going
16 to recover, her five daughters had to choose which one
17 of them would attend hospital to say their brief final
18 farewell, and she passed away alone on 25 March 2020,
19 her family then having to suffer the indignity and
20 the trauma of being unable to fulfil their mother's
21 funeral wishes.
22 Of course, from then we know the situation
23 escalated. Professor Medley warned starkly, just on
24 month later, in April 2020, that his reading of the
25 situation is that:

1 "We have widespread ongoing transmission in the
2 health and social care systems. Hospital and community
3 health and social care appear to be driving transmission
4 and potentially at an increasing rate. In effect, this
5 is the opposite of shielding, the vulnerable are being
6 preferentially infected."
7 Those chilling words resonate with so many of the
8 bereaved in Northern Ireland, and if I may conclude with
9 reference to some of them, including some who are here
10 today.
11 They include the family of Ann McIvor who lost their
12 very much loved mother. Mrs McIvor had been supported
13 and protected by her family in her own home in the early
14 stages of the pandemic, but when she required hospital
15 treatment they entrusted her to the health and social
16 care system. After weeks of moves and mixed messages
17 and chaos in a system that was ill equipped and ill
18 prepared to cope, Mrs McIvor contracted the virus and
19 passed away alone on 20 May 2020. On that same date up
20 to 200 people had been invited to a "bring your own
21 booze" party in Downing Street, an event that was
22 attended by the then Prime Minister.
23 Almost one year later, Nuala Scullion died on
24 24 April 2021. Her family are here today. She was
25 taken in an ambulance to the hospital and never saw her

family again. She was admitted to the ICU, placed on a ventilator for weeks, and the hospital imposed a DNR without contacting her family, and in circumstances where Mrs Scullion was not in a position to give informed consent. The indignity of her death and the denial of her funeral rights continue to cause her family anguish.

The family of Raymond McAleese, who was 52 years of age when he died. He was a much loved uncle and brother. He was also a man with Down's Syndrome. In September 2021, 18 months into the pandemic, and at a time when, as we have heard this afternoon from Mr Keith, Westminster once again flip-flopped or prevaricated on how to respond to the resurgence of the pandemic, Raymond contracted Covid in his care home and died within a matter of days. The confusion and fear he will have felt and faced, largely alone, in the days between his diagnosis and death continues to torment his family.

Later that year, on 23 December 2021, much loved husband, father and grandfather Peter Clarke passed away. Peter's wife and his daughter are here today. He was a retired fireman and a diagnosis of bronchitis had been a legacy of his service to the fire service. Even at that advanced stage of the pandemic, his family

harboured grave concerns about the preparedness of the response. He was admitted to a Covid ward without a Covid test, placed on a ventilator without the consent of his family, a DNR was noted on his records without proper consultation, and concerns persist about the medication and the move on to end of life care.

Of course there are many thousands more, including the father of Catriona Myles, from whom you will hear on Thursday of this week as part of the impact evidence.

My Lady, there's an important overriding point to make on behalf of those whom we represent. It's well known that Northern Ireland is a society that is divided politically, but the bereaved whom we represent are drawn from all sides of that community, sharing loss, grief, anger and trauma. That they do so reflects a basic scientific reality: a pandemic is not only or even properly a political challenge; it's a public health challenge. And as Sir Graham Medley observed, pandemics do not respect national or subnational boundaries, a global failure was not to have international co-operation and concerted strategies and to agree a common approach.

Those whom we represent consider that this global failure was replicated domestically by the Westminster government. Their response lacked the necessary

consultation to ensure effective co-operation and lacked strategies to agree a concerted approach with the aim of protecting lives.

We anticipate that the evidence in this module will show that the people of Northern Ireland and the UK as a whole were failed as a result of that.

Thank you.

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

Right, Ms Mitchell.

Submissions on behalf of Scottish Covid Bereaved by MS MITCHELL KC

MS MITCHELL: My Lady.

My name is Claire Mitchell KC, and along with my colleagues Kevin McCaffery and Kevin Henry, advocates, we are instructed by Aamer Anwar & Company, solicitors, on behalf of the Scottish Covid Bereaved at both the UK and the Scottish public inquiries.

In Module 1 we learnt that, despite expert groups and pandemic planning exercises, we were in no way prepared for the pandemic when it struck the UK. Healthcare workers had, on so many occasions, sounded the alarm that the NHS was already beyond breaking point. Austerity had bitten so hard that the NHS was already mortally wounded.

SARS and MERS outbreaks had not been properly

studied. Pandemic exercise groups made recommendations that were never implemented. Myriad groups were set up with abounding acronyms and overlapping duties and responsibilities, yet none seemed to have an overall grasp on pandemic planning.

Brexit put an end to preparations for the inevitable pandemic and no proper plans were put in place at all for health, economic and the social impact of a pandemic on the people and on the businesses in the United Kingdom.

In Module 2 the Scottish Covid Bereaved want to find out how the lack of preparation and resilience affected the decisions of our politicians and civil servants faced with the onslaught of a pandemic.

This module will need to explore the UK Government's relationship, or lack thereof, with the Scottish Government. It will be equally important to have this investigated from the Scottish Government perspective in Module 2A.

We will, of course, hear first from the Prime Ministers, the then Prime Minister Boris Johnson, his then Chancellor Rishi Sunak, Dominic Cummings, and many more who had key roles to play in the decisions made by the UK Government.

We must also hear from those who made decisions in

the Scottish Government to understand their role and what part they took in the decision-making process.

From what we have so far read, it is clear that constitutional strife, petty squabbles, territorial power struggles, dictated decision-making rather than the needs of people facing death on a devastating scale.

From that substantial disclosure received so far, including the controversial WhatsApps, there has managed to be prised open a Pandora's box at the heart of government in the critically early days of the pandemic. It reveals a government in crisis, scared and slow to act on expert advice, devoid of the relevant data needed to make critical decisions and significantly crawling behind other countries in protecting its population. As we now know of the thousands who died, there may have been those who could have been saved.

Senior Counsel to the Inquiry has in great detail highlighted that it will be important to closely examine the early days of the pandemic, and he has taken care this morning to set out what will be examined. I would like just briefly to look at a snapshot of that time.

By 24 February the World Health Organisation published a report of its mission to Wuhan, advising countries to immediately activate the highest level of national response management protocols to ensure that

the all of government and all of society approaches needed to contain Covid-19 with non-pharmaceutical public health measures were implemented. Yet it was not until one month later, on 23 March, that lockdown was declared.

On 26 May 2021, Dominic Cummings, once at the heart of Boris Johnson's government, gave evidence about what had been described as a crucial time, that being between Thursday 12 March and Sunday 15 March. It has been disclosed that at 7.48 on 12 March Dominic Cummings sent a text to the Prime Minister saying:

"We've got big problems coming. The Cabinet Office is terrifyingly shit. No plans. Totally behind the pace. We must announce today, not next week, if you feel ill with cold or flu stay home. Some around the system want to delay because they haven't done the work. We must force the pace. We are looking at between 100 to 500,000 deaths between optimistic and pessimistic scenarios. You've got to chair the daily meetings in the Cabinet Room, not COBR."

Mr Cummings has gone on to explain that the COBR system could not work as they couldn't get all the data in properly.

Now, my Lady, having looked at that data, it was clear that the tsunamic effect of the lack of

preparation was about to hit the UK shores. By Friday 13 March 2020 it was clear that the data showed that, even on the best case scenario, the NHS was going to become completely overwhelmed.

On 14 March Dominic Cummings said to the Prime Minister, "You're going to have to lock down but there is no lockdown plan, it does not exist, SAGE haven't modelled it, the Department of Health and Social Care don't have a plan".

So, as we see in the many thousands of pages disclosed in evidence to us, that despite advice from the World Health Organisation on 24 February, despite knowing the experience of other countries where Covid had already taken a grip, despite 16 March being the date SAGE eventually advised the government to embark on a lockdown, it was not until 23 March 2020 that the government announced it.

Where case numbers were doubling every three days, every minute counted, never mind every day. What was happening between those days, those hours, those minutes? Those are the questions that, my Lady, you will have to answer.

There is a very difficult balancing act between listening to all those who were affected and finding out from those who were in charge exactly what happened. As

noted by the Chair in her opening statement, given the inevitability of a future pandemic, we don't have the opportunity to call every witness affected. However, on listening to the Scottish Covid Bereaved, and to some of those people who we heard this morning, three requests appear again and again to emerge. Those are for answers, for accountability and, where due and sincerely made, for apologies.

The Scottish Covid Bereaved want to know the truth of what took place in those early days, to know about the decisions which directly impacted the death of their loved ones. Without truth, lessons cannot be learned, and without truth there can be no justice.

For the Scottish Covid Bereaved the knowledge of what happened cannot take away their grief, but it may, when analysed by this Inquiry, save the lives of many in the next pandemic to come. This, at the very least, is the legacy that they are entitled to expect.

These are the submissions on behalf of the Scottish Covid Bereaved.

LADY HALLETT: Very grateful indeed, thank you, Ms Mitchell.

Right, now, I think Ms Shepherd, you're standing in for Ms Harris, who's sadly got Covid, I gather. I hope she gets better soon.

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

MS SHEPHERD: I appear on behalf of Covid-19 Bereaved Families for Justice Cymru. I will refer to them as CBFJ Cymru.

The subject matter of this Inquiry continues to be as relevant and pressing today as it was in 2020. My Lady, as you have already alluded to, Covid-19 is still with us.

The bereaved families in Wales are still fighting for truth, justice and accountability. They seek answers to the following questions: why did the UK Government and devolved administrations -- what did they know about the risk posed by Covid-19 at each stage of the pandemic? Were the known risks given sufficient consideration? Was there anything that these administrations should have known but did not? And most importantly, for those who I represent, had those governments had sufficient heed to the risks posed by Covid-19, might there have been fewer deaths?

My Lady, in Module 1, CBFJ Cymru focused on whether the UK Government and devolved administrations were adequately prepared for a pandemic. In this module, we will see what happened when those inadequate preparations were put to the test. In Module 2 and the

related Module 2B, CBFJ Cymru want to know how the decisions taken by central government impacted on those in Wales.

While most of the decisions shaping the response in Wales were decisions for which the Welsh Government was responsible, there were many decisions taken by the UK Government which impacted on the people in Wales and shaped the response.

Notably, the financial levers remained with the UK Government. So decisions on extra financial support were made at central government level. The Welsh Government sat on COBR and followed the UK Government's approach at the early stages of the pandemic. They signed up to the coronavirus action plan, which was drawn up and initiated by the UK Government. The Welsh Government shared SAGE as a source of scientific advice, and a four nations approach remained, at least in part, a stated aim of the UK and devolved administrations throughout. Therefore, in order to understand decisions shaping the response in Wales, among the key areas for inquiry in Module 2 are: whether the UK Government and devolved administrations collaborated and worked together; the initial response to the pandemic leading up to the decision to impose the first national lockdown, which was taken on

23 March 2020, a decision which was agreed to by all four nations; how SAGE, the main source of scientific advice during the pandemic for both the UK Government and devolved nations, operated; and how decision-makers engaged with SAGE and the important matter of how scientific and health information, advice and data were shared between the UK Government and devolved nations.

CBFJ Cymru also ask the Inquiry to critically compare the decisions taken by the Welsh Government and the other devolved administrations alongside those taken by the UK Government.

The Welsh Government has long resisted calls to grant people in Wales their own public inquiry. Their position is that a proper understanding of governmental decisions affecting each of the devolved governments can only be achieved by seeing them within the context of the wider UK legal and policy landscape. We therefore invite that critical comparison?

Having introduced CBFJ Cymru's position, I shall now turn to my substantive remarks.

When the pandemic struck, it was foreseeable that its effects would be unequal and that existing inequalities would be exacerbated. The Inquiry will hear stark evidence of those inequalities, for example that people with disabilities experienced inequality in

access to healthcare, that domestic violence was persuasive, that some ethnic groups had greater representation in sectors of work where they were more exposed to risk of infection and, from the report of Professor Clare Bambra and Sir Michael Marmot striking evidence of the relationship between socio-economic inequality and unequal health outcomes.

This evidence provides vital context for examining the impact of the pandemic and what was required of the response to it.

CBFJ Cymru is concerned that there should be thorough examination of the position of older people. Prior to the onset of the pandemic, it was recognised by the Welsh Government that Wales has a higher proportion of older people than the rest of the United Kingdom, and that this cohort are more likely to develop chronic conditions and become frail. In Wales, the population was older than in other nations in the UK, and 71% of those over 65 had at least one long-standing illness. Wales and the UK generally are set to continue this trend towards an ageing population.

The expert evidence of Professor James Nazroo will highlight how older people are at risk of being suggested to ageism and deprioritisation in access to resources and healthcare, that it was known before the

pandemic hit that care homes with vulnerable residents provided a setting conducive to rapid spread of influenza and other respiratory pathogens, that infections may be introduced by staff, visitors or new or transferred residents, and that outbreaks of influenza could have devastating consequences.

With this picture in mind, it is crucially important that the Inquiry will identify whether the needs of older people were overlooked. Was there a subconscious or unconscious tendency to view this cohort as lesser, to view them as dispensable?

CBFJ Cymru say that the response of the UK and Welsh Governments was wholly inadequate to the task. The reason for those failings must be fully examined and understood so that they will not be repeated. Why was a better understanding of the virus not gained earlier by those who had responsibility to take decisions? CBFJ Cymru seek to understand the extent to which the initial response, which was a shared response by all four nations, lacked a coherent strategy. Did a contemplated end point of herd immunity -- and by "herd immunity", my Lady, I mean the second type of immunity referred to by Mr Keith earlier, one which was pursued by Government -- was that allowed to shape decisions on the timing and nature of interventions?

Was the policy of saving the NHS from becoming overwhelmed applied in a way which was inconsistent with the overall aim of preventing loss of life?

CBFJ Cymru asks that the Inquiry specifically investigates the extent to which decision-makers took into account the prevalence and risk of long Covid.

We ask the Inquiry to examine the evidence which was available at all stages of the pandemic in relation to asymptomatic transmission. Was the approach to scientific uncertainty in line with the precautionary principle?

It has been suggested in the written evidence that the difficulty with asymptomatic transmission was that there was a lack of evidence of it or a lack of understanding of it. However, the problem was not so much a lack of evidence or understanding but a failure to factor into decisions something that was uncertain, but which had the potential to have very serious consequences. In the absence or uncertainty of asymptomatic transmission but in the context of there being evidence of a risk, decision-makers should have erred on the side of caution. In light of what was known, the decision in both England and Wales to discharge people from hospital into care homes without testing was indefensible.

Given it was clear from early on that asymptomatic infection and transmission could have devastating consequences, this Inquiry must scrutinise the decisions on prioritisation of testing for those who were asymptomatic. The evidence before the Inquiry shows that decisions on testing demonstrated a lack of urgency. In Wales, the decision to extend testing to all staff and residents in care homes was not taken until 16 May 2020. This appears to have been slower than the other three nations.

We therefore ask the Inquiry to scrutinise the issue of airborne transmission and the state of knowledge concerning routes of transmission at each stage of the pandemic. The possibility of Covid-19 being airborne should have been recognised from an early stage. As early as 14 February 2020, several possible routes of transmission had been recognised by the UK's Chief Medical Adviser and the Chief Scientific Adviser. These included the potential for transmission via droplets, aerosols, direct physical contact and indirect or fomite based physical transmission. If aerosol transmission was considered at least as likely as other routes of transmission, the question must be asked as to why the predominant messaging in early 2020 centred merely around the need to wash hands and avoid close contact.

The failure to properly acknowledge that Covid-19 is spread by aerosol transmission and to adapt public messaging, guidance and non-pharmaceutical interventions, or NPIs, has important implications for infection prevention and control guidance, including the requirement for healthcare workers to wear FFP3 masks for the routine treatment of Covid-19 patients, as well as wider implications for decisions about what NPIs were implemented.

Given what was known, measures should have been considered at an earlier stage to mitigate against the risk of airborne transmission. For example, there should have been a greater focus on indoor ventilation and air quality monitoring, alongside the recommendation to meet outside where possible. CBFJ Cymru ask the Inquiry to ascertain whether decision-making and public messaging as it unfolded accurately reflected the scientific understanding on the possible routes of transmission of Covid-19.

One of the decisions which led to a change in the NPIs which were implemented was the declassification of Covid-19 as a high-consequence infectious disease.

CBFJ Cymru asks the Inquiry to scrutinise the rationale for this decision. We say that such scrutiny is warranted, given the extent of transmissibility of

1 Covid-19 and the number of fatalities that there had
2 been worldwide. This includes asking whether the
3 resource implications of classification were taken into
4 account when deciding to declassify Covid-19 as an HCID.
5 CBFJ Cymru also want to explore how scientific
6 advice was received by decision-makers and factored into
7 policy. There is evidence to suggest that there was
8 a blurring of policy decisions and expert advice, with
9 UK ministers adopting a mantra that they were following
10 scientific advice or following the science, rather than
11 exercising their ministerial judgement.
12 UK ministers and Welsh ministers should have been
13 informed by the science and not led by it. It has been
14 suggested that decisions were held off until scientific
15 advice was overwhelming, rather than using scientific
16 inputs alongside other analysis. The Inquiry should
17 seek to explore how decision-makers used the scientific
18 advice alongside other factors to inform
19 decision-making.
20 In a similar vein, there should be examination of
21 whether decision-makers who received advice from SAGE
22 knew how to effectively engage with it and to use it to
23 work out a coherent plan, which was their
24 responsibility.
25 Not only does the question arise of whether

1 decision-makers knew how to engage with the expert
2 advice, but whether the structure for seeking and
3 receiving advice from SAGE provided sufficient
4 opportunity to ask questions and to explore the issues
5 further with experts.
6 There should be no confusion about the fact that it
7 fell to ministers to evaluate the advice, to ensure that
8 relevant information was called for, and to make the
9 decisions.
10 Turning to intergovernmental relations, the way in
11 which the UK Government and the devolved governments
12 interacted with each other in a prolonged time of crisis
13 is a vitally important area of examination. People
14 across the UK are entitled to expect no less from their
15 elected representatives than that they will conduct
16 relations with each other in a way that is conducive to
17 the most effective response possible. The Inquiry must
18 examine whether COBR, which is in the initial stage was
19 the main forum for intergovernmental relations, was
20 an effective means of consultation with devolved
21 nations. Were the devolved nations mere observers on
22 COBR, not having the same information and advice as the
23 UK Government? Was policy analysis shared late? COBR
24 meetings were called on an ad hoc basis by central
25 government. There is evidence from the Welsh Government

1 that requests were made for a more structured, regular
2 and predictable arrangement. While SAGE was available
3 as a source of expert advice for all four nations, there
4 was no reliable protocol for how the devolved
5 administrations could engage more with SAGE.
6 SAGE provided its advice based on questions from the
7 UK Government alone. Though more direct engagement was
8 requested with SAGE by the devolved administrations, it
9 does not appear that this was achieved. We wish to know
10 why.
11 The Inquiry must ask whether enough was done to find
12 a reasonable and structured means by which to conduct
13 intergovernmental communication. Did these structures
14 enable orderly co-ordination and discussion concerning
15 divergences in policies? We believe the evidence will
16 show that such structures that there were were ad hoc
17 and unequal to the task. A good deal more work is
18 needed in this important area, notwithstanding the
19 recent intergovernmental review.
20 Internal border control is a particular area of
21 interest and concern to CBFJ Cymru. This was an area
22 where the decisions made by UK Government directly
23 impacted on those living in Wales. One of the measures
24 taken in Wales in the second wave of the pandemic was
25 the "Stay local" message which sought to prevent people

1 living in Wales from leaving their local area. The rule
2 of thumb was said to be 5 miles. In England, there was
3 no such restriction. As a result, people in England
4 appeared largely unaware of the travel restriction and
5 sought to come across the border. Then Prime Minister
6 Boris Johnson ignored calls from the Welsh Government to
7 assist in regulating travel between England and Wales.
8 Travel restrictions from parts of England to Wales
9 remained subject only to guidance as opposed to
10 enforceable restrictions.
11 The Welsh Government amended regulations to make it
12 clear that people living in areas with a high prevalence
13 of Covid-19 in England, Scotland and Northern Ireland
14 would not be able to travel to parts of Wales, but the
15 UK Government did not legislate to assist in restricting
16 cross-border travel.
17 CBFJ Cymru ask the Inquiry to scrutinise the
18 decision-making and communication on this issue, and to
19 ascertain whether there was evidence to suggest any
20 outbreaks in Wales were directly caused by cross-border
21 travel from England into Wales. There were many areas
22 of divergence in NPIs between the Welsh Government and
23 the UK Government. Given the shared border, there are
24 some towns which span the border. This had the
25 potential to cause confusion and disruption for those

living in Wales.

Some of the changes were small, such as the number of people from different households who could meet. Given the need for consistent and clear communication with the public, there should have been a good reason for any areas of divergence in policy between the territories of the four nations.

The Inquiry must examine whether divergences between nations and their NPIs were based on sound reasons. The Inquiry should examine whether, bearing in mind the risk for confusion, the leaders of all four nations did all they could have done to deliver a clear message to the public about measures being applicable to one part of the UK but not another.

The evidence will show that there were repeated failures at UK Government level to make it clear where measures being announced applied to England only. This caused unnecessary confusion for people living in other parts of the UK. A report commissioned by this Inquiry sets out how UK Covid press briefings repeatedly failed to clarify the territorial scope of the rules, namely that many of the new rules announced were England specific. An analysis of the texts of prepared speeches throughout 2020 shows that those speaking on behalf of the UK Government did an incomplete job of outlining the

territorial scope of their data, information and guidance.

The Inquiry must seek an explanation from the UK Government as to why there were such repeated and avoidable failures in its public messaging, which was ultimately to the detriment of the public.

To conclude, my Lady, it has been acknowledged by some witnesses that errors were made in the response to the pandemic. We say that acknowledgement does not go far enough, and that the errors which have been acknowledged are the tip of the iceberg in terms of what the evidence will uncover.

These errors caused unnecessary pain and suffering. This Inquiry must therefore reach findings which will lead to decision-makers making better decisions and the institutions of the government working more coherently and collaboratively with devolved administrations of the UK. Changes must be made speedily, in light of those findings so that when the next pandemic strikes, as it inevitably will, people across the UK will be better protected from harm and loss of life.

Diolch yn fawr, thank you very much.

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

Mr Metzer, there you are. I don't have a map today, so I couldn't find you.

Submissions on behalf of Long Covid Kids, Long Covid SOS and Long Covid Support by MR METZER KC

MR METZER: Thank you.

Forgotten, unheard, disbelieved, isolated, unemployed, disabled, immobile. These are the words that characterise the life-altering and devastating experience that people with long Covid have continued to suffer in the pandemic.

My Lady, I appear with Sangeetha Iengar and Shanthi Sivarkumaran on behalf of the long Covid groups, instructed by Jane Ryan of Bhatt Murphy.

The long Covid groups are Long Covid Kids, Long Covid SOS, and Long Covid Support, grassroots patient advocacy organisations whose members were compelled to come together in the early months of the pandemic to give voice to and raise awareness of long Covid, the long-term illness caused by Covid-19.

At the outset, the long Covid groups wish to acknowledge the pain suffered by the bereaved families who lost loved ones to Covid-19 and offer their condolences to them.

As Hugo Keith King's Counsel has previously noted, long Covid is an injury, a serious condition, even a serious morbidity, which is the result of having had Covid. People with long Covid are the surviving ongoing

victims of the pandemic. We have seen on the impact film people with long Covid explaining movingly that they did not know if there will ever be light at the end of the tunnel. My Lady, the long Covid groups ask your Inquiry to shed light on whether their suffering was avoidable. They seek truth and accountability for the harms they have suffered and, crucially, reassurance that the suffering of 2 million people in the UK is not an inevitable fate bound to be repeated in future pandemics.

The Inquiry will hear from multiple sources that the possibility of long-term post-viral illness was well known before this pandemic. Sir Patrick Vallance states:

"From my perspective, I was conscious that long-term sequelae were a possible outcome of Covid-19 from early on in the pandemic."

Professor Brightling and Dr Evans echo this view and point to lessons from previous corona pandemics, SARS and MERS, that should have been learned. Their expert opinion is that it was foreseeable that there was going to be long-term sequelae from Covid-19, extrapolated from previous coronavirus pandemics and previous knowledge of post viral syndromes.

My Lady, a running thread of concern for this

Inquiry will be: long Covid was foreseeable, so why was it not foreseen?

The Inquiry will hear of a dissonance in Westminster between knowledge of long Covid, on the one hand, and political recognition of it, on the other, and an even greater dissonance between knowledge of long Covid and any reaction to its risks.

The first of six framework questions which the long Covid groups hope the Inquiry will investigate is: what did decision-makers know and understand of long-term sequelae and long Covid? To answer that, the Inquiry will hear evidence from scientific advisers. Members of NERVTAG on 6 March 2020, before the first lockdown, had already advised that identifying the end of symptoms may be very prolonged or very difficult to define.

On 28 April 2020, SAGE 29 went further, advising on the importance of cohort studies of Covid-19 survivors to understanding the longer term effects.

By 15 May 2020, NERVTAG discussed the need for ongoing clinical issues post-Covid and the potential need for a clinical forum. There was also early understanding that long-term sequelae could pose a risk to children. NERVTAG noted this risk in February 2020 and by April 2020 SAGE 29 agreed to action priority

studies on Kawasaki-like syndrome in children.

The Department of Health and Social Care was equally alert to the long-term health impact of Covid-19, and in June 2020 recorded sequelae of the disease, potential long-term lung and organ disease, as one of four major implications for the health and care system that would have to be catered for.

By 17 July 2020, Matt Hancock chaired a roundtable mandated to discuss the long-term impacts of Covid-19 in order to better understand, prepare and prevent it.

The NHS similarly prepared a detailed briefing note in August 2020 estimating that 60,000 people in the UK were expected to experience persistent or permanent physical health problems similar to previous coronaviruses such as SARS and MERS.

Whilst the understanding of the long-term health impacts of Covid-19 in adults and children was growing behind the closed doors of scientific advisers and public health departments, the complete absence of public information and government advice created a vacuum which patients, parents and carers were forced to fill.

Long Covid is a patient-made term created by patients using social media to find solidarity and share their experiences of suffering the long-term health

impacts after infection of Covid-19.

The first posts on social media about protracted symptoms of Covid-19 were published in March 2020, closely followed in the traditional media. There was no government recognition or published advice on long Covid at this time. It was left to the long Covid groups to mobilise and advocate decision-makers for recognition of long Covid.

It was only on 7 September 2020 that the first official government guidance on the long-term effects of Covid-19 were published by Public Health England. The Inquiry will surely wish to examine the unique and significant role that patient advocacy was forced to play in the recognition and response to long Covid, the second framework question, and in turn to explore why the government delayed publicly recognising long Covid.

The early recognition of long Covid amongst scientists, clinicians, public health bodies, patient advocates and even the Secretary of State for Health and Social Care is clear. Against this backdrop, the evidence paints an entirely incongruent picture from the corridors of power in Westminster.

In October 2020 while the DHSC was publishing guidance on long Covid and called for recognition and support for people with long Covid, then Prime Minister

Boris Johnson scrawled in capitals that long Covid was "bollocks". Mr Johnson has admitted in his witness statement that he didn't believe long Covid truly existed, dismissing it as "Gulf War syndrome stuff".

The Inquiry will be concerned to probe how the former Prime Minister could possibly hold this view in October 2020, when SAGE, NERVTAG, DHSC, NHS, the WHO, and patient advocates around the world had recognised and registered the risk that long Covid was already posing with its own unique global ICD classification of the disease.

The Inquiry will no doubt wish to carefully scrutinise whether the science was followed.

It is perhaps noticeable that the former Prime Minister now accepts that long Covid is a serious health condition, but does not say when he changed his mind.

I'm sure, my Lady, you will be fully cognisant that adults and children were and still are suffering from debilitating, painful and terrifying symptoms for months and now years after infection, as we saw in the film earlier this morning, and yet Mr Johnson denied the truth of their suffering.

The UK's senior most decision-makers were dismissing, diminishing and disbelieving the very

existence and risk of long Covid. This inevitably led to inaction and a failure to protect the UK public from long-term harm to their health. That failure was three-fold:

First, a failure to monitor and collect data on long Covid.

Second, a failure to integrate the risk of harm from long Covid into decision-making.

Third, a failure to communicate the risk of long Covid to the general public.

The surveillance and monitoring of long-term sequelae is foundational to understanding its nature, severity and prevalence, yet seems to have been overlooked. The Inquiry will hear evidence to answer the third framework question, whether there was data collection and modelling of long Covid.

From the very outset of the pandemic, even though there was a foreseeable risk of long-term sequelae, the government focused only on the twin metrics of deaths and hospitalisations.

Professor Chris Whitty admits that initial planning for Covid-19 took no account of long-term impacts of Covid-19. The long Covid groups are concerned to understand why the gap in data monitoring wasn't remedied sooner. They ask why, on 7 May 2020, when

SAGE 34 identified the existence of longer term health sequelae and the importance of monitoring these impacts, was data not immediately sought by government decision-makers.

It was left once again to patient advocates to draw decision-makers' attention to this chasm in data monitoring. Patient advocates gave evidence on the need to collate data on long Covid in August 2020. However, it was only on 1 April 2021, one entire year after SAGE had noted the importance of monitoring long-term sequelae, that ONS began publishing the first statistics on the prevalence of long Covid. Delay and dissonance continued to define the government's response.

The ONS published its last bulletin on the prevalence of self-reported long Covid in March 2023 and had stopped collecting and publishing data. This is despite currently rising numbers of Covid-19 infections and where long Covid continues to be a current major health problem. So the long Covid groups are gratified to learn that the ONS has just announced a winter study on Covid-19 infections, which will include the impact of respiratory infections including long Covid.

The fourth question we ask is whether the prevalence and risk of long Covid was taken into account in decision-making on NPIs.

The only way to avoid long Covid is to avoid contracting Covid-19. The possibility of long-term damage to health should have been and surely must be a relevant factor. It was not simply a case of considering metrics for deaths and hospital admissions or balancing, in a binary assessment, the risk of harm the virus posed to the elderly and vulnerable against a risk of harm measures posed to the younger population. There is a fundamental third metric that affects children and adults: that's of long-term morbidity.

A government that was considering the long-term health impacts of the virus would have considered the harm that long Covid causes to individuals, the public health burden of people contracting long Covid including to parents and carers, messaging to warn the public against the debilitating health damage long Covid causes, the social and economic cost of workplace absenteeism long Covid causes, the cost of financial support for people with long Covid on sick leave, the extra demands on the social care sector to support people with this debilitating illness, policy implications such as categorising long Covid as a disability in line with the approach taken in the United States in July 2021.

Instead, the evidence before you, my Lady, will

demonstrate that tools like the dashboards and CRIPS that decision-makers used didn't include the risk to long-term health. Their analysis of risk was distorted, overlooking the very real impact of long-term and disabling health consequences. Professor Whitty acknowledges the shortcomings of not recognising the risk of long Covid, saying that when they did, "it made us more cautious of the effects of Covid-19 in young and otherwise healthy adults as the pandemic progressed".

The failure to integrate the risk of long Covid into pandemic decision-making continued throughout all the lockdowns and into the government's exit strategy in preparing for "Freedom Day".

When we look at the evidence, it prompts the question: was long Covid overlooked or was it dismissed? Minutes from a Covid-O meeting on 5 July 2021 suggest a dismissive attitude to long Covid persisted when it was recorded, alarmingly, that long Covid should not be used loosely, as it described a number of syndromes at a time when personal independent payment claims had reached an all time high.

Twinned with an assessment of decision-making around NPIs is the issue of whether timely and clear public messages were issued so that the public were alert to the risk of long Covid to adults and children. The

1 public cannot protect themselves from risks they don't
2 know about. During the relevant period there appears to
3 have been only one public health video on long Covid
4 released by the DHSC, in October 2020.
5 The evidence prompts our fifth framework question:
6 how and to what extent did decision-makers warn the
7 public about the risk of developing long Covid and take
8 the disease into account in public health
9 communications?
10 The distressing experiences of the long Covid groups
11 is one to be heeded and learned from. We hope
12 the Inquiry's important work will ensure that never
13 again will it take thousands of patients to fight for
14 recognition, to strive to be believed for their physical
15 suffering and to advocate for their own safety and
16 protection.
17 The final and most central question weighing heavily
18 on all those who have suffered from long Covid is
19 whether the government could and should have done more.
20 Was the long-term suffering of nearly 2 million adults
21 and children from long Covid avoidable?
22 Thank you, my Lady.
23 **LADY HALLETT:** Thank you very much indeed, Mr Metzer.
24 Mr Friedman, just two more to go, you're the
25 penultimate one.

1 I think I'm being encouraged ...
2 **MR FRIEDMAN:** Yes.
3 **LADY HALLETT:** A five-minute break, I think, by the look on
4 the face of our wonderful stenographer.
5 **MR FRIEDMAN:** Certainly.
6 **LADY HALLETT:** Right, and I will be back promptly just
7 before half past.
8 **(4.24 pm)**
9 **(A short break)**
10 **(4.29 pm)**
11 **LADY HALLETT:** Sorry about that, Mr Friedman.
12 **Submissions on behalf of Disabled People's Organisations by**
13 **MR FRIEDMAN KC**
14 **MR FRIEDMAN:** Not at all.
15 My Lady, I act for the Disabled Peoples'
16 Organisations, or the DPO, run by and for disabled
17 people. They are Disability Rights UK,
18 Inclusion Scotland, Disability Wales and Disability
19 Action Northern Ireland.
20 Disabled people died more of Covid-19 than anyone
21 else. Disabled people suffered physical and mental harm
22 during the lockdowns in ways that others did not.
23 People who took years to set up and maintain systems of
24 independent living lost those systems overnight. They
25 lived with the fear of non-resuscitation, lesser

1 prioritisation of treatment, or dying in their homes
2 because no one knew they were ill.
3 The questions our clients bring to this Inquiry are:
4 why did disabled people fare so badly during the
5 pandemic, and what does it tell us about the society we
6 have chosen to live in and could choose to change?
7 Disabled people are 20% of the UK population and six
8 out of ten of the Covid dead. That should make their
9 fate one of the most significant of public issues, but
10 it is not. The DPO therefore suggests an essential
11 starting point for the Inquiry, that the bulk of
12 disabled people's fatal and damaging outcomes during
13 the pandemic were chosen. They were the product of
14 the way our society is organised, and the dominant
15 values and beliefs that guide it. Our clients use
16 the terminology of disabled people because people are
17 disabled by the fact that social spaces, services and
18 provisions are modelled around certain kinds of bodies
19 and minds to the disadvantage of others.
20 That does not deny the reality of individual
21 impairments, but what disables people, because of their
22 conditions, are barriers and attitudes that are not
23 experienced by those without such conditions.
24 The predicament of disabled people overlaps with
25 having lower income and rates of employment,

1 inappropriate housing, and suffering food scarcity,
2 isolation and hate crime. Disabled people are often
3 treated worse because of their age, race, sex and
4 gender. Inequality is now a core issue in this Inquiry,
5 but during the pandemic these matters were initially not
6 spoken of, or characterised with euphemisms such as
7 "disparities" or "non-clinical vulnerability"; anything
8 other than the made inequalities and inequities that
9 they are.
10 One of the reasons for euphemism was to defend the
11 indefensible. Austerity had particularly severe
12 consequences for disabled people. It is perverse for
13 its architects to suggest otherwise. There is
14 an inescapable tension between, on the one hand,
15 government's withdrawing services in the ten-year period
16 before Covid -- a period when life expectancy ceased to
17 improve for the first time since the beginning of
18 the 20th century in this country -- and, on the other
19 hand, the central reliance on resilience within
20 UK Government emergency doctrine.
21 The foundation of the choices that rendered disabled
22 people particularly vulnerable during the height of the
23 pandemic is a dominant ideal of personhood in our
24 society. That person is autonomous, independent and
25 self-sufficient.

Nothing signifies the notion of personhood more than the central place of the home in the government's pandemic response. The person the government imagined when it told us all to stay at home was someone who could financially, physically and logistically afford to stay there. It did not imagine the person who had no spare room to isolate in, the person dependent on assistance from others, the person who could not stay at home or isolate within it because they need to care for someone else or because they could not survive without going out to work. Instead, it imagined a non-disabled, autonomous person who would regard their home as a place of safety and be capable of moving their life into it.

There is a different way to see all of this. It arises from the truth, that we are all vulnerable, we are all in a state of dependency at the beginning of our lives and are likely to be at the end of it. In between we will all, in some way, at some point, be affected by physical ailment, emotional suffering, or some kind of bodily limitation. In that respect, vulnerability is universal.

The opposite of vulnerability is not invulnerability, but resilience. Resilience is acquired over time by virtue of resources and relationships which the state is critical in either fostering or denying,

depending on its policies. Laws against discrimination that secure a level playing field are good in themselves but not enough to produce a fair and resilient society, one that can offer protection to us all in a pandemic.

What is required is a more positive conception of rights and responsibilities that deals with differences of power and situation in a more responsive, imaginative and resourced fashion.

My Lady, the inequities suffered by disabled people should be understood as issues of public health, but they are also human rights violations. The UK has signed and ratified the United Nations Convention on the Rights of Persons with Disabilities. What that global convention confirms is that disaster planning, data collection and co-production and co-design on policy are not just good ideas, they are binding international law. These rights were endorsed by the WHO's 2011 report on disability, and in the 2015 Sendai Framework for disaster risk reduction.

Also, as my Lady knows, in 2017 the UK was criticised for its non-compliance with the UN Convention, with identified shortcomings in emergency planning, data collection and failure of consultation.

Having considered tens of thousands of previously

confidential documents now disclosed by the Inquiry, what is extraordinary is how little these rights reports and guidance documents featured in government approaches at the outset and during the pandemic. These are some of the most important documents in the history of disability rights. On present disclosure, they left no footprint in the UK Government decision-making during the pandemic at all.

Against this background, the DPO identify nine failures in the Covid emergency state.

First, there was no system of disaster management because the UK does not have one. That much is clear from the evidence in Module 1. What we have scattered across legislation, regulations, guidance and plans does not cater for the critical collaboration between state and society that the Covid response demanded. Crucial links between central and local government are missing. Reliance is placed on the voluntary sector and community to fill gaps but without mandating that they be involved in planning or be funded to respond. Before 2020, none of the DPO were invited to engage on planning for a pandemic. They still have not been invited.

Second, with no plan beforehand, disabled people's situation was then made worse by no plan being created. We now know that there was no high-level ministerial

meeting on the impact of Covid on disabled people until 21 May 2020. On that day, the general public sector ministerial implementation group dealt with an agenda item on disability for the first time. The effect of that meeting was a plan to get a plan.

During the autumn of 2020 the government focused on the disproportionate impact of Covid on ethnic minority communities. Our complaint is not about that. Focus on all disproportionately impacted groups should have been prioritised. However, the Covid taskforce noted a direction from Mr Johnson and Mr Gove as late as November 2020 that planning for disabled people was to go on a "slower time". That was despite knowing by June 2020 that disabled people were dying in disproportionate numbers, and despite Michael Gove in October 2020 declaring that, "time is running out" for the risks to disabled people, amongst others, to be mitigated in the second wave.

As a result, there was no plan for disabled people throughout the first and second waves of the pandemic, and there is still no plan.

Third, when it comes to equality matters including with regard to disabled people, the machinery of government is minimal. Roles are dispersed across several departments and dual ministerial posts with no

1 overall lead minister. The Cabinet Office Equality Hub
2 is described as a creature of policy and not
3 an operational department. Yet the Minister for
4 Disabled People, Justin Tomlinson, will suggest that he
5 deferred to its Disability Unit, or DU, on the most
6 essential features of his role.
7 During the pandemic, aside from the abject failure
8 to escalate disability issues to ministerial meetings
9 for months, other shortcomings include
10 Minister Badenoch, whose portfolio did not include
11 disability, being commissioned in June 2020 to conduct
12 a review of disparities in pandemic impacts that did not
13 examine the impacts on disabled people.
14 Fourth, none of the key decision-making during
15 the pandemic was informed by the expertise of disabled
16 people. Of the many problems with the slogan "follow
17 the science" was that SAGE was initially dominated by
18 medical scientists. Those who gave or acted upon SAGE's
19 advice did not benefit from the expertise of service
20 providers or end users, including disabled people, and
21 for a very long time no one appears to have noticed
22 the problem. When it was noticed, the corrective action
23 focused on race, ethnicity and gender. The perspective
24 of disabled people remained missing.
25 Fifth, one of the consequences of no expertise is

1 that there was no proper recognition of how disabled
2 people fitted into the pandemic response. Most
3 significantly, the administrative and political
4 decision-making moved only incrementally from a clinical
5 shielding focus to a broader social focus. Even then,
6 disabled people remained subsumed within the notion of
7 vulnerability, locating their risk within them as
8 individuals as opposed to acknowledging inequality as
9 its source.
10 Sixth, despite obvious risks to disabled people from
11 the outset, the government did not properly engage with
12 them or their organisations during the pandemic
13 response. The encounters between Minister Tomlinson,
14 DPOs and other organisations were qualitatively too
15 little, too late, and too one-sided to constitute
16 compliance with the principles of co-production and
17 co-design. The Inquiry has evidence from multiple DPO
18 and other civil society groups whose insights and
19 networks could have been harnessed in the crisis but
20 were not.
21 Seventh, government needed to engage properly with
22 disabled people because they began the pandemic bereft
23 of sufficient data about them. The papers issued by
24 the DU on 21 May and 30 October 2020 registered
25 an increasing awareness of the problem.

1 As of 12 November 2020 the DU proposed a data
2 commission to understand factors driving increased
3 mortality risk, but that proposal was not acted upon.
4 On 30 March 2021 the DU still expressed concern
5 about data deficiency and the need for a data
6 improvement programme.
7 In July 2021 the DU published the national
8 disability strategy that committed to "strengthen the
9 data and evidence base to support policies that will
10 transform outcomes for disabled people", but did not say
11 how it would do that and still has not done so.
12 Eighth, failing to engage early with disabled people
13 and their organisations was a lost opportunity to afford
14 some of the most significant protections. The DPO
15 repeatedly emphasised that they could have assisted
16 earlier to prevent disabled people confined to their
17 homes being left without food. Other grave errors were
18 made regarding care homes, the risk of Covid to people
19 with learning disabilities, assumptions around digital
20 and other information access, making services only
21 available to those on official medical lists, sign
22 language, and earlier identification of long Covid, all
23 of which it is difficult to imagine would have been
24 overlooked with better engagement.
25 Ninth, and finally, government policy did not

1 involve any significant income distribution to disabled
2 people. The financial provision for disabled people
3 during the pandemic was extraordinarily limited. For
4 those who did not work or could not work, furlough meant
5 nothing. Those on carers' allowance did not receive the
6 extra £20 of Universal Credit, neither did those on
7 legacy benefits. In its briefing to the Covid-O group
8 on 30 October 2020, the Disability Unit acknowledged the
9 disproportionate financial impact of Covid on disabled
10 people but proposed no remedy, save a possible financial
11 package which did not come.
12 My Lady, that is why we say what happened to
13 disabled people during Covid was a choice. This country
14 could make different choices. It could comply with
15 international law and have us live under more responsive
16 government, but to do that there needs to be
17 a fundamental investment in collective resilience. What
18 happens to disabled people during disasters provides
19 an insight in what could happen to all of us.
20 The pandemic has made everyone more aware of the
21 life cycle, the limitations of the body and value of
22 relationships. It has dispelled the illusion that we
23 are islands unto ourselves. It has made the ethics of
24 mutual care far more pertinent in the way we might live.
25 One task of this Inquiry should be to embed those ethics

into its recommendations for the future.

Thank you, my Lady.

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

Right, Mr Cohen, last but not least.

Submissions on behalf of the UK Statistics Authority by MR COHEN

MR COHEN: My Lady, I have some brief opening submissions on behalf of the UK Statistics Authority.

The Authority is an independent statutory body encompassing a number of other entities. It's a non-ministerial public body reporting to the UK Parliament and to the various devolved legislatures. It has responsibility for the more widely known Office of National Statistics, as well as for the regulation of statistics in the form of the Office for Statistics Regulation, and next week, my Lady, you'll be hearing from the National Statistician, Sir Ian Diamond, who oversees the Authority.

My Lady, the Office of National Statistics have of course been very closely involved in understanding the cost and toll of Covid. They are keen that any contribution from them to this Inquiry should begin with an expression of their profound and sincere condolences to the bereaved, and their very great sympathy to all those otherwise adversely affected. The Authority

understand how devastating Covid has been in many sectors of society, and they recognise that in all that they can say and do now.

I'm also asked, my Lady, to thank the public for their willingness to co-operate with Office of National Statistics' attempts to gain information during the pandemic, as well as to thank the staff of the Authority for their work on behalf of the National Statistician.

My Lady, the Authority sees that it can assist this Inquiry, both because of the leading role it took in the development of insights and statistics during the pandemic and also because the Authority is determined to learn what happened and what could have been done better.

The recognition of the likelihood of future pandemics and other emergencies is central to the Authority's position. They are determined that in the event and when those matters come to a head, they are better placed than ever before to address them.

My Lady, it may be of value to trace out in broad brush terms some of the work that was done during the pandemic.

The role that the Office of National Statistics had remained constant, but it of course occurred in a difficult and unprecedented environment. There were

particular challenges in producing official statistics in relation to the accuracy and quality of data. It is very difficult to undertake survey data collection when social distancing is understandably in place, and where it is no longer possible to knock on doors and ask questions. However, the ONS did put in place significant measures to try and minimise those limitations, including by re-weighting results and finding new and innovative ways of collecting data.

This all occurred, of course, my Lady, in circumstances where the appetite and demand for official statistics was perhaps greater than ever before. That was partly because of a governmental need for more information and evidence to inform policy development, and also because of an understandable thirst from the wider public to understand the statistical picture and what was going on in the country.

In the light of that increased demand, the Office of National Statistics adapted and increased the level of insight provided within its standard releases such as those concerning mortality. A decision was taken that the data on mortality should be linked to different characteristics such as ethnic group, disability and occupation, in the hope that this could provide a new perspective and new levels of insight.

There was also, of course, significant new work being undertaken, such as through the development of the Coronavirus Infection Survey, a world-leading survey set up in exceptionally rapid time to measure Covid-19 infection as well as antibody rate in the wider population. At its peak, 400,000 samples were being collected each month by the ONS, and that formed part of the evidence base for the government's surveillance of the pandemic, as was occurring in the United Kingdom, with data broken down across the four nations and also by age, region and other characteristics.

The ONS also deployed statistical experts in other government departments, the devolved administrations and public bodies, including finding new ways of sharing their expertise, providing support to other departments on how best to use statistics and to understand what was needed from statistics professionals across government.

The lessons that the Authority has taken from that exercise, my Lady, are, first of all, that the need for immediate statistical assistance by government in the light of any new emergency is paramount. It is vital that statistical professionals and the ONS in particular are involved in future health emergencies from the first.

In addition, the understanding should be retained

1 that some of the insights that the ONS was able to
2 gather during the pandemic, such as its use of regular
3 flexible surveying and providing value in tracking
4 societal and economic issues, shouldn't be lost. There
5 has been an amount of knowledge built up which is of
6 importance.
7 Finally, my Lady, the Authority's regulatory
8 function -- which is spoken to in a witness statement
9 that is available, or will be available in due course --
10 shouldn't be overlooked. That is an important and
11 responsible aspect of the Authority's work, seeking to
12 ensure that official statistics are presented fairly,
13 properly and in a manner which is not misleading.
14 My Lady, as I say, the Authority is determined that
15 any lessons that can be learnt from this Inquiry are
16 taken on board, and stands ready to assist in any way
17 possible, most immediately through the evidence of
18 Sir Ian Diamond next week, but on an ongoing basis
19 of course.
20 **LADY HALLETT:** Thank you very much indeed, Mr Cohen.
21 Right, that completes the submissions for today.
22 I'm very grateful to everybody. Nearly everyone stuck
23 to the allotted time; some, I think, were even slightly
24 shorter. So I'm really grateful to you all, and
25 I appreciate how difficult it is to try and get

1 everything in, and also then not to be criticised for
2 speaking too quickly.
3 So we've done jolly well today, we've had a great
4 deal of information and a number of very interesting
5 submissions that obviously at some stage I'll be
6 considering with all the care that people would expect
7 of the Inquiry.
8 10 o'clock tomorrow morning, please.
9 **MR KEITH:** Thank you.
10 **(4.55 pm)**
11 **(The hearing adjourned until 10 am**
12 **on Wednesday, 4 October 2023)**
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