IN THE MATTER OF THE INQUIRIES ACT 2005
AND IN THE MATTER OF THE INQUIRY RULES 2006

THE UK COVID-19 INQUIRY

WRITTEN CLOSING SUBMISSIONS ON BEHALF OF THE DEPARTMENT OF HEALTH AND SOCIAL CARE FOR MODULE 2

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1. INTRODUCTION

1. The Department for Health and Social Care ("the Department") has listened with care to the evidence heard by the UK COVID-19 Inquiry ("the Inquiry") in Module 2. It accepts, as it did at the start of the Module 2, the enormous burden that COVID-19, and the restrictions imposed by the Government in response to it, placed on the public.

2. At the close of Module 2 the Department would repeat the thanks to all of those who helped the country to respond to the pandemic, including all workers across the health and care sectors, its own staff, other public services, all those who volunteered and all those who supported their friends, families and communities through the many challenges that the COVID-19 pandemic brought.

3. In its Closing Submissions for Module 2, the Department has taken the opportunity to reflect on the evidence that has been called. Below it provides a summary of some of these reflections.

2. SUMMARY OF THE DEPARTMENT'S REFLECTIONS

4. From its own reflections and the evidence heard by the Inquiry in Modules 1 and 2 the Department continues to believe that five lessons stand out (as identified in our Module 1 closing submission), which are set out below.

A toolkit of capabilities is more important than plans

5. The Department would suggest that whilst plans are important they are only as good as the core capabilities on which they are based and having a plan that can be 'pulled off a shelf' does not necessarily assist. This is the case in all aspects: science and research and development; surveillance and data; the regulatory system; stockpiles (including vaccines and personal protective equipment, "PPE"); on-shore manufacturing capabilities; and a legislative framework.

6. Areas where the UK had relative strengths and weaknesses in these areas were reflected in the pandemic response and thus in the decisions that were open to decision-makers.

The underlying resilience of the system matters

7. Higher resilience means that the National Health Service ("the NHS"), adult social care and public health will be more likely to be able to cope effectively and respond to shocks of any kind, including pandemics. Levels of core capacity include specialist and scalable laboratories, NHS general and critical/intensive care beds and sustainable bed occupancy levels, sustainable adult social care services, security of medical supplies and a resilient workforce.

8. The structure and health of the population itself, including for example age profiles or levels of smoking and obesity, are also clearly factors in resilience and outcomes.

9. The state of the UK's resilience, including health factors in its population, are also matters that had to be reflected in the decisions taken during the pandemic.

The ability to scale up in the first few months is essential

10. The Department considers that preparedness should clearly identify areas that must be developed in advance (e.g., stockpiles of PPE to buy time whilst more information is gathered about a particular virus and/or specific countermeasures are developed) and areas that can be responded to at the time (e.g., the provision of money for buying vaccines).

11. The Department believes that, on the whole, the immediate specialist Public Health England ("PHE") and NHS response was strong, but the first three-month period of 2020 was when the system was most under pressure because capabilities took a while to build up.

Preparedness should be along the five routes of disease transmission

12. Whilst there has been criticism of preparedness having been geared towards pandemic influenza rather than a coronavirus, both are diseases transmitted via the respiratory route. The Department considers that it would, however, be incorrect merely to plan for respiratory diseases, but rather the country should prepare along the five routes of disease transmission: respiratory (covid, flu), touch (Ebola, Lassa), sexual/blood (HIV, Mpox), oral (cholera, BSE/nvCJD) and vector (plague, zika).

13. This is important in circumstances where there are greater differences between the other routes of transmission that need to be prepared for. For example, the last major pandemic prior to COVID-19 was HIV, which required a very different response and where the endemic position is not based on an effective vaccine. This is also true in the continuing management of the endemic position.

14. The Department would suggest that evolving knowledge of routes transmission provided an important feature of decision making in responding to COVID-19.

Diagnostic surge capacity was a particular weakness

15. Whilst the country's initial scientific and technical response in genomic sequencing, testing and isolation was strong, and the end-state position of a capacity of over one million tests a day was amongst the best in the world, it was very challenging to scale up testing from the first stage of a small number of tests to the number and speed of testing required in both public and private sectors. The Department recognises that this was an area of significant weakness in the UK's response compared to some international comparators.

16. In addition to considering the reflections and lessons learnt identified above, the Department would once again invite the Inquiry to reflect on the 'Technical report on the COVID-19 pandemic in the UK, *A technical report for future UK Chief Medical Officers, Government Chief Scientific Advisers, National Medical Directors and public health leaders in a pandemic'* ("the Technical Report"), published on 1 December 2022 and authored by, amongst others, the UK Chief Medical Officers ("CMOs"), the Government Chief Scientific Adviser, the UK deputy CMOs most closely engaged with the COVID-19 response, the National Health Service England ("NHSE") Medical Director and the UK Health Security Agency ("UKHSA") Chief Executive.

Context for decision making

17. The Department also wishes to remind the Inquiry of its reflections on the context for decision-making in the period between early January and late March 2020, as detailed in its Opening Submissions to this Module.

    a. First, there was inevitably very limited data about the virus between January-March 2020, given it was a new disease.

    b. Second, the Department and Government were dealing with balancing major risks and there were no 'good' options.

    c. Third, as the Department has previously outlined, in combatting a pandemic of this kind there are only ever four realistic weapons: (1) non-pharmaceutical interventions ("NPIs"); (2) testing, tracing and isolation; (3) therapeutics; and (4) vaccines.

    d. Fourth, protecting the vulnerable was always a central feature in the decision making of the Department and the Government.

3. UNCERTAINTIES IN DECISION MAKING AND IMPACT

18. The evidence in Module 2 focussed in particular on the decision-making landscape, and the decisions taken, in January-March 2020. This early period of 2020 was when there was inevitably the most uncertainty in responding to the virus. Knowledge about key issues – such as how and

how fast the virus spreads, how infectious it is, how virulent the virus is and in which groups, what the role of variants might be, who would be most impacted, what, if any, post infection immunity was acquired and its duration, the role of asymptomatic and pre-symptomatic spread, any longer term consequences of infection and if, when and how effective vaccines and treatments could be developed – are not available when a novel virus emerges and only develop slowly over time. Society wide NPIs whether legal, voluntary or by guidance, were at this point the only countermeasures. These were known, even if they could not be quantified, to have negative effects on mental and physical health, the economy, society and individuals. Decision making in this early period was therefore characterised by needing to choose at speed the least bad options based on the incomplete information available at the time. Highly impactful decisions had to be considered, taken and, on occasion, reconsidered at an unusually rapid pace based on scientific understanding and the data available at that particular point in time. This is detailed in Section 2 of Sir Christopher Wormald's Third Witness Statement.[1]

19. The Department considers that the decision making challenges for the second and third lockdowns in late 2020 and early 2021 were fundamentally different from the first lockdown. At this point there was both a much more sophisticated understanding of the virus and the Government had more countermeasures either in place or in prospect through vaccines, therapeutics and test and trace. Here therefore the Government's response was more shaped by discussion over what was the best strategy, based on information available at that time alongside wider factors, rather than by response to uncertainty.

20. In particular given that more people died in this period than in the first wave, the Department is surprised that the balance of the discussion at the Inquiry has been on early 2020, rather than on the later period. To this, the Department draws the Inquiry's attention to Sir Christopher Wormald's Fifth Witness Statement at paragraphs 61 and 300 which demonstrate the significance of decision making beyond early 2020:

> *"…The two most significant drivers of events and the response of the Government were the emergence of variants and the development of*

[1] Third Witness Statement of Sir Christopher Wormald, §§78-146 INQ000144792_34-50

deployable vaccines. New variants, in particular Alpha from late 2020, drove different surges and need for government response…"[2]

"…This was followed by the introduction of the third national lockdown in January 2021 due to the significant increase in cases of a newer COVID-19 variant across the country, which contributed significantly to the increased prevalence of COVID-19 illness and mortality over the course of the second wave."[3]

21. There has been much discussion in the evidence about the content of WhatsApp and similar messages and the contents of informal diaries. While the Department shares the shock about some of the less than professional, and in some cases abhorrent messages the Inquiry has uncovered, it appears to the Department clear that many of these sources were written at speed, sometimes as 'brain dumps' and not always with appropriate fact checking. While the Department accepts that these sources speak to opinion and to culture it suggests that the best guide to what decisions were made and on what evidence base is to be found in the primary source material. In particular, Ministerial submissions, papers and minutes of the meetings of the Scientific Advisory Group for Emergencies, "SAGE", "COBR" and the COVID-O, and COVID-S and other ministerial and official meetings. The Department contends that it is these official, written records of decision-making that provide the most accurate representation of what happened and that they should be preferred to the unofficial, often after-the-event, recollected accounts. To that extent, where the evidence in Module 2 has identified conflicts between official minutes and WhatsApp conversations or 'brain dumps', the Department would invite the Inquiry to consider matters by reference to the official record.

4. THE ROLE OF THE DEPARTMENT AND OF SCIENTIFIC ADVICE

22. As mentioned in the Department's Opening Submissions to Module 1 of the Inquiry:

"Decisions were often finely balanced; contrary decisions could have rationally been made resulting in a different set of outcome. The Department will not seek to say that it did everything right, or that it would necessarily have made all the same decisions today in 2023, with

[2] Fifth Witness Statement of Sir Christopher Wormald, §61 INQ000253807_18
[3] Fifth Witness Statement of Sir Christopher Wormald, §300 INQ000253807_18

the benefit of hindsight. We will, however, propose that it is necessary to recognise that the context of the time was very different."

The Department would like to reiterate its thanks to the staff of the Department and our many partners for the extraordinary hard work and dedication that went into our response to the Pandemic, often in the most difficult of circumstances. Some evidence has criticised the response of the Department to the Pandemic in January and February 2020 and subsequently. As set out throughout its witness statements the Department believes that it responded appropriately given the circumstances and the limited information available at the time. With hindsight, of course, there is much to learn and much the Department would do differently knowing what is known now, as set out in section 1 of these Submissions and in the Technical Report. For example, the Permanent Secretary of the Department and the Chief Medical Officer in their personal witness statements have both suggested that lockdown could, with hindsight, have been implemented earlier.

23. The Inquiry has heard evidence from a number of witnesses who have commented on the work of the Department from their perspective. The Department would draw the Inquiry's attention to the comments made by the Secretaries of State for Health who were responsible for the work on the Department in the time period of the Inquiry, Matt Hancock[4] and Sajid Javid[5].

From Sajid Javid's evidence: "… in my experience I felt the organisation, the key people obviously that I was dealing with on a daily basis within it were very professional, very committed, incredibly hard-working, and I would actually go as far as to say amongst some of the best civil servants that I've worked with, including the expert advisers. […] I was impressed […] and I had worked in or ran five departments before I arrived at DHSC and I can make a proper comparison to other departments, and I think it was very professionally run…"

From Matt Hancock's evidence: "the senior personnel in DHSC were absolutely superb and rose to the challenge" and "… did the DHSC need to expand and grow? Of course. Did it get everything right? No, of course not. […] But did it rise to the challenge overall of responding to the biggest public health crisis in a century? I think it did…"

[4] Matt Hancock transcript 30.11.2023, p.7, II.10-12, p.9 II. 22-25, p.10, II. 1-2.
[5] Sajid Javid transcript 29.11.2023, p.136, II.8-23.

24. To this the Department draws the Inquiry's attention to Sir Christopher Wormald's Third Witness Statement at paragraphs 33-34:

> *"33. There was also a large degree of uncertainty and lack of data about the impacts of decisions on health (in respect of both COVID-19 transmission and on non-COVID-19 care and population health), on society and on the economy. At the outset, the Department's and the Government's understanding of the impact of the disease was informed by data on numbers of hospitalisations, Intensive Care Unit (ICU) bed capacity and deaths. As testing expanded, the data on infection rates became more reliable and therefore more important.*
>
> *34. In this context, highly impactful decisions had to be considered, taken and, on occasion, reconsidered at an unusually rapid pace based on scientific understanding and the data available at that particular point in time. The Department's and the Government's understanding at any point in time should be understood by reference to the published studies and documents that were then available. Decisions could often not be delayed until more and better data had become available as decisions not to act could be as impactful as those to take action."*[6]

25. There has also been discussion of the extent to which health advice was 'overruled' by economic considerations or visa versa. For clarity, the Department can not expect its advice to central government to be followed at all times and especially where the issues are not purely health related ones. It is the role of the Department and its scientific advisors to put forward the case for health outcomes and their technical underpinnings. It is the role of other Departments, such as the Treasury, to do the same for economic or other priorities. It is then the unenviable job of the Prime Minister, aided by his advisors and by Cabinet, to decide how to balance those arguments and which course of action best serves the public interest.

26. In respect of the scientific advice that was given to decision-makers during the pandemic, the Department would suggest that it is important to recognise that that scientific advice represented the central view of the members of SAGE, SAGE committees and PHE reached through rigorous scientific debate, which was then summarised in Minutes and presented, ordinarily, by the Chief Medical Officer and/or the Government's Chief Scientific Adviser, to decision makers. Science advice was not, therefore, the product of an individual, but was rather rooted in joint consideration based on the work of many scientists from multiple disciplines. It is also important to recognise that many of the scientists on SAGE, NERVTAG,

[6] Third Witness Statement of Sir Christopher Wormald, §§33-34 INQ000144792_21-22

SPI-M-O and other committees, unstintingly gave their time and expertise voluntarily and unpaid over many months, and did not nor should not expect to receive individual public criticism. It is a matter of vital importance for the future that professional independent scientists are not disincentivised from advising government in an emergency having now received unjustified public criticism.

27. The Department also considers that it is important to recognise in respect of scientific advice, and when considering uncertainties in decision-making, that science very rarely has eureka moments. Generally, science accrues on a gradual basis following the empirical method of observation, testing, refinement and evaluation. There was wide uncertainty on many key scientific issues, especially early in the pandemic; this was reflected in the advice given. This naturally means there is a tension between the uncertainty of science and the need for certainty in policy making.

28. The Department believes that the effect of certain issues raised at the Inquiry had on actual decision making should not be exaggerated. For the NPI decisions of March 2020 – as evidenced in the decisions of 12, 16 and 23 March, there is a clear line of sight between the evidence presented by SAGE and others to Ministerial meetings and the decisions taken and announced by Government. Some witnesses have suggested that decisions taken early in March took ten days to implement. This is not the recollection of the Department nor of the official record, which shows a move from advising mainly voluntary action on 12 and 16 March to a decision on legally enforceable NPIs on 23 March, which was then implemented very speedily.

29. The Department has been surprised by the evidence of the extent of the toxic culture between some Ministers, special advisers and civil servants particularly within No 10 and the CO. This exceeded what the Department knew at the time and the experience of the Department, and its senior officials in interacting with the centre of government was usually positive.

30. Likewise the Department is surprised at the extent of the ‘blame game’ that has emerged from very early in the pandemic. The Department

contends that it would have been better if this energy had been better spent on problem solving the many issues that the Pandemic brought.

31. Some witnesses have questioned the timeliness of the first lockdown. The Department draws the Inquiry's attention to the oral evidence of the then Prime Minister Boris Johnson. It was put to him by Counsel to the Inquiry that a delay might have been imposed by several factors such as debates on herd immunity, behavioural fatigue and other issues the Department considers were much less important than the lack of data at the time. The Prime Minister of the day was clear in his view in response:

> *"I think that the -- all your conditionals I would delete, except the one about the data. I think that that was the key thing that the -- that SAGE lacked, and it was -- it was the sudden appreciation that we were much further along the curve than they'd thought, we weren't four weeks behind France or Italy, we were a couple of weeks, maybe less, and they were clearly wrong in their initial estimation, we were clearly wrong in our estimation of where the peak was going to be. And so the -- that penny dropped, that – we realised that on the evening of the 13th into the 14th, and then we acted. But I think once we decided to act, I think it was pretty fast from flash to bang."*[7]

The Department agrees with this summary from Mr Johnson.

32. The Inquiry has heard much debate on the issues of herd immunity, asymptomatic transmission and behavioural fatigue. The Department would like to formally put on record that it fully supports the evidence on these areas given by the Chief Medical Officer.

33. In respect of the suggestion made during the hearings for Module 2 that the Department's Action Plan was out of date and lacking in detail when it was published on 3 March 2020, the Department would invite the Inquiry to consider the evidence of Professor Sir Christopher Whitty on this issue. The Action Plan was cleared across government in the usual way, and additionally was a UK-wide document agreed with each of the devolved Nations. There were benefits to it being a UK-wide approach, nevertheless the Department accepts that it would have been helpful if the plan had been published earlier.

[7] Boris Johnson transcript 6.12.2023, pp.144-145, II.14-1.

34. While the Action Plan was the public-facing document, the work of the Department in this period was organised around the Battleplan which has been explained and exhibited in the Department's evidence. The Department was carrying out very significant amounts of work between January and March 2020 on pandemic issues, it was the primary priority of the Department, and it had paused other work. As set out in Christopher Wormald's Third Witness Statement at paragraphs 46-47,[8] the Department's Executive Committee discussed the departmental phases for managing the response to COVID-19 on 6 February 2020. The Department moved to a whole Departmental response to address significant UK cases and pressures on the health and social care system on 4 March 2020.

35. The work is set out in detail in Sir Christopher Wormald's Third Witness Statement with the following areas highlighted here:

    a. Research: The NIHR and UK Research and Innovation ("UKRI") worked together to set up a rapid research call on COVID-19 in February 2020. The unprecedented speed of the call allowed the commissioning of 26 projects in March 2020. This included two on the Oxford/AstraZeneca COVID-19 vaccine, and key therapeutics studies such as the RECOVERY trial, a study for patients hospitalised for COVID-19 treatment which was designated as an Urgent Public Health research study on 11 March 2020.

    b. Legislation: The Department led the development of both primary legislation and secondary legislation during the early stages of the pandemic. For example, the Health Protection (Coronavirus) Regulations 2020 ("the Regulations") came into force immediately after they were made on 10 February 2020, in order to provide public health protection in response to the rapid repatriation of entitled people from Wuhan. The Regulations were revoked by the Coronavirus Act 2020 ("the CVA"). The CVA, which was led by the Department, received Royal Assent on 25 March 2020 to provide additional powers thought necessary for the UK Government and the Devolved Governments to respond effectively to the pandemic.

[8] Third Witness Statement of Sir Christopher Wormald, §§46-47 INQ000144792_25

c. Supply: Securing sufficient PPE and ensuring it was available to front line staff when they needed it was a major element of the Government's response to the pandemic, including action to increase the procurement of PPE.

d. International engagement: The Department's international engagement included bilateral engagement with other countries to exchange information on their COVID-19 response, and with the WHO, WHO EURO, the G7, the G20, the Global Health Security Initiative and the European Commission. Information on the Department's bilateral engagement with other countries is provided in Clara Swinson's Third Witness Statement.

e. Engagement with Devolved Governments: UK Health Ministers established regular, dedicated conversations on the health and social care COVID-19 response from 10 March 2020. These provided an important forum for the discussion of key issues and coordination on responses and communications in areas of devolved competence. More information on the Department's engagement with the Devolved Governments is provided in Clara Swinson's Third Witness Statement.

36. There have also been suggestions that the Department failed to raise the alarm in the early part of 2020. As the Inquiry has heard, the Permanent Secretary asked that the Prime Minister was briefed on the novel Coronavirus. This was done in the meeting on 4 February when the CMO set out what was known at that stage and told the Prime Minister that a pandemic with 100,000 and 300,000 was now possible. In his evidence session, the CMO made the following comparison with a possible terrorist threat:

Now, the point I would like to make on this, because I think this is actually something where we really do need to think very seriously in government, is that had, let us say, the Director General of MI5 or the Chief of the General Staff come in and said, "There is a possibility of 100,000-plus people sadly dying from a terrorist attack or an attack on the UK", the chances that this would have been the response in the letter and that this is what would have -- that the system would have continued as it did next COBR meeting, still chaired by the Secretary of State for Health and Social Care, I think is quite small.

The reason I'm making that point is: this was not a new consideration. Pandemic infection -- flu, but this is very similar to pandemic flu -- has been top of the National Risk Register for years. This is not a new potential threat. So my worry has always been – and I think this, in a sense, reflects it -- that hard geopolitical threats are treated in a different way -- and in my view an entirely appropriate way, this isn't a criticism of what they do -- to ones which are seen as natural threats or hazards. And that, I think, is something collectively that we should think about, without ascribing this to any person.

I don't think -- you know, I think the same could very easily have happened under a number of prime ministers and with a number of others in the room. This is not a statement about the individuals; this is a statement about the system, in my view, underplaying, relative to other threats, the natural threats, including health threats. So that, I think, is quite a fundamental point, because I think had that -- yeah, had we essentially had the centre of government electrified by this, I'm not saying the outcome would have been different, but I think it would at least have led to a stronger all-of-government think-through of all the potential consequentials."[9]

37. In this regard it is useful to highlight the COBR meetings held on Coronavirus, briefing to the National Security Council, the Leader of the Opposition, and the Speakers of the Commons and Lords as well as open briefing sessions for all MPs and Peers. It is a matter of fact that none of these actions are in the usual course of events and provide evidence of the level of concern and breadth of briefing that was undertaken in early 2020.

5. ADULT SOCIAL CARE

38. The Department has not heard any evidence during Module 2 that materially changes the position as set out by Sir Christopher Wormald in his Ninth Witness Statement at paragraph 83 (emphasis in underline):

"On 11 February 2020, I chaired a meeting to consider the response to COVID-19 in adult social care (CW9/58 – INQ000049363). I recall this meeting arose from my concern that there had been less focus in discussion on adult social care than on the NHS. <u>The minutes of this meeting make clear that the model we were working to at the time was a primarily local authority-led (LA-led) response with national support. This was in line with both the legislative framework and the arrangements set out in the Flu plan (as well as the Secretary of State's steer).</u> I further raised queries as to whether any new powers were required to manage the response in care homes and what legislative changes would be required to support the LA response. My recollections of this meeting are two-fold. First, at the time the locally led approach being undertaken seemed like the logical way forward. In retrospect, the locally led approach to the social care system was

[9] Chris Whitty transcript 21.11.2023, pp.163-164, ll.13-24.

demonstrated to be insufficient for the scale of the challenge and we adopted increasingly nationalised approaches to social care as the pandemic continued. Second, I remember being concerned about the ethical questions that were raised by approaches to social care the lack of infrastructure to consider ethical issues – hence the commissioning of an ethical framework for adult social care (CW3/402 – INQ000106252)."[10]

39. The Department would invite the Inquiry to note that in respect of adult social care, the Department acted in accordance with the legislative framework that existed at the time, but adapted its approach once it became clear that a locally led response was going to be insufficient.

6. INEQUALITIES AND LONG COVID

40. In respect of inequalities, the Department would repeat that which it set out in its Written Opening Submissions for Module 2, namely that protecting the vulnerable was always a central feature in the decision making of the Department and the Government and all of the policies that were put in place were aimed at their protection. The aim of the Department was to minimise the spread of the virus overall and by doing that, protect the vulnerable.

41. The protection afforded to the vulnerable evolved over time as the Department and Government's understanding of which people were particularly vulnerable changed, that too being an uncertain aspect at the start of 2020. By way of examples, the early assumption that old-age would be a significant vulnerability was borne out in the growing evidence, while it was not until later that it was understood that living with obesity was a vulnerability.

42. The Department would invite the Inquiry to carefully bear in mind the difficulties faced vis-à-vis the modelling and statistical analysis of a novel disease. Ultimately, such modelling and statistical analysis is only as good as the data that is available and this naturally improved over time.

43. Against the backdrop of evolving appreciation of vulnerabilities, the Department accepts that the particular vulnerabilities of certain minority

[10] Ninth Witness Statement of Sir Christopher Wormald, §83 INQ000280628_12

ethnic communities to the virus were not immediately understood and that the excellent work of Professor Kevin Fenton and others at PHE and their publication *'Beyond the date: Understanding the impact of COVID-19 on BAME groups'* clearly showed the need for additional support. To this the Department draws the Inquiry's attention to Sir Christopher Wormald's Third Witness Statement at Paragraphs 302:

> *"The UK was the first to develop a digital risk tool to support individual clinical decision making (QCovid) based on work commissioned on CMO's request by NERVTAG and delivered by Oxford University working with oversight and four nations support from the DCMO."*

44. As to the issue of Long COVID, the Department would invite the Inquiry to reflect on the evidence given by Lord Stevens when questioned how decision-makers responded to the August 2020 NHS England briefing note on managing the long-term effects of COVID-19:

> *"Well, I think that the Department of Health and Social Care shared our concern, and I know that senior clinicians, ministers, over the summer and into the autumn, were also engaging with the question of Long Covid and how appropriately to support, and there was sort of active dialogue between the Department of Health and Social Care and us in the NHS about what that should look like…"*[11]

45. Lord Stevens' evidence that the Department was engaged with the issue of Long COVID over the summer of 2020 was echoed in evidence from Sir Christopher Wormald[12][13] and Matt Hancock[14]. The Department also put in train extensive research on Long COVID.

7. CONCLUDING REMARKS

46. The issues faced by England and the wider UK in the spring of 2020 were not unique. Every country in the world had to respond to a novel disease, about which little was known. Whilst there was variability, many comparable countries responded in similar ways, along similar timelines, and struggled with one or more issues such as healthcare capacity, testing volumes, PPE supply, and introducing new legal restrictions. Many comparable European

[11] Stevens {Day 17/72:3-23}
[12] Sir Christopher Wormald transcript 02.11.2023, p.164, II.20-24, p.166, II.3- 7.
[13] Sir Christopher Wormald Eleventh Witness Statement, Supplementary Corporate Statement, §21, §§26-28.
[14] Matt Hancock Third Witness Statement p.2, §§5-8.

countries experienced sustained periods of excess mortality across the whole of the Pandemic. Some countries experienced higher and some lower excess mortality than the UK. Countries had different starting points in areas including age profile, international connectivity. The underlying health of the population, provision of health services, public health capacity, manufacturing base, research base and so on led to some important differences, in some (such as research) where the UK was in a favourable position and others (such an industrial base to scale up testing) it was in a relatively unfavourable position going into the pandemic. The UK like others was operating in a global market for the supply of PPE, and later on for vaccines. It was also cooperating with the international scientific community to learn as much as possible as fast as possible on the nature of the virus, and the effectiveness of mitigations.

47. The Department remains ready to assist the Inquiry in completing its functions.

15 January 2024