BEFORE BARONESS HEATHER HALLETT

IN THE MATTER OF: THE PUBLIC INQUIRY TO EXAMINE THE COVID-19 PANDEMIC IN THE UK

CLOSING STATEMENT

ON BEHALF OF COVID-19 BEREAVED FAMILIES FOR JUSTICE CYMRU

MODULE 2

Introduction

1. CBFJ Cymru is dedicated to campaigning for truth, justice and accountability for the bereaved in Wales. Its members have experienced first-hand failures to respond adequately to the pandemic in Wales and the UK as a whole, and the catastrophic effects of those failures. The group seeks answers about what happened in Wales and why decisions which impacted on Wales were made in the way they were, so that there can be true accountability and lessons learned.

2. The pandemic response in Wales was primarily the responsibility of the Welsh Government, acting under its devolved responsibilities, and it primarily must be accountable for that response. However the UK Government (UKG)'s decisions and UK level structures also shaped the response in Wales.

3. In the period leading to the first national lockdown Welsh Government decisions were aligned with UKG decisions. All Four Nations sat on COBR and agreed the Coronavirus Action Plan of 3 March 2020 and full national lockdown on 23 March 2020. How decisions relating to Wales were made will be examined further in Module 2B, but we know that after 23 March 2020, at times, Wales adopted the same policy as UKG's policy applicable to England, although at times with later implementation in Wales (e.g. testing of all individuals discharged from hospital to a care homes ; whole care home testing), and at other times policies were different, for example, the switch from *Stay at Home* to *Stay Alert* in May 2020 was not adopted in Wales, and in Wales there was an Autumn firebreak. The main financial levers were at the UKG level (although there is a debate as to the extent Wales was given more flexibility during

the pandemic). SAGE was the main source for scientific advice and information UK-wide including for Wales.

4. Against this background, a central concern for the Welsh bereaved families in this module is whether the UK Government and the Welsh and other Devolved Administrations collaborated effectively.

5. This statement considers the evidence in Module 2 on areas of UKG decision-making and UK structures where these shaped or are relevant to understanding the response across the UK including in Wales, under the following headings:

Preparedness (its relevance to this module)
Inequalities
The initial response to Covid-19
Asymptomatic transmission
Social care
Airborne nature of the virus
After the first national lockdown
Internal border issues
Intergovernmental relations (UK Government and the Devolved Administrations)
Public announcements and messaging
The sharing of UK science expertise throughout the UK

Relevance of preparedness in Module 2

6. The lack of preparedness of the UK for a pandemic (the subject matter of Module 1) is a key matter of context for the subject matter in this Module. Two significant aspects relevant across the UK were: the lack of an overarching plan for a pandemic response such as this and the lack of a scalable infrastructure for testing and for test and trace.

7. It was stated in the evidence, that had the public health infrastructure in the UK been as developed as in some other countries, other paths and outcomes may have been open to the UK[1]. Professor Hale's report states that the most effective governments were able to minimize the use of stringent measures by relying on effective systems

[1] Second witness statement of Sir Patrick Vallance, dated 14/08/2023 [INQ000238826/100]

for test, trace and isolate and that such strategies are particularly effective when combined with fast, stringent - but limited - NPIs when an outbreak escapes such a system[2]. The Royal Society's report (August 2023) assessing the effectiveness of NPIs during the pandemic says 25 studies illustrated that test, trace and isolate is "*a powerful tool for reducing transmission.*"[3]

8. The UK did not have this infrastructure, which could have given it a better chance of a response that would cause less harm. Professor Sir Christopher Whitty includes in his lessons the weakness in capacity to scale-up in testing and contact tracing. This, he points out, requires investment in advance[4]. This must be one of the key lessons for the future.

The extent to which regard was had to inequalities

9. The Inquiry was right to include in this Module an examination of the regard had to vulnerable and at risk groups including whether appropriate regard was had to pre-existing inequalities including structural racism. Of first importance is Sir Patrick Vallance's written and oral evidence stating that it was entirely foreseeable that pre-existing structural and health inequalities within ethnic minority and other vulnerable groups would result in disparities in risk and outcome[5]. He made the following important point for policy makers in any future pandemic: "*this is an historically true statement, that pandemics differentially affect the most disadvantaged and they drive further disadvantage and inequality*" and that "*it is something that policy makers needed to take into account*" (Transcript 22/174/18-22/175/1). The evidence to the Inquiry shows not enough regard was had to these foreseeable disparities, in the planning during the time of the emerging threat and after the pandemic struck.

10. The treatment of and attitudes towards the frail older population have been issues of concern to CBFJ Cymru. In the group's opening statement to Module 2, it asked if the older population were a cohort who were overlooked by the UKG, whether they were seen as lesser, or dispensable. The first point arising from the evidence is that this

[2] Report by Professor Thomas Hale, titled 'Expert Report for the UK Covid-19 Public Inquiry - Module 2: Oxford COVID-19 Government Response Tracker Evidence for UK Covid-19 Inquiry', dated 22/08/2023 [INQ000257925/14]
[3] Report titled Covid-19: examining the effectiveness of non-pharmaceutical interventions from the Royal Society, dated 24 August 2023 [INQ000250983/35]
[4] Fourth Witness Statement of Professor Sir Christopher Whitty, dated 22/08/2023 [INQ000251645/231]
[5] Second witness statement of Sir Patrick Vallance, dated 14/08/2023 [INQ000238826/180] para 552; Transcript 22/174/8-12

cohort were sometimes spoken about by the then Prime Minister in a way that suggested they were dispensable: "…*there will be more casualties but so be it they have had a good innings.*"[6]; "*Why are we destroying everything for people who will die anyway soon. – Bed blockers*"[7].

11. Further, the evidence to the Inquiry regarding policies relating to social care and the care home population showed in core decision-making an alarming lack of an effective response to the known vulnerability of frail older people resident in care homes to respiratory disease outbreak. See further on this subject in a separate section below.

12. Public messaging was lacking as regards addressing the needs of ethnic minority groups. Professor Whitty's observations were that, for specific ethnic minority communities, public health messaging was not done effectively at the beginning of the pandemic and, in his view, arguably, could have done better throughout (Transcript 24/123/14 - 24/124/8).

13. There were deficiencies in data gathering where disparities needed to be addressed. Ade Adeyemi, healthcare professional and general secretary of Federation of Ethnic Minority Healthcare Organisations (FEMHO), gave evidence of a lack of a systematic and urgent gathering of data where there was evidence that the pandemic was having a disproportionate impact on ethnic minority healthcare workers, and that groups of ethnic minority healthcare workers had to do their own data collection and information gathering (on top of their normal jobs) because they did not see such data being gathered or did not see it being acted on. The important point was made: if the data is not gathered you don't know what steps should be taken (Transcript 4/95/22 – 4/98/1).

14. Inadequacy in provision of PPE had disproportionate impact on ethnic minorities: there was evidence of ethnic minority healthcare workers feeling unable to raise issues with ill-fitting PPE because of power imbalances in the workplace or, if they did, were not listened to; evidence was submitted to the Women and Equalities Committee that 64% of BAME doctors reported feeling pressured to work in settings with inadequate PPE (Ade Adeyemi, Transcript 4/106/3 – 4/108/24).

[6] Inquiry Legal Team Chronological List of Key Extracts from Sir Patrick Vallance's Notebooks, dated between January 2020 and February 2022 [INQ000273901/245]
[7] Record in notebook of Imran Shafi [INQ000146636/92]; Transcript 31/128/10-22 – 31/129/1-22

15. As regards the foreseeable increase in risk of domestic violence during lockdown, action could and should have been taken early as soon as the potential for stay at home measures were anticipated but the response was slow and not comprehensive enough. When questions were put to Dame Priti Patel, Secretary of State for the Home Department throughout the relevant period, the upshot was that there was no evidence of substantive steps taken by the Home Office to protect those who would be put at increased risk of domestic abuse as a result of lockdown until 26 March 2023, 3 days into the national lockdown (Transcript 21/173/17 – 21/177/17). The lockdown regulations appeared to lack an exception to the rules to allow friends or relatives to provide refuge to a person fleeing domestic abuse (Transcript 30/100/4-19). The lack of sufficient serious thought to the foreseeable harm and how it could be mitigated was demonstrated by the fact that key public announcements about the lockdown restrictions were made by the UKG without mention of the exception from the requirement to stay at home for those needing to escape domestic abuse until January 2021 when the exception "*or to escape domestic abuse*" was stated (Transcript 32/185/22 – 32/188/12).

16. The Inquiry is asked to note the important evidence about how decision-making should be approached in order to effectively address and take into account inequalities and disparity in impact. The Inquiry heard evidence about the importance of proper consultation of those impacted and the value of co-design in making policy that addresses inequalities. As highlighted by the Disabled People's Organizations (Transcript 20/152/2 – 20/153/20 & 34/93/14-34/94/25), there should be proper consultation, not just consultation by representatives of disabled people in set piece meetings, but consultation should bring those who are actually affected by decisions into the room. In this context, the evidence of Lord Mark Sedwill, (Cabinet Secretary June 2018 - September 2020), also should be noted: that any good policy process should involve engagement with representative groups, particularly in these circumstances groups of the most vulnerable in society, and he too endorsed co-design, as resulting in better policy (Transcript 20/153/2-20).

17. There was evidence on the importance of the range of experiences that inform decisions and how this was lacking at the centre of government: "*Across the advice and discussions there was a striking absence of humanity or perspective about people or families or how people actually lived….policy advice was often impractical about the realities of how people actually live (e.g. that everyone would have a separate bathroom that an infected person could use)*", was the evidence of Helen MacNamara

(Deputy Cabinet Secretary January 2019 - February 2021). It was her evidence that there was a serious lack of thinking about domestic abuse and the vulnerable, about carers and informal networks for how people look after each other in families and communities, the impact on single parents of some of the restrictions, guidance for women who might be pregnant. She described a "*systematic failure to think outside the narrow perspective of the people involved in decision making.*"[8].

18. The above evidence was compelling in showing the need for greater diversity as to who is in the room when discussions are being had and decisions made, and for meaningful consultation with those who are affected by decisions.

19. The above paragraphs touch on only a few of the important aspects of the evidence on inequalities, essential to understanding the impact of the pandemic and evaluating the response to it. The issues will be further examined in relation to Wales in Module 2B.

The initial response to Covid-19

20. As to the early period of the response to the pandemic, the evidence showed fundamental problems in the decisions, actions and inactions at UKG level. The Welsh Government was closely tied into the response at UKG level in this period, so the evidence provides insight into the response in Wales too.

21. The UKG response lacked a sense of urgency; it lacked a plan and a strategy. The lack of a strategy impacted on how science advice could be provided: evidence was given to the Inquiry that throughout 2020, SAGE suffered from having little sense of what the high level strategic objectives of the Government were in managing the crisis and that, had it known, it may have reached conclusions about the need to adopt the policies that it ultimately advised faster[9]. It was Professor Sir Chris Whitty's evidence that sometimes the Government was waiting for SAGE to take a strategic position, so there was a potential circularity (Transcript 23/69/1-14).

22. The lack of a due sense of urgency was striking in the evidence as to the position as at 4 February 2020. It was known at this time there was a possibility of a pandemic,

[8] Witness statement of Helen MacNamara, dated 09/10/2023 [INQ000273841/52-54]
[9] Second Witness Statement of Professor Neil Ferguson, dated 11/07/2023 [INQ000248854/7]

and it was reasonable to assume that, if there was, there would be between 100,000 and 300,000 deaths (Professor Whitty's evidence (Transcript 23/162/18-23/163/3)). By this time the WHO had declared a public health emergency of international concern, COBR had met, and the advice was being given by SAGE. It was Professor Whitty's evidence however that at this time the Government was not "*electrified*" (which he attributed to a systemic attitude to natural hazards) and that, had it been, then this would have led to "*a stronger all-of-government think-through of all the potential consequentials*" (Transcript 23/164/22-24).

23. It is clear from the above evidence, we submit, that the state of affairs as early as 4 February 2020 was such that the UKG should have gone into a completely different gear: the UK was facing the possibility of many thousands of deaths; the UKG should have been "*electrified*" at that point, but it was not.

24. There was evidence of over confidence at the centre of government, and this was noted to be particularly strong in the Prime Minister's morning meetings – "*we were going to be world-beating at conquering Covid-19 as well as everything else*" (observations of Helen MacNamara) and this "*supreme confidence*" and the idea that the Italians were overacting was evident as late even as early March 2020.[10]

25. It was not until 2 March 2020 that the Prime Minister took the Chair of COBR. It was not until early March 2020 that the crisis shifted to become a whole-government effort (Matt Hancock, Transcript 29/19/9-11).

26. There was confusion about the extent to which herd immunity (from people becoming infected by the virus) formed part of the actual strategy the Government was pursuing. When asked about whether the Government promoted herd immunity as a goal, Professor Whitty responded that communications gave the impression it was pursuing a policy (of herd immunity) which it "*absolutely was not pursuing*" (see the evidence of Professor Whitty, Transcript 24/22/5-19). This was then, we submit, at the very least, a major failing of communication about what was or was not the strategy.

27. The only overarching plan for a pandemic response prior to 3 March 2020 was the 2011 pandemic flu plan which was aimed at managing the consequences of a flu pandemic, not stopping a virus from spreading; it was based on the wrong doctrine. It

[10] Witness statement of Helen MacNamara, dated 09/10/2023 [INQ000273841/15-16]

was a doctrine that led to identifying how many body bags would be needed rather than focusing on how to stop people becoming ill in the first place. Evidence has been heard about a tabletop exercise, Exercise Nimbus, in February 2020 – that this was based on the doctrine of the 2011 pandemic flu plan. Consequently, the exercise was directed, not at what could be done to counter the spread of the virus, but how to prioritize patients in the event of the NHS becoming overwhelmed (Matt Hancock, Transcript 29/105/12 – 29/106/16). Mr Hancock, the then Secretary of State for Health and Social Care, stated that, with hindsight, the exercise should have been about at what point to lock down, how much data was needed before making a decision, what NPIs were going to put in place and in what order, how do you save lives in the least damaging way and "*not are we going to find enough mortuary space and who should decide on prioritization of NHS treatment*" (Transcript 29/103/22 – 29/104/11). CBFJ Cymru submits, this is not just a matter of hindsight but a failure to focus adequately on what should have been focused on: what was actually needed to counter the emerging threat of the virus and to prevent people from becoming ill and dying.

28. The "*Coronavirus: action plan - A guide to what you can expect across the UK*", a Four nations' document, published 3 March 2020[11], set out an approach, but was less than a plan for action. References to action points to counter the threat of widescale spread of the virus were oblique (see page 18 of the plan), and it was short on action points[12]. The Action Plan overstated the extent of other existing plans in place (see page 8 of the plan).

29. As at mid-March 2020 the seriousness of the situation remained still not fully understood within the UKG: see the evidence of Professor Whitty, that by mid-March still not everyone in Government/the Downing Street machinery realized that the situation was heading in a very difficult direction and conceptualized how quite low numbers of cases through exponential growth would turn into very large numbers in an extremely short period of time because of the doubling time (Transcript 24/5/20 – 25/6/23); and Professor Dame Angela McClean (current UKG Chief Scientific Adviser (GCSA); Chief Scientific Advisor for the Ministry of Defence, acting deputy GCSA and SAGE participant during the pandemic) : "*in the first few weeks of March 2020, I began*

[11] Report from the UK Government titled Coronavirus: action plan - A guide to what you can expect across the UK, dated 03/03/2020 [INQ000182380]
[12] Discussed at 29/137/23-29/138/2

to feel that there did not seem to be a plan within government, or a clear sense of how many people were going to die."[13]

30. The Inquiry should find, as has been accepted in the evidence of Boris Johnson[14], that mass gatherings should have been banned earlier. The decision by the UKG was not to advise to ban mass gatherings until 16 March 2020, the same approach being adopted by the Welsh Government. By 12 March 2020, other countries could be seen to be banning mass gatherings and the number of cases was in the thousands and growing[15] CBFJ Cymru members say people in Wales recognized the threat and this was demonstrated by the fact that already by this time in Wales hand-gel was scarce to buy. The politicians whose job it was to make the decisions should have thought more widely than just the scientific advice about relative risks and taken account of a wider context at that time.

31. Evidence was heard from Sir Patrick Vallance that on 13 March 2020 information was received which "*unambiguously showed that the pandemic was far more widespread and far bigger and moving faster than we had anticipated*" from a number of sources, including surveillance systems, and that over that weekend it became very clear that much more stringent measures would be needed to control the virus and they needed to be introduced quickly. This was the view of Sir Patrick Vallance and of SAGE which was made known to the Prime Minister and which led to the decision on 16 March 2020 to introduce the voluntary measures to reduce contacts which preceded the eventual decision for a mandatory lockdown on 23 March 2023 (Transcript, 22/45/4 - 7).

32. This statement does not seek to identify the earlier point when the first national lockdown, which was necessary and unavoidable, should have been imposed, about which much evidence has been heard[16], but submits that the evidence overall clearly shows that information emerging throughout February and into early March 2020 about the growing threat of the virus was not responded to by the UKG with the focus and speed that the seriousness of the situation demanded; and this meant opportunities were missed to do vital planning for measures (large and smaller scale)

[13] Witness statement of Professor Dame Angela McLean , dated 19/10/2023 [INQ000309529/34]
[14] Boris Johnson, Transcript 31/118/20-23
[15] Witness statement of Sir Partrick Vallance, dated 14 August 2023, INQ000238826/194; COBR meeting minutes for 11 March 2020 INQ000056220/2
[16] For example, Professor Sir Chris Whitty, 23/56/9-13 and 23/58/9-13; Sir Patrick Vallance, 22/44/20-21; 22/50/4-8; 22/118/11-12; Sir Jonathan Van-Tam, 25/54/9-15; Dame Angela McClean, 25/54/9-15

to prevent people from catching the virus, and to try to minimize the potential harms that the larger interventions that were necessary would cause.

Asymptomatic transmission

33. CBFJ Cymru are deeply concerned by the evidence of how the risk of asymptomatic transmission was not factored into decision-making and the implications this is shown to have had. This subject is likely to have played out in similar ways in Wales as at the UKG level and in England because of the shared science and similarity in policies.

34. It is very clear in the evidence that, although uncertain, the risk of asymptomatic transmission was known early on. The minutes of the SAGE meeting of 28 January 2020 state, "*There is limited evidence of asymptomatic transmission, but early indications imply some is occurring. PHE developing a paper on this.*"[17] It was recorded in SAGE minutes of 4 February 2020 that "*asymptomatic transmission cannot be ruled out*".[18] NERVTAG meeting minutes for 21 February 2020 record the following comment on evidence from Singapore, South Korea and Japan – "*the evidence suggests that 40% of virologically confirmed cases are asymptomatic*"[19]. There was further discussion at the SAGE meeting on 27 February 2020 of the possible extent of asymptomatic transmission: Transcript, 18/136/17-20.

35. By the end of February 2020, evidence available from the outbreak on the Diamond Princess cruise ship was said to have "certainly *strengthened the principle that asymptomatic transmission was occurring*" (Professor Sir Chris Whitty, Transcript 23/181/13-14).

36. How it came to be the case that the possibility that the virus may be transmissible asymptomatically did not inform important decision-making in relation to people who were particularly vulnerable to the virus, given the potential for catastrophic consequences if the virus was spread to them, is impossible to comprehend. It was known from January 2020 that care home residents were some of the most vulnerable to Covid-19, acknowledged by the then Secretary of State for health and Social Care in his witness statement[20]. Hospital discharge to a care home gives rise to a specific

[17] Minutes of SAGE meeting 2, dated 28/01/2020 [INQ000057492]
[18] Minutes of fourth SAGE meeting, dated 04/02/2020 [INQ000051925/3]
[19] Minutes of NERVTAG, 21 February 2020 [INQ000119469/6] para 3.4
[20] Witness statement of Matt Hancock [INQ000232194/10] para 40

risk arising from the nature of the 2 environments: "*hospital discharge to care homes connects 2 high-contact environments.*"[21]

Policies relating to hospital discharge to care homes failing to address asymptomatic transmission

37. Decisions made in late March and early April 2020 in relation to hospital discharge and consequent admission to care homes did not factor in the risk of asymptomatic transmission. The policy decision was made for swift discharge from hospitals in the 19 March 2020 document "*Covid-19 Hospital Discharge Service Requirements*"[22] published by HM Government and the NHS, an instruction directed to hospitals and social care staff in England. The stated purpose was to free up at least 15,000 beds within a week of implementation and maintain discharge flows after that. Patients were to be discharged from hospital as soon as they were clinically safe to be discharged. There was no provision for the testing of symptomless patients prior to discharge to care homes, tests being limited and prioritized in accordance with a list of priorities. The issue arises not from the fact of discharge from hospital of those who no longer needed to be there but from the fact that when the UKG was driving forward such a policy that involved some of those discharged being admitted from hospital to care homes there was an absence of consideration of the impact on other care home residents of asymptomatic cases.

38. It has been established in the *Gardner* case brought in 2022 (*R (Gardner) v Secretary of State for Health and Social Care (1) NHS England (2) and Public Health England* (3)[2022] EWHC 967 (Admin); [2022] PTSR 1338) that the UKG (through its Department of Health and Social Care) failed to take into account asymptomatic transmission when it should have in relation to the consequences for care home residents of the 19 March 2020 hospital discharge policy. In the *Gardner* case, that policy and the related NHS document "*Next Steps on NHS Response to COVID-19*"[23] were subject to challenge by daughters of 2 former care home residents who died in the first wave of Covid-19. Also the subject of challenge was "*Admission and Care of Residents during Covid-19 Incident in a Care Home*", 2 April 2020 (published by the DHSC, PHE and others)[24]. The 2 April 2020 document acknowledged that some

[21] Technical report on the Covid-19 pandemic in the UK, dated 01/12/2022 [INQ000203933/299]
[22] Guidance from NHS titled Covid-19 Hospital Discharge Service Requirements dated 19/3/2020 [INQ000087450]
[23] [INQ000087317]
[24] [INQ000233798]

patients discharged from hospital or admitted from a home setting may have Covid-19, whether symptomatic or asymptomatic but nevertheless (inexplicably) advised that if an individual had no Covid-19 symptoms care should be provided as normal. The court found against the Department of Health and Social Care and PHE, not on the basis that discharging patients from hospital who no longer had a need to be in hospital was in error, but on the basis of the failure to take into account the risk to elderly and vulnerable residents from asymptomatic transmission: that those drafting the March Discharge Policy and the April Admissions guidance "*simply failed to take into account the highly relevant consideration of the risk to elderly and vulnerable residents from asymptomatic transmission*"(paragraphs 287-9 of the judgment). The court did not accept that nothing could have been done to mitigate the risk, finding that the 19 March 2020 document could, for example, have said that where an asymptomatic patient (other than one that has tested negative) is admitted to a care home, he or she should, so far as practicable, be kept apart from other residents for up to 14 days. However, the matter had simply not been addressed. The court made its findings against the DHSC and PHE because it was those bodies that bore responsibility for making arrangements for people admitted to care homes (paragraph 296 of the judgment).

39. On any view, this system for health and social care was not working rationally in publishing a policy directing discharge of untested individuals to care homes full of residents who were highly vulnerable to the disease without giving proper thought to how that would affect other residents and what should and could be done to address the issue. It is not an answer to say that it was right to discharge from hospital people who no longer needed to be in hospital. As to the response on this issue from the then Secretary of State for Health and Social Care, Matt Hancock, when asked about the hospital discharge policy, he referred to the finding in the *Gardner* case that to discharge individuals from hospital was in itself reasonable and appeared to misunderstand or ignore the full findings in the case (Transcript 30/38/20 – 30/39/15) - that there had been a failure to address the implications of such discharge given the risk of asymptomatic transmission in care homes.

40. The reasons Matt Hancock gave in his evidence to the Inquiry as to why the risk that there might be asymptomatic transmission was not factored into decision-making sooner than it was cannot be considered satisfactory or reasonable, given that the possibility of asymptomatic transmission was known and given what the potential consequences would be. Mr Hancock gave the reasons that the scientific advice from

the WHO until April 2020 was that there was no asymptomatic transmission; that he could not overrule what he referred to as a global scientific consensus; and that the advice from PHE to him was based on this global advice. He stated that the US Centre for Disease Control (CDC) published a study on 3 April 2020 demonstrating that asymptomatic transmission was likely to be occurring, that it was after that that he instructed PHE to review "all of our guidance", but that before that point, it had been decided to act on the CDC evidence. As regards the change of position by mid-April 2020, he said as regards that point in time, that as "*we were ramping up testing*", on 15 April it was decided that all patients being discharged from hospital into care homes should be tested and this was extended to asymptomatic care home staff on 28 April 2020.[25] It is not reasonable that such rigid thresholds were applied as to what should be taken into account in decision-making given what the state of knowledge on asymptomatic transmission actually was well before 3 April (see paragraphs 34-35 above).

41. Whilst the CMOs' technical report (2022) says that the epidemiological and genetic evidence suggests hospital discharge does not appear to have been the dominant way in which Covid-19 entered most care homes, it also states: "*some care homes outbreaks were introduced or intensified by discharges from hospital.*"[26] This report makes the important point: that hospital discharge to care homes should remain a high priority for preventative actions in similar pandemics.

Policy response to movement of staff between care homes too late because of failure to take account of asymptomatic transmission

42. It should have been noted early on that care home staff were a source of transmission of a virus into care homes because, even when symptomatic, care home staff might continue to work. The Inquiry has been referred to the article which Professor Sir Jonathan Van Tam co-authored in 2017 highlighting the risk of introduction of a virus by care home staff and the vulnerability of the sector. This article states, "*Long-term care facility environments and the vulnerability of their residents provide a setting conducive to the rapid spread of influenza virus or other respiratory pathogens. Infections may be introduced by staff, visitors or new or transferred residents*". It

[25] Witness Statement of Matt Hancock, dated 03/08/2023 [INQ000232194/82-84]
[26] Technical report on the Covid-19 pandemic in the UK, dated 01/12/2022 [INQ000203933/298]

highlights the issue that healthcare workers "*often continue to work despite having symptoms and may act as a source of infection to those in their care.*"[27]

43. It was not however until 15 May 2020 that the UKG introduced an advisory policy and funding to support the reduction in the movement of care home staff between care homes and there was further guidance in June 2020.[28] The Inquiry heard evidence from the then Secretary of State for Health and Social Care Matt Hancock as to the reasons why a policy to support reducing the movement of care home staff between different care homes was not put in place earlier than 15 May 2020 (when questioned by the TUC on this): "*Until we had clear advice on asymptomatic transmission following the CDC publication on 3 April, the advice was that, as I said, that if you were symptomatic and therefore didn't go to work if you were symptomatic, then that was essentially enough to address the problem, compare - given the known negatives of restricting the workforce*." (Transcript 30/114/12-18). Mr Hancock gave evidence of the importance and effectiveness of the policy that was introduced on 15 May 2020: that it "*reduced infection significantly*" and that this is "*a vital lesson for future pandemics – and indeed for normal times – that staff movement between care homes should be limited.*"[29]

44. We submit, a comprehensive policy response in relation to care homes that took account of the possibility of asymptomatic transmission via staff moving between high contact environments should have been in place much earlier in the pandemic, given the risks that were or should have been already known or at least identified in the period between January and March 2020 when the threat was emerging. The need to have acted earlier and more comprehensively in relation to this known vulnerable population is demonstrated clearly by the evidence: by mid to late April 2020, over 25 per cent of care homes had declared a Covid-19 outbreak and infection rates in care homes were considered to be higher than in the general community.[30]

45. The UKG (through its Department for Health and Social Care or otherwise) should have applied a precautionary approach where there was uncertainty as to the evidence on asymptomatic transmission, when dealing with highly vulnerable care

[27] Article published on Wiley titled 'Influenza in long-term care facilities', dated 27/06/2017 [INQ000269388/1-3]
[28] Witness Statement of Matt Hancock, Member of Parliament for West Suffolk, dated 04/10/2023 [INQ000273833/8-9]
[29] Witness Statement of Matt Hancock, Member of Parliament for West Suffolk, dated 03/08/2023 [INQ000232194/12]
[30] Ibid [INQ000232194/84]

home populations. Lessons must be learned from the way the system for health and social care failed to do what it was supposed to do – to protect vulnerable people – in the most fundamental way – and about how a risk that was uncertain, but one that has potential for devastating consequences, should be taken into account in the decisions that concern very vulnerable people. The issues will be returned to in the context of Wales in Module 2B because Wales adopted a similar hospital discharge policy to the one considered in this module and will have needed take account of asymptomatic transmission in relation to care homes and generally.

Social Care

46. Social care will be looked at in a separate module and this is a devolved area which will be examined in Module 2B. However, in addition to the points made above about the impact on the care home sector of the failure to factor in asymptomatic infection at an early stage, the following points about the response to the pandemic in social care are worthy of mention here, being particularly telling of the lack of early decisions to anticipate the needs of this sector:

(i) The written evidence of Helen Whately, the then Minister for Social Care in the Department for Health and Social Care, was that she was warned about the risk that lack of sick pay could lead to care home staff working despite having Covid-19 and therefore she wanted to make sure staff received their normal wages from day one of isolation, coupled with clear guidance on when to isolate. This, she says, was implemented in early June 2020.[31] The Inquiry should find that, given that the need for such a policy was predictable, this step should have been taken earlier.

(ii) The problems with getting key data should be noted. Helen Whately states she asked officials to provide her with figures for care home deaths, but she could not get timely accurate data on Covid-19 deaths in social care in stark contrast to deaths data from NHS hospitals. She first received reliable figures in April 2020.[32]

(iii) Professor Dame Jenny Harries, the then Deputy CMO for England, when giving her evidence, was asked about an email exchange in which she responded on 16 March 2020 to a question from a representative of the Department for Health and Social Care about what the approach should be to hospital discharge of

[31] Witness statement of Helen Whately, Minister of State (Minister for Social Care) in DHSC, dated 30/10/2023 [INQ000273897/46]
[32] Ibid [INQ000273897/14-15]

symptomatic individuals to care homes. In response Dame Jenny Harries had stated her predictions that: "*Whilst the prospect is perhaps what none of us would wish to plan for I believe the reality will be that we will need to discharge Covid-19 patients into residential care settings…This will be entirely clinically appropriate because NHS will triage those to retain in acute settings who can benefit from that sector's care. The numbers of people with the disease will rise sharply within a fairly short timeframe and I suspect make this fairly normal practice and more acceptable but I do recognize that families and care homes will not welcome this in the initial phase.*"[33] Dame Jenny Harries said in her oral evidence that this was a high-level view and an attempt to explain what the size of the problem might be (Transcript 28/8/3 – 28/16/6). The Inquiry is asked to note the risk to those in care homes that was being contemplated (in this email exchange) and that the comments are telling of shockingly low expectations as to what provision social care would therefore be making for this highly vulnerable cohort.

(iv) The evidence showed decision-making at a national level to be fragmented and unnecessarily complex. The Department for Health and Social Care is responsible for national policy in relation to social care[34], but national funding to the sector does not go through that department but through a different department namely the MHCLG: see the evidence of Matt Hancock, where he referred to having needed to use an "*unprecedented*" route for getting funding for the social care sector fast in March 2020, namely via the NHS, "*and when we took the proposal to Number 10, they said, 'We're in favour but you need to make sure that Treasury and MHCLG are supportive of using this approach, because it's novel'* " and , "*We invented new ways of getting money to care homes, in the same way that we gave free PPE where all the time in the past PPE had been bought by the care homes themselves*" (Transcript 30/48/9-17). This structure for decision-making in social care – requiring resort to routes that were considered novel and unprecedented to get urgent things done in a pandemic – was obviously very unsatisfactory.

Airborne transmission

47. In CBFJ Cymru's opening statement the group invited the Inquiry to examine whether enough was done to factor in the airborne nature of the virus. The way modes of transmission of the virus were understood and acted on at UKG level is likely to be

[33] Email of Professor Dame Jenny Harries to the Director for Adult Social Care, DHSC, dated 16/03/2020 [INQ000151606/1]
[34] Third Witness Statement of Sir Christopher Stephen Wormald, on behalf of Department of Health and Social Care, dated 29/03/2023 [INQ000144792/3]

relevant to understanding the approach adopted across the UK including the approach taken by the Devolved Administrations.

48. Several routes of transmission were recognized early as possible routes of transmission. There was scientific debate about the relative importance of each[35]. Early acknowledgement that airborne/aerosol transmission may be possible is seen in the document "Review of data on persistence of SARS-COV-2 in the environment and potential infection risk", 14 February 2020, p 2: "*airborne/aerosol transmission may be possible, particularly following aerosol generating procedures and events*", which also states "*preventing transmission of infectious virus in aerosols requires FFP3 respiratory protection*"[36] . It was stated by Professor Sir Chris Whitty, the scientific general view has shifted to consider suspended aerosol as being of more importance (a greater proportion) than was originally thought.[37] This, in turn, Professor Whitty says, led to a greater emphasis on the role of ventilation and he gives an example of a UKG public information TV advertisement in November 2020 which encouraged opening windows and using extractor fans.[38]

49. A specific sub-group of SAGE, the Environmental Modelling Group (EMG), was formed in mid-April 2020 to look at how the virus transmits, and also to look at local mitigations (not the "big tickets" like lockdown) but things like ventilation and face masks. (See Transcript 13/3/15-13/4/16.)

50. Professor Catherine Noakes, Professor of Environmental Engineering (who leads research into ventilation, indoor air quality and infection control in the built environment[39]) was the convenor and chair of the EMG. She gave evidence that it was her view that the aerosol transmission routes were being overlooked and that there was evidence upon which to operate according to a precautionary principle from January 2020. She stated that, although the evidence on aerosol transmission at the outset was weak, the evidence was weak for all transmission routes, and that on a precautionary basis it would have been appropriate to indicate that aspects like

[35] Witness Statement of Professor Sir Christopher Whitty, dated 15/08/2023 [INQ000248853/100]
[36] Guidance from Guidance Cell titled Review of data on persistence of SARS-CoV-2 in the environment and potential infection risk, to Public Health England internal / NERVTAG review, dated 14/02/2020 [INQ000047771/2]
[37] Witness Statement of Professor Sir Christopher Whitty, dated 15/08/2023 [INQ000248853/100]
[38] TV advertisement from HM Government and NHS, regarding protective measures dated 18/11/2020
[39] Rule 9 Questionnaire Response from Professor Catherine Noakes, [INQ000056505/2]

ventilation mattered early on and as the evidence base increased that people should have been made more aware of the relevant mitigations for aerosol transmission (Transcript 13/17/10 – 13/18/5).

51. The evidence showed that public information on this issue was deficient even in Autumn 2020 and later. Professor Noakes's evidence was: information on the websites of PHE and the NHS for members of the public - who may be trying to find information about how to manage the illness – as late as September 2020 was still focused on droplets and surfaces and did not mention airborne transmission. This caused Professor Noakes to email Professors Vallance and Whitty to express her concerns that the evidence base she had been collecting, discussing and agreeing was not feeding into these guidelines. The NHS did not change the information until June 2021 (Transcript 13/18/13 – 13/19/16).

52. The important point was highlighted by Professor Noakes that "*many buildings including a large proportion of hospitals do not meet current design standards particularly for ventilation rates*". She also highlighted an absence of engineering expertise at a strategic level for example in Infection Prevention and Control guidance where aspects around ventilation "*often receive scant attention in IPC documents*". She says it is "*critical that guidance for front line healthcare staff also includes information on how to manage ventilation and which devices/approaches to use when. I hope that one of the lessons from the pandemic can be the better joining up of engineering, microbiological and behavioural expertise to improve infection control strategies in healthcare and other buildings*".[40]

53. The importance of the continued development of learning on modes of transmission was also highlighted by Professor Noakes. The Government funded a £21 million National Core Study on Transmission and the Environment (PROTECT) which ran between early summer 2020 and 2023, after recognizing the lack of robust data on transmission. This has developed new capacity and capability to be able to measure and model transmission of respiratory infection which Professor Noakes said she hopes will be beneficial for future pandemics, but she said there were no firm plans to retain its capacity and no strategic investment for this. She said, the impact of the

[40] Witness Statement of Professor Noakes, [INQ000236261/4-5]

PROTECT study would have been greater had the learning it generated been present to a greater extent sooner. [41]

54. The Inquiry received written evidence from Dr Philip Banfield, Chair of the BMA's UK Council: referring to the need for: greater focus on indoor ventilation, a recommendation to meet outside where possible; FFP2/3 respirators available to vulnerable people as offering better protection from infection than ordinary masks, and the need for clearer public health messaging on this issue.[42]

55. The contention that there should have been greater focus on more effective mask wearing is supported by the findings in the Royal Society Report (August 2023), which are based on evidence from researchers around the world: that as regards mask wearing there was a "*gradient of effectiveness*" with evidence, mainly from studies in healthcare settings, that higher quality N95/FFP2 masks were more effective than surgical-type masks.[43] Sir Mark Walport, in his oral evidence, noted the importance of the gradient shown by the studies: "*importantly there was a gradient. In other words, respirator masks were more effective than surgical masks…the plausibility of the results was emphasized by that gradient effect. In other words you might expect that a very – you know, the sort of masks that you'd wear in a – if you're exposed to a dangerous toxin is much more likely to be effective than a loosely fitting mask*" (Transcript 7/120/17 – 7/121/3).

56. When Covid-19 was de-classified as a High Consequence Infectious Disease on 19 March 2020, this meant the loss of the requirements that status carried for certain PPE to be worn in relation to the care of patients, amongst other things, FFP3 respirators[44]. The Minutes of the NERVTAG meeting of 6 March 2020 show that already due to shortage of stock of FFP3 masks, guidance was changed so that healthcare workers treating suspected cases would wear surgical facemasks only and not an FFP3 respirator.[45] Dame Jenny Harries, when asked about whether cost played a part in decisions on the provision of FFP3 masks, said it did not but that at times there was difficulty in procuring them (Transcript 28/66/22 – 28/67/13), but this issue

[41] Witness Statement of Professor Noakes, [INQ000236261/72]
[42] Witness Statement of Professor Philip Banfield on behalf of the British Medical Association, dated 21/07/2023 [INQ000228384/36-37]
[43] Report titled Covid-19: examining the effectiveness of non-pharmaceutical interventions from the Royal Society, dated 24 August 2023 [INQ000250983/60]
[44] Third Witness Statement of Sir Christopher Stephen Wormald, on behalf of Department of Health and Social Care, dated 29/03/2023 [INQ000144792/66 and 208]
[45] Minutes of NERVTAG meeting 8, dated 06/03/2020 [INQ000087540/3]

has not been explored in detail in Module 2 and it is hoped will be looked at in more detail in Module 3. The evidence of Dr Philp Banfield was that current IPC guidance still does not require healthcare professionals to have access to "*PPE (such as FFP3 respirators)*" when dealing with Covid-positive or suspected positive Covid cases outside of when undertaking a limited range of aerosol generating procedures.[46]

57. On the evidence the Inquiry has received, it is submitted, the following point made in the witness statement of Dr Banfield is shown to be well-founded and the Inquiry is asked to find accordingly: "*a key failure of the Government was and continues to be the failure properly to acknowledge (and at an early enough stage) that Covid-19 was spread by aerosol transmission, and to adapt their public messaging, guidance to health services or the focus of their NPIs appropriately*".[47]

58. When it comes to Module 3 (on health), CBFJ Cymru considers the Inquiry must look in detail at and get to the bottom of how decisions have been made on FFP3 masks for healthcare workers across the UK treating Covid-19 cases.

59. CBFJ Cymru believes the seriousness of airborne infection is still not appreciated and acted on in Wales. This is relevant in many settings including in hospitals. CBFJ Cymru wishes the Inquiry to make recommendations at speed about responding to the airborne nature of the virus.

After the first national lockdown

60. CBFJ Cymru believes that the need to understand and provide up to date information about all the possible smaller scale countermeasures and mitigations was particularly pertinent at the time when the UK was coming out of the first national lockdown and afterwards. There should have been focus on identifying the fullest range of effective mitigations – on an individual, organization and workplace level, such as ventilation and appropriate mask wearing. The evidence in this module suggests there was not enough focus on these types of measures.

61. In this regard, a number of practical points about design, information and communication in relation to mitigating measures, made by Professor Noakes[48], are

[46] Witness Statement provided by Professor Philip Banfield on behalf of the British Medical Association, dated 21/07/2023 [INQ000228384/47]
[47] Ibid [INQ000228384/36-37]
[48] Witness Statement of Professor Noakes [INQ000236261/4, 17-18, 60-61 &70-71]

very pertinent, and provide important insights for future public health crisis responses. Her written evidence contained the following:

(i) There was a gap around dealing with the slowly changing evidence base. Officials would ask for evidence relating to a particular mitigation measure and having received this once it was rare that the question was asked again. This meant that guidance or the actions taken by an organization could sometimes be based on out-of-date evidence. A periodic check question of "*has anything changed*" would have been useful.

(ii) There is clearly a challenge in ensuring that updated evidence is effectively disseminated to those who need to act on it. By late 2021 large numbers of businesses were not following approaches that were supported by evidence. Many were still implementing significant surface hygiene measures but not implementing ventilation measures which were likely to be more important.

(iii) Guidance was issued by multiple different Government departments which could have some discrepancies. This can create a difficulty in particular for organizations that come under a range of different departments.

(iv) It is important, in Professor Noakes's view, to help the public to understand scientific evidence around transmission. Measures such as ventilation, distancing, face covering etc. were given limited explanation. The podium speeches could have been an opportunity to explain in more detail why these measures were likely to work. Professor Noakes believes that people are more likely to comply with measures if they understand how the virus spreads and therefore why actions they are being asked to do are likely to be effective.

(v) A large number of organizations in the engineering sector proposed technology solutions during the pandemic (new mask and respirator designs, air cleaning technologies for buildings, sensors for measuring and monitoring contact between people, technologies for cleaning surfaces). Whereas some were well designed and effective, others were ineffective, addressed the wrong questions or in some cases harmful. Professor Noakes stated that a need exists for higher standards and regulation for many of these technology solutions as well as a greater expectation of integrity in the sector to ensure approaches that work and are safe.

62. Turning to Eat Out to Help Out (EOTHO), CBFJ Cymru believes that the policy – which actually encouraged people to get together indoors – was the wrong way to decide to boost the economy at that time. It was not a responsible decision for the UKG to

make, to actively encourage indoor gatherings when people still needed to take precautions against an airborne virus. The failure to consult scientific opinion was poor practice and irresponsible. Boris Johnson stated in his witness statement, "*it was properly discussed, including with Chris and Patrick….Of course we considered the implications for infection, but we thought that this could and would be mitigated by the social distancing requirement still in force and it was very important to balance that against damage to the economy*"[49]. However, it is now known that a careful consideration and balancing of the weight of competing factors cannot have taken place, given that, in fact, as is now clear from hearing the evidence of Professor Sir Chris Whitty and Sir Patrick Vallance, they were not consulted about EOTHO, and Mr Johnson had merely assumed the proposal had been discussed with them (Transcript 24/63/1-24/64/2; 22/95/3 and 32/10/13-15). Mr Sunak's position on giving evidence was simply that those who had concerns "*had ample opportunity to raise these concerns between the announcement of the scheme and its implementation*" in fora that met at that time (Transcript 33/124/21-23).

63. EOTHO was a policy that extended to Wales. There was no suggestion in evidence in this module that the Welsh Government objected to it at the time. The position the Welsh Government took with regards to EOTHO and the reasons for it will be further considered in Module 2B.

64. The Autumn firebreak in Wales started on 23 October 2020, lasting 17 days. This was implemented over a month after it was advised by SAGE. The Inquiry has heard evidence from Professor Dame Angela McClean that measures should have been taken in September. She said that, while it was better than nothing, it did not cause a great decrease in cases (Transcript 24/113/6-24). England's lockdown, starting shortly later, lasted 4 weeks. Why the decisions on the Welsh Autumn firebreak were made in the way they were and whether it was effective will be further considered in Module 2B.

65. This module included evidence on the UKG's decisions on funding for Wales during the pandemic. The evidence in Module 2 provided two very contrasting pictures of what those funding arrangements amounted to. The evidence of Mark Drakeford, First Minister for Wales, in his first witness statement for this Module was that Rishi Sunak, the Chancellor of the Exchequer at the time, refused funding to support the

[49] Witness statement of Boris Johnson [INQ000255836/119]

Welsh Autumn firebreak, that this was misguided and meant the Treasury was acting as a Treasury for England only, because funds were extended to Wales only when a similar set of measures were introduced in England, and that had the Welsh Government had the confidence that the UKG would provide the money needed to support people during firebreak they probably would have implemented that lockdown earlier[50].

66. These criticisms were rejected by Mr Sunak on giving his evidence to the Inquiry. His evidence was that additional money was provided to the Devolved Administrations including Wales by way of an upfront funding guarantee in July 2020 and that this was uplifted on three occasions most notably on 9 October 2020, shortly before the Welsh firebreak, that the upfront funding guarantee was an unprecedented payment of money in advance, which provided flexibility outside of the Barnett formula for the Devolved Administrations to respond to the pandemic; and how they spent the money was a matter for them (Transcript 33/168/18-33/169/9 & 33/171/8 – 33/172/3) . There is likely to be further evidence to come in later modules including Module 2B on whether the upfront funding guarantee did provide an appropriate degree of flexibility in a public health crisis and whether or not Mark Drakeford's criticisms can be substantiated given what has been said by Rishi Sunak as to flexibilities and money provided.

Internal Border issues

67. One of the areas of difference between UKG and the Welsh Government in the latter part of 2020 was that Welsh Government wanted the UKG to take stronger action (to legislate not just issue guidance) to prevent people travelling from high incidence areas in England into low incidence areas in Wales potentially spreading the virus well beyond their locality. The Prime Minister Boris Johnson did not agree to this, stating that to legislate would be too resource intensive and that the guidance was clear[51]. No agreement was reached, and the Prime Minister wrote to Mark Drakeford on 15 October 2020, "*I deeply regret your announcement yesterday that you intend to legislate to prevent people from other parts of the UK travelling into Wales*" referencing that evidence as to potential impact was not clear and proposing continued dialogue to better understand the latest data and impact on the border region in particular[52].

[50] Witness Statement of Mark Drakeford, dated 14 September 2023 [INQ000273747/40-41]
[51] Ibid [INQ000273747/39] paras 132 and 134
[52] Letter from Boris Johnson to Mark Drakeford, 15 October 2020 [INQ000216550/2]

68. It may well be that there was no bridging this difference of opinion as to the correct approach, and that any different structure for decision making for UKG and Devolved Administrations (in respect of which, see further below) would not have been avoided the disagreement. This subject may be further considered in Module 2B.

69. Martin Hewitt of the National Police Chiefs' Council (NPCC) gave evidence about policing border areas: *"We had relatively limited challenges with Scotland because of the nature of the geography. With Wales there were more challenges with different regulations, different sides of what is essentially an invisible border, and that was very challenging I think for particularly a number of the Welsh forces and the English forces, where you had -- where you had different regulations either side of a road*" (Transcript, 21/47/23-21/48/6).

70. The evidence on these issues demonstrates why it was important that UKG and Devolved Governments should work together to minimize differences in the response as far as possible, and the importance of having suitable structures in place to give the best chance of working together and reaching agreement where possible; also that where there were unresolved differences, clarity of communications about which rules applied where was important (see further below on this subject).

Intergovernmental relations

71. Turning to how the UKG worked with the Welsh Government and other Devolved Administrations: CBFJ Cymru believes that the UK and Devolved Governments should have worked more closely together with a single aim of providing the most effective response they could to the pandemic across the whole of the UK.

72. How relations were conducted between UK and Devolved Governments mattered in order to have the best chance of reaching agreement on policies across the Four Nations, and where policies were different so that they could consider the implications for each other of their different policies and co-ordinate implementation and public announcements. In sum, co-ordination between nations would lead to a more effective response and better chance of saving lives.

73. In his written evidence to the Inquiry, Mark Drakeford, First Minister for Wales, referred to the UKG making announcements without notice to devolved governments. He said that when that happened it prevented the Welsh Government from having prepared a parallel announcement for Wales and led to avoidable uncertainties for the population when a policy was seen to be introduced in England with no equivalent for Wales.[53] For example the announcement of changes of policy on mandatory face coverings on public transport, on facemasks in NHS facilities, and on bubbling for single person households, which, he said in a letter to Michael Gove in June 2020, had big practical implications for Wales, but there was minimal or no prior communication[54].

74. In the evidence before the Inquiry there is frequent reference to a "*Four Nations approach*", used to signify not just the Four Nations acting uniformly but also flexibility for nations to adopt different policies whilst coordinating with each other. There are plenty of examples of ministers inviting and endorsing a Four Nations approach. The question should be addressed however: However did the UKG and Welsh Government do all they reasonably could to promote a Four Nations approach?

75. At the health minister level, the Inquiry heard evidence that the health ministers of the Devolved Nations met with Matt Hancock by regular Four Nations health minister telephone calls and shared a WhatsApp group. Mr Hancock said this filled a gap where there had been "*a missing piece of institutional architecture*" and worked well. He commended the other health secretaries for their approach saying they "*left politics at the door*" and he referred to substantive matters where there were tensions being resolved in a professional and business-like manner (Transcript 30/56/15 - 30/58/10). There will be further evidence in Module 2B on the Welsh perspective on these meetings.

76. There was regular close engagement throughout the pandemic between the four CMOs of the Four Nations. There was much evidence about how constructive these engagements were, for example the evidence of Professor Sir Chris Whitty (Transcript 23/35/13-23/39/21).

77. The question must be asked why, despite all the evidence of positive engagement at these levels, and when the core science was the same, were there still so many differences between policies in England and Wales that were not avoided –

[53] Witness Statement of Mark Drakeford, dated 14/09/2023 [INQ000273747/21]
[54] Letter from Mark Drakeford to Michael Gove, dated 11/06/2020 [INQ000216519]

differences as regards timing relating to mask wearing and testing or other differences in the plethora of rules after coming out of the first lockdown. The issue will be looked at further in Module 2B as to why Wales did things differently: whether it was lack of communication or delay in implementation or were there other reasons.

78. The position at the Prime Minister and First Minister level must also be considered. It is notable that Boris Johnson in his evidence made several statements to the effect that the relationship was good with the Welsh Government/Devolved Administrations and that there was more that united the UKG with the Devolved Administrations than divided them (Transcript 32/109/4-10 and 32/118/12-13). But Mr Drakeford pointed in his evidence to significant problems in the structure of the relationship at Prime Minister and First Minister level during the pandemic. He wrote to the Prime Minister asking for a more collaborative approach[55].

79. In the initial phase of the pandemic, COBR was convened regularly, providing a forum for meeting at the Prime Minister and First Minister level. However after 10 May 2020 the UKG decided that COBR would cease to meet regularly, and it did not meet at all between 10 May and 22 September 2020. This meant that the Four Nations having gone into lockdown together, when they were taking the careful steps out of lockdown, COBR was not meeting. At that stage and from then onwards there were more differences in policies between UKG and Welsh Government.

80. The Inquiry has heard that at that time it was suggested to the then Prime Minister Boris Johnson, by Helen MacNamara, that he convene the Joint Ministerial Committee (JMC) as a means of engagement with the First Ministers (Transcript 16/99/19 – 16/100/19). This was a structure specifically for meetings between UKG and Devolved Administrations, but no JMC was convened. Instead, it was decided, with the support of Dominic Cummings, that the First Ministers were to have regular calls with Michael Gove, the then Chancellor of the Duchy of Lancaster (Transcript 15/122/8-15/123/21).

81. The Inquiry has heard evidence that it was considered that Mr Gove did a skillful job in his conduct of regular meetings with the First Ministers, but this arrangement meant that the Devolved Administrations' First Ministers did not have direct contact with the Prime Minister on a regular or predictable basis. There was, as put by Mark Drakeford

[55] Witness Statement of Mark Drakeford, dated 14/09/2023 [INQ000273747/31]

in his witness statements, a lack of a "*regular rhythm of engagement*"; a lack of "*regular checkpoints that only the Prime Minister could provide*"; a "*vacuum*" at the final pan government level.[56]

82. The Inquiry has received the evidence of Boris Johnson orally and in his witness statement as to his reasons for making these arrangements in the way he did - that it was his view that it was "*optically wrong*" for the prime minister to meet with the Devolved Administration First Ministers "*as though the UK were a kind of mini EU of four nations*"[57]; he referred to wanting to avoid "*the risk of pointless political friction and grandstanding because of the well-known opposition of some of the [devolved administrations] to the government – and also to avoid unnecessary leaks"* (Transcript 32/121/16-20).

83. These were not good reasons. Mr Gove's evidence on leaks should be noted: that "*it is most important to have the right people in the room*"[58] and that "*overall in the greater scheme of things that that was not a particularly significant concern*" (Transcript 27/170/23-24). Boris Johnson's reasons for not meeting more regularly with the First Ministers of the Devolved Administrations betray a lack of commitment to serious and grown-up attempts to work with the Devolved Administrations. His own personal view of the "*optics"* of engaging with them should not have come into it: he was the Prime Minister for the whole of the UK in a public health crisis.

84. That there was a wrong mindset in operation in parts of the centre of UKG when it came to working with the Devolved Administrations is also evident from Dominic Cummings' evidence: that he thought Mr Gove would "*handle the process of dealing with the DAs*" better and that, generally speaking, the Prime Minister talking to the Devolved Administrations "*did not advance any cause*". (Transcript 15/122/13 – 15/123/14).

85. Dominic Raab in his witness statement said he found "*it became irritating as the pandemic went on that Scotland and Wales wanted to do things slightly differently or with different timings for what appeared to be political reasons.*"[59] When asked to identify an example he did not identify one (but said he was just giving his impression

[56] Supplementary witness statement from Mark Drakeford, dated 21/09/2023 [INQ000280190/6-9]
[57] Witness Statement of Boris Johnson, dated 31/08/2023 [INQ000255836/44]
[58] Second Witness Statement of Michael Gove, dated 1 September 2023 [INQ000259848/80]
[59] Witness Statement of Dominic Raab, dated 08/09/2023 [INQ000268041/66]

holistically) (Transcript, 28/237/18 – 28/238/24). It should be noted that there is a clear inconsistency in on the one hand criticizing the Devolved Administrations for not "*aligning*" with the UK, while at the same time denying them access to the decision-making process.

86. Mr Gove, in his evidence, suggested there was a case for overriding devolution when it came to a pandemic which affected Great Britain, and that, whilst issues such as "*how much fruit to eat and so on"* were *"quite properly a matter for devolved administrations*", such a pandemic would not be (Transcript 27/116/13-22). This however would be contradicting the approach taken by the Four Nations on going into the pandemic, which was on the footing of the devolved nations' existing respective responsibilities in public health.

87. The Inquiry has seen the record of a meeting on 22 April 2020 between Michael Gove and the Secretary of States for the Territorial Offices, which was called following Mark Drakeford's request for weekly meeting between the First Ministers and UKG ministers and a weekly COBR.[60] As mentioned, the arrangement that was put in place for intergovernmental relations during the pandemic was not in accordance with what Mr Drakeford requested, but instead the arrangement was for regular meetings with Michael Gove. The record of the meeting on 22 April 2020 contains several entries that show the discussion of what the arrangements for intergovernmental relations should be was informed at least in part by suspicion and fear of political advantage on the part of some of those present: there were references to a "*temptation for DAs to jockey for position*"; to an option being preferable as it would be "*easier to handle Scottish FM*"; "*Drakeford's request is positioning himself for the next year's Assembly elections*"; one of the Secretary of States reasons included that he was "*nervous of excluding DAs*"; Michael Gove summed up that he'd heard the Secretary of States' caution that *"regular meetings should be a potential federalist Trojan horse*"; it was said, "*DAs are dispersed in wider UKG meetings; if we convene them in a smaller meeting, they may prove more difficult to handle*"; and this was a "*fair point about handling the DAs*".

88. The tenor of the discussion clearly suggests the wrong mindset towards interactions with the Devolved Administrations in parts of the UKG - not a genuinely serious and grown-up attempt to find the best way of working together. It also strongly points to

[60] Email dated 22 April 2022 [INQ000091348/1-2]

the need for proper agreed structures for intergovernmental relations to be in place in advance of any future crisis.

Public announcements and messaging for the Four Nations

89. Clarity of public announcements and messaging of course was very important during the pandemic. Where the Four Nations were not all following the same policy there obviously needed to be as much clarity as possible about what applied where - for the sake of the most effective response to the pandemic. The evidence shows that UKG did not apply commitment to that goal.

90. Professor Henderson reported: "*an analysis of the text 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 or guidance…..There was little attempt to outline what applied UK-wide and what applied only to England."* and press briefings repeatedly failed to clarify that new rules in a whole range of areas were England-specific, from school closures to rail networks to retail. [61]

91. The handling by the UKG of its messaging when it switched from *Stay at Home* to *Stay Alert* from 10 May 2020 is telling of the lack of a plan to be clear about when the message for England did not apply in the DAs. The then Prime Minister Boris Johnson was aware that the DAs did not want to change their messages (they wished to take a more cautious approach out of Lockdown). Mr Johnson said at COBR on 10 May that the UKG would de-conflict where necessary[62]. When he was asked when giving his oral evidence what "*de-conflict where necessary*" amounted to and whether the UKG took all steps it could sensibly take to be clear that the change of message did not apply to the Devolved Nations, he did not provide an answer about what actual steps were taken in this regard (Transcript 32/124/10 – 32/130/18). It is to be inferred that there was no or little by way of a plan that took proper account of the fact that the DAs' message remained *Stay at Home*.

92. See also the evidence of Lee Cain, Director of Communications for the UKG, where his answers on the issue of the way communications were managed in relation to the

[61] Report by Professor Ailsa Henderson, Devolution and the UK's Response to Covid-19 [INQ000269372/49-50]
[62] Record of call between Michael Gove and the 3 First Ministers, 8 May 2020 [INQ000256846]; "Readout from COBRA 10/5" [INQ000216537/3]

switch to *Stay Alert* (Transcript 15/48/13 – 15/52/3), it is submitted, also imply the lack any proper plan to distinguish between the messaging applicable to England and messaging applicable to the Devolved Administrations.

93. See also Alex Thomas's report: reporting that in the 10 May 2020 address the Prime Minister announced an initial easing of restrictions but did not once make the point that it applied in England only[63].

94. UK media also contributed to the confusion by failing to state when public health messages did not apply in the territories of the Devolved Administrations. Professor Henderson commented on this in her report[64].

95. These errors were avoidable.

Structures for sharing science expertise and advice throughout the UK

96. As regards how SAGE provided its expertise on a UK wide basis - the following observations are made:
    (i) the Devolved Administrations' participation on SAGE was regarded as providing a valuable contribution (Transcript 22/163/10-12 & 24/101/9-13).
    (ii) DAs were invited to attend SAGE from SAGE No. 6 (Transcript 8/46/5-8); they should be invited from the outset. This appears to be accepted (Transcript 24/100/15-20).
    (iii) Scientific papers received by SAGE should be made available to the DAs. There was a delay in making them available. (Transcript 24/101/15 – 24/105/5).
    (iv) As regards SAGE sub-groups and NERVTAG, the evidence in the report of Professor Henderson[65] is that more than half the SAGE sub-groups did not have representation on them from Devolved Administrations.
    (v) As regards modelling, a lack of data from nations other than England was said to have been "*a difficult issue for quite some time*" making it difficult for SPI-M to do work specifically relevant to the Devolved Administrations (evidence of

[63] Report titled Political and administrative decision making in relation to the Covid-19 pandemic, Alex Thomas [INQ000236243/39]
[64] Report on Devolution and the UK's Response to Covid-19, Ailsa Henderson [INQ000269372/49]
[65] Report of Professor Ailsa Henderson, titled 'Devolution and the UK's Response to Covid-19', dated 07/09/2023 [INQ000269372/33-34]

Professor Dame Angela McClean (Transcript 25/36/2-5), however this got better over time. Professor Graham Medley (Transcript 8/91/21 – 8/92/5) said a "*kind of modelling unit for Wales*" was formed and he attended the Technical Advisory Group (TAG) meetings in Wales to help ensure coherence in modelling.

97. In sum, the evidence suggests the trend on SAGE and its sub-groups was towards greater embracing of the needs of and co-working with the Welsh Devolved Administration. These areas, the extent to which Wales did its own modelling, and the subject of presence on committees (whether as participant or observer) including NERVTAG, are likely to be examined further in Module 2B, and CBFJ Cymru will make further observations in light of the further evidence in Module 2B.

Findings and recommendations

98. When considering its findings and recommendations, the Inquiry is asked to take into account the evidence highlighted and observations made in the above paragraphs of this statement.

99. The sub-paragraphs below set out the main points arising from this statement relevant to recommendations for the future (with references to the relevant paragraphs of this statement):

Intergovernmental relations (Paras 71-88)

(i) The recently reformed system for intergovernmental relations between UKG and the Devolved Administrations should include structures suitable for a prolonged period of crisis. During the pandemic, a formal structure for regular meetings at Prime Minister and First Minister level *plus* the calls with Michael Gove would have been a better arrangement.

(ii) Intergovernmental relations should be approached with the sole aim of collaborating to achieve the most effective response to the crisis.

(iii) The Four Nations should seek to reach agreement on measures where possible. Where they have not agreed on the same response, they should co-ordinate their respective actions. In any event notice should be given by any administration in advance of any major announcements so that other nations can consider the implications for each of them of their different policies.

Further observations will be made on intergovernmental relations during the pandemic and recommendations after hearing the evidence in Module 2B.

Four Nations public health communications (paras 89 – 95)

(iv) UKG should have a proper plan to be clear in all communications about which measures apply where in the UK and should do all it sensibly can to make clear when a measure applies only to England.

(v) UKG publications should state whether data is applicable to the whole of the UK or just to England.

(vi) The media should make clear when public health messages apply just to England and not to the whole of the UK.

Sharing of science expertise across Four Nations (paras 96-97)

(vii) UK-wide science advice and advice structures (SAGE and its sub-committees and NERVTAG) should continue to be accessible to Devolved Administrations. This should be strengthened by Devolved Administrations being invited from the outset to attend all key groups and committees (as participants or observers as appropriate) and further developing collaboration between UK and devolved science bodies.

Unequal impact – structural inequality

(viii) Policymaking in response to future pandemics should reflect from the outset the principle "*that pandemics differentially affect the most disadvantaged and they drive further disadvantage and inequality*", by measures that address the unequal impact. (Para 9)

(ix) It should be a priority at the outset to identify implications for those at risk of Domestic Violence and to put in measures to address the risk (Para 15)

(x) There should be systems for speedy data-gathering where disparity in impact is suspected but not yet fully recognized or addressed, to be able to identify what steps need to be taken to address those disparities. (Para 13)

(xi) Effective public health messaging to specific ethnic minority communities requires attention from the outset. (Para 12)

(xii) Policymakers need to properly consult the people impacted by inequalities, and policymaking to address inequalities should involve co-design and collaboration with the relevant groups who are impacted. (Paras 16 – 18)

Public health infrastructure (Paras 7 – 8)

(xiii) The public health infrastructure should have the capacity to be scaled up rapidly for mass testing and widescale test and trace.

Airborne transmission of the virus (Paras 47-59)

(xiv) The airborne nature of SARS-CoV-2 should be acknowledged and acted on. This includes infection prevention and control that will protect people in hospitals from aerosol transmission (including appropriate PPE and ventilation).

(xv) Non-compliance with design standards for ventilation in buildings should be addressed and greater attention paid to ventilation in infection prevention and control. (Para 52)

Understanding of modes of transmission of a virus

(xvi) The capacity and capability developed during the pandemic to measure and model transmission of respiratory infection should be retained, so that the learning is not lost and will be available at the outset when the next pandemic or similar public health crisis strikes. (Paras 47-50 and 53)

(xvii) In a future pandemic the public should be helped to understand the scientific evidence on transmission of a virus so that they can understand the reasons for the steps they are asked to take. In the pandemic, more detail should have been given in the podium speeches as to why the measures advised (such as ventilation, face masks) were likely to work, to increase the likelihood of compliance. (Para 61(iv))

Public information about low harm countermeasures

(xviii) Public health information and messaging should be informed by the up-to-date scientific knowledge about the nature of the virus/disease and steps that individuals can take as mitigations, so that the full range of relevant mitigations (including the smaller interventions that will do least harm – such as for example in this instance opening windows; appropriate mask wearing) can be brought into play as soon as possible. (Paras 60-61)

(xix) Information made available to the public about the virus (for example on NHS or other public body websites) and information disseminated to businesses

and other organizations should be kept up to date with the changing evidence base. (Para 51, 61(ii))

(xx) Guidance issued by different Government Departments should be consistent and discrepancies between guidance issued by different departments avoided. (Para 61 (iii))

Asymptomatic transmission

(xxi) The lessons must be learned from the failure in the first wave of the pandemic to take into account in decision-making the possibility of asymptomatic transmission, when the evidence was uncertain. Where an aspect of the nature of the virus is uncertain but could result in serious harm, policymakers should take a precautionary approach especially in policy affecting vulnerable people. (Paras 33-41)

Social care

Whilst this area will be examined in the future module on social care, the following may be relevant to core-decision making in Module 2/any interim recommendations:

(xxii) Future decision-making on hospital discharge must ensure that hospital discharge will not cause the spread of infection into care homes (Paras 37-41; 46(iii))

(xxiii) Future decision-making on care homes should take into account the known risk that care home staff can transmit the virus to residents. There should be effective policies to counter this risk. (Paras 42-44 and 46(i))

(xxiv) A review is needed of how central government provides urgent funding to the sector; a process shown to be unduly complex in the pandemic. (Paras 46 (iv))

(xxv) A review is needed of the availability of data on the sector. (Para 46 (ii))

Central Government's capability to respond

Since the pandemic the Resilience Framework has been published and its implementation has started, resulting in some changes already to structures in the UKG for crisis management. The new framework should be developed having regard to the following:

(xxvi) the need for a trigger for earlier involvement of the whole of government in responding to an emerging threat;

(xxvii) the need for a review of how politicians can more effectively engage with the science advice they seek;

(xxviii) decision-makers need to recognize when they need to draw on a wider range of life experiences when making decisions affecting huge numbers of people's lives in major ways and properly consult those affected (see paragraph (xii) above);

(xxix) the need for a structure for decision-making during a time of crisis that is geared to ensuring better and more coherent decision-making at the heart of Government to reduce the chances a descent to such chaotic decision-making such as was seen in the centre of government during the pandemic, (e.g. in relation to EOTHO the then Prime Minister assumed scientific opinion had been obtained but it had not.)

Long Covid

(xxx) The recommendations made on behalf of the Long Covid groups (Transcript 34/85/9-23) are adopted here: that the long-term health consequences of a novel virus should be planned for, identified, monitored, measured and factored into any response to a pandemic.

Concluding observations

100. This Module has shown that the UKG was only in part willing to accept the Devolved Administrations' role: the issue lay at the Prime Minister level, where despite some warm words by Boris Johson about the relationship there was suspicion and failure to embrace the task of working with the Devolved Administrations for the benefit of the UK as a whole. There should have been a close and grown-up collaboration – which people across the UK were entitled to expect. Whether the Welsh Government did all it should have done to collaborate must be considered in Module 2B.

101. The evidence in this Module shows that decision-makers and institutions of the UKG were not equal to the task of responding to the pandemic, with serious consequences across the UK. This Inquiry's recommendations are much needed, because these same errors must not be repeated when the next pandemic or other major public health crisis inevitably occurs.

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12 JANUARY 2024