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

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

MODULE TWO CLOSING SUBMISSIONS

INTRODUCTION

1. The evidence in M1 highlighted the woeful inadequacies of UK preparedness: a virtual absence of pandemic planning, combined with a health care sector with no spare capacity, fewer doctors and nurses than comparable countries, and a shambolic social care sector. On any view that provided a challenging canvas for the emergency response, and a standing start which required immediate and dynamic action by those at the centre of power.

2. Instead, the evidence in M2 has exposed a high-level response devoid of leadership, with a dysfunctional centre, reactive to events only as they reached crisis point: too little too late. What was needed was a proactive response which mitigated the effects of the oncoming tide of infection. The absence of such a proactive approach led to devastating consequences.

3. The bereaved families were therefore particularly incensed by an evidence-free section of Boris Johnson's written statement where he attempted to claim that the UK fared well in comparison with other countries. On the evidence before the Inquiry, that is manifestly not true. The Inquiry will not wish to dwell on league tables, because to do so would be meaningless, in any event, comparisons are subject to too many variable characteristics to allow for exact judgments. However, on the best available evidence before the Inquiry, the mortality rate per head of population was higher in the UK than in almost all comparable countries. In our submission, that is beyond argument, and an important starting point. The answer as to why the UK fared so badly, is provided in paras 1 and 2 above.

4. Whereas the Inquiry will generally eschew exact comparisons, we invite it to look at the evidence of countries which plainly fared much better than the UK, and to find clues as to why. The Republic of Korea is comparable to the UK in terms of wealth and population. Its population is in fact older, and it has twice the population density of the UK. Yet it had a mortality rate about one quarter of that of the UK. Why?

5. On the evidence it appears that Korea, like several other countries in SE Asia, had learned the lessons from earlier virus outbreaks and had put both plans and capacity in place. Not only that, Korea responded far more quickly once the threat of Covid was identified. Whereas a test for Covid-19 was available in both the UK and Korea from as early as mid-Jan, by March, Korea had undertaken five times as many tests as the UK. Korea utilised a suite of NPIs early in the pandemic. In so doing it minimised the need for draconian measures such as lockdowns, and it emerged better economically and in terms of public health and collateral damage.

6. The same historical evidence about previous viruses was available to all countries, the difference was that some countries had not acted on it in terms of preparedness. Moreover, some governments refused to see and act on the problem as it came over the horizon, despite the warnings from afar, and the evidence before them.

7. Mr Johnson was absent from leadership of the Covid-19 response until he chaired COBR on 2 March 2020. Instead, his Health Secretary, Mr Hancock, was ineffectually taking the lead from Jan, asserting that the UK was well-prepared, when it was obvious it was not.

8. The UK Government was so ill-prepared and reacted so slowly that measures were taken in panic as it was overtaken by events. The consequence of the failure to stockpile and manage PPE, and to surge manufacture or source sufficient quantities, meant that in early April doctors and nurses were making their own protective gear from bin liners. While Covid-19 was recognised as a High Consequence Infectious Disease by early-Jan, quite remarkably it was downgraded as such a few days before the first lockdown in the eye of the storm, as infections had exponentially gone off the top of the graph. One must go back a century to discover a disease of higher consequence to humanity than Covid-19. The downgrading was plainly due to the failure to provide sufficient respirators, as required by the HCID designation. The effect of downgrading was that doctors and nurses could be sent into covid wards with paper masks. About a thousand healthcare workers died during the pandemic, no doubt some of them because of the lack of appropriate PPE.

9. In mid-March, thousands of vulnerable people were discharged from hospitals to social care to free up NHS beds because of the anticipated surge of Covid-19 patients. They were discharged without testing and without robust Infection Prevention and Control ('IPC') measures being in place in the care sector. Why? Because of the failure of Government to upscale testing capacity and ensure IPC measures were in place. Some have argued that this decision did not add substantially to infections in care homes, given the high number of

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ordinary visits from workers and others, but the reality is that there were explosive outbreaks within care homes and a very considerable proportion of deaths occurred in those facilities. Asserting that there was a failure to prevent other avenues of infection is no answer to the irresponsible decision to transfer a mass of vulnerable people from hospitals into homes where other vulnerable persons resided, without testing or proper IPC.

10. Similarly, the raft of voluntary measures in early March 2020, announced so late that their efficacy could not be assessed before the first lockdown was imposed, illustrated the government-by-panic which characterised the early stages of the response.

11. We submit that while the first lockdown was undoubtedly necessary, it was a decision taken far too late. This is uncontroversial in hindsight, and most witnesses have agreed, but in fact it should have been obvious in real time. With sufficient testing capacity, the exponential rise of infections in late Feb and early March would have been obvious. But instead, Lockdown measures had been imposed in Italy weeks before. But instead, Mr Johnson was doing photoshoots after shaking hands with covid patients in hospitals and going to the rugby at Twickenham, whilst tens of thousands travelled from Ireland to the Cheltenham Festival, and thousands travelled from the Madrid hotspot to Liverpool for their Champions League tie on 11 March 2020.

12. There are those who say that lockdowns should not have been imposed because of the collateral damage which they caused. The balance between economic damage and inevitable loss of life was wrongly made and we invite the Inquiry to give such views short shrift. Had the March lockdown not been imposed, there would have been even greater, catastrophic loss of life, as evidenced by the modelling done at the time. The reality is that there was no 'balance' to be struck. Had a suite of NPIs been in force well before mid-March, had the first lockdown been imposed even days earlier, the curve would have been flattened before it had got out of hand. Stronger, joined-up measures taken earlier would have saved far more lives but would also have lasted for shorter periods. Saving lives and avoiding economic and other societal damage went hand in hand, they were not competitors to be weighed against each other. We submit that this false binary persisted throughout the pandemic response.

13. If indecision and dither meant the initial response was poor, the evidence shows that lessons were not learned, or indeed, where lessons had been learned, weak leadership nevertheless bent to ideological pressures from the backbenches and parts of the media which impacted on the response in the summer and autumn of 2020.

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14. With respect to the initial period, a number of key witnesses have sought sanctuary behind scientific advice. Evidence following the first lockdown clearly negates that pretence. Eat Out To Help Out ('EOTHO') was rolled out without any recourse to scientists, who have unanimously told the Inquiry that they would have forthrightly advised against it. Evidence from the Vallance diaries shows that by early Sept, Mr Johnson was well aware that infection rates were returning to the "*grim days of March*" and that he would have to stand up to the anti-lockdown brigade: "*FUCK YOU, Daily Mail*" was his inimitable expression [**INQ000280061/153**]. But just ten days later, SAGE were urging a second lockdown and suite of measures, only to be roundly ignored in favour of ineffectual localised tiers, once again not referred for scientific advice.

15. A second lockdown may have been avoided had a better approach been adopted to emerging from the first, and scientific advice sought and taken seriously before measures short of lockdown were rendered ineffectual. Once again, there was indecision, bending to ideological voices who erroneously considered joined-up public health measures were anathema to the economy. Once again, action was too little too late.

16. Marbled through these events and the governmental emergency response was real dysfunction at the heart of Government, and an ambivalent relationship with science. Sometimes scientific advisers were held close, as a shield for ministerial decisions, and sometimes their advice was ignored because of ideological pressures. Frequently scientific advisers were used as cover for decisions at daily press conferences, but inconvenient advice was either not sought or not followed. We invite the Inquiry to consider how scientific advice can best be positioned at arms' length to Government. The standing scientific committee on pandemics we proposed as a recommendation following M1 would be a starting point.

17. The Inquiry will not wish to dwell on the language used by some at the centre of these events – largely a distraction – but we invite attention to the contemporaneous messages and diary entries as evidence of internecine conflicts between advisers and civil servants and Ministers. Rivalries and personality clashes are common to all organisations, but the evidence before the Inquiry goes far beyond those norms and indicates a corrosive and dysfunctional culture which must have affected the quality of decisions taken.

18. It is said that this evidence should be given little weight as it is a snapshot of what would otherwise be corridor chats or constituted written reflections to maintain wellbeing at the end of a long day. Whereas those points have some validity, the messages and diary entries constitute a rich vein of contemporaneous, unguarded record, and cannot be lightly dismissed. They illustrate a toxic male, misogynist culture, a lack of diversity, and the absence

of a team spirit. They also assist in determining what was considered, when, and what was overlooked. By way of example, Mr Cummings' "stiletto" message to Mr. Johnson [**INQ000283369/38**] regarding Ms MacNamara graphically evidences a negative attitude to women which must have adversely affected the emergency response processes by excluding sources of diverse lived experiences and opinions.

19. The "Daily Mail" message referenced in para 14, indicates the knowledge of the former PM in early Sept, and its dissonance with his lack of action in the following weeks. The WhatsApps exchanged by those inside No. 10 in autumn 2020 regarding the causes of the disproportionate impact of Covid on people from black and other ethnic minority communities [as discussed below in Section A §56], illustrate the failure to consider structural and institutional racism and other forms of discrimination. The UK Government also demonstrated a lack of respect for the devolved and local administrations. Ministers in Westminster failed to engage, misunderstood, patronised and underestimated the devolved administrations, and tried to leverage power over regional Mayors on party political grounds.

20. We note also the missing WhatsApps of Mr Johnson and Mr Hancock from the crucial early stages, and of Mr Sunak from throughout the relevant periods. Proper explanations for the missing messages are notably absent, regarding those of Feb to June 2020 for Mr Johnson, for which we only have the conjecture of his lawyers **[INQ00030950 and INQ00030951]**.

21. The families invite the Inquiry to be forthright in its findings concerning political leadership and the dysfunction in the government machine during the Covid-19 Pandemic. How the Inquiry deals with these issues of dysfunction for the future is complicated by the constitutional issue of democratic accountability, and the relationship between Ministers, their political advisers and the civil service. The failure of political leadership is a matter for the ballot box and Parliament, but the Inquiry is free to make recommendations as to changes to transparency and the relationship between advisers and public servants and should do so.

22. The lack of preparedness and the dysfunction at the centre of Government did affect the ability to mitigate the effects of structural discrimination. So too did the ideological ambivalence of Ministers to the concept, as shown by the evidence of the Equalities Minister, Ms Badenoch. Black and ethnic minority communities were worse affected and faced different challenges during the pandemic. This should have been planned for, and the response should have recognised it from the outset, but little was done. There are many examples of older people being considered expendable or their lives of lesser weight because of their age. The

Government response failed to identify or recognise the needs of Disabled people, including those with physical and mental disabilities, autism, and Down Syndrome.

23. For the families, a starting point in examining the high-level response to the pandemic has been the way in which the M1 evidence of absence of preparedness, has segued into M2. From that point, the evidence has shown weak and indecisive leadership and a dysfunctional government team at war with itself, which either failed to spot problems coming at them and constantly reacted too little too late or ignored those realities because of ideological pressures from elsewhere. The cost of this lack of planning, capability and capacity, compounded by absence of leadership has been counted in lives lost.

SECTION A: KNOWN RISKS AND INEQUALITIES

24. The UK's response was undermined from the outset by the lack of preparedness for a 'whole system' emergency, and particularly for a pandemic. This lack of preparedness had several causes: (a) lack of pandemic planning; (b) weak national, regional and local resilience structures; (c) lack of capabilities and capacities; and (d) pre-existing impacts of austerity, structural and institutional inequality.

25. This put the UK at a severe disadvantage, but the weaknesses were compounded by a secondary failure: an arrogant and baseless belief amongst key decision-makers that the UK was *"extremely well-prepared"*, discussed in Section B below. This resulted in a failure to mitigate the effects of the weaknesses outlined above until it was far too late.

Planning

26. In M1, Mr Hancock described the pandemic flu plan as "*wholly inadequate*" [**M1/10/71/21-10/72/2**]. The inadequacy of pandemic planning was obvious on the face of the plan. In Prof. Whitty's view, this was not simply due to the characteristics of Covid-19: *"had we had a flu pandemic... it would also have been woefully deficient"* [**23/121/1-14**].

27. As Mr Cain told the Inquiry, "*quite a few people in No.10 were starting to get concerned because if this is the plan, then we clearly don't have a plan*" [**15/16/10-15**]. Helen McNamara recalled having the same impression upon her review [**16/23/11-22**]. Nor was the lack of planning restricted to DHSC. As recognised by Mr Reynolds, there were no sufficient plans in the Cabinet Office [**14/46/4-12**]. Lord Sedwill agreed that *"DHSC had no plans sectorally for those areas of the country and those areas of government for which it was responsible, and the Cabinet Office had no plans or documents which co-ordinated the plans... brought them together or refined them"* [**20/60/18-25**].

28. It is striking then that this recognition is wholly absent from contemporaneous documents throughout the early period examined in M2. If Prof. Whitty and Mr Hancock reviewed the document in Jan and had the concerns that they expressed to the Inquiry, there is no evidence to suggest that they shared their concerns. On the contrary, Prof. Whitty asserted to the Cabinet in mid-Feb that there were *"plans in place"* [**23/176/2-5**].

29. Mr Hancock now accepts that the serious inadequacy of preparation had significant implications for DHSC's ability to respond to the pandemic [**29/3/7-22**]. In his M1 evidence, he was at pains to emphasise that flawed planning meant a *"huge amount of other things that need to happen when you're trying to stop a pandemic didn't happen"* [**M1/10/25/5-10**].

30. Mr Hancock's contemporaneous assertions were very different. In a WhatsApp to Mr Cummings on 25 Jan 2020, he asserted that DHSC had *"full plans up to & including pandemic levels regularly prepped and refreshed."* Why, at a time when – as he accepted – the only plan was "*a single document from 2011 based doctrinally on a completely inappropriate approach*", would Mr Hancock make such an assertion? Similarly, in briefing the Cabinet on 6 Feb he asserted that the Government *"has a plan to deal with this illness."* In attempting to explain away these statements, Mr Hancock asserted that *"we had a whole series of plans*" [**29/40/10-25**] and cited the UK's ranking in 2019 and Exercise Cygnus. The Inquiry may find Mr Hancock's answers both unconvincing and self-serving. The evidence shows there was no *"whole series of plans."* The 2019 ranking had no bearing on Mr Hancock's awareness of adequate plans. Cygnus ought to have been a cause for concern, not reassurance.

31. A more plausible explanation is that Mr Hancock failed to adequately conduct the investigations he claimed he had by 23 Jan, failed to review the obviously inadequate 2011 plan and had no basis for his complacency. This is also indicated by the wholesale failure to recognise at all, until March, the absence of planning in relation to an area of paramount importance in any pandemic response: social care. This despite Helen Whately asserting on 3 March that plans for the care sector were "*non-existent or inadequate*" [**30/30/18-22**].

32. It is clear from the evidence heard in M2 that beyond DHSC there was little effort to obtain or interrogate the plans which were in place until late Feb [**31/78/19-25**]. Given the scale, cross-cutting and massive impact of Covid-19, this failure cannot be explained by the assurances provided by Mr Hancock. Lord Sedwill accepted that *"plans should have been interrogated more carefully by me and at the Cabinet level"* [**20/34/1-7**].

Weak resilience structures

33. The failure in planning was compounded by pre-existing weaknesses within resilience structures. As set out in our M1 closing submissions [**INQ000235080/24-30**], at the time when Covid-19 struck, the UK did not have a civil contingencies system but a disconnected collection of uncoordinated fragments. There was little central leadership by design. This would have great impact in relation to response and particularly the disconnect between central and local Government. An example of this which had a profound impact on bereaved families was in relation to planning for dignified death, as set out in Section H.

Capacities and capabilities

34. Prof. Whitty explained that *"Capabilities trumps plans every single time"* [**23/122/14-23**]. We do not disagree, but the lack of planning meant that the lack of capabilities to prevent the spread of the virus was not interrogated at Cabinet until it was too late [**20/36/1-15**]. One essential capability is the capacity within the healthcare system to treat patients and stem the spread of infection. As the Inquiry heard in M1, it was well-known before the pandemic that the NHS regularly operated at 95% capacity and 'ran hot' every winter. The state of play was no different in Jan 2020 and was exacerbated by Covid-19. Between waves, Sir Patrick Vallance commissioned a report which reiterated this fact and warned of the need to urgently increase bed capacity ahead of Winter 2020 [**INQ000192120/3-6**]. If any attempt was made to increase capacity, it was insufficient; given that by Oct 2020 the need to 'protect the NHS' was at the forefront of ministerial deliberations once more.

35. We set out in our M1 Closing the pre-existing weaknesses in three core capabilities: testing, PPE and data capacity [**INQ000235080/35-39**]. The evidence in M2 has borne out the impact of the weakness in these three core areas. Indeed, Prof. Whitty's evidence was that the "*big problems*" in March resulted from the lack of data and testing [**23/129/1-5**]. The lack of capabilities was not unforeseen or unforeseeable but was the result of decades of underinvestment. As Prof. Whitty explained, absent long-term investment *"you can't just switch on [capabilities] at short notice"* [**23/41/12-23/42/2**]. This lack of investment resulted not only in a lack of specific capabilities leading into the pandemic but, *"much more important"* failings stemming from *"the erosion of public health facilities"* [**23/119/4-22**].

36. Regarding social care, Caroline Abrahams spoke of the *"fragmented"* nature of the Adult Social Care ('ASC') sector which resulted in a *"reluctance, and actually to begin with an inability* [within Central Government] *really to know how the Government could help"* [**3/190/10-18**]. The Inquiry also read out a summary of questionnaire responses, including from Care UK, which described *"the absolute primacy given to the NHS in all aspects of the Government's response to the Pandemic"* [**3/173/10-17**]. Prof. Harries commented in April 2020 that although the ASC sector was "*inextricably linked*" to the NHS, it was *"alienated"* by

the UK Government *"very regularly"* [**INQ000151694/3**]. These statements reinforce the evidence from M1 and outline the deleterious impact during the pandemic of the Government's failure in the decade prior to grasp the ASC sector and recognise the *"absolutely crucial public service"* it provides [**3/190/12**].

37. Prof. Nazroo highlighted the particular impact of underfunding and associated issues of security of employment on the fragility of the social care system, affecting both residential and domiciliary care. This fragility was particularly evident in *"the low pay and lack of resilience across the sector, carers moving from setting to setting, dependence on private agencies, problems sustaining packages of care and lack of PPE"* [**3/167/17-3/168/19**].

38. Lord Stevens told the Inquiry, *"there have been long-standing problems with the availability of social care that has often meant that patients end up stuck in hospital"* [**17/46/9-13**]. In our submission, this problem is long-standing and permeates every winter. As outlined by Prof. Nazroo, the patients most affected often have comorbidities and/or disabilities that make them especially vulnerable to infection [**3/152/7-14**]. The Government's failure to resolve this decades-old problem meant there were fewer options available in March 2020 when the remarkable decision to discharge untested patients into residential care settings was taken.

Pre-existing austerity and inequality

39. In M1, Professors Marmot and Bambra reported that "*the UK entered the pandemic with its public services depleted, health improvement stalled, health inequalities increased and health among the poorest people in a state of decline*" [**INQ000195843/29§58**]. The correlation between pre-existing inequality and higher mortality and morbidity from an infectious respiratory virus was also known [**INQ000195843/75**].

40. The Inquiry has also heard evidence during M2 of pre-existing inequalities and the disproportionate impact of Covid-19 on people from ethnic minority backgrounds and racialised groups, disabled people, older people, LGBTQ+ communities, children and women which, when assessed against the background of known pre-existing inequalities, strongly supports the conclusion that the disproportionate impact of Covid-19 on people from particular groups was both foreseeable and able to be mitigated.

41. Our submissions will focus on the disproportionate impact of Covid-19 on people from ethnic minority backgrounds and racialised communities, Disabled people, and older people and their intersectionality given the impact on the bereaved.

42. We endorse the oral submissions made on behalf of all of the non-state Core Participants. And in particular for the purposes of this section, the Disabled People's

Organisations on the disproportionate impact of Covid-19 on Disabled people and the intersection of disability, age and race. We also endorse Section D of the written submissions of the Trades Union Congress on payment for self-isolation and movement of workers in the ASC sector.

Race and Inequality

43. Structural racism is reflected in disadvantaged access to physical, economic, political, social and cultural resources, resulting in, for example deep and persistent socio-economic inequalities. This also has cultural and ideological dimensions, the justification of inequality through the stereotypes of and values attached to others. Institutional racism is reflected in routine processes and procedures within institutional settings that translate into actions that negatively shape the experiences of people from racialised groups [**INQ000280057/6§13.3**].

44. The Inquiry has heard evidence from which it should conclude that health inequalities among people from particular ethnic minority groups presented a foreseeable risk which should have informed decision making and the UK Government's response to Covid-19. The evidence also suggests that the disproportionate outcomes of people from ethnic minority backgrounds were underpinned by both structural and institutional racism.

45. It was well-established that health inequalities between ethnic groups were entrenched in the UK prior to the pandemic, with general poorer health among people from some BAME groups, thereby increasing their risk of severe illness or death [**INQ000280057/7-11§14-33**].

46. Socio-economic inequalities exacerbated vulnerabilities among people from BAME backgrounds and increased their morbidity and mortality rates from Covid-19, particularly in relation to housing and employment. Black Caribbean men and women experience higher rates of unemployment than their white counterparts. It was well known and long established that people from ethnic minority backgrounds were more likely to be employed in sectors which increased their risk to exposure such as the transport sector, delivery jobs, health care assistants, hospital cleaners, social care workers and in nursing jobs and medical jobs when compared to the majority white population. They were more likely to experience insecure job tenures, be paid less, in jobs on zero-hour contracts and the gig economy. We suggest that it was foreseeable that people from ethnic minority backgrounds working in these sectors would be at greater risk of contract Covid-19 in a pandemic.

47. It was also well documented that people from particular ethnic minority backgrounds were more likely to experience deprivation and to live in overcrowded housing, in urban areas with less access to green spaces and high pollution levels (thereby increasing their

susceptibility to respiratory compromise) [**INQ000280057/13§37**]. The risk of contracting Covid-19 in these households was therefore also foreseeable.

48. Although pre-existing health inequalities among people from ethnic minority backgrounds and their interrelationship with socio-economic inequality and environmental determinants of health have been well documented, and were known factors that were likely to have impacted on the health outcomes of people from BAME communities during the pandemic, they do not appear to been considered in the Government's planning and response measures to Covid-19 at the start of the pandemic and through the first wave.

49. Research by the Runnymede Trust confirmed the Government's failure to consider pre-existing inequalities among people from BAME backgrounds in its response to the pandemic, evidenced by a lack of equality impact assessments [**INQ000099679/3**].

50. The evidence suggests that the structural inequality among people from BAME backgrounds did not inform decision making during the pandemic even at the height of the first wave. Likewise, the disproportionate impact of Covid-19 on people from BAME backgrounds only became a topic of Government discussions after the first wave and publication of the PHE report on health disparities. Dominic Cummings confirmed that the disproportionate fatality rate from Covid-19 was discussed only after the first wave following the publication of data which raised the issue [**15/144/13-21**].

51. Lee Cain told the Inquiry that the PM's top team was comprised of largely middle-aged white men and its decision making lacked the diverse experiences from people from different socio-economic and ethnic backgrounds. He cited the Government's rejection of Marcus Rashford's proposal for 'free school meals' as being a decision impacted by a lack of diversity. In response to questions on the impact of the Pandemic on people from ethnic minority backgrounds, Mr Cain recalled that although it was discussed in the meetings it may not have been given the weight of someone with lived experienced and although the need for diversity in decision making was raised, nothing was done about it [**15/86/3-14**].

52. The evidence suggests that the decision makers in government had a homogeneous outlook, lacked diverse lived experiences and the diversity of different socio economic and ethnic backgrounds which invariably impacted on the Government's response to the disproportionate impact of Covid-19 on people from BAME backgrounds.

53. Ms Badenoch, who seemed to both minimise structural race issues and suggest that addressing disproportionate impact was unlawful under the legislation, suggested that: "t*he evidence has shown that being an ethnic minority was not the cause of being*

disproportionately impacted; it correlated with what the causes were, the comorbidities" [**25/182/8-11**]. That was not the evidence. The disproportionate impact was related to structural issues such as the fact that BAME workers make up a huge proportion of the health, social care and transport sectors, and wider gig economy: all high risk. Later, Ms Badenoch chose an example of Pakistani taxi drivers and told the Inquiry it would be wrong to provide funding and measures aimed at alleviating their risks because targeted measures are unlawful. No one was suggesting that black workers should be favoured over white workers. Measures aimed at addressing disproportionate impact are plainly not favouring persons of one background over another, and they are not unlawful in the way suggested.

54. For health inequalities to be reduced, policies must be considered in relation to the whole population, but the scale of intervention should be proportionate to the most disadvantaged. In practical terms this means that any policy or operational measures that the Government put in place during the pandemic should have considered what different groups needed and how they would access any particular service or provision, so the outcomes were optimal for everyone. The failure to address disproportionate impacts was in our submission, of itself an aspect of structural discrimination, and the views of the Equalities Minister appear to triumph ideology over reality and the law.

55. The SAGE ethnicity subgroup was not formed until late Aug 2020 – well after the publication of PHE report in June 2020. There was no urgency to address the disproportionate impact of Covid-19 on people from particular ethnic backgrounds, because it was an afterthought.

56. Furthermore, rather than tackling underlying inequalities contributing to the disproportionate outcomes, time and resources were spent pursuing investigations into biological or genetic factors such as Vitamin D deficiency, which had already been debunked and was in any event inconsistent with the PHE report 'Beyond the Data' [**INQ000106482**]. In Sept 2020, Dominic Cummings posted a follow up on the need to invest in Vitamin D supplies in a WhatsApp group which included the former PM [**INQ000102079/2**]. In Nov, Damion Poole posted a message on behalf of the then Health Secretary, Mr Hancock requesting that NICE and PHE re-review existing evidence on the link between Covid-19 and Vitamin D [**INQ000094975/2**]. All efforts which ignored the real issues.

57. Although people from BAME backgrounds account for a significant proportion of doctors, nurses and health and social care workers; measures were not taken at the start of the pandemic to source culturally appropriate PPE to accommodate facial hair, head coverings (including religious wear) and non-European facial structures, including cheekbones and nose

bridges. Lord Stevens confirmed that, at the start of the pandemic, PPE was being sourced without assessing its suitability for workers from ethnic minority backgrounds [**17/50/15-17/51/5**]. This left BAME workers more exposed to Covid-19. The Inquiry also heard that doctors from ethnic minority backgrounds were more likely to be faced with a shortage of PPE and pressure to work in environments without sufficient PPE, and those with a disability or long-term health condition were more likely to report feeling worried or fearful to speak out about a lack of PPE. FEMHO highlighted the disproportionate impact of Covid-19 on BAME staff, particularly in the health and care sectors. Delays in addressing impact and the provision of national guidelines and policy led, they said, to inconsistencies between hospital trusts as to how to protect staff, and NHS employers did not provide updated guidance on prioritisation and management of risk, including ethnicity, until July 2020 [**4/58/4-17**]. We submit these failures which impacted on the disproportionate outcomes for healthcare workers constituted institutional racism.

58. The analysis of the impact of Covid-19 on people from BAME backgrounds was exacerbated by a lack of data, which the Inquiry has heard was due to underinvestment in data and research in the preceding 10 years. One of the gaps in data capture is the non-recording of ethnicity on death certificates in England, Wales and Northern Ireland (it is recorded in Scotland). The lack of data on ethnicity and health inequality invariably affects health outcomes. We submit that such persistent failure to invest in data analysis to improve the health outcomes of people from BAME backgrounds, also constitutes structural and institutional inequality.

Older People and Ageism

59. The vulnerability of older people to respiratory viruses such as Covid-19 was known and documented before the pandemic. PHE's analysis showed that once infected, people aged 80 and over were 70 times more likely to die than 40-year-olds [**INQ000280058/6§18**]. Older people were more likely to suffer from underlying comorbidities and physical or mental disabilities, including dementia. Many older people with care and support needs live in care homes. Prior to the pandemic, it was known that older and Disabled people living in community residential settings were at greater risk of complications or mortality from a respiratory infection. By 11 Feb 2020, the UK was in possession of data from China up to 29 Jan which recorded a lower risk of mortality of those aged under 50 [**INQ000280058/6§17**] giving ample time to ensure decisions safeguarded older people from the risk of contracting Covid-19.

60. Between 17 March and 15 April 2020, the NAO reports that 25,000 patients were discharged from hospital beds into care homes in England, many without being tested [**INQ000280058/19§76**]. Many bereaved families lost loved ones to Covid-19 in care homes

during this period, many of whom died alone because of the restrictions on visitors that were in place. Whilst appreciating that there will be further investigation of this issue, the Inquiry has heard sufficient evidence to conclude that the disproportionate deaths of care home residents were a foreseeable outcome of the March discharge policy.

61. The Inquiry has also heard evidence of statements by the former PM about older people which constitute ageism, some of which were said to have been made in the context of decision making. These included entries in the Vallance diaries and WhatsApps between Mr Cain and Mr Johnson. Sir Patrick's diary entries note: "*he is obsessed with older accepting their fate and letting the young get on with their life and the economy going*"; "*PM says... Covid is just nature's way of dealing with old people*"; "*Chief whip says I think we should let the old people get it and protect others" PM says a lot of my backbenchers think that I must say I agree with them*" [**INQ000273901/150;308;312**].

62. In WhatsApp messages with Lee Cain on 15 Oct 2020 about whether to go into lockdown at a time of increased infection – Mr Johnson said: "*I must say I have been slightly rocked by some of the data on Covid fatalities. The median age is 82-81 for men and 85 for women. This is above life expectancy. So get Covid and live longer… I no longer buy all this nhs overwhelmed stuff. Folks I think we need to recalibrate….*" To which Lee Cain responds: "*All understood --- but how does this change the policy?*" To which the former PM says: "*It shows we don't go for nationwide lockdown*" [**INQ000267902/1**].

63. In our submission, the former PM's WhatsApps are an unfiltered reflection of his views on older people expressed during a period of exponential growth and increased hospital admission, which impacted his decision-making and, in turn, the rate of infection and mortality among older people.

64. Sir Patrick's diary entries are contemporaneous notes of daily events and taken in the context of the former PM's WhatsApps with Lee Cain are particularly chilling with respect to older people. We invite the Inquiry to find that the entries and WhatsApps record statements by the former PM which were highly discriminatory towards older people.

Disabled people and Ableism

65. It is estimated that 21% of the UK population is disabled, amounting to approximately 14 million people. Of this figure 8% are children, 19% of the working population and 44% are pensionable adults. Disabled people faced significant levels of structural discrimination going into the pandemic. These included in employment – in 2018 51% of Disabled people were employed compared to 81% of non-Disabled people [**INQ000280067/6§17**]; higher levels of

poverty than non-Disabled people with 50% of those people living in poverty being either disabled themselves or lived with a disabled person; poorer access to transportation and gaps in educational attainment. By 2020, a decade of austerity had seen cuts to the ASC budget that left many Disabled people with their needs either not met or poorly so.

66. People with intellectual disabilities were particularly disproportionately impacted by Covid-19. ONS reported that 59% of England's deaths were Disabled people although Disabled people only accounted for 21% of the UK population. Although it was known that Disabled people faced an increased risk of harm from respiratory viruses, there was no plan to protect them at the start of the pandemic nor was safeguarding of Disabled people a feature of the UK Government's response strategy. Justin Tomlinson's evidence highlighted glaring failures to safeguard Disabled people and supports the view of Disabled people and the bereaved that they were forgotten.

67. The disproportionate impact of Covid-19 on Disabled people was not acknowledged until May 2020 and research into its causes was hampered by inadequate data. A paper on the impact of Covid-19 on disabled individuals dated 21 May 2020 noted a need for greater data on this demographic. Although raised in subsequent meetings in Sept and later in Dec 2020, the call for data to facilitate research on the disproportionate impact of Covid-19 on disabled individuals does not appear to have been progressed.

68. The UK Government initially failed to acknowledge the needs of Disabled people and thereafter displayed a lack of urgency or prioritisation. For example, PHE was not commissioned to conduct research on disproportionate impact on disabled people as it had on BAME communities.

SECTION B: THE INITIAL UK GOVERNMENT RESPONSE

69. It is submitted that the UK Government response should have been led by the Cabinet Office and No.10 from 25 Jan 2020, at the latest, when it had become clear: (a) the risk of a pandemic affecting the UK was 50-50; (b) the UK's health and social care system had no capacity to withstand even a moderate pandemic; (c) an effective response to the RWCS was inevitably going to require comprehensive cross-government engagement and resources; (d) the involvement of First Ministers from the Devolved administrations was essential; and (e) a COBR chaired by the Health Secretary meant the PM would not attend, and it was not going to guarantee the attendance, or attention, of other senior Ministers.

70. 25 Jan 2020 was a key date in the trajectory of the pandemic. By then, the situation had escalated so rapidly that the Chinese Government convened an exceptional Politburo

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meeting on Lunar New Year; described in a diplomatic telegram as "*comparable to a COBR meeting on Christmas Day*" [**INQ000064689/1§3**].

71. The same day, Prof. Woolhouse wrote with alarm to Sir Jeremy Farrar and Prof. Ferguson that the doubling of gross mortality and complete overwhelm of the NHS was based on central estimates and told Sir Jeremy he was *"hoping that the calm face of Government (risk is "low"!!!)* [was] *masking some serious behind-the-scenes preparation"* [**INQ000103233/1-2**]. Sir Jeremy and Prof. Ferguson said they had raised similar concerns with Prof. Whitty and Sir Patrick Vallance, which was put to Prof. Whitty in evidence. He told the Inquiry he had no doubt by 25 Jan that this was a very dangerous and transmissible virus [**23/135/10-11**]. By now, The Lancet had published its first article suggesting the possibility of asymptomatic transmission [**INQ000212897/8**]; discussed in Section C.

72. Meanwhile, PHE noted evidence of human-to-human transmission in Vietnam, a super-spreading (amplification) event at a health care facility in China, and the first confirmed cases in France [**INQ000223315/5-8**]. The UK Government began preparations to evacuate older UK nationals and those with pre-existing health conditions from Wuhan.

73. The WHO Regional Director for Europe stressed the importance of being ready to "*detect sick people, test samples… manage patients adequately, maximise infection control, and maintain open communication with the public*" and highlighted: "*The first cases of 2019-nCoV confirmed in Europe were not unexpected... no country can afford postponing the establishment of all necessary measures to protect their people... The time is now to make ourselves ready*" [**INQ000308736/1-2**].

74. As outlined by Prof. Costello, the third week of Jan was the first indication that things were *"serious*" and the moment when preparations would *"need to be made for any virus for which test, trace, isolate and support could reasonably be expected to control the virus"* [**10/124/12-25**]. This aligns precisely with the WHO alert and was not a point lost on Government scientific advisers: as we detail elsewhere, Prof. Van-Tam said that he realised by 16 Jan 2020 that the UK was facing a major pandemic [**24/177/18-24/179/3**].

75. Repatriations and border measures, including travel advice, were already starting to require the engagement of multiple Government departments. Although nothing had been planned, non-pharmaceutical interventions ('NPIs') had begun to be discussed and, as Mr Hancock outlined, designing them *"was a Cabinet Office thing"* [**29/20/5-23**]. It is submitted that, from this early stage, when it was apparent that multiple departments needed to work together at pace, the response should have been seized by the Cabinet Office and No.10.

76. By 4 Feb 2020, global numbers had skyrocketed from 850 cases and 25 deaths the day before Lunar New Year [**INQ000056214/4§2**] to 24,533 cases and 492 deaths 10 days later [**INQ000056148/2**]. There had also been major developments in the risk to the UK:

(a) Matt Hancock informed the House of Commons that returnees from Wuhan were now required to self-isolate regardless of symptoms, "*...as concerns have been raised about limited pre-symptom transmission...*" [**INQ000106066/2**] (27.1.20).

(b) The FCO advised against all but essential travel to mainland China (28.1.20).

(c) British Airways suspended all flights to and from China (29.1.20).

(d) WHO raised the global risk level to high (29.1.20).

(e) WHO declared a Public Health Emergency of International Concern (30.1.20).

(f) Human-to-human transmission was reported in the USA (30.1.20).

(g) The first cases were announced in the UK and Italy (31.1.20).

(h) The number of infected people surpassed SARS (31.1.20).

(i) NHS England declared a level 4 incident (31.1.20).

(j) The USA banned non-US citizens entering the country from China (31.1.20).

(k) The first death was reported outside China (2.2.20).

(l) A G7 meeting was held (3.2.20).

77. Prof. Whitty told the Inquiry that he wrote to No.10 on 28 Jan 2020 to brief the top tier of Government that the UK was facing the *"dichotomous position"* of containment in China with a few spillover cases or a pandemic with far-reaching consequences. According to Prof. Whitty, he deliberately did not include *"a fudge in the middle*" to focus minds on the fact that the UK was *"in pandemic territory*" with no hope of stopping the virus from taking hold, only delaying it [**23/135/12-23/138/23**].

78. Prof. Whitty acknowledged that sustained community transmission in the UK would be a red flag [**23/139/13-15**], but caveated his views by saying that, on 28 Jan, there was still *"widespread international debate among serious experts"* about whether sustained transmission outside China would happen and WHO had not yet declared a PHEIC. Leaving aside the fact Prof. Whitty's Office confirmed by email on 28 Jan 2020 that, *"We are fairly sure* [WHO] *are going to call a public health emergency"* [**INQ000047583/1**], by 4 Feb the situation had changed: A PHEIC *had* been declared, the risk to the UK *had* been increased, the NHS *had* declared a level 4 incident, and the UK *had* announced its first cases. A diplomatic telegram confirmed reports from the Chinese Government of asymptomatic transmission [**INQ000064689/1§2**]. Sustained community transmission was on the horizon in Europe following the infection of a healthcare worker in France [**INQ000064692/1§2**] and confirmed human-to-human transmission in Germany [**INQ000056148/2**].

79. On 28 Jan 2020, SAGE had agreed with the triggers which would require a change in HMG's approach; sustained human-to-human transmission outside China and/or a severe UK case [**INQ000203936/3§28**]. Prof. Whitty told the Inquiry that either of these triggers would activate a whole-Government response because *"at this point you're talking about measures which inevitably will require cross-Government agreement"* such as border measures and alerting the economic system [**23/147/3-17**]. By 4 Feb 2020, border measures were being discussed by senior Ministers [**INQ000047661**] and HMT had produced economic advice [**INQ000328752**]. On 4 Feb 2020, the FCO took the decision to advise all UK nationals to leave China [**INQ000047671/1-2**]; WHO published its Strategic Response Plan repeating, "*All countries are at risk and need to prepare*" [**INQ000087457/14**]; and Prof. Whitty briefed the PM directly, which he said *"you wouldn't do under ordinary circumstances*" [**23/155/8-11**]. This was the last opportunity for the response to be seized in time for the crisis, but the UK Government abjectly and fatally failed to do so.

Causes of the failure to escalate to a Cabinet Office and No.10 led response

80. Why was the response not escalated? Prof. Whitty pointed the Inquiry to a "*systemic*" and long-standing difference in attitude towards natural hazards and terrorist threats, which we urge the Inquiry to address in its recommendations [**23/169/24-23/170/15**]. The Inquiry must, however, consider the extent to which personalities played a part too. It has heard evidence from Ms MacNamara of the *"nuclear levels of confidence that were being deployed*" by Mr Hancock [**16/108/23-16/108/24**] and seen Sir Patrick Vallance's note that he was *"desperate to own and lead*" [**INQ000273901/1**]; and there is no reason to doubt the honesty, accuracy or integrity of either witness on this point.

81. Mr Hancock refuted the suggestion that he was protective of the response and insisted, "*We were trying to wake up Whitehall to the scale of the problem*" [**29/15/6-9**]. He told the Inquiry he had been "*blocked"* from convening COBR to illustrate resistance from the Cabinet Office [**29/15/21-24**]. Whilst it is true that there was a delay of 48 hours, WhatsApps between Sir Chris Wormald and Lord Sedwill suggest it might have been caused by a lack of clear communication between all elements of DHSC and the Cabinet Office as opposed to a forceful resistance. On the one hand the Cabinet Office was trying to *"reset from the Cameron practice of having a COBR every time someone loses a dog"*; on the other, Lord Sedwill was asking Sir Chris, "*Do you have what you need? Should we get the CCS machine into gear? Or not yet*?" to which the response was, "*Think too early for full gearing up – let's keep under review for the next few days*" [**INQ000279872**].

82. Mr Hancock's determination to chair COBR is clear [**INQ000092995/2**]. It is submitted that, if Mr Hancock had genuinely wanted to activate the top tier response, there would be evidence of him urging the PM to chair COBR before the end of Feb, but there is none. In contrast, Mr Hancock reassured Mr Johnson that he only needed a *"great unifying clarion call… when the time* [was] *right"* to urge the public to "[help] *old folks if they have to stay at home*" [**INQ000129226**], just as the crisis of March 2020 was unfolding.

83. Mr Hancock's reassurances were constant and persuasive, as has been said by other witnesses. That does not, however, absolve the former PM of his ultimate responsibility to steer the UK through the looming Tier 1 emergency. Mr Johnson told the Inquiry he accepted responsibility for the manner and speed of the Government response [**31/12/7-17**]. From 25 Jan 2020 at the latest, it should have been clear to him that a pandemic of the sort unprecedented in living memory, was likely. Instead, he accepted Mr Hancock's baseless reassurances. Rather than being "*electrified*" by the CMO briefing on 4 Feb as Prof. Whitty suggested he ought to have been [**23/164/20**], Mr Johnson remained so far distanced from the plans that he did not attend Nimbus on 12 Feb, and did not attend, let alone chair, COBR for another month.

84. When asked about the CMO briefing on 4 Feb 2020, Mr Johnson accepted that "*my mindset... was not as alarmed as we -- as* [I] *should have been"* [**31/70/2-6**]. He told the Inquiry, "*Covid was pretty much like a cloud on the horizon, no bigger than a man's hand, and you didn't know whether it was going to turn into a typhoon or not"* [**31/45/24-31/46/4**]. In our submission, that is a remarkable statement in light of the above evidence, the view of scientists such as Prof. Edmunds that by mid-Feb there was only a hope that a "*very, very major pandemic*" might be stopped from reaching the UK [**13/50/3-11**] and Mr Cummings' WhatsApp to Mr Johnson in early Feb that, "[the] *Chief scientist told me today it's prob out of control now and will sweep world"* [**INQ000236371/37**].

85. Mr Johnson said it was *"fundamentally the problem"* that by 14 Feb Ministers including himself were *"not yet believing, perhaps irrationally… that the RWCS or anything like it is going to happen*" [**31/75/23-31/76/3**]. On the evidence, it was certainly irrational. In his statement, Mr Johnson describes the Cabinet meeting of 14 Feb but conveniently omits the CMO briefing that there were around 60,000 cases and 1,000 deaths in China; which *"could in reality be ten times higher"* [**INQ000255836/18§59-68 and INQ000056138/6**]. Recalling that the number of infections had already surpassed SARS by 31 Jan and recognising that the number of deaths had now done so too, these figures were enough to engulf the *"man's hand"* on the horizon; and were 6 times higher than at Cabinet on 31 Jan [**INQ000056125/10**]. They should have

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been a *"loud enough claxon of alarm"* for the PM without anyone else needing to sound it [**31/61/1**].

86. The events of the 10-day period between 25 Jan and 4 Feb emphasised a lesson that should have been held in mind by Government throughout the pandemic, namely that periods of increased travel correlate with increased transmission and require increased vigilance. This was not new information; the UK Government had predicted a rise in cases before Lunar New Year [**INQ000047544/11**]. Just as they do not respect international boundaries, major respiratory epidemics do not respect public holidays.

87. Instead of ramping up the Government response immediately in line with WHO warnings, Mr Johnson went to Chevening after 14 Feb for a week. Mr Cain makes clear that these actions reflected the perceived importance of Covid-19 from inside Downing Street at the time [**INQ000252711/5§21**]. Of particular concern is the absence of any communication with the PM during this crucial 10-day period regarding Covid-19. Notably during this timeframe, SPI-M-O had confirmed sustained transmission, and the UK became aware of lockdowns in 10 municipalities in Italy. Mr Reynolds admitted that he did not engage with Mr Johnson to apprise him of any of these critical matters during this period [**14/72/3-17**].

What difference would a centrally led response have made?

88. It is submitted that an earlier response led by both the Cabinet Office and No.10 could have significantly altered the trajectory of the pandemic in the UK, not just in March 2020 but also throughout the second and third waves.

89. Plans to contain a coronavirus outbreak were a figment of the imagination before March 2020, but there *was* a written strategy in place that outlined the UK Government escalation process and was approved by COBR on 24 Jan 2020. Although the strategy is not called 'Contain, Delay, Mitigate', that is the substance of it. The first UK cases were to be managed using traditional public health measures including test, trace and isolation. A similar approach was to be taken in the event of significant transmission in hospitals but there was also to be a *"plan for how to enforce possible hospital lockdown"*. In the event of sustained human-to-human transmission in the UK, testing would cease, tracing would cease, PHE would be stood down at airports, and PPE use would be reviewed. In the event of a pandemic, the plan was "*Initiation of the relevant sections of the Health and Social Care Pan Flu Plan*". The rows for Scotland, NI and Wales were left blank [**INQ000279876/1-3**].

90. This document does not contain nearly the level of detail Ms MacNamara described expecting in a plan [**16/23/11-22**]; even as an outline UK Government strategy drafted at the

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end of Jan 2020, it is incomplete and woefully inadequate. Yet, it remained unaltered until March 2020. Had the response been seized by the Cabinet Office and No.10 by 25 Jan 2020, it is reasonable to expect that somebody from No.10 or the Cabinet Office would have requested a copy; just as they did in March. If they had, the extent of the lack of preparedness would have been known and preparations could have been rapidly accelerated before the crisis hit. A cursory glance at this document would have raised questions of the lack of overall planning; plans and provision for IPC; capacity in the health and social care sectors; stockpiling, management and distribution of PPE and essential medical supplies and food; and the absence of provision for TTI, at a minimum.

SECTION C: KEY FAILURES IN DECISION MAKING

91. Below are some of the key failures from M2. The Inquiry will only receive evidence on some of the most catastrophic failures in future modules M3 and M6; such as the discriminatory use of DNACPR orders and decisions on triage, including use of the Clinical Decision Support Tool. The failures set out below are not exhaustive. The bereaved families firmly reject the Government 'line' that "*the NHS was not overwhelmed*". A system that suffers reduced IPC standards and marshals bed spaces in panic *was* overwhelmed and that aligns with the experiences of the families and frontline workers from whom the Inquiry will hear in M3.

I. FAILURE TO FOLLOW THE PRECAUTIONARY PRINCIPLE

92. Prof. Van-Tam told the Inquiry that, by the middle of Jan 2020, *"on the balance of probabilities"* his "*instincts*" were telling him that there would be a *"significant pandemic"* which would cause the UK "*real trouble*" [**24/177/18-24/179/3**]; an instinct based on 30 years' experience, a specialist interest in respiratory viruses, and a 'close watch' on the novel infection. At the point the DCMO considered that a pandemic was coming over the horizon, the UK Government ought to have adopted a precautionary approach to this disease.

93. A precautionary approach at that point would not have involved precipitative measures but would have required urgent action to address the lack of UK preparedness and ramp up surveillance, and to commit to a *"safety-first principle"* that would last the lifespan of the pandemic. In our submission, until there was evidence to the contrary, Covid-19 should have been seen as airborne, and potentially asymptomatic, able to reinfect, and able to spread widely and undetected; four of the issues which, according to Prof. Whitty, "*had we known them at the time a decision was taken, might well have led to different decisions*" [**INQ000251645/67§6.24**].

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Airborne or aerosol transmission

94. As outlined by Prof. Doyle, *"there was always a recognition... that aerosol transmission could occur"* [**17/211/12-14**]. This was reflected in the classification of Covid-19 as a HCID (discussed further below) and in an email from Prof. Van-Tam on 18 Jan 2020 in which he said *"We do not know modes of transmission, may well be droplet or aerosols"* [**INQ000151333/1**]. When asked if there were any reasons not to take steps to guard against aerosol transmission, Prof. Noakes replied, *"I don't see that there were, no... I think there was just a tendency to require the evidence for airborne transmission"* [**13/17/18-13/18/5**]. Evidence of superspreading events, such as the Diamond Princess, were a "*red flag*" in her opinion [**13/13/13-22**] that had significant implications for IPC [**13/16/15-13/17/22**].

95. Although a precautionary approach to airborne transmission was adopted in early Jan, when Covid 19 was designated a HCID, it was lost when it was declassified as a HCID on 13 March 2020; bizarrely as the evidence had become overwhelming. In our submission, the two material changes between 10 Jan and 13 March 2020 were the declaration of a Pandemic and the realisation that the UK Government did not have sufficient PPE to protect healthcare workers from airborne transmission, a fact about which Prof. Van-Tam had warned as early as 24 Jan 2020. Once Infectious Disease Units were full, he cautioned, "*to be clear there will not be enough high-level PPE in this scenario"* [**INQ000047541/3**]. Prof. Noakes told the Inquiry of her efforts to prompt a change of PHE and NHSE messaging on airborne transmission in Autumn 2020, which took NHSE around 8 months to address [**13/18/13-13/19/16**]. From Jan to Oct 2020, the evidence for airborne transmission had only become stronger.

Asymptomatic transmission

96. As he outlined in his evidence, Prof. Whitty knew from the outset that asymptomatic transmission *"would be a major issue"* [**INQ000151336/2**]. This was reflected in emails he sent to Prof. Van-Tam and Sir Jeremy Farrar on 19 Jan 2020 following informal reports of asymptomatic transmission. As Prof. Van-Tam had elucidated on 9 Jan 2020, it turns out that *"Rumours are rarely incorrect in this space"* [**INQ000236466/2**].

97. Over the following days, those rumours became louder and more widely reported. On 24 Jan 2020, The Lancet published an article suggesting the possibility of asymptomatic transmission. The authors warned, "*These cryptic cases of walking pneumonia might serve as a possible source to propagate the outbreak"* [**INQ000212897/8**]. On 27 Jan, Mr Hancock outlined "*his concern upon hearing the update from the Chinese government that the virus is transmissible when patients are asymptomatic"* [**INQ000106067/1**].

98. Although Mr Hancock told the Inquiry that he was informed by the Director-General of WHO and the "*UK system*" that this was a "*translation error*" [**29/52/10-21**], the next day the FCO received a diplomatic telegram from Beijing stating that the Chinese Government had *"confirmed cases of asymptomatic human-to-human transmission, making control of the outbreak more challenging"* and WHO had warned of the possibility [**INQ000064689/1§2**].

99. Whatever the likelihood of an official FCO report containing a translation error of this magnitude – we suggest vanishingly unlikely – on 28 Jan, Prof. Whitty told Mr Hancock that "*there is now credible evidence of asymptomatic transmission within Germany*" [**INQ000233747/2**]. During the NERVTAG meeting that day, Prof. Whitty conferred with the CMOs of the Devolved Administrations about the German cases and said "*… we should now assume it may be happening*" [**INQ000282744/2-3**].

100. Prof. Whitty told the Inquiry that although the possibility of asymptomatic transmission was known early on, the UK Government was still thinking *"it was probably not a major driver of the epidemic"* [**24/77/1-5**]. In our submission, a precautionary approach should have been adopted, considering the warnings and the central importance of the issue. Moreover, after a NERVTAG meeting on 21 Feb 2020, Prof. Edmunds reported that "*40% of virologically confirmed cases are asymptomatic*", so a precautionary approach would have been vindicated within a short period [**INQ000119469/6§3.4**]. Regrettably, this was not the approach adopted at that point, and complacency prevailed.

101. It has been asserted to the Inquiry that PHE advised against asymptomatic testing in Jan 2020, which appears to be correct. On 25 Jan, the testing of repatriates was ruled out for this reason [**INQ000093009/5-7**]. It is submitted, however, that by Feb the position had moved on, when all repatriates were tested on release from isolation regardless of symptoms [**INQ000049440/13**]. This suggests a precautionary approach <u>was</u> adopted to a limited number of cases – just not more widely, including in care homes or hospitals.

<u>*Ability to reinfect*</u>

102. The Inquiry has heard evidence of the UK Government's 'Plan A' from Dominic Cummings [**INQ000273872/30-33**] which, we submit, was a strategy only to mitigate the worst excesses of a raging pandemic, and therefore a strategy of herd immunity. So much was said by Sir Patrick in his 'Today' interview on 13 March 2020 and in contemporaneous WhatsApps on the comms "*nightmare*" of the *"herd immunity argument*" [**INQ000048399/1-3**]; and so much has been described by senior officials in their evidence [**19/149/23-25**]. One day later, members of a WhatsApp group including Mr Hancock agreed the line that herd immunity was a "*by-product*" not a strategy [**INQ000102697/19-20**]; a line the Inquiry has heard variously

espoused throughout this Module [**17/136/24-17/137/3**]. In our submission, it matters not whether herd immunity was the strategy or a by-product of it; before March 2020 the Government was working to a plan that would do little but *"slightly"* mitigate an *"unbelievably large"* number of deaths [**25/41/21-25/42/9**]. That was *"incredible"* to Prof. McLean, and it is devastating to bereaved families.

103. An important fallacy at the heart of the herd immunity argument was that Covid-19 did not have the ability to reinfect. Although Prof. Whitty told the Inquiry he did not hold that view, that was what was said at the press conference on 12 March 2020 [**INQ000237417 at 10:40**]; and in any event, civil servants and senior Ministers certainly did. On 28 March 2020, when discussing a campaign to recruit people who had been infected to work in Adult Social Care, Mr Hancock and Mrs Whately still appeared to be harbouring the perception that once a person had Covid-19 they would not get it again [**INQ000274068/5-6**].

Ability to spread widely and undetected

104. No doubt the Inquiry will explore the tracing of the first possible UK cases in Jan and Feb 2020, in the 'test and trace' Module. From the evidence, it appears that the first possible case was not tested using the specific Covid-19 test developed by PHE [**INQ000151327/1**]. On 3 Feb, the contact tracing exercise for one case was described as "*chasing shadows*" [**INQ000047666/2**]. On 10 Feb, SPI-M-O opined, *"It is a realistic probability that there is already sustained transmission in the UK"* [**INQ000320600/2§13**]. By 11 Feb, it was being widely reported that a super-spreader from Brighton, who had visited a conference in Singapore where he contracted Covid-19 and then gone on a skiing holiday in France where he infected five British nationals, had infected a healthcare worker on his return to the UK [**INQ000051994/12**]. And on 3 March 2020, Prof. Whitty told COBR that "*contact tracing for the... last two cases in the UK had not been successful"* [**INQ000056217/5§2**].

105. It is consequently not clear (a) how the Government could reasonably consider that transmission was not already sustained in the UK before 28 Feb 2020; and (b) why it had not been working on the basis that it was. An article published by The Lancet on 28 Feb, co-authored by Prof. Edmunds, highlighted that *"Transmission before symptom onset could only be prevented by tracing contacts of confirmed cases and testing (and quarantining) those contacts*" [**INQ000212222/2**]. Prof. Van-Tam had written to DHSC on 26 Jan 2020 saying, "*if we do get a confirmed case I feel absolutely sure that we want to be isolating all close contacts"*

106. as was being done in China [**INQ000151360/1**]. So why were no steps taken to plan and cost this exercise and urgently ramp up test manufacture and sourcing? There is no evidence that this happened before March, save in the limited context of repatriations. The

failure to TTI effectively, appears to be a key difference between fatality rates in the UK versus comparable countries.

The impact of the failure to follow the precautionary principle

107. As outlined by Prof. Costello, the UK Government's intent to follow a pandemic influenza strategy "*went against WHO advice at the time and it went against all the practices of the East Asian states that managed to reduce their death rates to five times lower than our death rates*" [**10/88/21-10/89/4**]. Rather than adopting this flawed strategy, the UK Government ought to have planned on the basis that the same *"safety-first principle"* that is used for other coronaviruses, such as SARS and MERS, would be used for Covid-19 throughout the Pandemic, as it was in the very initial phase [**INQ000119453/6**].

108. Mr Johnson told the Inquiry that if the Government had fully understood key metrics like IFR and CFR: "*clearly we would have acted immediately to accelerate test and trace... we'd have put huge quantities of time and effort and money into diagnostics, into PPE, into all the things that we were going to need."* [**31/63/6-16**] It is submitted that this is exactly the type of response that should have been expected from the third week of Jan. Immediate steps ought to have been taken to produce an inventory of necessary capabilities; to conduct a stocktake of countermeasures including PPE; to urgently expand NHS capacity; to drive preparations in the ASC sector; and to stress test the plan. If the response had been pulled into the centre by 25 Jan 2020, the resource and force of Whitehall could have been utilised to scale up the ineffectual efforts that had begun in DHSC.

109. A precautionary approach should have resulted in immediate efforts in Jan 2020 to scale up testing and contact tracing and protect against known risks; such as the risk of nosocomial infection [**INQ000222003/4**] and *"explosive"* outbreaks in care homes [**3/148/20**]. Even in the absence of asymptomatic transmission, Prof. Whitty told the Inquiry that these things *"should have happened anyway"* [**24/79/12-18**]. Instead, there was indecision and dither, leading to delay in the advice to the public on mask-wearing and advice to care homes in Feb that they had nothing to worry about [**17/161/10-13**].

II. INADEQUATE USE OF NPIs SHORT OF LOCKDOWN

110. Prof. Hale described the *"rollercoaster"* element of the UK Government response in his evidence to the Inquiry, which had a *"trifecta"* of health, economic and social impacts [**7/103/17-23**]. In our submission, as well as treating patients, a competent response required countries to *"find, test, trace, isolate and support"* cases and their contacts [**INQ000281260/4§16**], as outlined by Prof. Costello and Prof. Banfield, and by WHO. In our

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submission, the number and length of lockdowns in the UK were a function of the utter lack of resource and preparedness, and chaos in the UK Government response.

111. On 1 March 2020, Mr Cummings wrote to the No10/DHSC Covid19 WhatsApp group and said, *"reasonable people will look to Singapore as a competent English-speaking state that tried to learn from SARS etc and is ahead of us in the cycle"* [**INQ000102697/3**]. In our submission, the UK did not need to reinvent the wheel to act responsively and responsibly; it only had to look to the experience and response of the countries that were ahead of it [**23/57/24-23/58/5**]. As outlined by Prof. Whitty, if SAGE had been instructed to advise on a strategy of maximal suppression, it would have *"undoubtedly"* done that [**23/59/9-15**]. If there had been a Standing Scientific Committee on Pandemics, that would have been obvious and done.

112. In our submission, if the UK had pursued such a strategy before Feb half-term, the extent of the first lockdown would have been substantially reduced if not avoided [**25/69/19-23**]. It would have required: (a) the rapid and continuous expansion of testing and contact tracing; (b) sufficient high-level PPE for the health and social care workforces; (c) the rapid expansion of hospital bed capacity; and (d) a suite of other NPIs such as restrictions on mass gatherings and advice to the public on wearing masks and working from home.

113. Some of the voluntary NPIs we suggest were offered as examples by Prof. Edmunds when he said "*there are things that* [SAGE] *could have perhaps emphasised in Feb that might have slowed things a little bit*" [**13/53/13-13/55/5**]. As Prof. Ferguson outlined, the relative impacts of NPIs, such as school closures and restrictions on mass gatherings *"add up"* in combination, even if their individual efficacy was minimal [**11/149/5-11/150/5**]. They were not, however, modelled in combination until March 2020 [**INQ000056217/5§3**].

114. As outlined by a number of witnesses, voluntary measures in March were introduced too late for the Government to quantify their impact. As to whether they could have been introduced earlier, Prof. Van-Tam told the Inquiry he thought they could have been introduced 1-2 weeks earlier [**24/173/20-24/175/3**]. In our submission, that is not a matter of hindsight. As Mr Cummings wrote on 11 March 2020, *"all sensible people can see the trajectory and how social distancing will be needed to flatten curve... *'WHY WAIT 5 DAYS WHY NOT MOVE NOW AND FLATTEN CURVE EARLIER?'*"* [**INQ000102697/17**].

115. The evidence suggests that some decisions were ruled out because of operational concerns. PPE for healthcare staff is discussed in the section on HCID declassification below, but on the use of face masks by the public, the evidence of Prof. Riley was that there was no

scientific reason not to recommend their use in enclosed spaces in April and that his advice would have been the same had he been asked to provide it at the end of Feb 2020 [**11/80/7-11/81/20**]. On 16 April 2020, Mr Hancock wrote on WhatsApp, "*WE DO NOT HAVE ENOUGH MASKS TO SAY THESE THINGS*" [**INQ000102697/33**].

116. In our submission, a concerted and colossal effort should have been made from Jan 2020, and maintained throughout the pandemic, *"to start seriously considering steps for social restriction"* [**10/147/3-13**], but this was not done until it was far too late. The UK Government should have fully planned and costed border restrictions when they were under consideration in early Feb 2020 and escalated that decision to the PM [**12/197/2-12/198/7**]; considered targeted flight restrictions [**24/85/15-24/86/2**]; advised all visitors to the UK from China to self-isolate from 27 Jan 2020 when the same announcement was made for Wuhan [**23/149/17-25**]; advised all visitors from countries with sustained transmission, such as Italy, Spain, France and Germany, to do the same in Feb 2020; restricted mass gatherings *and* closed hospitality from at least 27 Feb 2020 [**INQ000203874/2§15**]; urgently increased hospital bed capacity when it was discussed at Exercise Nimbus or earlier [**INQ000195891/4§4**]; and massively ramped up the infrastructure for test and trace [**15/151/4-15/152/2**].

117. A precautionary approach should have prompted a change to the DHSC 'top line' that "*The UK is extremely well prepared for these types of outbreaks* [and was] *one of the first countries in the world to develop a test*" [**INQ000049649/4**]; used repeatedly in internal and press briefings and parliamentary statements through Jan [**INQ000086862/1**], Feb [**INQ000056138**/7] and well into March to reassure Ministers and the public there was a plan. Prof. Edmunds told the Inquiry that even he assumed there was a plan because of the reassuring public messaging [**13/56/3-12**].

118. Not only was this line inaccurate and misleading, but it also meant the UK public was wrongly reassured that they did not need to do anything differently before March 2020, save for washing their hands and abiding by travel advice. They were asked to put their trust in a Government that did not have a plan to do more than mitigate the worst effects of a pandemic predicted to kill hundreds of thousands of people if the RWCS was realised. Internally, it meant Ministers from across the four nations were under the misapprehension that the DHSC had a plan. The impact of this overly reassuring approach is illustrated by the evidence the Inquiry has heard from former UK Government civil servants that they only realised the horror of what the UK was about to face on or around 13 March 2020 when Ms MacNamara walked into No.10 and said, *"I think this country is heading for a disaster. I think we are going to kill thousands of people"* [**16/36/10-16/37/22**].

III. FAILURE OF TEST, TRACE AND ISOLATE

119. The Government's failure to scale up and maintain an effective infrastructure to test, trace and isolate cases and their contacts is a critical and fundamental flaw of the response, as well as of preparedness. Even before WHO issued its imperative for countries to 'Test, Test, Test', the need to do so was obvious. As Prof. Costello told the Inquiry, the WHO imperative was not mainly directed at "*lower and middle-income countries*" as suggested by Prof. Harries at the press conference on 26 March 2020; and the UK's plan of containment and delay was not *"entirely consistent with the science and epidemiology"*. Prof. Costello told the Inquiry he disagreed with *"almost everything"* Prof. Harries had said and emphasised that the UK "*ended up with five times the death rates of… East Asian states*" such as South Korea and Japan which "*are not poor countries, they have the same life expectancy if not better, same age, same GDP, and similar health systems to us*" [**10/174/3-10/175/15**].

120. Prof. Banfield told the Inquiry the BMA could not understand *"why the government was apparently abandoning basic public health protection measures"* of testing and isolating *"and making sure that you can support people to do that"* in March [**3/93/24-94/8**]. Prof. Costello told the Inquiry that he could not see *"any reason"* why the UK could not have adopted the same approach to testing, contact tracing and isolation as the Republic of Korea: "*way different from the later one that we set up that was never going to work"* [**10/92/12-16**]; which aligns with the evidence of Prof. Hale [**INQ000257925/37§68**].

121. In addition, Prof. Costello's evidence on the Institute of Biomedical Sciences' frustrations at the Government's plan to scale up the response using private companies in March 2020 [**10/154/11-25**] aligns with the Institute's M1 statement: "*The rush to establish the Lighthouse laboratories... without apparent exploration or understanding of the actual testing capacity that already existed within UK pathology laboratories illustrated the lack of understanding of capacity and capability"* [**INQ000185344/3-4§10-15**].

122. According to Prof. Costello, the second wave was caused in part by the ineffectiveness of the Government's Test and Trace strategy [**10160/23-10/161/5**]. Prof. Woolhouse "*very, very strongly"* agreed [**10/73/15/22**] with Prof. Hale's assertion that *"at* [no] *point was the UK able to achieve a level of testing, contact tracing, and isolation and support at which it could be confident that these light intervention measures would have a chance of preventing new waves from arising"* [**INQ000257925/37§66**].

123. Mr Cummings said, *"DH basically trashed the idea of mass testing from March and, therefore, the months of March to July were wasted... in building that whole infrastructure up"* [**15/228/17-21**]. In our submission, the plan should never have been to abandon testing and

contact tracing, and supported isolation, as it was from Jan to March 2020; on the contrary, the need for mass testing should have been recognised from the outset and every opportunity should have been taken to understand the laboratory capability that already existed in the UK, to increase it, and to use it. These are fundamental lessons for the future.

IV. FAILURE TO PROTECT THE MOST VULNERABLE

124. It appears to the bereaved families that there was a complete failure to protect those whom the UK Government knew would be most vulnerable to severe illness and/or disability if they contracted the virus. We do not suggest that the Government's sole strategy should have been what was advocated in the Great Barrington Declaration, a stance we firmly reject. However, we submit that it was entirely unacceptable that, as of the COBR meeting on 9 March 2020 there persisted a *"series of currently undetermined measures to safeguard the elderly and vulnerable individuals"* [**INQ000056219/5§5**].

125. Prof. Harries indicates that work was not begun on the *"potential approaches that could be adopted"* before 7 March 2020 [**INQ000273807/83§8.55**]. There was no attempt to contact NHS Digital before mid-March [**INQ000273807/85§8.60**] and when asked how many people were assessed to be in need of shielding support, Mr Ridley told the Inquiry, *"So, I mean, I think it's ... firstly, I think we didn't know with any great certainty"* [**19/6/17-21**].

126. The UK Government's *"core narrative"* is set out in a document that was compiled ahead of a PAC session on 22 Feb 2021 and shows how little was done before March. The 'top lines' include that *"this was a crisis response, so was set up from scratch incredibly quickly"* and "[the Government is] *confident shielding saved lives"* [**INQ000112365/4**]. In our submission, this narrative does not hold water. There should have been plans in place to identify and protect the people most vulnerable well before Jan 2020. Given that there were not, planning to mitigate this deficit should have started immediately; and included plans for practical support *and* IPC for people in need of community care from NHS and social care professionals and unpaid carers; to protect them and the people caring for them.

127. In our submission, the Government narrative that "*shielding saved lives"* is partial. Where shielding was operated it will have certainly saved lives, but the failure of preparedness and the subsequent failure to mitigate the lack of comprehensive shielding plans certainly did not. In addition, there was clearly an ambivalence in how vulnerable groups should be treated. On 14 March 2020, Mr Cummings sent a WhatsApp to the GCSA, CMO, PM and Health Secretary: *"On Monday press conference, you 3 must talk through again the issue that once we put the older into multiple month isolation we know we are killing an unknown number plus causing other severe suffering"* [**INQ000048399/3-4**]. The harms of lockdown were obvious

and ought to have been planned for in Jan 2020 when the Government could see so clearly what was happening in China. Once again, we emphasise that earlier decisive action to implement a suite of NPIs, and an earlier lockdown, would have limited its extent, and its collateral deleterious effects.

V. HIGH CONSEQUENCE INFECTIOUS DISEASE DECLASSIFICATION

128. The decision to declassify Covid-19 as an airborne HCID was one of the most adverse consequential decisions of the pandemic for patient and staff safety in healthcare settings. It should be considered in the light of the fact that Covid-19 has caused the seventh highest number of deaths from known pandemics throughout human history. Declassification marked a radical shift from a *"safety-first",* precautionary approach to IPC which required enhanced PPE in all settings where contact with a suspected Covid-19 patient was possible [**INQ000184034/3-5**] to the position where only standard PPE was required unless an aerosol-generating procedure, like intubation, was being carried out.

129. Hospitals should have been effective settings for infection control, but the tragic reality was that they were one of the worst environments for catching the virus. This decision, taken at the very point when it was known that infections were rising exponentially, had huge ramifications. It placed frontline health and social care workers – doctors, nurses, cleaners and support staff – at far greater risk. As we know, around 1,000 healthcare workers died. In so doing it increased the chance of healthcare systems being overwhelmed because of staff sickness. And it provided increased transmissibility from Covid-positive patients to the general population through infection.

130. Prof. Banfield described the desperate lack of PPE across the healthcare system, including primary care and most settings outside Intensive Care Units, and the inadequacy of the guidance from the BMA's perspective [**3/89/18-25; 3/90/21-3/91/4**]. WhatsApps show ENT specialists "*around the country... seriously worried*" about the lack of PPE and the acknowledgement of the then Director of the Policy Unit at No.10 that, "*We will have a major battle if we ask doctors and nurses to fight this without the protection they need*" [**INQ000102697/28**]. Not only that, the declassification of Covid-19 as an airborne HCID signalled that the route of transmission was principally droplet and fomite, and not aerosol; even though "*in truth* [the evidence] *was weak for all transmission routes*" [**13/17/20-22**].

131. As outlined by Prof. Doyle, Covid-19 was classified as an airborne HCID on 10 Jan 2020 on a precautionary basis [**INQ000223380/1-2**]. IPC guidance was introduced which recommended, among other things, isolation rooms for suspected cases, FFP3 respirators for

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all people entering the room and the use of a long-sleeved gown [**INQ000184034/5**] which Prof. Van-Tam said were *"sensible and pretty standard precautions"* [**24/218/10-14**].

132. We respectfully and firmly disagree with any suggestion that it was reasonable to declassify Covid-19 on the basis that it had a lower CFR than SARS or MERS [**12/162/4-20**]. A CFR of 1% in a disease as transmissible as Covid-19 cannot reasonably be described as low. The HCID criterion is that the disease *"typically has a high case-fatality rate"* [**INQ000106267/3**], there is no further gloss. As outlined by Professors Horby [**12/202/8-13**] and Costello, *"... even at 1%, if you've got a respiratory virus that spreads around a country and infects 60% of the population, 1% is a lot of deaths"* [**10/132/12-14**].

133. In our submission, Covid-19 was in fact declassified to enable the slackening of restrictions on PPE in healthcare settings in England and in Scotland, where the decision appears to have already been taken [**INQ000366265/4**]. Unlike laboratory containment level, which had been changed 10 days prior, declassification coincided with updated IPC guidance on 13 March 2020 [**INQ000309002/9§33**]. The change followed the declaration of a pandemic on 11 March 2020 and the move to Delay in the UK on 12 March 2020.

134. Prof. Doyle said that Covid-19 was declassified so *"any laboratory who could provide the test at 'Containment Level 2+'... could engage with testing"* [**INQ000371232/3§11 and 17/184/20-17/185/2**]. Although we do not suggest Prof. Doyle intentionally misled the Inquiry, in our submission this is inaccurate, and we note the contents of David Osborne's letter to the Inquiry on this issue [**INQ000366265/2-4**]. The decision relating to laboratories had already been taken 2 weeks earlier when Prof. Whitty predicted *"this may well be about to go quite fast"* given the *"large numbers of asymptomatic and minimally symptomatic cases"* and that *"cases in the 100s, and potentially 1000s a day may happen within weeks"* [**INQ000223410/5**]. As he confirmed in evidence, that decision, limited to laboratories, did not necessarily require HCID declassification [**24/84/5-7**]. HSE said it supported the proposal provided there were *"appropriate comms to stress the specific nature of the derogation"* [**INQ000223410/1**], making it clear this was not a statement on wider derogation.

135. Prof. Van-Tam told the Inquiry he shared the opinion of a PHE official that *"...I would want to maintain the HCID label if it became more widespread, to maintain appropriate IPC precautions and general levels of clinical concern/awareness"* [**24/221/9-12**]. However, at a NERVTAG meeting on 13 March 2020, he was told that Covid-19 would have to be declassified before NERVTAG could approve updated IPC guidance "*needed to help relieve pressure points on the NHS in England*", which reduced the need for FFP3 in most settings [**INQ000212195/4§2.5-2.11**]. Although NERVTAG had endorsed the earlier decision it was felt

that ACDP, which was meeting at the same time, should endorse this one. And so it was; without any prior commission from DHSC and without any rationale in either the ACDP minutes [**INQ000223384/2-3**] or Prof. Tom Evans' letter [**INQ000115534/1**], the matter was discussed under 'AOB' and the decision was made. Despite denials from Prof. Van-Tam, the only proper inference from these NERVTAG minutes is that the rationale for declassification was to facilitate lesser requirements of PPE. The failure to stockpile, or manufacture or source supplies at scale, led to the pretence that Covid-19 was not a HCID.

136. Prof. Van-Tam was keen to tell the Inquiry that the NERVTAG minutes had not been *"retro-constructed"* [**24/228/17**]. It was not suggested that they were. On the evidence the Inquiry has received to date, the decision to declassify Covid-19 as a HCID had been made and communicated to DHSC on 13 March before the PHE four nation group considered the matter on 16 March because that is what both the ACDP minutes and a contemporaneous email from Prof. Van-Tam to PHE and NHSE say [**INQ000224002/1**]. The due process, of PHE deciding and ACDP endorsing [**INQ000251906/88§389**], was not followed. When the PHE decision was eventually taken, the only criteria said to not be met were (2) high CFR and (4) often difficult to detect rapidly [**INQ000119498/1-2**]. On the evidence the Inquiry has heard, it is submitted that on 16 March 2020 it was irrational to conclude that Covid-19 did not have a high CFR or that it was not difficult to detect, given how far behind the curve the UK had only just realised it was and how many people were expected to die.

137. In our submission, Covid-19 was declassified because of the lack of PPE which had prompted the NERVTAG discussion and change of IPC guidance. It cannot rationally be suggested – and no witness has – that it was no longer clinically appropriate to afford healthcare workers, and their patients, the highest level of protection at work. Yet, that is what they lost as a consequence of this decision, taken in the eye of the storm. The Inquiry will recall the headlines of healthcare workers resorting to wearing bin bags for protection [**INQ000274087 and INQ000274088**]. As David Osborne points out, on 17 March 2020 the Chair of the Health and Social Care Committee read out a comment from one worker: "*It's absolute carnage in A&E, utter chaos. We don't have any proper PPE... I feel like we are being thrown to the wolves here. Some of us are going to die*" [**INQ000283199/18**].

VI. DISCHARGE OF UNTESTED HOSPITAL PATIENTS INTO CARE HOMES

138. Just as nosocomial infections were increasing exponentially, hospital patients were discharged into residential care settings without testing or the expectation of dedicated isolation facilities. While accepting that it was important not to keep patients in hospital who were fit for discharge indefinitely due to the risk of nosocomial infection, in our submission

discharge without testing, isolation or proper IPC measures being in place was a disastrous move characterised by a wholesale lack of forethought and appreciation of the risk to residents and staff in care home settings, and the wider ASC sector given the movement of staff across settings (that is, including domiciliary care).

139. Knowing that it would present a considerable issue during a pandemic, the development of a rapid discharge protocol was an action from Cygnus [**INQ000022792/14**] so this was not an 'unprecedented' concept by any stretch. During Exercise Nimbus on 12 Feb 2020, Lord Stevens told attendees that, in this theoretical scenario, 30,000 beds had been made available through elective cancellations; but not a single attendee, including Ministers and DCMO, thought to ask, 'how do we start doing that?' [**INQ000195891/4§4**].

140. As outlined in Section A, the decision followed years of underinvestment and inadequate resourcing of the ASC sector. Had the sector been adequately resourced and funded and had the UK Government rapidly *"gripped"* the response in the sector in Jan and Feb 2020 by ramping up testing, PPE procurement and identifying isolation facilities, this policy could have been made reasonably safe. Instead, the decision was made in panic, ill-considered and countless lives were needlessly put at risk. It truly was an "*appalling error*"[1]. The UK had developed a test in Jan, but it had not followed through in scaling up manufacture or sourcing of sufficient tests, unlike some other countries. By the time this decision had been made, South Korea had undertaken five times as many tests as the UK.

141. By March 2020, the following was known to the Health Secretary and/or to DHSC: that "*there were likely three ways that the virus could enter a care home (infected people moved into homes; staff; visitors)*" [**INQ000049363/2**]; that there was a lack of adequate planning locally [**INQ000273897/11-12§45**]; that there was *"hard evidence"* of PPE stock intended for the ASC sector being requisitioned for NHS use [**INQ000114887/1-2**]; and that British repatriates were being tested regardless of symptoms [**INQ000049440/13**].

142. By 6 March 2020, Mr Hancock recognised himself that "*the impact of coronavirus... poses a complicated set of problems on the social care sector due to the higher risk for older people and the need to be gripped as soon as possible"* [**INQ000049530/1**]. By 19 March 2020, just 9 days after the first notification of a Covid-19 case in a care home and two days after the first death, PHE was aware of 37 outbreaks [**INQ000119476/4**].

<u>*Failure to consider other options and to consult*</u>

[1] https://publications.parliament.uk/pa/cm5801/cmselect/cmpubacc/405/405.pdf

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143. Although the Inquiry has heard that this decision was one of only two "*bad options*" [**30/38/25-30/39/5**]; it was not binary. A DHSC note, provided to Sir Chris Wormald and Matt Hancock for the purposes of the meeting on NHS resilience on 12 March 2020, outlined five options, including the use of live-in carers and greater use of the independent healthcare sector, which was urgently being explored [**INQ000309002/13§40 and INQ000325232/3**]. In relation to option 1, "*Extending free care to speed up discharge to residential care homes*", the author noted: "*The policy implies that emptying the hospital is more important than protecting residential or domiciliary care capacity to support people currently in the community. We would need this to be taken on a clinical basis*" [**INQ000325232/2**]. At the meeting, option 1 was "*the preferred choice*" [**INQ000309002/13§41**]. There appears to have been no further business case for any of the other options before the announcement on 17 March, despite ongoing exploration of options within the independent healthcare sector [**INQ000146639/1**].

144. As to whether a clinical opinion was sought, Lord Stevens told the Inquiry that he thought it had been discussed with "*senior doctors*" on 11 March 2020 [**17/66/14-16**]; but no witness has pointed the Inquiry to written clinical advice. Prof. Whitty told the Inquiry that he was not closely involved [**INQ000251645/102§7.128**]. There was no advice from SAGE or SPI-M-O. Prof. Harries told the Inquiry that her email of 16 March was not a "*policy statement*" or an "*invitation to be discharging Covid patients*" [**28/9/23-28/10/2-3**].

145. At the time the decision was made, the UK Government had shifted course to a strategy of suppression in an attempt to quell the spread of the disease; something that "*had not previously* [been] *included in pandemic flu planning*" [**INQ000073663/3**]. In that context, one might have thought it would have been useful for Mr Hancock to have read the PHE briefing on containment, but he did not see it at the time [**30/27/17-23**]. If he had, he would have seen the PHE advice that, in the event of a cluster outbreak in hospital there should be: "*No discharges to care or residential homes*" even at a time when the cancellation of elective surgery was being posited. By 11 March it was [**INQ000074910/2**]. Although PHE drafted the later guidance, it "*was not a formal consultee of the... policy*" [**INQ000119481/10-11**].

146. Ms Whately has told the Inquiry that she was not involved either. On 16 March 2020, she relayed to colleagues "*a plea to work with LAs/LRFs on this not bypass... please give LRFs and LAS advance notice of things that will affect them eg mass discharges... 'no surprises' please*" [**INQ000102698/36-37**]. The Inquiry will no doubt explore in later Modules the extent to which the Interim Chief Social Workers and the CNO were consulted. On the evidence the Inquiry has received so far, in our submission there appears to have been an appalling lack of consultation for a decision so significant, and one which cost many lives.

No protective ring around care homes

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147. In his statement, Prof. Van-Tam commented on Matt Hancock's suggestion that he had thrown a 'protective ring' around care homes: "*a ring is a circle without a break in it. If you want to achieve that, you have to close off the three routes of ingress identified above that create a break in the circle. Doing that would have required more testing, more resources for isolating individuals in both hospitals and care homes, and far more stringent policies on care home workers moving in and out of homes*" [**INQ000269203/124§9.16**]. In his evidence, Mr Hancock accepted that Prof. Van-Tam was right [**29/196/19-20**].

148. Assessments of the impact of the policy all suffer the same limitation: because testing was so limited, it is impossible to know the true number of lives lost. But lives were lost, nonetheless. The 1.6% figure relied on by Mr Hancock [**INQ000232194/12§49**] represents 286 actual lives and avoidable deaths, and likely to be higher in reality.

149. The internal communications about older people have been deeply painful for bereaved families to read. In the context of care homes, examples include:

(a) The Director of ASC 'flagging' in a meeting on 6 March 2020 "*that around 50% of people will likely have died within seven months regardless*" [**INQ000049530/1**].

(b) WhatsApps between Mr Cummings and Mr Hancock on 15 March: "DC: *Must update PM at 915 on plan for clearing beds of bed blockers*" [**INQ000102697/21**]

(c) Prof. Harries's email of 16 March 2020 – with CQC, NHSE and DHSC in copy – in which she said, "*I believe the reality will be that we will need to discharge Covid-19 positive patients into residential care settings… I do recognise that families and care homes will not welcome this in the initial phase*" [**INQ000151606/1**].

(d) Mr Hancock's SpAd asking on 4 April: "*Do we also need a push on testing people in care?... I know it is complex and the people dying in care homes are often people who were near the end regardless, but I worry that if a load of people in care start dying, there will be front pages demanding why we weren't*" [**INQ000093254/6**].

(e) Another DHSC SpAd saying, on 7 April 2020, "*Deaths in care homes - sounds alarming at first, but there's a good reason why allowing people dying in care homes (of CoV) is often the right thing for the individual*" [**INQ000102675/93**].

150. For the bereaved families, the deaths of their loved ones were contributed to by an abject lack of care by the state for older people and particularly those living in residential and domiciliary care settings. There was no protective ring, the March 2020 discharges were made in panic, there was no proper planning either before the Pandemic or in response to it, or for IPC across the social care sector. Many lives were lost as a result and many people spent the last part of their lives in isolation and confusion.

VII. <u>EAT OUT TO HELP OUT</u>

151. The EOTHO scheme ran from 3 until 31 Aug 2020. All witnesses, including Mr Sunak, accept that no scientific advice was sought on either the scheme or its impact. Sir Patrick Vallance's evidence was unequivocal: neither he nor SAGE had been consulted and he knew nothing about the scheme until it was announced. This aligns with the evidence of Prof. Whitty [**24/63/1-25/64/1-4**]. According to Sir Patrick, EOTHO turned *"on its head"* the public health advice: that interaction between households in enclosed spaces was high-risk and should be limited. In his opinion, the scheme *"inevitably"* increased transmission and *was "highly likely"* to have increased the number of deaths [**22/156/10-22/157/5**].

152. It was suggested by Mr Sunak during his evidence that it was open to the CMO and GCSA to raise their objections to the scheme after it was announced [**33/119/18-33/122/11**]. It was not their role to restrain the Government from implementing decided policy, but to provide advice. Had their opinion been sought, the scientists from whom the Inquiry has heard unanimously said they would have warned against the scheme. Prof. Edmunds told the Inquiry, *"To be honest... I'm still angry about it. It was one thing taking your foot off the brake... but to put your foot on the accelerator seemed to me to be perverse"* [**131/12-17**].

SECTION D: SCIENTIFIC ADVICE

153. The magnitude of the threat posed by Covid-19 was recognised at a very early stage by the scientific community. On 9 Jan, Prof. Riley expressed concern on X (then Twitter) that a 'milder' novel coronavirus could pose a much bigger public health problem than SARS [**11/8/25-11/11/4**]. In Prof. Woolhouse's view, a report from around 8 Jan contained evidence that a pandemic was already underway and possibly irreversible [**10/5/21-10/6/3**]. On 21 Jan, he was sufficiently concerned to email Sir Jeremy Farrar about the likelihood of the virus going global, to be told that: *"It will. It probably already has. So many asymptomatic, very mild infectious individuals who can transmit – sort of worst hybrid of flu + SARS!"* [**INQ000103349/1**]. Sir Patrick said that in late Jan it was *"very clear from the numbers... in the first SAGE meeting we'd called that this had the potential to be really quite devastating, and the numbers of potential deaths and infections was extremely high"* [**22/26/3-9**].

154. The Inquiry has in our submission rightly interrogated how effectively this analysis, so clear and obvious to the advisers, was communicated to Government and the public, and asked why the impending threat of countless deaths and an overwhelmed NHS was not spelled out bluntly and repeatedly in unambiguous terms that could not be ignored. There is clear evidence that the academic language of the SAGE minutes, for example, failed to highlight the gravity and urgency of the situation: see Prof. Woolhouse's observation that

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SAGE minutes did not capture the concern that he knew some members felt [**10/34/24-10/35/5**].

155. Prof. McLean said that with hindsight scientific advisers could have done more "*to impress on decision-makers just how serious the situation was*" in the early stages, reflecting on how "*forceful and repetitive*" one must be when alerting decision-makers to a serious risk [**INQ000309529/36§122**]. Such reflection is to be welcomed and should inform present practice and future planning. However, Prof. McLean's reflections are set in the context of the lesson she learned about Government's tendency to delay making decisions on interventions until the last possible minute. She concluded that advisers should have thought more critically about the state of mind of those they were advising and the reasons they were delaying: *"to assume that elected officials do not want to make unpopular decisions, and that it is extremely difficult for them to do so"* [**INQ000309529/38§129**].

156. While this should be taken on board for the future, it illustrates a key concern about the failure of central Government, to grasp and act upon the scientific evidence and advice which was being provided, in a timely way. From the first SAGE on 22 Jan, which revealed the 'devastating' potential impact of the virus, there were not only attendees from DHSC and PHE but also observers from across government, including CCS [**INQ000174700/1**]. From 13 Feb Dr Warner attended SAGE regularly [**INQ000269182/13§42**] and Mr Cummings also attended SAGE meetings. Sir Patrick spoke with Mr Cummings in advance of the first COBR meeting on 24 Jan and believes he was in attendance [**INQ000238826/29§82**]. A further COBR took place on 29 Jan and on 4 Feb the CMO provided an update on Covid-19 to the PM direct [**INQ000146558**]. Sir Patrick again spoke with Mr Cummings on 7 Feb and arranged a meeting with the PM on 10 Feb [**INQ000238826/39§113**]. There were ample opportunities for the Government to get on top of the scientific evidence and advice from the outset, and it was for them to do this and make the tough decisions in line with their democratic mandate.

157. In fact, in decision-making terms Feb was, as Prof. Woolhouse characterised it, "*a lost month*". Prof. Medley's view was that *"the reality of the epidemic... was not given sufficient weight initially"* and there was a sense that Government strategy was being created "*on the hoof*" during Feb and March 2020 [**INQ000260643/18§§3.27-3.28**]. There was a *"lack of decision-making under uncertainty."* Prof. Medley told the Inquiry that, under most strategies, NPIs such as self-isolation would have to be put in place, and he was frustrated that they were not implemented early enough to see if they would work. What seemed to happen was *"doing nothing and then suddenly changing your mind"*. In his view, *"regardless of the outcome you want to achieve... putting those kind of interventions... in place sooner would have seemed... more sensible"* [**8/129/25-130/16**].

158. In this regard, the Inquiry must consider the evidence before it about the framing and commissioning of advice. Prof. Riley's evidence was that in the early stages of the response, particularly in Feb 2020, some key commissions were too narrow. In particular, his view was that from Jan 2020 there should have been active consideration of the feasibility of emulating the 'innovative' approach of the Wuhan authorities in seeking to contain the virus. Prof. Riley viewed the failure to consider more stringent / severe interventions at an early stage as a lost opportunity [**11/11/12-11/14/20**]. The Inquiry will also recall the evidence of Dr Warner that the UK should have developed alternative plans, including lockdown and methods of control such as TTI, from early 2020 [**18/152/22-154/4**].

159. Prof. Medley and other scientist witnesses gave a great deal of evidence about the lack of even a high-level strategy in this period and the impact on the advice provided. Prof. Medley said that he was frustrated *"that there was not a clear and apparent strategy to mitigate the epidemic wave that was impending and deal with the remainder of the epidemic"* [**INQ000260643/49§5.11**]. His "*underpinning concern"* was that *"the strategy for dealing with the whole epidemic was unclear"* [**INQ000260643/49§5.16**]. Prof. Riley noted that *"many of the other witnesses have commented on how difficult it was to scope the scientific evidence in the absence of* [even a fairly high level] *framework"* [**11/73/23-74/5**]. Prof. Ferguson gave similar evidence, noting the lack of visibility of Government red lines **[11/145/1-6]**. While the witnesses were fairly challenged on how this should have impacted their ability to raise the alarm or provide advice, there was no sense that their expertise was being effectively harnessed to work with Government on a common strategy to address the pandemic.

160. Sir Patrick's evidence was that a lot of modelling and other work was done in Feb, meaning *"there was a lot of evidence that there were things that needed to happen in order to achieve this aim of suppressing the curve".* However, he was "*not convinced that there was a very effective operational response to that"* [**22/31/14-18**]. Sir Patrick recalled that advice on NPIs was presented at COBR but operational implementation plans were not as advanced as they should have been [**22/39/1-40/8**]. The understated view he expressed in evidence was that he "*wasn't sure"* that the necessary "*urgency of action was as consistent and reliable as it should have been across Whitehall at that time"* **[22/40/6-8].** In his evening notebooks he recorded *"All departments should use their plans & activate (*[...] *What action actually happened)"* and asserted that in Feb *"NHS absent or very low key at COBR*" and *"Bed numbers – we keep asking for and not getting".* He asked rhetorically, *"Why not ramping pandemic flu plans?"* [**INQ000273901/656-657**].

161. In this regard we note that after a SAGE meeting on 27 Feb Dr Warner was sufficiently concerned about the absence of NHS modelling to email Sir Patrick. Sir Patrick responded that he had been pushing on this for the previous 10 days or so, noting that there had been a lot of NHS modelling but the 'input variables' had not been well-enough defined or validated [**INQ000195863**]. Prof. Ferguson agreed that it was apparent to everyone at this SAGE meeting that the number of deaths and hospitalisations would be enormous [**11/141/8-14**] yet it was not until 13 March that NHS representatives confirmed on record that the NHS would be overwhelmed under any of the mitigation scenarios that had been modelled up to that time [**INQ000249526/45§147**]. In an email the same day, he said he was "*amazed that Chris and Patrick hadn't appeared to have previously asked whether the NHS could cope with what the govt policy would likely produce*" [**INQ000149061/1**].

162. Prof. Ferguson also expressed frustration at the length of time it took SAGE and SPI-M-O to accept the estimate of the crucial metric of the IFR [**11/138/24-140/1**]. However, there was a lack of early and decisive implementation of control measures whose impact could have been monitored and measured. This contravened both Prof. Woolhouse's maxim that "*if you go early, you don't have to go so hard*" [**10/40/11-12**] and Sir Patrick's lesson that you have to go earlier, harder and broader than you would like [**INQ000238826/71§225**]. Instead, NPIs only began to be introduced in earnest in March, leaving no time to monitor and evaluate and, ultimately, no option but to go into lockdown. According to the scientific advisers, lockdown itself was imposed 1-2 weeks later than it ought to have been [**25/54/4-55/2; 22/48/24-50/8; 11/59/19-60/1; 13/126/2-20; 24/173/20-24/175/3**].

163. Why, then, did the world-leading independent scientific expertise available to Government not lead to better decision-making in the early stages? As set out in Section B, firstly we submit that there was a systemic lack of concern about natural as opposed to geopolitical threats which produced a reactive rather than proactive response. Secondly, and relatedly, the absence of a standing committee to advise specifically on pandemic threats meant there was no existing and holistic analysis of the risks and how they might be addressed. Such a committee would also have established formal links across government that could have been used to communicate urgency and facilitate a rapid whole-government response. Instead, there was a reliance on ad-hoc relationships between independent academic scientists, their government counterparts and policy and decision-makers.

164. Thirdly, there is clear evidence of a lack of ability within the Government to understand scientific advice and its implications for policy and decision-making. Stark evidence on this was given by Dr Warner, who said that "*Throughout the pandemic I thought that there was a lack of scientific capability within the different teams and groups that I was working with.*"

Clarifying that he meant across Government rather than in SAGE, he went on to say that within COBR/Cabinet Office he was *"continually concerned about their understanding of what SAGE was saying and how that was being translated into the documents that were produced for Ministers"* [**18/130/6-25**]. The impact of this is illustrated by the fact that as late as March 2020 Prof. McLean was left in doubt as to whether decision-makers knew the implications of their then-strategy [**18/158/13-15**].

165. One specific and highly relevant example relates to the concept of exponential growth. When asked whether he communicated the threat to Cabinet on 14 Feb 2020, Prof. Whitty spoke of his surprise at how difficult it was to convey the 'extraordinary power' of such growth: *"do I think that most people round the table fully grasped what would happen if this started to run exponentially? I suspect the answer to that is no"* [**23/178/25-180/22**]. This theme was also picked up by Prof. McLean, who agreed that understanding of scientific data and other outputs was a challenge and identified a difficulty in decision-makers' lack of grasp of two key concepts, namely fast exponential growth and lagged controls. In her view, the difficulties in appreciating those two concepts *"seemed to cause a lack of appreciation that very quick decisions were needed, and that the approach of 'watch and wait' was, in itself, a decision capable of producing damaging consequences".* She described this as the most significant short-coming in decision-making during the pandemic and said that *"watch and wait"* tactics were very damaging [**INQ000309529/16-17§§56-57;25/20/21-25/23/20**]. Others including Prof. Hayward [**10/204/11-17**] and Prof. Christina Pagel [**INQ000056364/10**] have similarly highlighted the importance and lack of appreciation of this concept.

166. The Inquiry will recall Sir Patrick's evidence in relation to the difficulties experienced in providing scientific advice to Mr Johnson, and the notebook entries he made as a result [**22/58/21-64/13**]. While this challenge was not unique to the PM, and indeed was experienced by Sir Patrick's counterparts elsewhere in the world, it is self-evidently a matter of serious concern if important concepts and their devastating implications could not be mastered to the extent necessary to enable decisions to be taken at proper speed. This is a matter which must be addressed for the future, including by the recommendation for a Standing Scientific Committee on Pandemics. It should be noted, however, that in Prof. McLean's view understanding of key concepts does not require a scientific mindset: *"you can draw it out in a picture in a way that anybody who's prepared to listen and think about it ought to be able to grasp"* [**25/24/6-9**].

Filling the gaps

167. When considering the role played by scientific advice, the Inquiry should also consider the extent to which independent advisers were required to fill in gaps in Government capacity.

This was explained most clearly by Dr Wainwright, who referred to the *"lack of capacity of PHE and others going into this situation"*, creating a gap which was filled only by SAGE having to grow into something it was never meant to be. For GO-Science in late Feb and into March there was *"a feeling of other parts of Government either not being there or not being allowed to be there... but science advice, technical advice, public health advice was needed, and we had to grow our structures to be able to provide that. That wasn't out of design, certainly not by desire, but I think it was out of necessity"* [**8/56/18-57/25**]. See also the evidence of Prof. Ferguson on this point [**11/189/6-18**].

168. Sir Patrick agreed that SAGE ended up filling gaps; for e.g., by the establishment of a subgroup to deal with the vital issue of care homes [**INQ000238826/173§524-8**]. The Inquiry should consider the impact of this, noting that SAGE was not intended to offer an operational perspective, and was ill-equipped to do so; particularly given the absence of an independent public health expert as highlighted by Prof. Costello [**10/82/24-83/4**].

Transparency and the focus on scientific advice

169. Several witnesses drew attention to an imbalance caused by focus on scientific advice and the publication of SAGE papers in circumstances where other relevant analysis, notably economic analysis, was not made public. This lack of transparency meant that there was little public focus on or challenge to the economic analysis or to the false binary between health and economic harms. The Inquiry is invited to consider Prof. McLean's evidence that if there had been better understanding of the economics advice, advisers may have been *"better placed to put to bed the false trade-off between public health and the economy"* [**INQ000309529/49§164**]. This is a matter of particular concern to the families.

Following the science?

170. There has been near unanimity among witnesses about the Government's early message that it was 'following the science'. Prof. Whitty and Sir Patrick were initially in favour of the concept on the basis that it recognised the importance of science in Government. However, they soon realised it was a millstone around their necks because it blurred the boundaries between technical advice and political decision-making [**23/92/19-23/93/7**]. Dr Wainwright [**8/65/19-8/68/12**] and Professors Ferguson [**11/190/15-11/191/2**] and Riley [**INQ000270553/39§11.6**] gave evidence indicating that the concept was unhelpful, with Prof. Keeling observing that it *"sounded like we almost had too much power, and I don't think that was ever the case"* [**8/180/9-11**]. Prof. Edmunds was blunt in his assessment: *"they were doing it so they could hide behind us"* [**13/73/21-74/23**]. Sir Patrick linked this with the uncertainty and unfamiliarity with science he perceived in Government and said that there was *"a bit of dependence, that this was a scientific problem and people would listen slavishly to this and*

wanted to sort of slightly hide behind this at times" [**22/57/3-20**]. This chimes with an entry in his diary that "*Ministers try to make science give the answers rather than them making decisions"* [**INQ000273901/44**].

171. As well as considering whether it was appropriate, the Inquiry must weigh the Government's public rhetoric in this regard against the evidence contained in Sir Patrick's diaries and elsewhere of the attitude displayed by ministers towards the scientific advice, including for example Mr Sunak's comment that *"it is all about handling the scientists, not handling the virus"* [**INQ000273901/112**] and the note that No.10 are *"pushing very hard and want the science altered"* [**INQ000273901/98**].

172. Finally, the Inquiry must consider the gap between rhetoric and action. Far from following the science, the Government repeatedly omitted to seek independent scientific advice on the epidemiological implications of its policies before they were enacted. A range of policies, from the five tests identified by the Deputy PM in April 2020 for exiting lockdown, through to the rule of six, the tier system, and most obviously EOTHO were implemented without specific advice from SAGE and its sub-groups on how they would affect the course of the pandemic. At the same time, the Government chose not to act when advised by SAGE, most obviously in Autumn 2020. The impact of this on the trajectory of the pandemic and death toll in the second wave was profound, as we set out in Section G.

SECTION E: CHAOS IN DOWNING STREET

The lack of direction from the top

173. Clear and decisive leadership, a hallmark of good governance, was needed to steer the UK through the pandemic. The former PM's characteristic indecision for which he was labelled *"the trolley"* [**15/114/7-18**] was a feature of the UK's response and undoubtedly contributed to its comparatively poor outcomes. Lee Cain spoke of the impact of Mr Johnson's indecision on staff at No 10 in terms: *"...indecision can sometimes be worse than the wrong decision in certain circumstances, and I think indecision probably was the theme of Covid that people did struggle with inside No.10"* [**15/31/8-11**]. This level of indecision was seen during the first and second waves and in the delaying of the implementation of the lockdowns. The Inquiry will recall Mr Cain's evidence: *"The system works at its best when there is clear direction from No10 and the PM, and these moments of indecision significantly impacted the pace and clarity of decision making across Government. With foresight and hindsight, it is undeniable that the Government took too long to move into a national lockdown but that the right decision was eventually taken"* [**INQ000252711/11§43**]. We submit, that the applicable

lens for the assessment of Mr Johnson's and the Government's actions is neither hindsight nor foresight but real time.

A dysfunctional Cabinet

174. Cabinet is the senior decision-making body in government and its ultimate decision maker. Its meetings are chaired by the PM and attended by all Cabinet Ministers and the Cabinet Secretary. Decision making is based on collective responsibility whereby Ministers are expected to abide by positions agreed upon. A properly functioning Cabinet is also expected to enhance decision making by bringing together a wider perspective from MPs' public interface and accountability to their constituents.

175. The Inquiry has heard that following Brexit, by Jan 2020, an unhealthy pattern of bypassing Cabinet in decision making had taken root [**16/90/3-16/91/13**] and decisions were being led by Mr Johnson's inner circle. The grounded perspective of Cabinet gave way to that of a cabal of officials and civil servants, No.10 advisers and the PM [**20/16/20-20/17/20**]. Mr Cummings' WhatsApps with Mr Johnson on 12 March 2020 are one such example of Mr Johnson's inner circle taking charge and a divisive decision-making structure: *"We got big problems coming. CABOFF is terrifyingly shit, no plans, totally behind pace, me and Warners and lee [Cain] /slacky are having to drive and direct"* [**INQ000048313/22**].

176. Mr Cummings confirmed the relegation of the Cabinet to irrelevance in the Government's pandemic response in 2020 citing its size, the inability of the Mr Johnson to chair it and its propensity to leaks [**INQ000273872/16-17**]. Mr Johnson's unsuitability to lead Cabinet and collective decision-making was also confirmed by Lord Sedwill who recalled needing to remind the PM of the importance of having his Cabinet colleagues, not just in the formal decision but in the formulation of that decision [**20/15/5-16**].

177. The UK's best chances were dependent on clear decisive leadership and functional systems of government both of which were entirely absent.

SECTION F: IGNORING DEVOLVED ADMINISTRATIONS & THE ENGLISH REGIONS

178. With respect to the relationships with DAs, and decisions taken with relevance to those jurisdictions, the following conclusions can be drawn from the evidence:

(a) Central government took the view that there should be a one size fits all approach dictated by Westminster. This approach was political. It was not based on what was required to combat the pandemic in the DAs. It was also flawed in practice.

INQ000399534_0043

(b) This meant that, in the main, devolved interests were not considered at all or were considered only as an afterthought whilst DAs (including some of their elected representatives) were treated as political problems to be managed.
(c) The 'one size fits all' approach had an Anglo-centric focus to the exclusion of consideration of the unique positions of the DAs.
(d) The Anglo-centric approach also filtered through SAGE and the scientific response.
(e) As a result, UK Government decisions were frequently taken absent any properly informed consideration of devolved issues. That prevented a fully informed response. This was not only inappropriate and should not be repeated in the future, but in fact had detrimental consequences in practice.

179. It is important to observe that the evidence heard in M2 has not yet been put in the full context of evidence from the DAs. This has, in some aspects, hindered the extent to which issues of relevance to devolved jurisdictions can be fully addressed at this stage (issues such as NI Test and Trace, and in relation to the date of NI attendance on SAGE, to name but two). Accordingly, these submissions should be considered with this caveat in mind. It is likely to be necessary to return to some of the issues addressed below in light of the evidence in M2C, or indeed in any of the devolved Modules.

I. DESIRE FOR A SINGLE UK RESPONSE DICTATED BY CENTRAL GOVERNMENT

180. The UK is made up of four nations, three Devolved Governments, and two separate epidemiological units on separate islands. Given that political and geographical reality, a coherent pandemic response on the part of the UK Government should have been founded on effective mechanisms of engagement with DAs and was required to take into account epidemiological reality. In fact, the evidence suggests this did not happen. Rather, the UK Government took the view that it was important that there be a single response to the pandemic, and (in practice) that this should be dictated from Westminster.

181. Repeatedly in his statement, Boris Johnson emphasised his view that there should have been a single UK response to the pandemic, implemented throughout the UK: *"[144]I was keen to try to encourage everyone to follow SAGE's advice insofar as possible and for the Four Nations to stick together as one United Kingdom*" [**INQ000255836§144;143;151**]. Matt Hancock, also emphasised his view that it was "*vital that all parts of the UK moved in lockstep...*" [**INQ000232194§156**]. However, there are fundamental problems with the UK Government implementing a one-size fits all approach to the pandemic, and the evidence shows that these affected the UK response in predictable and detrimental ways.

182. Firstly, it is clear that such an approach is not consistent with epidemiological reality. This will be addressed in some more detail below. At this stage it is sufficient to note that Mr Johnson (and indeed other key witnesses) appeared to accept this under questioning in oral evidence: *"So when it comes to Northern Ireland, yes, clearly you're right, there's a -- we have to take account of the greater epidemiological unity of the island of Ireland, and what you say has force, but … but I still think that there's a -- you asked generally about the DAs. I think the more unified we can be the better"* [**32/112/4-11**].

183. This recognition, which ought to have been obvious at the time of (and indeed prior to) the pandemic, appears to have been belatedly reached. However, it supports the conclusion that the Government's preferred approach was inconsistent with epidemiological reality and scientific advice. Rather, the evidence tells us that the Government's 'management' of the DAs during the pandemic was motivated by the political preferences of those in power in Westminster and the desire to keep the DAs in their place. The Inquiry will note, by way of example, that in explaining the rationale for a single UK approach, Lord Lister did not cite any scientific advice to this effect, rather he identified that it came from *"the media side at number 10"* [**19/190/11-17, see also 190/18-25**]. That suggests it was not a decision based on the welfare of the citizens of devolved regions, rather the belief in a single UK response was founded on the representation of political power. That is self-evidently a problem in itself.

184. Lord Lister identified that, notwithstanding that parts of the country had their own responsibility for health, the PM took the view that "*there should be one simple message that goes out to everybody*" and that he should decide that message because "*well, he's the PM*" [**19/185/24-19/186/3**]. That answer, of course, does not explain how Westminster's preferred approach could be consistent with the UK's devolution settlement. Indeed, it is plainly inconsistent with the constitutional settlement of the UK, in which devolved powers are necessary for responding to the pandemic to DAs. As observed by former NI First Minister Paul Givan '*There was not a 'one size fits all' approach…Each jurisdiction has a right to take its own decisions which needs to be respected under devolution'* [**INQ000256605§18**].

185. Given the apparent preference to centralise power in the UK pandemic response, it may therefore be considered unsurprising that Central Government treatment of the DAs was characterised by shutting them out of the decision-making process, and attempting to dictate to rather than consult with, devolved leaders.

II. DEVOLVED NATIONS WERE ABSENT, AN AFTERTHOUGHT, OR A PROBLEM TO BE MANAGED

186. At each stage of the pandemic, the DAs were seen as an afterthought, a problem to be managed, or were entirely absent from relevant decisions. At no point were they treated as they should have been, as respected and valued partners with unique perspectives on behalf of their respective citizens and who could contribute to and improve the UK-wide response in order to save lives across the four nations.

Political problem to be managed.

187. The conclusion that DAs were treated as a political problem is apparent from the UK Government criticism of decisions of DAs which diverged from the UK Government's approach. Such criticisms, the Inquiry will note, routinely focused on the political impact of divergence on the Government. Indeed, there is a stark absence of any consideration of whether divergence was either necessary or justified as a proportionate pandemic response.

188. At the outset it must be emphasised that these submissions do not dispute Prof Medley's warning of the danger of divergent approaches in a pandemic when nations start *"gaming"* against each other. Indeed, we agree that political 'gaming' in a pandemic response, be it from Central Government, DAs or opposition parties, risks leading to less than optimum outcomes [**8/90/1-24**]. However, the warning should not be read to mean that all divergence on the part of the DAs was 'gaming', nor was it necessarily detrimental. Even Mr Johnson accepted that "*the interests of the DAs did not always align with England's or the UK's interests. That's an inevitable part of a devolved system*" [**31/151/4-8**].

189. It is also important to note that Prof. Medley's reasoning operates to suggest that the risk of *"gaming"* equally applied on the island of Ireland, and this would not be solved by preventing divergent approaches by the UK alone.

190. Taking into account Prof. Medley's warning, it is particularly striking that, where there were criticisms of divergence, there does not appear to be any instance of a Central Government actor criticising a different approach taken by a DA on the basis that it would fail to protect health or lives, or would otherwise lead to worse outcomes either for the jurisdiction in question or for another in the UK. Rather, the focus was on political optics.

191. This is perhaps most glaringly apparent in the one example given by Boris Johnson to demonstrate why he believed that divergence was a problem. In his statement he focuses on Scotland bringing in restrictions on mass gatherings prior to any such step by Central Government, adding that the *"occasionally divergent Four Nation approach became a growing presentational problem… When public sentiment was at variance with what the scientists at the time were saying (as in the case of these mass gatherings), there was always a risk that*

the DAs would diverge and choose a more restrictive measure, or one that was perhaps different for the sake of being different" [**INQ000255836§153**].

192. It is explicit in this criticism that the problem identified was not related to pandemic outcomes, but rather was *"presentational"*. Strikingly, despite Mr Johnson's criticism that the decision was at variance with scientific advice, the evidence now suggests that restrictions on mass gatherings should have been taken earlier. Prof Whitty was of the view that this was one area where he would *"push to do things differently"* [**23/189/20-190/2**]. Sir Patrick concluded that, "*large events should have been stopped earlier together with instructions about smaller indoor meetings and gatherings in pubs and clubs*" [**INQ000238826/196§597**].

193. Those changes of view are perhaps unsurprising. In his report, Prof. Hale identified that, when it comes to NPIs, speed matters, noting that a study estimated, "*a single day of delay in implementing a mass gathering or school closures meant respectively a 6.97% and 4.37% increase in cumulative deaths*" [**INQ000257925/12§19-20**].

194. In his oral evidence to the Inquiry, this change of heart was also adopted by Mr Johnson, who when asked by Mr Keith KC whether mass gatherings should have been stopped before Cheltenham and the Liverpool Atletico Madrid match, said "*with hindsight … we should perhaps have done that and I agree with you*" [**31/118/12-23**].

195. Given that the evidence now suggests that earlier action to restrict mass gatherings was likely to improve the pandemic outcome, it is remarkable that Mr Johnson still considers this decision to be an example of objectionable divergence. It is difficult to see how this conclusion is consistent with a concern to best protect those living in Scotland from the pandemic. Rather it reinforces the conclusion that any concerns about divergence were about political optics irrespective of pandemic outcomes.

196. The view that the concern of those in Westminster was focused on political optics rather than public health decisions, is reinforced when the records of internal meetings attended by Central Government Ministers are considered. The most glaring example may be found in the readout of a meeting with the CDL, Secretaries of State for Scotland, Wales and NI, and cabinet office officials [**INQ000091348**]. This was convened in April 2020 in order to determine the response to a request from the First Minister of Wales for more meetings between Central Government and the DAs. It is clear from the summary of the meeting that the overwhelming focus of those attending was on political control rather than consideration of what was in the best interests of the devolved jurisdictions. That is particularly concerning given the involvement of the territorial offices. The overwhelming impression from the readout

is the respective TOs were determined to keep the DAs (and First Minister of Scotland and deputy FM of Northern Ireland in particular) in their place.

197. By way of example, the readout shows that the CDL identified one reason for the call was the "*temptation for DAs to jockey for position.*" The SOSNI was concerned that it was the TOs job to get DAs "*to the right place*" for wider UKG meetings, with the concern expressed that "*in a smaller meeting they may prove more difficult to handle*" and that the "*default position of the dFM will be to agree with the approach in the ROI.*" Starkly absent from that comment, of course, is any apparent openness to consider whether that 'default position' may have merited further consideration given its likely epidemiological benefits.

198. In the same meeting, the SOS Scotland was focused on what approach would make it "*easier to handle Scottish FM and likely to be fewer leaks*", and what would better "*avoid Scottish FM grandstanding*". The SOS for Wales focused on what was "*useful for defending and promoting UKG*". Even the request by Mr Drakeford was viewed as a political move rather than a good faith effort to ensure an effective pandemic response: "***SOS Wales** – thinks Drakefords request is positioning himself for next year's Assembly elections.*" The Minister for the Constitution did not mention the need to involve the DAs in decision-making to ensure better decision-making at a local level in light of the constitutional settlement devolving relevant decision-making power, but instead focused on the "*need to hold them to account on their approach to Covid-19.*" The CDL noted in conclusion that he had heard that "*regular meetings could be a potential federalist trojan horse.*"

199. What is most striking from this readout is what is not expressed. There does not appear to have been any substantive consideration that the request for such meetings could be a good faith effort to address the pandemic in an effective way. Nor is there substantive consideration of what would best ensure an effective pandemic response. The focus is on political considerations. The sole goal is control of the DAs.

200. Prof. Henderson, when asked about this noted: *"It's clear there was a desire to structure intergovernmental relations for ad hominem reasons, so there's a clear effort to control or handle one of the First Ministers in particular, there is a fear of federalism, there is a fear of leaks, there is a perceived kind of venality or self-serving nature to the motives of the devolved administrations, and never a reflection that this might also be true for all actors, and no real expression in this document that it might improve decision-making if more voices from more parts of the UK were included in the decision-making"* [**5/151/16-5/152/1**].

201. The same approach to DAs, treating them as a political problem rather than a partner in effective decision-making against the pandemic, were expressed in private WhatsApps. By way of example, the date for vaccine V-day was set but at the same time plans were made for acceleration "*if a DA tries to jump gun*" [**INQ000275431/78**].

202. A further justification advanced by Westminster for seeking to limit the involvement of the DAs in decision-making, and which was emphasised in the readout from the meeting above, was concern about leaks. It is not in fact clear whether this was a valid concern in practice, given the evidence of leaking from Westminster only decision-making [**e.g. INQ000129680;INQ000129268;INQ000129312;INQ000129411;INQ000129446**]. However, even if this was a valid concern, it is clear that leaks were an issue for political reasons. There is little identification of how, in reality, such leaks would hinder pandemic response. Moreover, the point should be firmly made that a fear of leaks should never be regarded as a valid public health reason to exclude those with local knowledge from the decision-making process. Instead, the exclusion of the DAs from decision making for apparent fear of leaks amounts to a prioritisation of political optics over public health considerations and the real need to protect the lives of the citizens of NI.

203. Consistent with an approach of treating the DAs as a political problem, rather than considering how best they could inform and improve the pandemic response in a collaborative way, deliberate decisions were taken not to utilise established mechanisms to involve the DAs in decision-making. In order to identify this, it is helpful to consider in brief detail what mechanisms were available before considering what mechanisms were used.

Pre-existing structures for Intergovernmental Relations ('IGR')

204. Structures for intergovernmental working between the UK Government and DAs were improvised as the pandemic developed [**INQ000273747/6§85**]. Pre-existing mechanisms, namely the Joint Ministerial Committee ('JMC'), the British Irish Council ('BIC'), and the British Irish Inter-Governmental Conference ('BIIGC') were not used.

205. Mark Drakeford notes that meetings of the JMC stopped when Boris Johnson became PM [**INQ000273747/5§14**]. As a result, modes of working had to be drawn up virtually from scratch: *"I consider that the decision-making process would have worked better if there had been an established history of joint working with the PM upon which we could have drawn in a crisis. Unfortunately, that history did not exist"* [**INQ000273747/52§185**].

206. Similarly, Prof. Henderson explained that arrangements for IGR had been neglected by the UK Government: "*the other reason why we see kind of underdeveloped*

intergovernmental relations is partly the spirit with which the UK Government in particular has approached them and has sort of let them languish" [**5/127/17-20**].

207. In the initial stage of the pandemic, DAs were generally invited to COBR meetings and did attend, although this was not as of right. Although problems were identified by the DAs relating to notice of meeting dates and the approach to sharing analysis and relevant papers [**INQ000256826**], DA attendance at COBR meant that there was regular contact between the four nations and the PM, though evidence suggests that the decisions were in fact being taken elsewhere [**5/33/16-34/3**]. Representatives for the DAs also attended Ministerial Implementation Groups ('MIGs') from March 2020.

208. However, on 10 May 2020, Covid meetings ceased and MIGs were replaced by new Cabinet structures. Four nations work became much more limited and Boris Johnson avoided contact with the First Ministers and deputy First Minister. It is important to emphasise that this was not inadvertent but was a deliberate decision, consistent with a desire on Mr Johnson's part to keep away from the DAs [**INQ000255836/45§188-189**]. The reasoning also makes clear an intention to bind DAs to a UK strategy after it had been set in meetings to which they were not invited) [**INQ000217045**]. This is consistent with the view that the DAs were a political problem to be managed, noted above.

209. Prof. Henderson notes that, by May, inter-governmental coordination "*was waning, with less frequent meetings to which the devolved administrations were invited*" [**INQ000269372/25§67**]. From May onwards, there was no structure to facilitate regular meetings or contact between the DAs and the PM, and contact was delegated to Michael Gove. Nicola Sturgeon considered that this was in order to *"reduce the requirement for the PM to engage directly with the devolved governments*" [**INQ000235213/13§39**].

210. DAs repeatedly raised concerns regarding the frequency and quality of communication with the UK Government and made multiple requests for regular contact. For example, on 20 April 2020, Mark Drakeford wrote to Michael Gove asking for "*a regular rhythm*" of meetings, proposing a mid-week meeting followed by a meeting of COBR at the end of the week to consolidate progress and shared understanding [**INQ000216489**]. No specific commitments were made by the UK government in relation to meeting schedules [**INQ000256939**] and a meeting of COBR did not take place again until 22 Sept 2020.

211. On 12 May 2020, Mr Drakeford wrote to the PM again to "*set out the case for a regular and reliable rhythm to engagement"* between the Governments [**INQ000256848**].

212. There is little evidence of proper consideration being given to the relevant structures for management of the pandemic response across the four nations, in particular by the PM. For instance, on 22 May 2020, Ms MacNamara and Mr Case wrote to the PM setting out the proposed changes to Cabinet response structures, namely the introduction of COVID-S and O. The proposal recommended: "*that we use the usual Joint Ministerial Committee mechanisms to manage the DAs*" [**INQ000183934/2§1**]. Although, to her credit, Ms MacNamara acknowledged that the words 'to manage the DAs' were poorly chosen [**16/100/24-16/101/2**], it is perhaps further evidence that the culture of 'management of the DAs' had also infected the Cabinet Office. In any event, although the proposal was agreed by the Cabinet Secretary, the JMC was not utilised. The DAs were not generally included in COVID-O meetings in the Summer and early Autumn of 2020 [**INQ000259848/11§19d**]. There was no suggestion of DAs being included in COVID-S [**INQ000256854/4**].

213. On 11 June 2020, Mr Drakeford wrote to Mr Gove raising concerns about the lack of communication between the UK Government and DAs, including the making of significant announcements with minimal prior communication, and the difficulty he faced in continuing to defend the four-nations approach without a predictable rhythm of engagement with the UK Government [**INQ000216519**].

214. Communications between the UK Government and the DAs thereafter took place primarily through meetings between representatives of the DAs and Michael Gove, at first in his role as CDL, then as SoS for Levelling Up, Housing and Communities. This was sometimes through COVID-O meetings (for example in the late autumn/winter of 2020), and at other times through four nation calls. Significantly these were not meetings or calls where decisions were taken [**INQ000255838/29§104,106**]. Rather they provided a forum for DAs to be informed about decisions which had been taken and were due to be announced.

215. In his oral evidence, Mr Gove refused to accept that there was a "*halt*" in the DAs' access to UK Government decision making between May and Autumn 2020 but did accept there was a "*diminution*" [**27/124/13-27/125/17**]. Whilst we suggest that his characterisation is self-serving, we also consider that these semantics should not overly trouble the Inquiry. This was an unprecedented pandemic. Significant aspects of the response were the responsibility of the DAs. There was therefore a need for coordination across administrations, and involvement of DA leaders in Westminster decisions with relevance for their electorate. Far from a halt or a diminution, there should have been a maintenance or an increase in regular and systemic contact at the highest levels, and in involvement of DA leaders in decision-making. Whether there was a halt or merely a diminution in DA engagement with the UK

Government throughout this period, this amounted to a failure in ensuring adequate communication mechanisms in the circumstances.

Failure to communicate & consult.

216. The Memorandum of Understanding, as agreed between the four nations in 2013, provides that: "*All four administrations are committed to the principle of good communication with each other, and especially where one administration's work may have some bearing upon the responsibilities of another administration*" [**INQ000102927/5**]. The evidence in M2 makes plain that the UK government failed to uphold even this basic statement of intent during the pandemic, when the epidemiological context made good communication more important than ever.

217. In May 2020, leaders of the DAs, along with the Mayor of London, shared concern that the Government was not engaging sufficiently, despite prior assurances by the PM [**INQ000118867**]. For example, without warning, the PM had dropped the stay-at-home message and people were being encouraged to return to work [**INQ000221436/51§236**]. Michael Gove confirmed that the Scottish Government was not informed in advance of the change in the UK Government messaging from "*Stay at Home*" to "*Stay Alert*" **[27/129/6]**.

218. Surprisingly, Mr Gove did not acknowledge that that failure to communicate or consult led to "*any particular detriment to the handling of the pandemic*" [**27/129/12-14**]. In our submission, that betrays a lack of value placed on hearing the views of the four nations in relation to decisions affecting the people who lived there.

219. The Memorandum of Understanding also provides that the administrations will seek to "*alert each other as soon as practicable to relevant developments within their areas of responsibility, wherever possible, prior to publication*"; "*give appropriate consideration to the views of the other administrations*"; and "*establish where appropriate arrangements that allow for policies for which responsibility is shared to be drawn up and developed jointly between the administrations*" [**INQ000102927/5**].

220. The political leaders of NI, Scotland and Wales who took part in "four nations" engagement with the UK government were unanimous in their evidence that they were too often informed about major announcements as an afterthought. Mark Drakeford explained that where meetings did take place, they were "*too often as a forum for communicating decisions already taken*" and "*in some crucial instances major announcements were made by UK ministers, without even this level of engagement*" [**INQ000273747/56§197**].

221. That conclusion is reinforced by the readout of the meeting between CDL and TOs, referenced above at §194 above. The summary records that SOSNI was "*clear on the call*" that he did not see the need for further weekly meetings with the DAs, "*given they already have plenty of exposure to UKG Covid-decision-making*" [**INQ000091348/1**]. That the term used was 'exposure', and not 'effective input', speaks volumes. As a result of that meeting it was decided that there would be no commitment to weekly meetings [**INQ000091348/2**].

222. As Prof. Henderson noted, it is remarkable that *"the fact that the devolved administrations were "exposed" to UK Government decision-making, as if being in the room and listening to what the UK Government was going to do was enough and satisfied commitments in terms of* intergovernmental *relations"* [**5/150/23-5/151/3**].

223. The note of the meeting makes clear that the concerns held by DA representatives that they were being excluded, marginalised and or treated as mere observers to the response were, in essence, justified; the tone of the meeting makes clear that the UK government, and in particular the Secretaries of State, viewed them as problems to be managed. In that context, it is perhaps unsurprising that there was little opportunity for genuine consultation or involvement in decision making.

<u>*Failure to consider DA interests/treatment of England as the UK*</u>

224. Analysis of the texts of Government announcements in 2020 carried out by Prof. Henderson shows that there was a repeated lack of clarity in relation to whether data, information or guidance applied to the UK as a whole or just to England. For e.g., the PM's 12 March 2020 statement about schools remaining open [**INQ000086751**], or the decision six days later to close them, would have been a decision for England only (since education is devolved in Scotland, Wales and NI) but this was not made clear. In the 10 May 2020 address, the PM announced an initial easing of restrictions but did not once make the point that it applied in England only [**INQ000236243/39§137**]. References to re-opening retail (an announcement given 15 June 2020), which was England-only, referred to re-opening *"British high streets"* [**INQ000269372/49§152**].

225. Prof. Henderson notes that the lack of clarity caused confusion for citizens, risking compliance with lockdown rules [**INQ000269372/62§193**]. She elaborated: *"They wanted citizens to change their behaviour, but when the rule applied only in England, it was only English residents whose behaviour would need to change, and that wasn't clarified at any point, and it led to confusion on the part of electorates in Scotland, Wales and Northern Ireland, and it meant that the media picked up those statements and ran with them, and also didn't*

clarify what applied to England alone and what applied to Scotland, Wales and Northern Ireland; and so bad was the lack of clarity that Ofcom got involved" [**5/180/2-13**].

226. Mr Gove did not perceive there to be a particular issue around announcements assumed by the UK Government to be applicable to the whole nation, rather than just England, stating "*I don't believe that it led to any particular detriment to the effective delivery of policy*" [**27/128/18-19**]. He considered the impact to be "*at best marginal"* [**27/186/18**], noting: "*One could hone in on someone mixing up the phrase "English" and "British" at one time, but if that is the gravamen of a charge of high-handedness on the part of the UK Government, then I would argue that that is... perhaps not the most significant*" [**27/188/13-18**].

227. Mr Gove's response on the issue again betrays a lack of consideration of the perspective of citizens and political leaders in the DAs, in this case to ensuring that public health messaging could be understood across the four nations.

228. In any event, it was not simply announcements which were England-centric, but frequently the reasoning and analysis which underlay decision-making. For example, in July 2020 the Covid-19 Taskforce produced a document entitled "*the Route to Normal*", to map the route to recovery, which was sent to the PM [**INQ000207294/27§3.34**]. As part of this exercise they identified 3 scenarios which would constitute normal. These are almost embarrassingly south of England focused (as well as embarrassingly culturally, socio-economically exclusive):

- Scenario 1: A large multi-generational family gathers at their home in Norfolk, outside Sandringham, where they have gathered for Christmas for many years...;
- Scenario 2: A doctor switching on Christmas tree lights at a busy Oxford Street, London;
- Scenario 3: A capacity Twickenham watches England defeat the All Blacks [**Ibid/1-2**]

229. This further reinforces concerns about a London or Anglo-centric focus on the part of those in Westminster. Moreover, this blinkered focus, and lack of consideration about issues of importance for devolved jurisdictions, appears to have become a feature of the scientific advice used to inform Central Government during the pandemic.

Unequal representation in UK scientific bodies and agencies

230. Prof. Henderson explains that bodies such as SAGE had an English frame of reference, including use of English-only data and decision-making linked to English timing [**INQ000269372/46§140**]. Nicola Sturgeon expressed frustration that, although she perceived SAGE advice to be of a high quality, the commissioning of it originated from UK Government departments concerned primarily with conditions in England and taking less account of the Scottish context, and, particularly in the initial response, she or her Ministers were unable to

ask questions directly of SAGE to probe its advice [**INQ000235213/23§71**]. The UKHSA likewise had a "predominantly English focus" [**INQ000269372/46§141**].

<u>*Lack of attendance on SAGE from NI*</u>

231. One glaring example of the apparent failure to consider DA issues by GO Science or SAGE is that there was no NI representative on SAGE at the crucial early stage until after the first lockdown, at the twentieth SAGE meeting on 29 March [**INQ000089720/122**].

232. The submission that this amounted to a failing is made in the knowledge that SAGE is not a geographically representative body. However, the circumstances of this pandemic, and the particular circumstances of the north of Ireland, meant that geographic diversity should have been considered important in order to provide effective advice based on epidemiological realities, as well as to ensure that devolved responses were fully informed.

233. That is not simply the position of CBFFJ and NICBFFJ. Prof Whitty agreed that it was "*one thing to be aware of the conclusions and advice of SAGE and quite another, particularly if you don't have the expertise within the particular discipline, to have a complete understanding of the range in views and the weight of opinion expressed within the scientific discussions which led to those conclusions*". He therefore agreed with Sir Patrick that in the future it was important to ensure that the "*geographic diversity*" on SAGE was right [**24/92/3-10; 24/90/8-13; 22/152/16-17**]. That suggests that the prolonged absence of someone from NI on SAGE would have operated to prevent full understanding of the advice that was being given by SAGE, and therefore amounted to a failing.

234. However, it was not simply the response of DAs which may have suffered from such absence. The evidence of Prof. Whitty was that the attendance of Prof. Young benefitted SAGE itself. When asked about the lack of an NI participant on SAGE he stated: *"Yes, and that should have happened earlier and I think we would all agree that. And he is a very good scientific colleague and has many insights that are different from others. His own expertise I think is an additional contribution. So I think that's an example where you get both benefits: the geographical experience but also a different disciplinary background and that, I think, was useful for everybody*" [**24/91/11-18**].

235. It is significant that Prof Whitty made a point of emphasising the geographical experience Prof. Young brought to the committee. This was of course significant, as there were important geographical implications for devolved jurisdictions generally and NI in particular in the context of this pandemic given the two epidemiological units in the UK. The lack of an NI representative on SAGE at this early stage hindered SAGE itself by depriving it

of geographical experience which was necessary for an informed response to the pandemic. The failure to ensure NI attendance from an early stage at SAGE amounted to a failing for SAGE itself which should be avoided in any future pandemic.

236. However, in light of this evidence, it remains concerning that GO-Science did not (and still does not) appear to appreciate that this absence of an NI voice would have detrimental consequences for the advice SAGE provided and therefore for the pandemic response. In light of these detrimental consequences, they should have taken prompt proactive steps to ensure that there was such attendance. In order to address whether the failure to take such steps amounted to a failing this it is necessary to briefly consider the circumstances in which a representative from NI was invited and when they finally attended.

237. Whilst some evidence suggests that scientists from the DAs were routinely invited from early Feb there is a difficulty in resolving the reason for the lack of attendance. In this regard, one calling notice was disclosed following the end of the public hearings in M2 [**INQ000274126**]. We note that this notice was issued on 7 Feb 2020. The notice was not addressed to but was CC'd to the NI CMO (not the CSA). Whilst the subject line of the email identifies a meeting on 11 Feb the text of the invite identifies that the meeting was to be held on 4 Feb, suggesting that the meeting had already been held. The email requested acknowledgement of receipt and none has been disclosed. The late disclosure of the calling notice and the absence of devolved witnesses in this Module who could give evidence on the issue prevent informed conclusions being reached at this stage about why there was no NI attendance at the SAGE meeting on 7 Feb, or until 29 March. Further consideration of this may be required in M2C. It is fair to note, however, that the belatedly disclosed material raises as many questions as it answers.

238. The calling notice was disclosed alongside a witness statement from Dr Hayden of GO-Science [**INQ000274125**]. His evidence identified the February calling notice and then notes that the first attendance from NI was on 29 March. It does not suggest any steps were taken to clarify why no one from NI was attending during this crucial period despite being invited. In the closing oral statement on behalf of GO-Science it was suggested that the lack of attendance was the responsibility of the DAs: "... *it was for the Northern Ireland Executive and departments, in common with their colleagues from other devolved administrations, to decide how and when they chose to attend SAGE meetings to which they were most certainly invited*" [**35/25/19-25**]. Whether or not the failure to attend was a failing of the DA or a devolved actor (and this will require consideration in M2C), this washing of hands by GO-Science suggests a failure to appreciate that the absence of an NI voice was likely to cause detriment to the pandemic response in NI, and hindered SAGE in providing informed advice, and that

for both reasons it should have been considered an issue that required to be proactively resolved. The failure of GO-Science to appreciate this, and to take steps both to identify whether their invitation was adequate and/or received by the relevant individual and why there had been no attendance in response to fourteen separate invites at a crucial point in the pandemic, amounts to a failing in itself. It is suggestive of a lack of concern about the detrimental consequences of non-attendance. Notably that detriment was most likely to be caused to the people of NI.

239. A further glaring example, addressed in detail below, was the failure of SAGE to adequately consider at an early stage that NI formed part of a separate epidemiological unit and to address how this should be factored in to pandemic response.

240. Similarly with respect to NPIs, modelling informed the decisions taken and the measures implemented. However, it appears that NI was not considered in the modelling advice provided to SAGE and the UK Government. Prof. Medley stated in his evidence: "*The nation that I didn't really have much involvement with at all is NI. I think right at the beginning or early in the epidemic it had been suggested that I have a call with the CMO for NI, but that I don't think ever transpired. So, yeah... I'm not very proud of that, it didn't happen... I didn't have sight of what Northern Ireland were doing in terms of modelling*" [**8/92/11-21**].

241. The Co-Chair of SPI-B, Prof. Rubin, also admitted to a lack of knowledge about NI and information required to make informed conclusions for pandemic response. He accepted, in the context of knowledge of the rules and messaging for the devolved nations, that those in NI indirectly received messaging from the Republic of Ireland. When asked whether this presented a challenge at all he accepted that he had "*gone over the limits of my understanding of the messaging in Northern Ireland*" [**12/108/21-12/109/4**].

242. At its highest, consideration of NI specific issues was expressed by Prof. Rubin as follows: "*We did have observers from each of the DAs who attended the group sessions. Occasionally they would voice issues about, you know, "we don't think that would work in NI for example, because we have a different community set-up that you haven't considered*" [**12/27/1-11**]. While this reinforces the conclusion that geographic expertise was necessary for an informed response, the failure to proactively pursue the involvement of an NI representative on SAGE, SPI-B and SPI-M-O, suggests a lack of concern for how the absence of such a representative could hinder detailed scientific analysis, as well as the NI response. Whilst that latter issue may have been a matter for the NI Executive it should also have been a matter of concern for the UK Government and for those advising them. That concern is reinforced by the apparent lack of knowledge about the situation in NI by the Chairs of SAGE sub-groups.

INQ000399534_0057

We note that neither failing appears to have been appreciated at the time nor is even now accepted by GO-Science. We consider that the inquiry should make clear that this was a failing and recommend that proactive consideration is given to the benefits of geographic diversity of representation on SAGE in any future pandemic.

Detrimental consequences of the above in practice

243. Evidence suggests that the above issues led to detrimental decisions and responses to the pandemic in practice. Perhaps the most serious example of such a failing on the part of Central Government was the Anglo-centric bias in relation to the availability of funding for pandemic response. Mark Drakeford describes how Wales likely would have gone into lockdown sooner in Oct 2020 but delayed due to the absence of financial support from the UK Government. He notes that the then Chancellor "*refused to fund the consequences of a public health decision taken in Wales.*" This contrasted with the situation when a similar set of measures were adopted in England. Mr Drakeford notes his view that HMT "*was, in effect, acting as a Treasury for England, not a Treasury for the UK*" [**INQ000273747/40§136-9**].

244. Two points arise. Firstly, this clearly has the potential to undermine UK cohesiveness. Secondly, it suggests that DAs have good reason to be wary of proposals to implement a single UK pandemic response, dictated by Westminster.

III. THE UK AS TWO EPIDEMIOLOGICAL UNITS

245. A glaring omission in M2 has been the failure of the Government to seek, or SAGE to provide, any scientific advice about the fact that the UK did not form a single epidemiological unit. This cannot be regarded as a minor oversight. Evidence to the Inquiry repeatedly highlights the importance of this reality for those in NI. By way of example, the NI CMO identified at an early stage that the fact of being on a separate island was a relevant feature which required consideration for the response, messaging his fellow CMOs on 10 March 2020: "*I not only have to secure UK wide agreement re timing but North/South otherwise we risk mixed messaging and confusion…social distancing messages, timing of introduction and consistency across these islands... is absolutely essential for me*" [**INQ000282744**].

246. The difficulties which resulted from not taking into account the land border on the island of Ireland were and are obvious. They were identified by an independent SAGE report in May 2020, which noted one lacuna which resulted from this reality, and suggested: "*it makes much more sense either to treat the two main islands of Britain and Ireland as separate entities for human health purposes, as is already the case for animal health, or for the UK and Republic of Ireland to agree a common approach*" [**INQ000249693/6;20-21**].

247. Witnesses repeatedly accepted this epidemiological reality; however, it seems that this issue was not considered by the scientists advising the UK Government, possibly because it was considered too politically difficult. On being asked whether it would have been better for the UK and Ireland to agree a joint approach, or to treat the two islands as separate entities as they were for animal health, Prof. Whitty did not provide a view, and further insisted that it was proper that SAGE had not advised on this question, on the basis that "*the alignment of Northern Ireland with Great Britain or with the Republic of Ireland is one of the most politically difficult areas in UK politics*" [**24/95/9-17**].

248. It is not disputed that the answer to this question may raise political issues when considering how to implement a response, but the question of epidemiological principle as to how best protect the residents of NI was in fact a scientific question. As noted in our opening, that point was made in the statement of Prof. Medley [**INQ000260643§12.5**], where he observed: "*(P)andemics do not respect national or sub-national boundaries. A global failure was not to have international co-operation and concerted strategies to agree a common approach.... The situation in Northern Ireland is particularly complicated and complex given the border with Eire means that a country outside of the UK has particular influence on the UK's epidemic. Having a co-ordinated and concerted approach to the next pandemic would improve strategy development.*"

249. The omission on the part of SAGE to identify this issue and to provide advice about it amounted to a stark failing, which ensured that the approach to the pandemic in NI by Central Government was not based on informed scientific advice on how best to protect those in the jurisdiction. Whilst the failing lies primarily with the UK Government, which ought to have actively considered the epidemiological reality and sought advice, it also appears, from the testimony of Prof. Whitty, that SAGE was influenced by the political difficulties that the answer to these questions may cause, and deliberately stayed away from the issue as a result. From the perspective of the citizens of NI, this ostrich approach is simply not good enough. The politics of the matter should not have influenced SAGE in this way. The failure of SAGE to advise on this issue makes it difficult to suggest that the approach followed was one which purported to simply "*follow the science*".

250. The failure to obtain informed advice about how best to address this reality may have resulted in a lack of prioritisation or political will in coordinating with the Republic of Ireland. On 20 March 2020, in a phone call between Simon Coveney (the Irish Tánaiste) and the Foreign Secretary, Mr Coveney suggested holding a BIIGC as a mechanism to involve all administrations (including DAs). The stated and obvious benefit of a BIIGC was that not only

North-South issues would be addressed, but also East-West [**INQ000075137/2§7**]. Notwithstanding that the UK Foreign Secretary expressly agreed that this, chaired by himself of CDL, was a good idea, there was no such conference held that year. That is despite the fact that it found support in repeated four nations calls [**INQ000226015/2-3; INQ000226017/2-3**] and in a meeting between the PM, FM and dFM [**INQ000226018**/1-2]. We have not identified evidence which would explain why this was the case, however this is suggestive of a failure to appreciate the significance of engaging with the Republic of Ireland together with the DAs to ensure a coherent pandemic response for those in NI. Again, it may be that it is the absence of evidence that is most telling here, as it suggests a lack of consideration of how important this was for the NI response.

251. A further detrimental consequence of failing to address this issue falls to be considered in the context of the instance by Central Government actors of a single UK message to avoid confusion. Ms Myles, the corporate witness for NICBFFJ, identified clearly the confusion which resulted from the failure to address epidemiological reality: "*there's no denying -- doesn't matter what political persuasion you are, we share an island with the Republic of Ireland and the rules and legislation set out in Westminster didn't really allow for the fact that we had a land border that... meant that in some cases, on, for example, the Derry and Donegal border, you could have a house on one side of a fence having to abide by one set of rules and legislations and yet the neighbours on the other side of that fence had a completely different set of rules. And then because of that you had people that were moving about through the two different regions for work purposes, social purposes, et cetera. It got so confusing at times for people, it was very hard for normal people to work out if they were abiding by the rules, which rules they were abiding by*" [**3/14/13-3/15/3**].

<u>Failure to consider important issues for pandemic response for devolved jurisdictions</u>

252. The failure to seek or obtain scientific advice about devolved issues was not solely linked to those questions which were politically difficult. In some cases, it appears that the issue was simply not considered at all. One issue where this is apparent is in relation to test and trace at an early stage of the pandemic.

253. By mid-Feb, SAGE had identified that capacity for community testing on the part of PHE would run out in 2-4 weeks, and that is in fact what happened. However, it appears that consideration of test and trace, to the extent it was considered, was limited to PHE. The importance of testing is addressed elsewhere in this submission, but a further significant aspect of SAGE advice, at least at this stage of the pandemic, is that there is no reference to the situation in NI at all. There is limited evidence before the Inquiry about test and trace in NI

and this will no doubt be considered further in M2C, however the Technical Report states that NI only initially had "*a short pilot project involving contacting a sample of people who had a confirmed positive test result before a full operational contact tracing service was implemented from May 2020*" [**INQ000130955/218-9**].

254. Given the importance of test, trace and isolate for dealing with the pandemic, we suggest that the failure to SAGE to identify with clarity the position in each of the devolved jurisdictions at an early stage amounted to a failing in itself which would necessarily have prevented an informed response. There is no expression of concern in early SAGE minutes about the lack of a comprehensive system in NI.

255. This issue is not to criticise SAGE alone. The advice they provided was sought and considered by Central Government. There is no evidence of any questions being directed to SAGE by Central Government Ministers, civil servants, or political advisers asking whether the position on testing was the same for the DAs. It appears that they were simply not considered significant enough to consider.

256. The failure to consider the difference between the devolved jurisdictions also appears to have resulted in advice which was not entirely comprehensive. The evidence about mass gatherings provides a good example for how decision-making failed to take into account the particular circumstances of the citizens of NI, and how the geographical and epidemiological reality may mean that divergence in decisions was appropriate. The basis for the SAGE recommendation that there was no benefit to banning mass gatherings was explained by Prof. Noakes, and it is the reasoning rather than the conclusion, which is significant for those in NI: "*lets say you go to a football match, its unlikely that you're going to have transmission from someone sat on the other side of the pitch to you, its more likely to happen very close to you. I think where the mass gatherings perhaps do pose risk is that people travel to them, so they will travel in coaches or all together, so there's risks in there. They will perhaps stay overnight in places, and will perhaps as part of that go and visit pubs and restaurants. So its likely that the activities alongside the mass gathering that pose more risk than the mass gathering*" [**13/29/1-21**].

257. It will, or should be, apparent that the concerns about the risks associated with mass gatherings clearly apply to those travelling from the island of Ireland to a mass gathering in Great Britain. That suggests there is a different level of risk associated with large numbers of people travelling from NI to GB to say, attend a football match, with an overnight stay, necessarily eating in restaurants and quite likely socialising in a Liverpool pub, than there is to a Liverpool fan travelling locally to and from the stadium to watch the match. It is not clear

INQ000399534_0061

that this was given any consideration by either SAGE in their advice or the UK Government in their decision-making.

258. Despite what was said by Prof. Hale, noted above, about delays in banning mass gatherings resulting in more detrimental pandemic outcomes, it has been suggested that this decision did not matter in practice for Great Britain. By way of example, Prof. Ferguson said he agreed that permitting mass gatherings in the UK in March 2020 was like throwing a lit match upon a fire, based on reasoning that the virus was already established in the UK, so there was no difference in permitting a single mass gathering to take place [**11/148/24-11/149/4**;**11/148/3-13**]. However, it is not at all clear on the evidence that this reasoning properly applies to NI. The concern about this is that the mass gatherings in question, a Liverpool Atletico Madrid football match, the Cheltenham festival, were events that attracted significant attendance from NI and the Island of Ireland. On 9 March 2020, 36 people tested positive in England, bringing the total to 280, and there had been five deaths. In NI there had been 12 positive cases in total and no deaths. The analogy of a lit match on a fire appears misplaced for NI. Rather it appears that geographical and epidemiological reality was not considered either at the time of this decision, or when assessing its consequences. Consistent with Prof. Rubin's observations about DA contributions benefitting SPI-B with geographic expertise, the presence of a representative from NI may have ensured that the circumstances of NI were considered and addressed in the advice on mass gatherings.

Did the UK Government respect and value its devolved partners?

259. The fact that issues around infrequency of meetings and lack of prior communication were repeatedly raised with members of the UK Government, and yet their concerns were not addressed, suggests a lack of respect and a failure to value the contribution of its devolved partners. Nowhere is this as clear as in Boris Johnson's first witness statement, which appears in turn to misunderstand, insult, patronise and underestimate the DAs.

260. For one, Mr Johnson appeared to be confused as to the appropriateness of his own intergovernmental engagement within the UK constitutional settlement. In his witness statement, he suggested that it is: *" It is optically wrong, in the first place, for the UK PM to hold regular meetings with other DA First Ministers, as though the UK were a kind of mini EU of four nations and we were meeting as a 'council' in a federal structure. That is not, in my view, how devolution is meant to work"* [**INQ000255836/45§188**]. Prof. Henderson noted that *"parity of esteem"* tends to be a metric upon which academics rate the strength of mechanisms and organisations for implementing intergovernmental relations and yet, in this case, Mr

Johnson is saying "*…parity of esteem is not a goal. In fact I find it distasteful because it implies that there is parity of esteem. I don't believe there is*" [**5/166/18-5/167/2**].

261. Mr Johnson suggested that perhaps he could have "*tried to spend more time with the DAs and really tried to bring them with me*" [**31/155/15-21**], although described doing so as "*constitutionally a bit weird*" [**31/156/5-8**]. Not for the first time, he appears to inadequately consider the basic principles underpinning good intergovernmental relations in the UK.

262. The second reason given by Mr Johnson to explain the decision to delegate DA meetings was that he "*was conscious that* [he] *tended to be a particular target of nationalist ire*" and so "*rather than provoking the SNP*", he "*wanted to mollify and gain consent*" [**INQ000255836/45§189]**. Other comments by Mr Johnson include that the DAs needed to be "*handled with care*"; which Mark Drakeford notes: "*betrays a cast of mind. It appears to me that his thinking, as the then PM of the UK, was not that the UK Government needed to co-operate effectively with the devolved governments as equal partners who should be properly involved in decision-making, but that they had to be handled with care like a set of unruly, unreliable adolescents whose judgments were flawed*" [**INQ000280190/5§16**].

263. Similarly, Mr Johnson's comment that there was a risk of the Devolved Governments being "*different for the sake of being different*" (§153), echoed by Mr Gove [**INQ000259848/80§178**] and Mr Raab [**INQ000268041/66§228**] indicates an expectation that the DAs would follow blindly where the UK led, even in circumstances where they were not being provided with full information or rationale for interventions. It also assumes, wrongly, that decisions made at a UK level were generally right and worthy of adoption; the evidence in M2 shows this was far from the case.

264. M2A-C will consider specific decisions made by the DAs relating to the imposition or non-imposition of non-pharmaceutical interventions. What is clear on the basis of the M2 evidence is that the epidemiological reality of the UK required clear, regular communication, coordination and careful consideration of where converging or complementary policies *were* required in order to stop the spread of the virus. This did not happen.

265. Evidently, different crises call for different modes of intergovernmental work and communication, and there may be no standard formula that is appropriate in all cases, but it is clear that, to work, there must be mutual respect, openness and a commitment to genuine cooperation. The "*culture*", or as Prof. Henderson comments, the "*spirit*" matters: *"The existence of fora on paper matters little if they are not called into session, or have a limited approach to information sharing, or where voices are excluded"* [**INQ000269372/42§129**].

266. As Nicola Sturgeon said in her witness statement: *"…no structure will be effective unless it is underpinned by parity of esteem and mutual respect between the four nations - it is this which is too often lacking in the UK Government's interactions with the devolved governments. In answer to the second question, my view is that COBR would be the best structure to use in any future pandemic. However, to be effective, the Scottish Government and other devolved governments require to be there as full participants and decision-making partners, with access to the same information and advice as the UK Government, rather than as mere observers as it has sometimes felt"* [**INQ000235213/14§41**].

Civil Contingencies Act

267. In light of the above, it is important to address one proposal which has given our clients concern, namely the suggestion on the part of a number of witnesses, most notably Boris Johnson, that the UK response should have been bound together as one, under the Civil Contingencies Act [**INQ000255836/37§155**]. It is notable that Mr Johnson resiled from that view in oral evidence [**31/154/10-12. See also 32/110/1-9**], however given the concerns that the proposal causes to those we represent, and the views of a number of witnesses that divergence was not helpful, it is necessary and appropriate to address this suggestion.

268. At the outset we note that, despite appearing his written statement being provided only in August, Mr Johnson apparently disagreed with important aspects of its contents in relation to devolved issues by the time of his oral evidence in December. By way of example, in his written statement he dismissed the suggestion that he should have tried harder to bring the DAs with him **[INQ000255836/37§157]**, whilst in his oral evidence he suggested that he should have tried harder [**31/155/15-19**]. The resonance with criticisms of *"trolleyism"*, addressed above, is striking. Similarly in relation to the Civil Contingencies Act suggestion, he said that he no longer supported the view expressed in his statement, having (apparently belatedly) listened and accepted the views of others.

269. There are fundamental problems with the proposal for a binding pan-UK CCA. Most obviously, the fact that NI formed part of a separate epidemiological unit necessarily meant that at times a different response would be necessary and appropriate. While Prof. Medley identified that there may be difficulties when neighbouring jurisdictions diverge, this risk is not solved for those in NI by adopting a single UK-wide approach, given NI's land border with ROI.

270. Furthermore, despite the fact that the pandemic response was not bound together, the above submissions identify concerns that an Anglo-centric approach was in any event adopted by both Central Government and SAGE, that the DAs interests were not considered, with

deliberate steps not to involve them in decision-making. There is no reason to believe that these concerns would be addressed should Central Government hold complete control over a one-size fits all pandemic response, rather the reverse. It is also striking that this proposal finds little support among the DAs [**INQ000273747/57§200; INQ000255838/48§180; INQ000235213/29§92**].

271. For these reasons it is suggested that the Inquiry should make clear that a single one-size-fits-all approach to the pandemic, dictated by Westminster, would not have been appropriate and would not be recommended in any similar future pandemic.

Conclusion

272. As noted at the outset, fully informed submissions on a number of issues will require to await the evidence and hearings in M2A, B and C. However, we consider that the following failings were apparent in the Central Government response in the context of M2.

273. There were flaws in the Central Government approach to devolved jurisdictions and issues in the pandemic response. Many of these stemmed from the desire of the UK Government to impose a one-size-fits-all response on the UK. This was a political rather than a public health decision and was fundamentally flawed in practice. It also resulted in Anglo-centric decision-making and communications.

274. Consistent with this political preference, decisions were taken to exclude the DAs from decision-making, and to include them in meetings where they were simply informed of decisions taken. This did not respect the constitutional position, which gave the DAs important powers to respond to the pandemic. It also amounted to a failure to appreciate the importance of including locally elected representatives with important responsibilities for responding to the pandemic and for protecting the health and lives of those they represented. In turn this failed the people of NI, Scotland and Wales.

275. There was also a failure on the part of SAGE to appreciate the importance of devolved involvement in the decision-making process, or to consider devolved issues when advising the UK Government.

276. It is important to avoid such failings in future. It is therefore respectfully suggested that a one-size-fits-all solution should not be imposed in response to any future pandemic. Instead DAs should be involved in decision-making in an established mechanism which respects the power they hold and which recognises the benefits they can bring to pandemic response.

There is also an important need for the involvement of devolved jurisdictions in the scientific advice provided, including particularly by an entity such as SAGE.

277. NICBFFJ look forward to fully supplementing these conclusions and proposed recommendations following the conclusion of M2C.

IV. THE ENGLISH REGIONS

234. The treatment of the DAs chimes with the experiences of those in regional and local Government. They experienced the same "*bad faith*" approach from Central Government. Councils already faced a bleak picture going into the pandemic after a decade of austerity and the impact on resilience and preparedness. In M1 the Inquiry heard that local authorities had their core funding reduced by £15bn from 2010 to 2020, a decrease in spending of 26% [**M1/19/127/22-129/3**]. The "*significant financial pressures*" meant that less money and time could be spent on pandemic preparedness [**M1/19/77/20-21**].

278. As expert Gavin Freeguard notes, a decade of "*hollowing out*" of Local Government was exacerbated by the lack of financial certainty for extra pandemic costs, along with a lack of trust from Central Government. He explains (citing a Blavatnik report): "*This meant local Government in England 'did not have the infrastructure, capabilities, data or governance frameworks to execute a localised approach effectively'*" [**INQ000260629/45§88**].

279. Against this extremely challenging background, instead of supporting councils to deliver the local response to the pandemic, Mark Lloyd, Chief Executive of the LGA tells the Inquiry there was a failure by Central Government to engage on key issues and decisions. This delay "*affected the design of schemes of very great importance to the community at large, for example, shielding... and contact tracing*" [**INQ000215538/8-9§25-26**].

280. There was "*considerable frustration across local Government that neither the LGA nor councils had advance notice of decisions on amending, extending, or ending the use of NPIs*" and "*councils would typically only become aware... when they were announced at the evening press conferences*". As a result, councils had no better information than the public. This undermined their ability to deliver crucial public health messages and many contacted the LGA seeking guidance from Government or more information [**INQ000215538/46§126-128**]. According to Sadiq Khan, "*the approach taken by the Government was consistently characterised by three key things - one of which was "an absence of engagement with regional and local leaders on decision making*" [**INQ000221436/76§350**].

281. These failures were likely attributable to a culture in Central Government which tended towards "*big announcements*" made "*prior to conducting meaningful dialogue both as to the merits and practicalities of implementation*" [**INQ000215538/41§117].** It is perhaps no surprise therefore that, according to Alex Thomas, the pandemic "...*exposed serious problems"* in the working between Central and Local Government **[INQ000236243/36§129].**

282. Communication was so poor that on 10 May 2020, Nicola Sturgeon warned the UK Government that *"leaders should not be reading each other's positions in the newspapers*" [**INQ000221436/36§228**]. Sadiq Khan shared her frustrations; *"discovering stuff in the media"* was a common theme, as was things *"being said in... newspapers that we either hadn't agreed upon or hadn't said*" [**26/79/9-19**]. Mr Johnson accepted in his evidence that "*there was generally insufficient information given to local leaders"* [**31/161/2-15**].

283. Andy Burnham gave examples of the practical consequences of the Government's failure to consult him on decisions affecting the region, such as the announcement of a testing site at Manchester Airport, which was difficult to reach for many GM residents. This was a simple point that he could have explained had he been asked [**26/116/19-26/117/2**].

284. As with the DAs, Mr Burnham received "*zero consultation*" or notice of the change from *"Stay at Home"* to *"Stay Alert"* in May 2020 messaging, despite high case rates in GM at the time [**26/121/22-26/122/18**] and received minimal notice of the imposition of local restrictions on household mixing on 30 July 2020. The short notice of the changes meant that it was near impossible for the Mayor and his office to properly communicate the restrictions to councils and members of the public. After Mr Hancock announced the changes, Mr Burnham was "*absolutely inundated"* with questions of whether GM residents could go to work the next day. Yet, he had received no guidance [**26/129/19-26/131/10**].

285. Steve Rotheram described how, in late Jan 2020, he found out on the news that individuals had been repatriated from Wuhan and sent to Arrowe Park Hospital on the Wirral [**26/166/20**]. Echoing the evidence of Mr Lloyd, he learnt of nearly every major Government announcement on the TV [**26/170/17-22**; **26/166/7-17**]. This posed obvious problems in the preparation for major changes and the ability of regional authorities to communicate rules and important public health messages to their constituencies [**26/171/6-12**].

286. On one occasion, the Government carried out an exercise which considered the impacts of a major resurgence in cases within London, and the M25 being used as a quarantine ring. London's regional Government was not informed of or included in the exercise [**INQ000118961**]. Sadiq Khan was frustrated by a lack of trust and *"bad faith*", which contrasted

with his experience working on previous crises: "*If the Government under different PMs can trust me on issues to do with terrorism, counterterrorism and other issues, you'd think they'd be able to trust us when it comes to issues to do with a civil emergency*" [**26/79/24-26/80/11**]. As a result, Government missed out on *"advice from the coalface"* from Mayors, councils and other local bodies with a central role in the pandemic response.

287. One of the starkest consequences of the Government's approach was the failure to share crucial data. This became apparent to Mr Burnham in June 2020 when he found, in the context of stubbornly high case rates in Greater Manchester, that Directors of Public Health could not access data for positive cases. This was problematic because it was clear at the time that national contact tracing was not working [**INQ000216991/31§105**]. The Inquiry has heard that multiple requests for such data were refused [**26/124/19-26/126/13**].

288. Similarly, Mark Lloyd said councils "*were being told that there were positive cases in their areas but then they struggled to find out exactly who had tested positive*". This hindered their ability to ascertain who needed support to self-isolate, or with caring responsibilities. The failure to provide this information *"impacted councils' ability both to support people and to contain the virus."* [**INQ000215538/50§141-142**].

289. The Inquiry is invited to find, in line with the expert evidence of Gavin Freeguard, that: *"The UK Government was slow to share data with local Government during the pandemic, with the result that many parts of local Government in England did not have the data they needed... local Government was, according to one director of public health, 'effectively blind' at the start of the pandemic"* [**INQ000260629/44§85**].

290. Given the repeated complaints of inadequate engagement by Central Government; of a dismissive approach that failed to properly consider the voices of local leaders and the realities of the communities they represent, the Inquiry must consider these were systemic problems in governance. As Mr Khan said, *"I genuinely think fewer lives may have been lost had there been a more collegiate response... Poor process, poor judgement, poor decision-making"* [**26/82/16-26/83/3**]. CBFFJ UK and NICBFFJ families agree.

SECTION G: PHASE 2 OF UK RESPONSE; NOT LEARNING FROM MISTAKES

291. By easing restrictions at a time when there were still 500 new cases per day without sufficient capacity for testing, tracing, isolation and support, the Government turned an avoidable second acute wave into an *"inevitable"* one [**3/100/22-3/101/3; 10/160/23-10/162/6**]. The risk of the infection rebounding had been known from the outset of the pandemic. By 16 Sept 2020, the PM recognised that unless the Government took *"grip"* there would be *"more*

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deaths than last spring" [**INQ000146638/45**]. In our submission, the devastating scale of the second wave was clearly preventable [**INQ000260643/58§6.17c**]. As outlined by the Health and Social Care and Science and Technology Committees "*Due to the much higher transmissibility of the Alpha variant, in the absence of a test, trace and isolate system capable of arresting the spread of the virus, a circuit-breaker in Sept and an earlier, more stringent lockdown, would likely have reduced deaths"* [**INQ000075336/55§137**].

292. In our submission, relatively little attention has been paid by the Inquiry to the UK Government decision-making before and during the second wave in comparison to the initial response. CBFFJ UK and NICBFFJ families understand the need for the Inquiry to move at pace and hope it will explore more of the detail of the second wave in later Modules.

March – Sept 2020

293. In April 2020, a SAGE working group considering *"The science of exit"* from lockdown concluded that it would be preferable to manage the pandemic by maintaining low incidence of infection through NPIs until a pharmaceutical solution was achieved, in the hope that a good contact tracing system would allow for greater levels of social contact. As Prof. McLean explained, *"low incidence was preferable as we suspected that immunity might not be long lasting, and that there was not enough benefit from accrued immunity to counterbalance the detriment of running the epidemic hot"* [**INQ000309529/40§§131-136**].

294. As Prof. Edmunds suggests in his statement, the message of this working group was not heeded [**INQ000273553/64§10.12],** although Prof. McLean was "*pretty sure"* it was taken to Cabinet by Prof. Whitty and Sir Patrick Vallance [**25/67/9-12**]. Prof. McLean observes that the strategy that the Government in fact adopted post-lockdown was to keep R below 1, without taking a view about how many infections were tolerable. In her view, this demonstrated a lack of joined up thinking in Government upon exit from the first lockdown, because the aim of keeping R below 1 was "*only half a strategy"* [**INQ000309529/40§§136**].

295. On 19 May, Prof. McLean said in a press conference that if lockdown restrictions were to be lifted they needed to be replaced with another way to keep R below 1 (such as an effective TTI system) and that easing of restrictions should be based on observed levels of infection. A similar note of caution was expressed by Professors Whitty, Vallance, Van-Tam and Harries in a letter to Simon Case on 26 May 2020. Described by Prof. Whitty as an attempt to "*leave a mark in the sand"* the letter warned of a risk that a combination of small decisions could lead in aggregate to a significant risk of a return to exponential growth [**INQ000069418**]. Yet by 23 June Prof. Whitty was advising COVID-S that their proposed actions were *"high risk"* and they were *"treading the line between high risk and being foolhardy"*

[**INQ000238826/108§329**]. There was no attempt to learn about what worked by lifting restrictions in a phased way [**INQ000273553/65§10.13**].

296. By the end of July, cases were rising again; yet at the beginning of Aug, the Treasury launched EOTHO. As Prof. Edmunds said in his statement, the Government's handling of the pandemic was characterised by *"flip-flopping of policy objectives, from suppressing the virus to encouraging (even paying for) epidemiologically risky behaviour* [showing] *a lack of strategic thinking and planning"* [**INQ000273553/66§10.18**].

The tier system and the second lockdown

297. By Sept 2020, infections were rising at a worrying pace. According to Imran Shafi's notes, the PM opened a strategy meeting on 1 Sept 2020 by saying: *"walking a difficult tightrope – looks as though other countries paying price on infection rates. UK spared so far – but brace for it hitting us same way... cannot go back to the solutions of March... we need a new strategy; elements coming together"* [**INQ000146638/1**]. Around 11 Sept 2020, it became apparent to the PM that "*the grim history of March"* was repeating itself [**INQ000280061/153**]. The phrase "*fuck you DM* [Daily Mail]" also appears in a note by Mr Shafi, which confirms Sir Patrick's evening note is an accurate reflection of discussions at the time [**INQ000146638/27**].

298. Against this background, a scientific discussion entitled "*Should Government intervene now and if so, how?*" was held with the PM, Chancellor, Prof. Whitty and Sir Patrick Vallance on 20 Sept 2020. The Inquiry has heard a significant amount of evidence about this meeting, but it is submitted that the focus should be on the clarity with which Profs Edmunds and McLean presented the case for urgent action. In his summary, Prof. Edmunds explained the rapid increase in cases and said that "*a large package of interventions"* would have to be implemented to meet HMG's aim of keeping R below 1. The response needed to be *"fast and large"* and we should not make the same mistake as in March. Cases were increasing exponentially, and immediate action would have an *"enormous impact".* Any delay would result in far more cases [**INQ000137261/7**].

299. Prof. McLean's one-page summary reminded the reader that both the COVID-S operating scenario and the extant RWCS worked on the basis that decisive action would be taken in mid-Sept. She noted that numbers of new infections, hospitalisations and deaths were close to the RWCS and under current trajectory *"hospitalisations will increase exponentially, surpassing the first wave by early Nov".* The paper concluded that "*Without immediate, decisive action we expect COVID epidemiology to breach the RWCS in the next few days. It will then exceed HMG, T&T and NHS planning assumptions. T&T will not function effectively in a large second wave"* [**INQ000137261/13**].

300. It is difficult to see how much clearer the advice could have been at this stage, yet, instead of *"following the science"* and imposing the circuit breaker and package of NPIs proposed at SAGE 58, the UK Government opted for the Rule of 6; seemingly to appease the UK press and backbenchers [**32/95/24-32/100/17**]. The Inquiry will recall the evidence of Profs McLean and Edmunds on this meeting and in particular Prof. Edmunds' simple statement that *"I didn't manage to persuade them"* [**13/139/18**]. For Prof. McLean, the consequence of the decision not to implement a circuit breaker was an increase in deaths [**25/105/14-22**].

301. In our submission neither Mr Johnson nor Mr Hancock have satisfactorily explained their reasoning for deciding not to follow the advice of SAGE for urgent and decisive action. Mr Hancock said that he did not support the 17 Sept proposal for a circuit breaker because it would "*only delay the problem*". However, this fails to address the consistent advice from SAGE that a stringent package of measures was needed and that some restrictions would be necessary for a considerable time (at least through the winter) [**INQ000061566/1-2**].

302. In a COVID-O meeting of 11 Oct 2020, Mr Hancock noted that "*the number of hospitalisations per day was greater than it had been in March at the height of the pandemic*" and some areas were running out of ventilated bed capacity [**INQ000090163/5**]. On 14 Oct, the Government implemented the tier system in England. As with the rule of six, no advice was sought from SAGE as to the epidemiological implications of the policy before its introduction. On 11 Oct, Prof. Whitty and Sir Patrick had advised that unless local leaders decided to go much further on level 3 the proposed baseline package was unlikely to reduce R below 1. This advice was echoed by the PM himself [**22/158/13-19**]. Matt Hancock confirms that he was aware at the time that the tiers system as it was introduced was not enough to keep the R below 1 [**29/215/22-23**]. Sir Patrick described it as "*a massive abrogation of responsibility"* [**INQ000273901/220**]. Profs Edmunds and McLean described this iteration of the tier system as *"epidemiological levelling up"* [**13/140/8-10; 25/109/23-24**]. Sir Patrick noted on 12 Oct: "*PM trying to explain things in HoC. How to explain "we recommend Tier 3 but don't believe it will work"!"* [**INQ000273901/223**].

303. Mr Hancock states that on 12 Oct 2020 he *"was in despair that we had announced a policy that we knew would not work*" [**INQ000232194/138§539**]. The bereaved families ask: why did he then go along with the policy? He referred to fears about opposition by Conservative MPs to another national lockdown [**30/5/12-20**] and it is clear, for those around him, that there was a related desire to avoid imposing restrictions on Conservative voters for the sake of those in urban areas with higher rates of Covid-19. For instance, Nadine Dorries sent Matt Hancock a WhatsApp on 20 Aug 2020: "*We can't put whole towns and villages with*

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extremely low R rates in lockdown (our voters)... bcse of the behaviour of non compliant communities... It's political." Matt Hancock simply replied: "*we can impose*" [**INQ000164677/1-2**]. It is striking that a Health Minister, in conversation with the Health Secretary, thought it appropriate to frame the response to an imminent second wave in terms of how actions might impact on their electoral hopes, rather than a bid to reduce infection and prevent the loss of life. This exchange reflects the political considerations of Ministers as they resisted a further lockdown.

304. Predictably, as tiers were implemented, friction and setback ensued. Announcements were made with little notice to local leaders [**26/177/5-12**], and negotiations conducted in a chaotic fashion [**26/130/7-12**]. On 15 Oct 2020 Kate Josephs, then Director General of the Cabinet Office Covid-19 Taskforce, discussed the status of negotiations with Greater Manchester and local authorities in Lancashire with Henry Cook, No.10 SPAD: "*A few districts with mental labour leaders are holding out. I've told them If they don't all go all money off the table and we may have to go for harsher restrictions. They have until 8am tomorrow and then we give up… This is a fucking stupid strategy*" [**INQ000226310/9**].

305. The Inquiry has heard of local leaders 'holding out' on further restrictions because they did not feel they were getting the financial support they needed. Mr Burnham, for example, described finding himself in a position whereby severe restrictions were being imposed without a financial package sufficient to "*prevent a winter of real hardship and homelessness in the region*" [**INQ000216991/29§97**] at a time when the Government's own health experts could not confirm the restrictions would be effective [**26/143/23-25; INQ000216991/28§95**]. When those criticisms were put to Mr Gove, he merely commented: "*I think it was broader than just Manchester in the way it was flawed*" [**27/137/21-22**].

306. The Inquiry has also heard evidence of pressure from other local leaders and the members of the Government's own Party not to impose tighter restrictions in their respective areas [**32/64/4-10 and INQ000273901/315**]. Conversations which took place within Government at the time suggest that negotiations with local areas were viewed as an opportunity to "*win*" against political opponents rather than ensure areas were given sufficient resource to effectively implement the changes without financial hardship. For example, Jack Doyle described "*going to war with Burnham*" in a WhatsApp group which included David Frost, Dominic Cummings and others [**INQ000226277/46**].

307. The Inquiry has been told that the back-and-forth between local leaders and Central Government caused delay [**30/7/18-25**]; and the failure to impose measures 'early', 'hard' and

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'broad' enough opened the door to rising infection and higher prevalence in areas where it might have remained low had there been a targeted system of TTI [**22/136/2-14**].

308. Meanwhile, those in Government were preoccupied with political gameplaying; when the GM negotiations failed, in a WhatsApp group which included key No.10 and CABOFF figures, discussions took place as to how any further financial support might be provided in such a way as to give the six Conservative Greater Manchester MPs "*a win rather than Burnham*". Photo opportunities, press engagement and a potential visit from the PM were discussed and Declan Lyons messaged; "*We have let Burnham whack us about on this stuff for 10 days so we need to do something pretty dramatic to wrestle the narrative back and give our folks a win*" [**INQ000226277/48**].

309. Mr Johnson accepted that there was generally insufficient information given to local leaders in relation to local restrictions and the imposition of tiers [**31/161/7-13**]; the introduction of restrictions in particular areas was often delayed; the general public found it confusing [**INQ000255836/148§529**]; and, ultimately, tiering did not work effectively [**INQ000255836/196§676].** It is therefore staggering that he concludes in his witness statement: "*At the time I think we were right to try it*" [**INQ000255836/148§530**].

310. Despite the improvements in data about which the Inquiry has heard, the UK Government again failed to act decisively and competently; and the UK was again forced into lockdown in Nov 2020, described by Prof. Edmunds as *"a panic decision"* with *"no real strategy, no long-term thinking*" [**13/143/20-144/1**]. In his evidence, Sir Chris Wormald attributed the delay to *"disagreements about the right strategy"* [**17/151/11-17/152/14**].

311. Given the compelling evidence that the available scientific advice was that the tiering system *would not* work, *why* was such a misguided approach announced? Having seen the horrific consequences of the first wave, those who lost loved ones ask: why would the Government risk losing control of the virus once again? As Michael Gove accepted, the tiering system *"overall was inherently flawed*" [**27/138/7**] and "*it must have been obvious that there were very real severe flaws in its design and in its application"* [**27139/15-19**].

312. It is clear the Government response in this period contributed significantly to what Prof. Ferguson rightly called a *"catastrophic second wave"* [**11/185/18-186/4**]. Prof. Edmunds explained compellingly that there was *"no reason"* for 20-25,000 people to have died in the Autumn wave. In his statement, he described how the Government *"let this second wave happen"* and told the Inquiry *"we could have avoided much of the autumn wave".* Instead *"we entered the winter phase with our hospitals full, NHS staff having been under stress for*

months" [**INQ000273553/70§10.28; 13/141/9-142/20**]. Prof. Edmunds went further, saying that *"if we'd have been in a lockdown we might have stopped [Alpha] at source, when it first emerged"* [**13/145/9-15**].

<u>*The Alpha Variant and the Third Lockdown*</u>

313. Unlike the first lockdown, the second was neither long nor strong enough to bring R below 1 [**13/143/3-8**]. By the end of Nov 2020, it had become apparent that the incidence of infection in Kent was not reducing in line with expectations. So much was said by Mr Hancock in WhatsApps with Ms Whately when he asked the *"real question"*: *"why is the virus spreading so fast in kent?!"* [**INQ000176785/29**].

314. It is submitted that knowledge of the Alpha variant ought to be explored in the Inquiry's Module on testing and tracing. The Inquiry has received a number of statements which suggest that the UK Government first became aware of Alpha in Nov or Dec 2020, but it is apparent that it was known to PHE and Prof. Van-Tam in Sept [**INQ000153486/1**]. On 13 Dec 2020, Matt Hancock said he had heard about a sample dated 20 Sept; describing it as a *"total outrage"* that Prof. Hopkins had been *"tearing her hair out"* about it [**INQ000167435/6**].

315. Although it is often referred to as the 'Kent' variant, on 11 Dec 2020 Alpha was present in 42 Local Authority areas [**INQ000229917/2**]. Regardless of when the variant was identified, advice from DHSC cautioned, *"In light of this early warning signal, the public health recommendation is to act quickly, proactively and decisively"* [**INQ000234215/1**]. In our submission, that was absolutely necessary given the uncertainty and spread.

316. On 13 Dec 2020, Helen Whately told Mr Hancock, *"It's not at all clear to me how Kent's hospitals will cope over next few weeks"* [**INQ000176785/30**]. In an email to Sir Patrick on 13 Dec, Prof. Whitty said he did not think there was a *"full understanding"* by all involved *"that the London epidemic is almost certainly feeding the epidemic across the Southeast and East"* [**INQ000072141/1**]. It is submitted that local restrictions would never have worked if the epidemic was being fed by London; yet, Kent was not put into Tier 4 for another 6 days and there was no urgent move to reinstate a national lockdown. Moreover, it is apparent that Mr Hancock delayed telling Covid-O about the new variant for reasons unknown [**INQ000223544; INQ000167414/1; INQ000229920/2**].

317. The UK had watched China during Lunar New Year and witnessed Leicester following Eid; and yet, just as the PM headed to Chevening during Feb half-term, Ministers broke up for Christmas and the UK did not go into lockdown until 4 Jan 2021. It is submitted that during this period, the UK Government appeared more concerned about having a 'normal' Christmas

[**INQ000273901/309 and 313**] and 'getting Brexit done' [**INQ000095068/4**] than it was about saving lives in the face of a real and immediate risk.

SECTION H: NO DIGNITY FOR THE DECEASED OR THE BEREAVED

318. As nominally recognised in the draft guidance produced for local planners by MHCLG (now DLUHC), an integral part of planning should have been ensuring dignity for the deceased and compassion for the bereaved [**INQ000108395/4**]. However, as with much of the national guidance, while there was a bare recognition of this, there was a failure to take a person-centred approach which set clear and consistent standards and appropriately considered the cultural needs of different groups.

319. Communities and faith groups were not consulted on the impact of restrictions on burial rites and practices. For example, while there is generic guidance as to the limitation of funerals and burials [**INQ000108395/16§3.21**], there is no guidance at all as to minimum standards, when these measures should be considered, the known needs of specific groups such as observant Muslims and Jews, or particularly the importance of rituals in the grieving process and any guidance as to the potentially traumatic effect of some of the measures suggested, such as deferring or time-limiting religious ceremonies.

320. The Inquiry will recall the evidence of Catriona Myles from NICBFFJ, emphasising the integral role of wakes in the grieving process during funerals in NI. She shared the emotional impact of not being able to see her father in the coffin for the last time, stating: "*I just remember looking at that coffin and thinking to myself that could be a bag of potatoes in that coffin, how do I know what's in that coffin?*" [**5/11/15-25**]. Additionally, the distress caused by restrictions was evident in the experience of her cousin, whose father was laid to rest by hazmat-suited individuals at a designated time, without the presence of family members [**5/18/1-12**]. Jo Goodman of CBFFJ UK spoke of not being able to have a wake as part of her father's funeral and a 10 person-limit on attendees [**4/116/1-6**].

321. The failure of 'excess deaths' planning to produce national or local guidance and standards for the dignified treatment of those who died was highlighted through the evidence of Mark Lloyd in M1, who explained that the LGA had not been consulted at all in relation to the guidance [**19/139/11-14**]. He agreed that there was a need to implement a person-centred approach to excess death management and clear and consistent standards to help everybody, including Local Government, to understand the issues. He "*100%*" agreed that such guidance would need to consider issues of dignity such as specific post death rites for different communities and communication with the bereaved [**19/141/3**].

322. The lack of national planning and failure to consider the impact of death and loss on the bereaved has exacerbated their trauma from the deaths of their loved ones which, in many cases has compounded the grieving process. There was also a lack of consistency in the treatment of deceased and bereaved. For example, some family members had all their possessions removed and destroyed. Some of our clients experienced practices such as being timed for 15 minutes with a stopwatch at the grave of their loved one, and there was no consistency in funeral practices between areas.

323. The Inquiry's own impact films illustrate the horror and trauma experienced by the bereaved who were not able to properly grieve the loss of their loved ones; bereavement in these circumstances is qualitatively different from bereavement in 'normal' times. These were all issues that could and should have been foreseen and planned for and are clearly critical areas of learning for future pandemics.

RECOMMENDATIONS

324. The evidence heard by the Inquiry over the course of M2 has shown that the UK Government's response to the pandemic was wholly inadequate. Mr Johnson was the wrong PM for the Covid-19 pandemic. The crisis exposed his weakness and indecision, and the fractious, chaotic and dysfunctional nature of the administration around him. As Alex Thomas noted, "*Any organisation will be less effective if the person at its head does not provide consistency and clarity*" [**INQ000236243/27§86**]. When the next pandemic strikes, an entirely different leadership approach is required. The UK public deserves nothing less.

325. As it has exposed the personal weaknesses of individual political decision-makers, so too has the evidence exposed profound and longstanding deficiencies in the machinery of Government and systems for the management of public services. In that context, CBFFJ UK and NICBFFJ urge the Inquiry to make the following recommendations to address the profound and systemic dysfunctions exposed in M2:

No.	Recommendation	Relevant evidence
Resilience, public health, inequality and austerity		
1.	**Ministerial responsibility for disabled people should be held by a Cabinet Minister in the Cabinet Office.**	**[INQ000280035/27§90]; [5/67/1-68/22]**
2.	**There should be an audit of UK scientific and public health bodies and agencies to ensure that public bodies with a UK-wide remit are representative of the UK as a whole in the future.** This should include a review of observer versus full membership status on all associated bodies to determine if there is a need for greater participation from DAs and from individuals / organisations that represent people with diversity of lived experience.	[**INQ000269372/46§139-141,63§R4**]

3.	**There should be a 'data needs' analysis for each risk on the NSRA which sets out what data is needed to assess, prevent, mitigate and respond. This should be integrated into an overall civil emergency data strategy and published.** This should include consideration of which data will be required (including ownership and access), which datasets will need to be linked and how, who will analyse the datasets, and which datasets need to be created. This should include an urgent review of (a) access to and sharing of health and social care data (b) data collection capability across local government and (c) capacity within the DAs.	[**INQ000186622/7-8**]; [**INQ000260629/40§75**]; [**28/38/4–39/19**]; [**INQ000269372/46§R7**]; [**INQ000260629/50-51 §106**]; [**28/38/4–39/19**]
4.	**UK agencies tasked with emergency planning should commit to incorporating UK-wide data in their decision-making and communications and to gathering such data if it would not be gathered otherwise.**	[**INQ000269372/63§R8**]
Civil contingencies structures		
5.	**In line with the above, the Secretary of State for Resilience, supported by the relevant Permanent Secretary, should publish guidance setting out the model within government for pandemic planning and response.** This should include clarity in relation to the responsibilities held by permanent secretaries and other senior civil servants within the Cabinet Office and other departments for long term contingency planning, and structures to be employed during the emergency response. Provision should be made to ensure that all Tier 1 risks are responded to equivalently to ensure that natural threats or hazards are not treated differently to geopolitical threats; and guidance on the triggers for escalation to a centrally led response, recognising that this will not be exhaustive. The guidance should also address the role of special advisors and where, if at all, they fit in to the structures to be used. The guidance should be reviewed on an annual basis and the National Office for Resilience should provide independent Oversight.	[**INQ000236243/43 §142.10**]; [**23/164/4-17**]; [**23/169/24-23/170/15**]; [**28/212/2 –213/8**]; [**INQ000273841/26§46-47/27§48**]
6.	**Alongside the review of IGR, detailed plans should be produced for an oven-ready mechanism for a "four nations by default" approach to emergency planning and response using the JBC's structure and membership as a template.** Mechanisms should bring relevant actors into regular, sustained rather than ad hoc contact and a commitment to parity of esteem.	[**INQ000269372/63**]
7.	**There should be an independent agency - a 'National Office for Resilience' - which brings together research and knowledge, sets standards and provides training and independent advice to the Secretary of State, and local tiers.** The first task of this organisation should be to conduct an urgent review of the National Standards, in line with the concerns raised by the Independent Commission and opinions of Bruce Mann and Professor Alexander. The Office should report annually to Parliament. The inspectorate could be based in this organisation. The annual reports produced by the Office should specifically address capabilities to develop and scale-up key infrastructure at national and local levels, including on test and trace, isolation, financial support, PPE and hospital infection control procedures, including hospital building ventilation systems. The Secretary of State for Resilience and Civil Emergencies must respond to the report within four weeks to confirm the action being taken by government.	[**INQ000203349/190§21, 189/21,192§32,192§34**]; **[INQ000236261/4§3.3]; [INQ000174768/9§27]**
8.	**Ministers, their advisers and civil servants with relevant responsibilities should be trained in decision making under conditions of uncertainty, and civil contingency management.** MPs should receive this training on their first Ministerial appointment. Training should also be provided to all current Cabinet Ministers.	**[6/21/8-18]; [6/25/16-23]; [9/80/18-25]**
Pandemic response		
9.	**Test, trace and isolate capability and capacity, paired with early adoption of effective economic support measures, including financial support for self-isolation, should be pursued as soon as possible in order to keep community transmission under control.** The Secretary of State for Resilience must ensure that these capabilities and capacities are in place ahead of the next pandemic (and as soon as possible).	[**INQ000257925/14§27-15§30,38§69**]
10.	**For any emergency with UK-wide impacts, the default position should be that representatives for the devolved administrations are invited to attend meetings of COBR or other key UK-wide decision-making structures or mechanisms on a standing basis.**	[**INQ000269372/41§126-43§131**]

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11.	**Where an emergency has impacts on specific regions of the UK, the default position should be that representatives for regional authorities representing those areas are invited to attend meetings of COBR or other key UK-wide decision-making structures or mechanisms on a standing basis.**	[26/149/23 – 150/3]
12.	**The Secretary of State for Resilience should conduct an urgent update and refresh of data requirements.** The Government must share all the available data with local areas (including local and combined authorities) in as much detail as possible, ideally to patient level.	[INQ000260629/52§ 108]
13.	**Transparency in relation to the rationale and evidential basis for decisions should be the default. The Government should report publicly where they have and haven't sought scientific advice and if such advice was sought, how they responded.** Evidence, economic or scientific models, scientific advice (including SAGE minutes) and requests for advice should be published from the outset unless this is not possible for national security reasons. The confidence and, if applicable, limitations of the evidence base should be identified where relevant. Minutes should be taken by a recognised note-taker to ensure that they are accurate, comprehensive and that those who were not an attendee are able to clearly understand the contents.	[25/31/17-32/1]; [18/30/15-31/10]; [INQ000309529/49§ 164]
14.	**Cabinet Committees should not be chaired by the "responsible" Secretary of State in order that they can be questioned in relation to the performance of their departments.**	[INQ000236243/29§ 96]; [27/36/20-37/23]
15.	**The Code of Conduct for Special Advisers should be reviewed and strengthened. The Code should emphasise that special advisors are accountable to ministers, who are in turn accountable to parliament and the public.** Special advisors must not make critical decisions which have not been approved by ministers, or direct officials on the basis of views or priorities which are not representative of those held by the relevant minister. The Civil Service Code should provide that where officials have concerns that special advisors are not acting in line with the updated Code of Conduct, this should be reported immediately to the Cabinet Secretary, or in line with the process set out by a new Independent Complaints Scheme (recommendation 16).	[6/64/19-65/6]; [6/66/6-14]; [INQ000235593/7§2 9]; [16/143/24-144/17]; [[INQ000273841/11 §20]; [INQ000136755]
16.	**A new Independent Complaints Scheme should be introduced to investigate complaints against Special Advisors.**	[INQ000273841§20] ; [INQ000273872]; [INQ000162937]; [INQ000162938]
17.	**Representatives for the devolved administrations should be given full membership status of SAGE and should be able to commission advice from the outset.**	[INQ000235213/23§ 71]; [INQ000089720/122] ; [24/92/3-10; 22/152/16-17]
18.	**SAGE must have greater diversity of membership, ensuring pan-UK geographical representation and including practicing public health professionals and international experts.**	[10/82/24-83/4]
19.	**When advice from SAGE is transmitted to decision makers, this should include the 'consensus' view but also a 'minority report' to make clear to decision-makers the range of opinions.**	[9/80/9-13]; [10/34/24-10/35/5]
20.	**A member of the Independent UK standing scientific committee on pandemics (as recommended in M1) should generally attend inter-ministerial meetings relating to pandemic response.** This would help to avoid significant policy decisions, such as Eat Out to Help Out, being taken without the input or knowledge of scientific advisors.	[INQ000273553/66§ 10.18]; [24/63/1-25/64/1-4]; [22/156/10-22/157/5]
21.	**A statutory requirement for Government to report to Parliament and to the public whether and when they have been alerted to an incoming threat or crisis by a standing scientific committee on pandemics.**	[31/70/2-6]; [31/75/23-31/76/3]; [31/61/1]

22.	**Government should (1) continually monitor and adapt policy interventions during a pandemic and (2) monitor and incorporate best practice by other countries in its pandemic response.**	**[16/157/1-9]; [INQ000221436/20§ 89]**
23.	**Government must assess the two-way impact of the economic policies on health of the population and the impact of the health of population on the economy.** This would ensure decisions made in a pandemic explicitly assess policies aimed at protecting public health (e.g. NPIs) in relation to their impact on the economy (e.g. reduced acute and long-term sickness rates etc). When considering the impact of NPIs (such as lockdowns), assessment of mental impacts should also include negative impact on mental health of bereavement.	[**INQ000309529/49§ 164**]
24.	**Ethnicity (as has been self-identified by the person who has died) should be recorded on death certificates.** Consideration should also be given to whether other relevant information, including immigration status and protected characteristics such a sexual orientation, can be recorded.	[**26/78/16 - 18**]; [**25/ 191/21-192/24**]; **[34/181/1-17]**
Institutional culture		
25.	**Government decisions, particularly in relation to the assessment of potential impacts, should be considered, debated and recorded with a more consistently formal process, brokered and coordinated by the Cabinet Office.** Where informal mechanisms such as Whatsapp are used for relevant or related discussions, the decisions reached, individuals involved and rationale should be summarised and documented using formal processcties and captured on government systems. Responsibility for this in relation to key decision-making rests primarily with private offices, but is shared with all officials, SPADs and Ministers. Ministerial communications in relation to government business should only take place via authorised devices which should be secure, backed up and subsequently accessible to authorised persons. Relevant records should be stored on a secure system backed-up by HMG IT. Disappearing message functions should not be used for WhatsApps relating to government business, and messages should not be deleted manually. Government guidance as to the use of non-corporate communication channels (e.g. WhatsApp, private email, SMS) for government business should be updated to reflect these expectations.	[**INQ000236243/28§ 88-91**]; [**INQ000236243/43§ 142.9**]; **[9/73/1- 74/11]**
26.	**Intergovernmental relations should be founded on a principle of mutual respect and parity of esteem. In the context of a UK-wide emergency, in line with the plans at recommendation 6, above, representatives for the devolved administrations should be informed in advance and consulted in relation to any decisions or announcements affecting the nations they represent.** Emergency planning and response to be viewed as an instance of inter-governmental relations rather than separate from it.	[**INQ000269372/63**]
27.	**Overall accountability for intergovernmental relations lies with the Prime Minister, the First Ministers of Scotland and Wales and the First and deputy First Minister of Northern Ireland.** In line with the plans at recommendation 6 above, in the context of a UK-wide emergency, the Prime Minister and Heads of Devolved Governments Council should have regular, sustained rather than ad hoc contact. The First Ministers (and deputy First Minister in the case of Northern Ireland) should each have the power to call for a meeting of the Council.	[**INQ000269372/63**]

326. In Annex A we have distilled our key submissions to the Inquiry for ease of reference. In Annex B we provide a composite schedule of the submissions we have made in respect of the Chair's Recommendations for M1 and M2 to assist the Inquiry.

327. The time for change is now long overdue. We are living in a 'pandemic age' and can expect more frequent and complex pandemics. The major drivers of pandemics are features of the 21st century and are not going away. Institutional lessons learned during the pandemic

must not be forgotten. Failure which is not addressed will recur and more lives will be lost. CBFFJ UK and NICBFFJ urge those in Government who are participating in the Inquiry, or following the evidence, including those who have been forced to reflect on their own failings and limitations, to act now to learn lessons and to adopt the recommendations contained within these submissions. It is obvious on the evidence heard that change is urgently needed. There is no time to spare.

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15 January 2024

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

Covid-19 Bereaved Families for Justice UK and NI Covid-19 Bereaved Families for Justice
M2 CLOSING SUBMISSIONS
ANNEX A: SUMMARY OF KEY SUBMISSIONS

SECTION A: KNOWN RISKS AND INEQUALITIES

1. The UK's response to the pandemic was undermined at its outset by pre-existing and known weaknesses.
2. The lack of adequate planning, structures, capacities and capabilities meant that the UK entered into the pandemic in a state of poor resilience and preparedness. This should have been evident to key decision makers in January, and urgent mitigation measures should have been taken.
3. The impact of austerity and pre-existing inequality left the UK chronically unprepared for any significant pandemic.
4. Despite this alarming state of affairs, there was an unjustified and arrogant overconfidence in the UK's ability to respond to the virus.

SECTION B: THE INITIAL UK GOVERNMENT RESPONSE

1. The UK Government response should have been led by the Cabinet Office and No.10 from 25 Jan 2020, at the latest.
2. The failure to escalate the response timeously was a combination of systemic lack of concern about natural hazards as against geopolitical threats, lack of a central scientific pandemic advisory group, the lack of central government systems to coordinate a 'whole system' emergency response to a pandemic, the characteristics of particular Government Ministers and advisers, and the failure of the former PM to believe the risk or act decisively.
3. The result was a woefully inadequate strategy for responding to the virus and multiple missed opportunities to rapidly expand necessary capacities and capabilities, draw up plans, contingencies and guidance, properly liaise and coordinate with international and devolved governments and institutions, maintain open communication with the public and save lives.

SECTION C: KEY FAILURES IN DECISION MAKING

1. Until there was evidence to the contrary, Covid-19 ought to have been seen as airborne, asymptomatic, able to reinfect and able to spread widely and undetected.
2. The key failures in decision-making include failures from the outset to:
   (a) Recognise and foresee its potential to have devastating consequences;

(b) Urgently address the “woefully inadequate” UK preparedness evidenced in Module 1, to mitigate a swiftly as possible the lack of contingency planning and capacity;
(c) Audit resources and capacity, including medical supplies, PPE, and health and social care provision, and put in place plans to rapidly manufacture and source the same, and increase capacities at the earliest stage;
(d) Properly consider and utilise a suite of non-pharmaceutical interventions short of lockdown;
(e) Rapidly and massively upscale test, trace and isolate provision;
(f) Protect the people most vulnerable to the direct and indirect harms of the disease;
(g) Address known issues of structural and institutional discrimination, which could be expected to lead to disproportionate outcomes;
(h) Maintain the classification of Covid-19 as an airborne HCID; and
(i) Make discharges from hospitals into residential care settings reasonably safe.

3. Each of these failings could have been avoided had a precautionary approach been adopted and maintained throughout the Pandemic.

SECTION D: SCIENTIFIC ADVICE

1. Early recognition of the magnitude of the risk did not translate into timely and effective decision-making.
2. The government approach to scientific evidence and advice was flawed and inconsistent.
3. 'Following the science' messaging was unhelpful and misleading
4. Systems for the commissioning, provision and dissemination of scientific advice, and its use in policy and decision-making, must be improved.

SECTION E: CHAOS IN DOWNING STREET

1. Indecisive leadership, poor, ineffective governance structures, and a system of government infected with a toxic and sexist culture all contributed to the UK’s poor outcomes.
2. Two clear threads have emerged from the evidence: a lack of leadership at the helm and a dysfunctional Cabinet structure.
3. Individual and collective rule breaking culminated in the ‘Partygate’ scandals which undermined public confidence.
4. For the bereaved families whose loved ones paid the ultimate price by sticking to the rules – some of whom died alone in care homes or hospitals – the flagrant disregard for rules which ought to have had equal application was unforgivable.

SECTION F: IGNORING DEVOLVED ADMINISTRATIONS & THE ENGLISH REGIONS

1. With respect to the relationships with DAs, and decisions taken with relevance to those jurisdictions, the following conclusions can be drawn from the evidence:
(a) Central Government took the view that there should be a one size fits all approach dictated by Westminster. This approach was political. It was not based on what was required to combat the pandemic in the DAs. It was also flawed in practice.

(b) This meant that, in the main, devolved interests were not considered at all or were considered only as an afterthought whilst DAs (including some of their elected representatives) were treated as political problems to be managed.
(c) The 'one size fits all' approach had an Anglo-centric focus to the exclusion of consideration of the unique positions of the DAs.
(d) The Anglo-centric approach also filtered through SAGE and the scientific response.
(e) As a result, UK Government decisions were frequently taken absent any properly informed consideration of devolved issues. That prevented a fully informed response. This was not only inappropriate and should not be repeated in the future, but in fact had detrimental consequences in practice.

SECTION G: PHASE 2 OF UK RESPONSE; NOT LEARNING FROM MISTAKES

1. The overarching failures of the UK Government during this period were:
   (a) to implement a consistent strategy for managing the pandemic after the first lockdown; and
   (b) to have in place an effective infrastructure to test, trace and isolate cases and their contacts, and the necessary financial support to do so.
2. Had those objectives been met, the pandemic could have been managed at low incidence, and deaths – including those of the loved ones of countless CBFFJ UK and NICBFFJ families – could have been avoided.
3. The toxicity and infighting in Government that pervaded the first wave continued into the second. There was a lack of coherence and coordination among decision-makers, as demonstrated by the EOTHO scheme; and an adversarial relationship between HMT and the DHSC, when the national interest demanded cooperation.
4. The July AMS report commissioned by Sir Patrick Vallance had outlined the need for an effective test, trace and isolate system and all the capabilities that would be required for winter, but this appears to have been totally ignored.
5. All the learning was there for the UK Government to respond better than it had in early 2020 but, without the critical infrastructure necessary to competently control a Pandemic, it failed again.

SECTION H: NO DIGNITY FOR THE DECEASED OR THE BEREAVED

1. The lack of dignity afforded to the deceased and their grieving families emerges as a profound concern for the bereaved.
2. The UK Government's excess death planning and response failed to have due regard to the need to ensure the preservation of dignity for those who died and support to their families throughout the grieving process.
3. There has been no additional Government funding for bereavement support for those bereaved in the pandemic nor for Covid-specific bereavement support, despite the very specific and traumatic ways Covid bereavement differs from 'normal' grief.

IN THE UK COVID-19 PUBLIC INQUIRY
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Covid-19 Bereaved Families for Justice UK and NI Covid-19 Bereaved Families for Justice
M2 CLOSING SUBMISSIONS
ANNEX B: COMPOSITE SCHEDULE OF M1 and M2 RECOMMENDATIONS

Previous module 1 recommendations/evidence are shown in black font, module 2 recommendations/evidence in blue

ANNEX A		
No.	**Recommendation**	**Relevant evidence**
Resilience, public health, inequality and austerity		
1.	**The UK Government and devolved administrations should publicly restate their commitment to improving health inequalities, and publish clear plans as to how they intend to do so.**	[**INQ000195843/47§26**]; [**15/91/25/92-92/4**]; [**INQ000195843/82§199.1**]
2.	**Resilience planning, and healthcare, public health and social care capacity should be adequately resourced. In order to ensure democratic accountability, the responsible Secretary of State should publish an annual statement setting out the sufficiency of resilience and capacity resources, and how deficiencies are being addressed.**	[**INQ000203349/186§1c**]; [**INQ000203349/191§26**]
3.	**The UK and devolved administrations should commission and fund research to examine the drivers of pandemic inequalities and how to reduce them. This should include combatting structural and institutional discrimination.**	[**INQ000195843/82§199.2**]
4.	**Pandemic planning and preparation should integrate a 'health equity lens' across all aspects of the process.**	[**INQ000195843/82§199.3**]
5.	**Plans and programmes relating to health inequalities must be co-produced (produced in collaboration with relevant communities) and culturally competent.**	[**INQ000148405/11§38**]; [**INQ000196611/34§87b**]
6.	**Scientific, practitioner (e.g. local authority Directors of Public Health, regional officers from the Office for Health Improvement and Disparities) and voluntary sector expertise on health inequalities should be integrated into all planning and preparation processes.**	[**INQ000195843/83§199.4**]
7.	**Health Equity Impact Assessments should be routinely applied to pandemic planning to ensure that the full range of differential social, economic and health risks - and how to mitigate them - are systematically identified, understood, and acted upon.**	[**INQ000195843/83§199.5**]

INQ000399534_0084

8.	**To aid policymaking in general and preparedness for a pandemic in particular, better data surveillance and monitoring of health inequalities needs to be undertaken across all of the UK administrations.**	[**INQ000195843/83§199.6**]
9.	**There should be a duty on all who hold responsibilities regarding resilience and planning, or advising on the same, to raise with the responsible Secretary of State any issues of capacity or resourcing which might impact on the ability of the UK to optimise its response to a pandemic.**	[**INQ000203349/190§23**]
10.	**All civil emergency plans should incorporate clear statements indicating (a) how they will combat the effects of structural and institutional racism, other forms of structural discrimination relating to protected characteristics, the effects of health inequalities, and how they will protect vulnerable persons. (b) how the plans protect human rights and ensure a people-centric approach.**	[**INQ000195843/83§199.5**]; [**INQ000203349/196§42**]
11.	**Ministerial responsibility for disabled people should be held by a Cabinet Minister in the Cabinet Office.**	**[INQ000280035/27§90]; [5/67/1-68/22]**
12.	**There should be an audit of UK scientific and public health bodies and agencies to ensure that public bodies with a UK-wide remit are representative of the UK as a whole in the future.** This should include a review of observer versus full membership status on all associated bodies to determine if there is a need for greater participation from DAs and from individuals / organisations that represent people with diversity of lived experience.	[**INQ000269372/46§139-141,63§R4**]
Failure in risk assessment and planning		
13.	**The NSRA should set out for each risk the full scientific evidence base for the assumptions made within that risk. There should be an assumption that the full risk scenario and underlying evidence base is made public unless this is not possible for national security reasons.**	[**3/177/1-8**]; [**16/93/13-17**]
14.	**Responsibility for the NSRA should lie with the Minister identified in recommendation 24.**	[**6/54/17-55/14**]; [**7/31/L7-32/25**]; [**INQ000236243/31§103**]
15.	**The devolved administrations should provide an important layer of scrutiny and develop their own processes for challenge so that risks are considered, analysed and if appropriate, adapted, rather than simply reflexively adopted.**	[**11/55/25-57/1**]; [**11/61/8-16**]; [**14/4/4-6/14**]
16.	**A range of scenarios should be generated for each risk and these should be included within the NSRA to ensure transparency.**	[**7/35/20-36/20**]
17.	**The NSRA should address prevention and mitigation measures in respect of each risk.**	[**7:30:16-25**]; [**7:40:10-42:17**]

18.	**There should be a 'data needs' analysis for each risk on the NSRA which sets out what data is needed to assess, prevent, mitigate and respond. This should be integrated into an overall civil emergency data strategy and published.** This should include consideration of which data will be required (including ownership and access), which datasets will need to be linked and how, who will analyse the datasets, and which datasets need to be created. This should include an urgent review of (a) access to and sharing of health and social care data (b) data collection capability across local government and (c) capacity within the DAs.	[**INQ000186622/7-8**]; [**INQ000260629/40§75**]; [**28/38/4–39/19**]; [**INQ000269372/46§R7];** [**INQ000260629/50-51 §106**]; [**28/38/4–39/19**]
19.	**UK agencies tasked with emergency planning should commit to incorporating UK-wide data in their decision-making and communications and to gathering such data if it would not be gathered otherwise.**	[**INQ000269372/63§R8**]
20.	**Expert scientific advice and scrutiny should be built into the risk assessment process. In particular, the proposed independent standing scientific committee on pandemics (see recommendation 32) should have a formal role in advising on the NSRA.**	[**INQ000022709/7**]
21.	**Risks should not be prioritised according to likelihood, beyond an initial assessment of plausibility. Particular attention should be paid to high impact risks.**	[**3/108/14-109/3**] [**6/31/24-33/20**]; [**7/46/4-47/4**]
22.	**The advice that forms the basis of the national risk assessment should be appended to it and should have recorded on it the names of the experts and institutions or organisations giving the advice, and the date for review.**	[**8/140/8–141/18**]
23.	**Alongside the 'scenarios based' NSRA there should be an assessment of flexibility and adaptability of planning for each group of risks.**	[**2/136/9-20**]; [**3/63/10-18**]; [**7/36/4-7**]
Civil contingencies structures		
24.	**There should be a Secretary of State for Resilience and Civil Emergencies, who is the single point of responsibility for UK civil emergency resilience and planning. They should be responsible for the assurance of resilience across Central Government, intergovernmental cooperation with the devolved administrations, and assurance of regional and local civil emergency tiers. The responsibilities of this Minister should not be diluted by other portfolios.**	[**INQ000203349/189§21-2, 191§25**]; [**6/39/14-40/14**]
25.	**In line with the above, the Secretary of State for Resilience, supported by the relevant Permanent Secretary, should publish guidance setting out the model within government for pandemic planning and response.** This should include clarity in relation to the responsibilities held by permanent secretaries and other senior civil servants within the Cabinet Office and other departments for long term contingency planning, and structures to be employed during the emergency response. Provision should be made to ensure that all Tier 1 risks are responded to equivalently to ensure that natural threats or hazards are not treated differently to geopolitical threats; and guidance on the triggers for escalation to a centrally led response, recognising that this will not be exhaustive. The guidance should also address the role of special	[**INQ000236243/43 §142.10**]; [**23/164/4-17**]; [**23/169/24-23/170/15**]; [**28/212/2 –213/8**]; [**INQ000273841/26§46-47/27§48**]

	advisors and where, if at all, they fit in to the structures to be used. The guidance should be reviewed on an annual basis and the National Office for Resilience should provide independent Oversight.	
26.	**For whole system risks, the responsibility for planning and preparedness should lie with the Secretary of State for Resilience and not with a Lead Government Department.**	[**6/54/17-55/14**]; [**7/31/7-32/25**]
27.	**Alongside the review of IGR, detailed plans should be produced for an oven-ready mechanism for a "four nations by default" approach to emergency planning and response using the JBC's structure and membership as a template.** Mechanisms should bring relevant actors into regular, sustained rather than ad hoc contact and a commitment to parity of esteem.	[**INQ000269372/63**]
28.	**Each devolved administration should appoint a counterpart Minister.**	[**INQ000203349/190§22**]
29.	**There should be an inspectorate established to assure resilience, both at central and local levels.**	[**INQ000203349/186§3-188§13**]; [**3/133/25-134/12**]
30.	**There should be an independent agency - a 'National Office for Resilience' - which brings together research and knowledge, sets standards and provides training and independent advice to the Secretary of State, and local tiers.** The first task of this organisation should be to conduct an urgent review of the National Standards, in line with the concerns raised by the Independent Commission and opinions of Bruce Mann and Professor Alexander. The Office should report annually to Parliament. The inspectorate could be based in this organisation. The annual reports produced by the Office should specifically address capabilities to develop and scale-up key infrastructure at national and local levels, including on test and trace, isolation, financial support, PPE and hospital infection control procedures, including hospital building ventilation systems. The Secretary of State for Resilience and Civil Emergencies must respond to the report within four weeks to confirm the action being taken by government.	[**INQ000203349/190§21, 189/21,192§32,192§34**]; **[INQ000236261/4§3.3]; [INQ000174768/9§27]**
31.	**Legal duties should be placed on central government to ensure up to date national planning, and guidance, information sharing and oversight to the local tier, and assurance.**	[**INQ000203349/190§23**]; [**3/142/20-143/6**]; [**8/24/2-10**]
32.	**There should be an independent, UK standing scientific committee on pandemics with terms of reference to advise those formulating the N(S)RA and planning and to challenge where necessary, and to advise Government on resilience and preparedness for pandemics, including prevention, mitigation and adequate levels of resourcing.** This Standing Committee should include a diversity of experience and expertise including frontline medics and social care experts. The Standing Committee, should be funded and supported, meet regularly, publish an annual report, which should include preparedness (resilience, capacities, planning, and prevention and mitigation measures, monitoring	[**INQ000196611/35§88d**]; [**12/11/10-25**]; [**INQ000195843/83§199.4**]; [**INQ000203352/23§69**]; [**12/3/13-14**]

	lessons learned and implementation of recommendations) and it should be as transparent as possible in all its activities.	
33.	**A 'red team challenge' mechanism should be established.**	[**12/14/14-15/1**]; [**INQ000184637/10§7.4**]; [**INQ000177796/7§27,15-16§70**]; [**INQ000177810/3§9**]
34.	**Structures must ensure that scientific advice is not only independent but autonomous. In particular, advisers must have the discretion to pose their own questions and a budget to commission necessary research.**	[**INQ000196611/34§87c**]
35.	**Ministers, their advisers and civil servants with relevant responsibilities should be trained in decision making under conditions of uncertainty, and civil contingency management.** MPs should receive this training on their first Ministerial appointment. Training should also be provided to all current Cabinet Ministers.	**[6/21/8-18]; [6/25/16-23]; [9/80/18-25]**
Learning from infectious disease outbreaks and exercises		
36.	**The Inquiry should adopt the recommendations of Professor Heymann, Professor Whitworth and Dr Hammer, and Dr Kirchhelle.**	[**INQ000195846/56§266**]; [**INQ000196611/35§88a-g**]; [**INQ000205178/95§148**]
37.	**Reports on exercises and learning from infectious disease outbreaks should routinely be published to support corporate memory and ensure that lessons are publicly-available, collated, and learned.**	[**5/182/21-22**]
38.	**There should be a 'transparent independent assessment of the UK's preparedness capacities, which should also be available for public scrutiny.'**	[**INQ000148421/7§12**]
39.	**'The UK must be an energetic contributor – financially, technically and diplomatically - to WHO and its work on global health security'.**	[**INQ000148421/11§20**]; [**INQ000182610/24**]
40.	**UK funding should be sufficient for national academic and technical experts to support international activities that strengthen global epidemic and pandemic preparedness.** Funding for research and development should not be limited to vaccine programmes.	[**INQ000195846/55§264**]; [**INQ000207281/7**]; [**INQ000148421/11§19**]
41.	**There should be continued and sufficient Official Development Assistance funding on pandemic prevention, preparedness and response capacity.**	[**INQ000182610/24**]
42.	**The UK should be proactive in negotiations around the revised International Health Regulations and Pandemic Treaty, to expedite change, and to try to make them as binding and enforceable as possible.**	[**INQ000195846/56§263**]
43.	**The UK should meet its commitment to returning to the UN target of 0.7% of Gross National Income on Overseas Development Assistance, which is essential to global pandemic resilience and warning systems.**	[**INQ000182610/24**]; [**INQ000195846/56§263**]

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Core capabilities		
44.	**An urgent review of the UK's capacity to respond to an emerging infectious disease with a view to making a business case for the financial investment required.** The review must include tangible assets such as infectious disease beds and stockpiles of pharmaceutical and nonpharmaceutical countermeasures, and intangible assets such as staffing levels, staff training and the integration of the adult social care sector through mechanisms such as a national care system distinct from the NHS.	[**INQ000196611/35§88c**]; [**INQ000182608/22§52**] [**5/153/24-155/14**]; [**INQ000148421/8§15**]; [**INQ000182610/22-23**]; [**INQ000184638/75§7.2**]; [**INQ000205178/100-1§147**]; [**INQ000192268/10-11§39**]
45.	**Ensure a public health workforce that is fit for the future.** There must be a clear plan for recruiting and retaining public health specialists, at all levels, with expertise and knowledge in health protection, and clarification and strengthening of the role of Directors of Public Health	[**INQ000183419/47**]; [**15/64/22-65/2**]; [**INQ000148405/12§40**] ; [**INQ000182604/3§9-4§11**]; [**11/129/17-24**]; [**INQ000177803/77-78§317**]; [**INQ000196611/36§88h**]
46.	**Ensure there is sufficient resource in the health and social care sectors to deliver high quality care on a routine basis <u>and</u> to respond to infectious disease outbreaks with pandemic potential as required.**	[**INQ000182610/26**]; [**INQ000177796/15§67**] [**7/186/17-18**]; [**INQ000177809/47§119-121**]; [**INQ000177802/52§205**]; [**INQ000148416/19§69, 22§85**] [**INQ000148421/8§15**]; [**10/95/17-96/17**]; [**28/162/5-12**]
47.	**The Secretary of State for Resilience should be responsible for ensuring that all sectors of the public have adequate access to PPE.** Every health and social care setting should be required to have its own stockpile of PPE resourced by the Government. It should be the responsibility of the Secretary of State for Resilience to ensure all frontline essential services have access to sufficient, in-date and appropriate PPE, and to provide guidelines for the private sector. The Secretary of State for Resilience should ensure that PPE planning includes key workers from all sectors, and not simply health and social care. Emergency supply lines and surge manufacturing contingencies for PPE must be in place, to maintain provision for essential services and workers, and for the general public. There must be an adequate plan for distribution of PPE.	[**10/68/24-69/9**]; **[3/167/17-3/168/19]; [INQ000047541/3]; [3/89/18-25; 3/90/21-3/91/4]; [INQ000283199/18].**
48.	**Establish a national care service.** Consideration should be given to the creation of a national care service to improve resilience and preparedness in the social care sector in order to better protect service users and health and social care staff from the next	[**INQ000181825/19§86**]; [**INQ000148421/8§15**]; [**INQ000203352/24-25§73**]

	pandemic. This should address the disparity in quality of care and preparedness within the social care sector.	
49.	**Ensure that it is possible to rapidly scale test and trace capabilities.** There should be a review of capacities across the four nations for testing and tracing contacts of those infected. This should also include support for people to self-isolate.	[**INQ000205274/12§43**]; [**INQ000177802/52§205**]; [**INQ000148421/8§15**]
50.	**Invest in specialist isolation facilities for infectious diseases.** The UK government should learn from the Covid-19 pandemic and specifically consider the role of ventilation in the transmission of infection.	[**INQ000177809/47§118**]
Pandemic response		
51.	**Test, trace and isolate capability and capacity, paired with early adoption of effective economic support measures, including financial support for self-isolation, should be pursued as soon as possible in order to keep community transmission under control.** The Secretary of State for Resilience and Civil Emergencies (recommendation 24) must ensure that these capabilities and capacities are in place ahead of the next pandemic (and as soon as possible).	[**INQ000257925/14§27-15§30,38§69**]
52.	**For any emergency with UK-wide impacts, the default position should be that representatives for the devolved administrations are invited to attend meetings of COBR or other key UK-wide decision-making structures or mechanisms on a standing basis.**	[**INQ000269372/41§126-43§131**]
53.	**Where an emergency has impacts on specific regions of the UK, the default position should be that representatives for regional authorities representing those areas are invited to attend meetings of COBR or other key UK-wide decision-making structures or mechanisms on a standing basis.**	[**26/149/23 – 150/3**]
54.	**The Secretary of State for Resilience and Civil Emergencies should conduct an urgent update and refresh of data requirements (recommendation 18).** The Government must share all the available data with local areas (including local and combined authorities) in as much detail as possible, ideally to patient level.	[**INQ000260629/52§108**]
55.	**Transparency in relation to the rationale and evidential basis for decisions should be the default. The Government should report publicly where they have and haven't sought scientific advice and if such advice was sought, how they responded.** Evidence, economic or scientific models, scientific advice (including SAGE minutes) and requests for advice should be published from the outset unless this is not possible for national security reasons. The confidence and, if applicable, limitations of the evidence base should be identified where relevant. Minutes should be taken by a recognised note-taker to ensure that they are accurate, comprehensive that those who were not an attendee are able to clearly understand the contents.	[**25/31/17-32/1**]; [**18/30/15-31/10**]; [**INQ000309529/49§164**]

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56.	**Cabinet Committees should not be chaired by the "responsible" Secretary of State in order that they can be questioned in relation to the performance of their departments.**	[**INQ000236243/29§96**]; [**27/36/20-37/23**]
57.	**The Code of Conduct for Special Advisers should be reviewed and strengthened. The Code should emphasise that special advisors are accountable to ministers, who are in turn accountable to parliament and the public.** Special advisors must not make critical decisions which have not been approved by ministers, or direct officials on the basis of views or priorities which are not representative of those held by the relevant minister. The Civil Service Code should provide that where officials have concerns that special advisors are not acting in line with the updated Code of Conduct, this should be reported immediately to the Cabinet Secretary, or in line with the process set out by a new Independent Complaints Scheme (recommendation 58).	**[6/64/19-65/6]; [6/66/6-14]; [INQ000235593/7§29]; [16/143/24-144/17]; [[INQ000273841/11§20]; [INQ000136755]**
58.	**A new Independent Complaints Scheme should be introduced to investigate complaints against Special Advisors.**	**[INQ000273841/11§20]; [INQ000273872]; [INQ000162937]; [INQ000162938]**
59.	**Representatives for the devolved administrations should be given full membership status of SAGE and should be able to commission advice from the outset.**	[**INQ000235213/23§71**]; [**INQ000089720/122**]; **[24/92/3-10; 22/152/16-17]**
60.	**SAGE must have greater diversity of membership, ensuring pan-UK geographical representation and including practising public health professionals and international experts.**	**[10/82/24-83/4]**
61.	**When advice from SAGE is transmitted to decision makers, this should include the 'consensus' view but also a 'minority report' to make clear to decisionmakers the range of opinions.**	[**9/80/9-13**]; [**10/34/24-10/35/5**]
62.	**A member of the Independent UK standing scientific committee on pandemics (recommendation 32) should generally attend inter-ministerial meetings relating to pandemic response.** This would help to avoid significant policy decisions, such as Eat Out to Help Out, being taken without the input or knowledge of scientific advisors.	[**INQ000273553/66§10.18**]; [**24/63/1-25/64/1-4**]; [**22/156/10-22/157/5**]
63.	**A statutory requirement for Government to report to Parliament and to the public whether and when they have been alerted to an incoming threat or crisis by a standing scientific committee on pandemics.**	[**31/70/2-6**]; [**31/75/23-31/76/3**]; [**31/61/1**]
64.	**Government should (1) continually monitor and adapt policy interventions during a pandemic and (2) monitor and incorporate best practice by other countries in its pandemic response.**	**[16/157/1-9]; [INQ000221436/20§89]**

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65.	**Government must assess the two-way impact of the economic policies on health of the population and the impact of the health of population on the economy.** This would ensure decisions made in a pandemic explicitly assess policies aimed at protecting public health (e.g. NPIs) in relation to their impact on the economy (e.g. reduced acute and long-term sickness rates etc). When considering the impact of NPIs (such as lockdowns), assessment of mental impacts should also include negative impact on mental health of bereavement.	[**INQ000309529/49§164**]
66.	**Ethnicity (as has been self-identified by the person who has died) should be recorded on death certificates.** Consideration should also be given to whether other relevant information, including immigration status and protected characteristics such a sexual orientation, can be recorded.	[**26/78/16 - 18**]; [**25/ 191/21-192/24**]; **[34/181/1-17]**
Institutional culture		
67.	**Government decisions, particularly in relation to the assessment of potential impacts, should be considered, debated and recorded with a more consistently formal process, brokered and coordinated by the Cabinet Office.** Where informal mechanisms such as Whatsapp are used for relevant or related discussions, the decisions reached, individuals involved and rationale should be summarised and documented using formal processes and captured on government systems. Responsibility for this in relation to key decision-making rests primarily with private offices, but is shared with all officials, SPADs and Ministers. Ministerial communications in relation to government business should only take place via authorised devices which should be secure, backed up and subsequently accessible to authorised persons. Relevant records should be stored on a secure system backed-up by HMG IT. Disappearing message functions should not be used for WhatsApps relating to government business, and messages should not be deleted manually. Government guidance as to the use of non-corporate communication channels (e.g. WhatsApp, private email, SMS) for government business should be updated to reflect these expectations.	[**INQ000236243/28§88-91**]; [**INQ000236243/43§142.9**]; **[9/73/1-74/11]**
68.	**A legislative framework such as that proposed in the Public Authority (Accountability) Bill should be passed to encourage a culture of candour amongst public authorities, especially in their approach to inquests and inquiries.**	**Open Source link to Bill**
69.	**A National Oversight Mechanism should be established to monitor lesson learning from major inquests and inquiries.**	**Open source link to INQUEST proposal**
70.	**There should be a people first approach with duties placed on both local responders and at the national level, to require the integration of community and voluntary groups into civil emergency plans, to require positive community engagement with transparent public communication regarding threats and planned mitigations.**	[**INQ000203349/196§42-3**]

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71.	**There should be trauma informed national guidance for the local tier about dignity in death.** This should provide analysis of burial rights of different communities, analysis of the importance of the grieving process for coming to terms with the loss of a loved one and examples to local authorities of the poor treatment of bereaved families during the Covid-19 pandemic and other emergencies to ensure that lessons are learned. Minimum standards for local planning and operations in relation to burial rites and the grieving process should be included. These minimum standards should include the requirement to analyse needs in the local community and the requirement to ensure that measures taken are necessary, based on the risk of infection.	[**19/134/3-141/3**]
72.	**There should be a review of processes from other sectors where integrating learning and safety is better achieved, specifically the airline industry, with consideration of whether processes can be adopted.**	**Open Source** comparative review of aviation and healthcare with implications for patient safety.
73.	**Intergovernmental relations should be founded on a principle of mutual respect and parity of esteem. In the context of a UK-wide emergency, in line with the plans at recommendation 27, above, representatives for the devolved administrations should be informed in advance and consulted in relation to any decisions or announcements affecting the nations they represent.** Emergency planning and response to be viewed as an instance of inter-governmental relations rather than separate from it.	[**INQ000269372/63**]
74.	**Overall accountability for intergovernmental relations lies with the Prime Minister, the First Ministers of Scotland and Wales and the First and deputy First Minister of Northern Ireland.** In line with the plans at recommendation 27 above, in the context of a UK-wide emergency, the Prime Minister and Heads of Devolved Governments Council should have regular, sustained rather than ad hoc contact. The First Ministers (and deputy First Minister in the case of Northern Ireland) should each have the power to call for a meeting of the Council.	[**INQ000269372/63**]
	SECTION B	
The absence of the NI Executive		
75.	**The Inquiry recommends that the UK government introduce legislation to require that if the ministers of the Northern Ireland Executive with powers and duties for civil contingencies and pandemic preparedness have not be in position for a period of no more than 6 months, all the powers and duties of that/those minister(s) shall revert to a designated minister of His Majesty's Government at the end of a 6 month period from the first date of the Northern Ireland minister(s) absence.**	McBride:D17:P130:L1-23; Foster:D18:P22:L6-P23:L15; O'Neill:D19:P35-P39; Pengelly:D18:P93:L13-14; McMahon:D16:P13:L13-18; Swann:D16:P158:L15-P159:L9
The impact of No Deal EU Exit planning		

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76.	**The Inquiry recommends that Westminster and devolved legislation be introduced in which minimal levels of funding and staffing for civil contingencies and pandemic preparedness are identified and below which funding and staffing cannot fall. There should also be statutory provision that such levels are indexed linked, be kept under review and amended in accordance with identified risks.**	Dawson:D19:P174-177; McBride:D17:P185:L15-22; O'Neill:D19:P61:L13-P62:L1; McMahon:D16:P15:L21-P16:L1
Scientific advice		
77.	**The Inquiry recommends that there should be legislation at Westminster and/or devolved level requiring that a Chief Scientific Adviser to the Northern Ireland Executive be appointed.**	Foster:D18:P53:L17-20; O'Neill:D19:P55:L25-P57:L8
78.	**The Inquiry recommends that a review of the failed process to appoint a Chief Scientific Adviser to the Northern Ireland Executive be undertaken in order to identify the reasons for that failure.**	McMahon:D16:P94:L6-11
79.	**The Inquiry recommends that legislation be introduced at Westminster requiring that Northern Ireland, Scotland and Wales each have permanent and full rights of participation and representation on all central governmental scientific networks and organisations in the UK.**	INQ000187306/1§70,74 & 84; McBride:D17:P158:L7-9; Foster:D18:P55:L16-17
80.	**The Inquiry recommends that the Public Health Act (Northern Ireland) 1967 be updated urgently to: (a) at least mirror the rest of the UK so that it encompasses non-disease public health hazards; and (b), list new pathogens with a provision to keep same updated by way of regulations to be made the relevant Northern Ireland minister.**	Dawson:D19:P162:L7-P163:L16
Civil contingency legislation		
81.	**The Inquiry recommends that a complete review of the civil contingencies in Northern Ireland takes place overseen by an independent chair with a terms of reference to consider how the civil contingency structures in Northern Ireland can be improved, simplified and codified in legislation with the objective of creating accountability, transparency and statutory duties. Such a review must take into consideration the other recommendations of this Inquiry.**	Foster:D18:P60:L14-16; O'Neill:D19:P58:L8-P59:L13
82.	**The Inquiry recommends that, at the very least and as a matter of urgency, similar provisions of the Civil Contingencies Act 2003 that pertain elsewhere in the UK are extended to Northern Ireland either through amendments to the 2003 Act or through separate devolved legislation in Northern Ireland and should make Part 1 applicable to Northern Ireland government Departments.**	McMahon:D16:P59:L2-15; McMahon:D16:P101:L1-15

83.	**The Inquiry recommends that legislation be introduced which requires NI departments with responsibilities for civil contingencies to publish regular reports on the state of civil contingencies in general including funding issues, and with a requirement that those ministers have due regard to such reports with a duty to provide reasons for not following recommendations made therein.**	McMahon:D16:P18:L9-P20:L16
84.	**The Inquiry recommends that legislation be introduced which requires NI departments with responsibilities for civil contingencies to undertake and publish regular risk assessments on civil contingencies and with a requirement that those ministers have due regard to such reports with a duty to provide reasons for not following recommendations made therein.**	Allen:D19:P91:L5-P92:L24
85.	**The Inquiry recommends that legislation be introduced requiring that civil contingency budgets are ringfenced, perhaps with direct funding from central government, and regularly updated.**	McMahon:D16:P40:L16-18; McMahon:D16:P101:L15-17
86.	**The Inquiry recommends that legislation be introduced requiring the consultation and involvement of local councils in Northern Ireland and/or the Northern Ireland Local Government Association in the development, drafting and review of civil contingency plans, policy and guidance.**	Allen:D19:P107:L2-18; Allen:D19:P91:L5-P92:L24
87.	**The Inquiry recommends that the Westminster and the devolved governments attempt to agree between themselves and the Irish government, perhaps using the framework of the Belfast/Good Friday Agreement, a statutory framework in each jurisdiction to allow for cross-border co-ordination and co-operation on civil contingencies, and in particular pandemic planning.**	McBride:D17:P154:L11-P155:L1; McBride:D17:P152:L25-P153:L16; Pengelly:D18:P119:L20-P120:L15
88.	**The Inquiry recommends that legislation be introduced to require social dialogue between central and devolved governments and trade unions on civil contingencies and in particular pandemic preparedness**	Bell:D21:P39:L1-P41:L23; Murphy:D21:P41:L17-21
The chronically poor state of the health service and the impact of austerity in NI		
89.	**The Inquiry recommends that legislation be introduced to require that before any real-term reductions are made to the NI central block grant and/or any NI departmental budgets, an impact assessment must be carried out by the Chancellor of the Exchequer and/or the NI Minister for Finance on how such cuts will affect resilience for pandemics, and that the Chancellor of the Exchequer and/or the NI Minister for Finance must take into consideration any such impact assessment before the reduction is made.**	Kirchhelle:D17:P21:L10-13; Kirchhelle:D17:P109:L19-P110:L2
90.	**The Inquiry recommends that legislation be introduced to prohibit single-year budgets for the NI Department of Health and that recurrent budgets for the NI Department of Health are guaranteed.**	Swann:D16:P175:L1-P176:L6

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91.	**The Inquiry recommends that the structural reforms to the NI health and social care system identified in the Bengoa Report are implemented as a matter of urgency.**	Swann:D16:P159:L22-P160:L4; Dawson:D19:P182
Statutory exercises		
92.	**The Inquiry recommends that legislation is introduced to require that regular and scheduled pandemic planning exercises are undertaken and published by the devolved government in Northern Ireland.**	O'Neill:D19:P22:L20-P24:L16; Foster:D18:P40:L15-16; Pengelly:D18:P114:L15-P117:L1; McBride:D17:P121:L16-P125:L15
93.	**The Inquiry recommends that legislation is introduced to require that pandemic planning exercises have the direct involvement of the First and Deputy First Ministers and the Minister for Health in Northern Ireland.**	Ibid
94.	**The Inquiry recommends that legislation is introduced to require that the First and Deputy First Ministers and the Minister for Health in Northern Ireland have due regard to the outcome and recommendations of pandemic planning exercises.**	Ibid
95.	**The Inquiry recommends that legislation is introduced to require that Ministers who decide not to introduce recommendations made by the statutory pandemic planning exercises are required to give reasons for not doing so.**	Ibid
96.	**The Inquiry recommends that legislation is introduced to require that, once a minister has made a decision to implement certain recommendations of a pandemic planning exercise, an oversight group to be appointed to ensure their implementation within a reasonable period.**	Ibid