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 & NI Covid-19 Bereaved Families for Justice

CLOSING STATEMENT FOR MODULE 5

I. INTRODUCTION

1. Throughout this module, the Inquiry has heard the stark reality of procurement during the Covid-19 pandemic: it is a story of inadequate preparedness; of procurement and distribution systems collapsing; of a desperate scramble to secure PPE and medical equipment from any source and at any cost; of a parallel procurement system designed in such a way that it enabled those with political connections to jump the queue; of opportunistic intermediaries and middlemen exploiting the pandemic to make a quick profit; and of an enormous waste of public money.

2. But, above all, it is a story of a failure to 'Protect the NHS & Save Lives' by the Westminster Government, through their failure to prepare, procure and provide adequate PPE, ventilators or supplies.

3. The root cause of that failure, like so many other issues within the Inquiry's Terms of Reference, was the absence of any meaningful civil emergency planning or pandemic preparedness strategy. When Covid-19 arrived on the UK's shores, government lacked the systems, structures, capacity, resources and relationships that were necessary to procure the vital supplies we needed.

4. Much of the evidence in Module 5 has focussed on the HPL or VIP Lane. The starting point for the Inquiry must be the findings of Mrs Justice O'Farrell DBE in *R (Good Law Project) v Secretary of State for Health and Social Care* [2022] EWHC 46 (TCC) that:

"…the High Priority Lane was in breach of the obligation of equal treatment under the [Public Contracts Regulations 2015] and therefore unlawful…" [518]

5. The argument that some contracts made through the HPL would likely have been awarded in any event cannot justify the HPL's existence. Rather, this argument demonstrates the very reason why the HPL was an inappropriate framework — because rather than triaging and prioritising the best offers impartially, the effect was to prioritise based on the political connections of the referrer.

6. We are clear: establishing the VIP lane was a choice. When facing the unfolding health emergency in early 2020, the government could have followed a rules-based, transparent and accountable process that rose to the "*key challenge for procurement systems"* identified by Prof Sanchez-Graells to *"address issues of covert corruption and, in particular, conflicts of interest"*. Instead, government chose to establish a system built on a foundation of preferential treatment, that prioritised those with political connections, and which enabled unscrupulous individuals to make huge personal financial gain from the emergency. No other country did so.

7. The VIP Lane was enabled by a culture of ministerial deference "*embedded in the way the English Civil Service operates*" [**2/110/16**], as explained by Prof Sanchez-Graells, which "*in this case created a very significant problem*" [**2/111/3**]. It is a remarkable fact that, not only was the VIP Lane proposed as a suggested 'solution' for politically-connected individuals' demands for access to the PPE market, but it was put into action by a small army of civil servants who did not, or did not feel able to, call out the incompatibility of the system with the most basic requirements of fairness and transparency and the constitutional separation between civil service and government.

8. An eye-watering £13.8 billion of public money was spent on PPE during the pandemic, of which £8.6 billion was through the parallel supply chain; and a shocking £3.8 billion was wasted on substandard and surplus PPE that could not be used in the NHS [**INQ000528391_0192, §729 & Table 11 and _0227, §855**]. Every pound overpaid for PPE, or wasted on defective contracts was a pound that could have been spent on the health and social care system.

9. But the impact is not just financial. Procurement failures cost lives. The Inquiry has heard from those on the frontline that PPE supply was "*woefully inadequate*" (Prof Banfield), that this contributed to the spread of the disease, and that insufficient or inadequate medical equipment posed a "*potential risk to patient safety*" or affected decisions "*about whether or not to send patients to intensive care*" (Prof Moonesinghe).

10. The families we represent were left in disbelief at the evidence of Mr Gove, Mr Hancock, Lord Feldman, Lord Agnew and others. Their combative and defensive tone was ill-befitting of former ministers and appointees, accountable to the public. And the substance of much of their evidence was disingenuous in the extreme: claiming procurement efforts to be an unmitigated success, with a chorus of denial that they should have acted differently, justifying cronyism and patronage, defending the VIP Lane and dismissive of the acute public concerns that this Inquiry is established to investigate.

11. Mr Gove, now Lord Gove, used the Inquiry to launch a shameful attack on those who have taken leading roles in exposing the cronyism of the procurement process, describing Jolyon Maugham KC of the Good Law Project as a "*politically motivated grifter*" [**5/116/15**], an allegation of dishonesty. Mr Gove is of course protected from any defamation claim by witness privilege under Section 37 of the Inquiries Act 2005. In response Mr Maugham has described Mr Gove as "*a deliberate and disgraceful liar*" [**INQ000587348_0005, §15**]. In turn Lord Agnew suggested the bereaved families and others had been misled:

> "…*I want to reassure your people that you act for, there was no heinous plan to enrich a few of our mates. I mean that's such bollocks…I just want to get that through to your people. This was not some kind of plan, right wing people trying to enrich themselves…its important because they've been whipped up your people*…" [**10/162/7-22**]

12. These attacks were made possible by the failure of the Inquiry to call relevant supplier witnesses who could have been challenged concerning the issues raised, as we cautioned in our opening submissions.

13. The vacuum they have left in the evidence has allowed the politicians to blame conspiracy theories, and the civil servants that were called from the Buy Cell were able to say that they thought that someone else would ultimately ensure that due diligence and proper checks were completed.

14. Without accountability there is no impulse to change. Despite not hearing from the suppliers directly, it is vitally important that the Chair resists any inclination to avoid proper criticism in the M5 report. Our clients were alarmed to read, in the Chair's 11 March 2025 Core Participant Determination for PPE Medpro Ltd (et al) that "*I do not expect it will be necessary for me to say anything that criticises the Applicants in my Module 5 report*".[1] In respect of all suppliers

[1] https://covid19.public-inquiry.uk/wp-content/uploads/2025/03/12085608/2025.03.11-M5-Determination-MedPro-Ltd_Douglas-Barrowman_Baroness-Michelle-Mone-APPROVED-AND-SENT.pdf, para 14

about whom the Inquiry has heard evidence, where there are grounds to criticise, those criticisms should be made in the interests of accountability and learning lessons for the future.

15. We urge the Chair to take a robust approach to these issues in the Module 5 report; to call out the cronyism, corruption and profiteering that occurred (detailed below at §169-244); to challenge the disingenuous justifications of former ministers; and to make recommendations capable of ensuring that when the next emergency strikes, lives are not lost because of a failure to prepare or procure the vital supplies we need.

II. IMPACT

16. The impact cannot be overstated: procurement failures cost lives.

17. Many of the families we represent lost their loved ones because of inadequate or unavailable PPE and medical supplies. In some cases, they were keyworkers who lacked the necessary PPE for their own protection. In others, they contracted Covid-19 in hospital or care settings in which healthcare workers had insufficient PPE to prevent transmission. And others did not receive the escalation of care that they required because of a real or perceived lack of medical equipment such as ventilators.

(i) Lack of adequate PPE

18. Contrary to the assertions of politicians that they were living in a 'real world' that others could barely understand, in the actual real world patients, clinicians, health and social care workers were exposed to preventable infections from Covid-19 due to a lack of appropriate PPE.

19. In the initial stages of the pandemic, PPE supply was hand-to-mouth. Graham Russell spoke of the "*enormous challenges in trying to get safe PPE. There was a massive public demand. The government was very aware of that, ministers were very aware of that.*" [**7/56/18-25**], Emily Lawson recalled Great Ormond Street Hospital going to Screwfix to buy goggles [**6/8/3-8**], and Gareth Rhys Williams explained "*there were days when … Emily Lawson got a demand signal from nurses in the NHS that 'Gowns are very urgent today, we're about to run out', or 'Gloves are very urgent today', in which case that would be a good reason for accelerating pulling things through the system*" [**2/196/8-13**].

20. The Inquiry has heard clear evidence from those on the frontline, from clinicians and carers, and from Prof Philip Banfield of the BMA:

> "*The supply of PPE to staff across the health and care sectors during the pandemic was* ***woefully inadequate****. This was a result of a number of issues, namely: failure in pre-pandemic planning and stockpiles, levels and type of stock and distribution issues during the pandemic, issues with fit testing; and IPC guidance that consistently failed to properly acknowledge airborne transmission of Covid-19 and recommending PPE that left healthcare workers exposed to a risk of infection from Covid-19.*" [**INQ000562457_0016, §47,** emphasis added]

21. As a result, staff were forced to go without PPE, reuse single-use items, fashion items out of bin bags, use items that were out of date with multiple expiry stickers visibly layered on top of each other, or use homemade/donated items [**INQ000562457_0016, §48-49**].

22. Similarly, Daniel Mortimer described the "*profound anxiety*" amongst primary care staff due to "*a lack of confidence both in the supply but also the guidance*" [**10/12/10-17**] and recalled "*general practitioner leaders who weren't able, or worried they wouldn't be able, to provide equipment to their staff who were treating patients, that they wouldn't be able to properly protect their staff from contracting the virus*" [**10/9/8-13**]. This led to healthcare workers relying on local shops, beauty and tattoo parlours to access PPE or crowdfunding to buy equipment.

23. As we reminded the Inquiry in our opening submissions, these concerns were raised with politicians at the time. This is evident from the statement of Caroline Lucas, former MP for Brighton Pavilion, in which she describes receiving reports from March 2020 onwards of difficulties in accessing PPE in local hospitals, care homes and for care workers in the community who were caring for vulnerable adults [**INQ000528583_0010**]. In one emotional email, a frontline care worker pleaded for the necessary PPE saying "*I'm so so scared for the people in my care and I don't believe the government is doing enough at all to protect those more vulnerable than myself.*" [**INQ000522197**].

24. As in Module 3, we maintain that these PPE shortages led to IPC guidelines being weakened. As Daniel Mortimer said in his evidence: "*absolutely, there was a feeling that guidance and the reframing of guidance … was a function of availability*" [**10/18/5-8**].

25. Even when PPE was available, it was often unsuitable or out of date. Rosemary Gallagher of the RCN explained how a failure to understand how products are used in practice meant that, despite conforming to relevant specifications, "*when it actually reached [nurses] on the front line, the products just simply weren't fit for purpose*" [**10/44/13-15**]; and spoke of "*many concerns from members around material degrading*" and "*real concern*" that *"what they were receiving was not fit for purpose and potentially causing them harm*" [**10/37/8-18**].

26. Ms Gallagher also explained how staff "*suddenly found themselves without the normal type of respirator they had been fit tested for, so that necessitated a change and additional fit testing.*" [**10/36/5-21**]. However, those doing the procuring often did not understand the need for fit testing. Ms Gallagher includes in her statement some feedback from an RCN member that "*When I have fed back to cabinet office that they don't fit, I was told any mask was better than nothing.*" [**INQ000553817_0007, §23a**]. This lack of understanding exacerbated the lack of PPE and put people at risk.

(ii) *Disproportionate impact and structural and institutional discrimination*

27. The evidence shows that issues relating to the supply and adequacy of PPE impacted some groups more than others. As Prof Banfield said: ethnic minority doctors more commonly experienced PPE shortages, had higher rates of failing a fit test, felt pressure to work in environments without sufficient PPE and felt fearful about speaking out about safety issues; and women were less likely to find well-fitting masks due to the gender bias in PPE design [**INQ000562457_0016-17, §51**].

28. Prior to the Covid-19 pandemic, available PPE in the UK was modelled on Caucasian males, so that women, smaller individuals and people of non-Caucasian ethnic backgrounds, or those with certain disabilities and illnesses, were not likely to gain a good fit from standard RPE. The Inquiry must address the structural and institutional racism which led to deficiencies in the PPE that was stockpiled, including the fact that PPE that would fit minority ethnic staff was purchased in smaller quantities [**M3: 30/121**], despite the obvious knowledge that the NHS workforce is diverse and in disregard of duties imposed by the Equality Act 2010. Given that the use of PPE is not limited to emergency situations, it is beyond the comprehension of the bereaved families that this discrimination persisted not only during the pandemic but prior to 2020.

29. In his evidence, Daniel Mortimer explained the "*real area of concern*" that black and minority ethnic staff were being disproportionately impacted:

> "*it became very clear in the early part of the pandemic that black and minority ethnic staff were being disproportionately impacted by coronavirus, disproportionately represented in terms of fatalities in particular, and in the April, that was a real area of concern. And again, that was both about total availability, but also about the availability of appropriate equipment or equipment that was most appropriate for the range of staff that we benefit from having in the health service, but yes, at its heart, it was about profound anxiety and a profound understanding of the risk that frontline staff were facing, and were placing themselves in, in terms of caring for patients with the virus.*" [**10/12/18-13/7**]

30. The Runnymede Trust found that the rate of healthcare workers not being given appropriate PPE at work was 60% higher amongst black and minority ethnic groups than their white counterparts (32% compared with 20%) [**INQ000518353_0002**].

31. For female black and minority ethnic healthcare workers, the disproportionate impact was even starker. For example, female Filipino nurses had a "*high fit fail test rate*" on several of the standard FFP3 masks [**INQ000504938_0036, §147**], despite that group being the third most common nationality amongst NHS staff.[2]

32. For those with disabilities, including individuals who are deaf and hard of hearing, the development of suitable PPE — such as clear masks to enable lipreading — was "*painfully slow*" according to Prof Banfield [**INQ000562457_0017, §51b**].

33. This issue was poorly understood at the outset of the pandemic, especially in respect of FFP3 masks that needed to be fit tested, with stock modelling and procurement activities still viewing FFP3s as a class until around May 2020:

> *"…to start off with, the model only looked, for example, at all FFP3s as a class. What we came to understand particularly in May, was that, actually, there was a whole range of FFP3 models that we needed to supply in order to meet the needs of staff…*" [**6/64/15-20**]

(iii) <u>*Lack of adequate medical equipment*</u>

34. As with the lack of PPE, the Inquiry has heard cogent evidence from those on the frontline about the "*risk to patient safety*" of inadequate and unavailable medical equipment such as ventilators. As Prof Ramani Moonesinghe stated:

> "*I do not consider that there was a robust system in place to ensure an adequate supply of key healthcare equipment and supplies to the NHS during the initial phase of the pandemic. … because of a lack of availability of resources to meet the demand in the first wave, clinicians were required to use unfamiliar or less than ideal equipment, medicines and consumables, which will have augmented the pressure under which they were working. These factors combined posed a potential risk to patient safety and may have added additional psychological burden to staff who were working under conditions of unprecedented challenge*." [**INQ000518349_0047, §187**]

[2] House of Commons Briefing 'NHS staff from overseas: statistics'

35. But, as Prof Moonesinghe expanded in her oral evidence, the anticipated or real pressure of a lack of essential lifesaving equipment may have also changed the way that clinicians thought about how to escalate some critical care patients:

> "*…take the specific circumstances of the pandemic and it is possible that anticipated pressure or real pressure may have changed subtly the way that clinicians thought about whether or not to send patients to intensive care or escalate their care*." [**9/156/3-7**]

36. These were decisions with life-or-death consequences, and sadly many of the bereaved families we represent have direct experience of this kind of care rationing in the context of a shortage of medical equipment. We repeat here from our opening submissions the examples of Dr Glen Grundle and Geraldine Anderson.

37. Dr Glen Grundle's mother died in a hospital due to Covid-19 on 12 April 2020. She was treated by staff who were not wearing PPE. She also had a DNACPR that she had not agreed to and her ceiling of care was on the ward and set at "*continuous positive airway pressure*", rather than admission to ICU or ventilation. Glen has serious concerns in relation to the basis on which this decision was made, given the extreme pressure on medical equipment at this time and specific fears that the country was going to run out of ventilators.

38. Geraldine Anderson's husband, Seamus Martin Anderson, passed away on 3 July 2021 in an ICU in Altnagelvin Hospital in Derry. She had requested that he be placed on an ECMO machine, which she understood would have assisted him, only to be informed that there were none available in the jurisdiction, save in Newcastle. This is suggestive of a shortage of potentially life-saving equipment.

39. Any life lost because of a lack or perceived insufficiency of medical equipment is a life that was lost unnecessarily. Adequate planning and resilience in the procurement systems would have and should have saved lives.

(iv) *Impact on the public purse*

40. The impact of procurement failures was not limited to people through inadequate and insufficient PPE and medical supplies, but also the cost to the public purse. In simple terms, every pound overpaid for PPE, or wasted on contracts for defective PPE was a pound that could have been spent on the health and social care system.

41. The Inquiry has heard varying figures for the total spend on PPE, but in the DHSC Corporate Statement, Jonathan Marron states that the total spend was circa £13.8 billion, of which SCCL spent £5.2 billion and a further £8.6 billion was spent by the DHSC through the Parallel Supply

Chain. Of the DHSC spend, almost half (£4.2 billion) was spent on contracts awarded through the HPL [**INQ000528391_0192, §729 and Table 11**]. Similarly large sums were spent on ventilators and testing, with Dan York (HM Treasury) providing a figure of £22 billion for the Test & Trace programme [**M7: IN0000587305_0009, §30**] and the UK Anti-Corruption Coalition calculating a total Covid-19 procurement spend of £48.1 billion [**INQ000527634_0041, §91**]. On any view, that is an enormous amount of money, with PPE spend representing the equivalent of around 8% of the entire 2019 NHS budget;[3] and total procurement equating to over £716 per person based on the 2020 UK population.[4]

42. Was this money well spent? While there was, of course, an urgent need to procure considerable volumes of PPE and inevitable price inflation due to a surge in global demand, these factors alone cannot excuse wasteful use of taxpayers' money. The evidence has shown that the UK overpaid for PPE on numerous occasions and that significant volumes of the PPE sourced was wasted either because it was unsuitable or surplus to requirements.

43. These overpayments and excessive waste were a result of the government adopting a greater appetite to risk, as Gareth Rhys Williams stated: "*There is always a need to ensure value for taxpayers' money even in the midst of an emergency. But with global demand at unheard of levels, and much manufacturing capacity for key products closed due to COVID-19, our risk appetite had to change.*" [**INQ000497031_0041, §3.17**]. On behalf of the UK and NI Covid bereaved families, we contend that the abject lack of planning, and the very slow response, meant that government failed to get the balance right.

44. Despite HM Treasury making it a condition of the PPE funding envelope that DHSC should "*make best attempts to stay within a 25% tolerance level*" [**14/38/16-19**] as against benchmark pricing, this was regularly exceeded.

45. In far too many instances, the UK paid an unacceptably high 'Covid Premium' for its PPE. One example comes from Chris Young's evidence about Cargo Services Far East contract, in which it is said that the contracted price was 900% over benchmark for aprons and 400% over benchmark for gloves [**INQ000510725**][5].

[3] ONS data – 2019 UK government healthcare expenditure
[4] ONS data – 2020 UK population (67.1 million)
[5] We note that the document that CTI referred to in posing this question [**INQ000510725**] is redacted and we have relied on the percentage figures given in CTI's question, but we also note that in fact this document appears to relate to a deal with Uniserve. We draw this to the Inquiry's attention to ensure the correct document reference number is included.

46. Additionally, of the PPE that was secured, Johnathan Marron told the Inquiry that some £3.8 billion (around 25% of the total spend) could not be used either because the products were deemed unsuitable or the quantity procured exceeded requirements [**3/134/12-14**].

47. The waste was on such a scale that 1.4 billion items were burned [**INQ000528391_0226, §850**], and Lord Agnew describes how this "*vast overordering*" was so bad that it almost "*blocked Felixstowe Docks*":

> "*Disposal of surplus PPE was one of the most upsetting parts of the whole procurement journey. There was vast overordering. At one point it almost blocked Felixstowe docks. Penalty rates were being paid on seaborne containers that were kept because there were no storage facilities. Warehouses were rented eventually but then began the destruction of PPE*." [**INQ000536345_0019, §96**]

48. The eye-watering sums of taxpayers' money involved in PPE procurement and the considerable waste of inadequate or excess items was inexcusable and will be felt for generations to come.

(v) *Impact on public trust and confidence*

49. The public rightly expect their politicians and the government to act with integrity and responsibility. When it comes to procurement, this is embodied in the principles for Managing Public Money: honesty, impartiality, openness, accountability, accuracy, fairness, integrity, transparency, objectivity and reliability – carried out in the spirit of, as well as to the letter of, the law, in the public interest, to high ethical standards and achieving value for money [**INQ000068420_0007**].

50. The purpose of accountability, and relatedly, transparency, is to prevent and identify maladministration and corruption. In the context of a health pandemic, this ensures that lives are not lost through the provision of, for example, inadequate PPE, or faulty tests, or to prevent unjustified loss of funds to the public purse to fraudulent profiteering, where those funds are urgently needed to purchase otherwise effective equipment which could be used to protect health and life.

51. As Prof Sanchez-Graells explained, one of the "*core aims*" of public procurement regulations is "*preventing corruption and maladministration*", including "*the abuse of entrusted power for private gain*" and the procurement of goods of such low quality that they go unused [**INQ000539153_0015**].

52. Throughout Module 5, the Inquiry has heard evidence that politicians frequently fell below those standards. Procurement was not impartial, accountable or transparent; there was a significant failure to achieve value for money; and, given the impact on people outlined above, it was all too often not in the public interest.

53. The government created a system which facilitated and enabled instances of wrongdoing, allowing individuals (often those with political connections) to make personal financial gain at the potential expense of individuals' health and lives. That government permitted, facilitated and encouraged such behaviour is particularly galling. The full impact of this on public trust and confidence is unknown but will be significant and long-lasting.

54. Through this Inquiry, politicians had an opportunity to address this impact and seek to restore public trust and confidence in themselves and in the democratic institutions that they represent. Instead, they have sought to downplay, diminish or deny the significance of the failures in the procurement system. Had they approached their evidence with candour, honesty and commensurate repentance, that may have gone some way to restore that broken trust and confidence. Sadly, they did not.

55. Mr Gove was true to form – his well-known disregard for experts and evidence resurrected in Dorland House. His evidence was an insult to the Inquiry and an insult to the families we represent.

56. Mr Hancock's combative and dismissive approach was on greater display in Module 5 than ever before, unrepentant for his failings.

57. Lord Agnew, with his direct attacks on the families we represent, belittling their concerns as having been "*whipped up, your people, by a narrative…*" [**10/168/21-22**] was nothing short of contemptuous.

58. Their individual and combined lack of candour displayed in this module will, sadly, have further eroded public trust and confidence and will further exacerbate and lengthen the impact of the pandemic on the future of our democracy.

III. PLANNING & PREPAREDNESS

59. The root cause of the procurement issues and impacts identified in Module 5 was a failure of preparedness. As Professor Moonesinghe told the Inquiry, we were "*woefully unprepared*" even for what was thought to be the Reasonable Worse Case Scenario [**9/141/13**].

60. The Inquiry's starting point must be the Module 1 conclusion that "*the processes, planning and policy of the civil contingency structures within the UK government and devolved administrations and civil services failed their citizens*".[6]

61. With no emergency procurement plans and virtually no stockpiling, vital time was lost. Prof Sanchez-Graells was clear that at the outset of the pandemic the UK Government had perfectly good legal frameworks and procedures for procurement, including emergency procurement, but because of a lack of preparedness, the system was quickly overwhelmed.

62. This was acknowledged by Johanna Churchill, former MP and Parliamentary Under Secretary of State for Public Health and Primary Care, who stated that:

> *"It was clear to me once the pandemic had begun, there was minimal preparedness … There were years of lack of preparation and the focus had been on a potential flu pandemic. The level of stock held at Haydock was not sufficiently inventoried for there to be any confidence that this represented the PPE that was needed*." [**INQ000533311_0008-0009, §30 & §32**].

63. There is no question that disruption to global supply chains and increased demand made the procurement of key healthcare supplies and equipment extremely challenging. But these issues were entirely foreseeable, and should have been addressed through proper planning well before the pandemic came over the horizon. Instead, by March 2020, the country faced a critical shortage in PPE, there were fears that we would soon run out of ventilators, and there was an urgent need for testing equipment and capacity.

64. Rather than respond in a level-headed manner, the lack of planning caused panic in government trying to address these critical challenges. Lord Agnew described Department of Health as "*so panicked that they just went rushing off to get whatever they could. And so there was no coordination that I could see.*" [**10/128/1-3**].

65. It was this panic and lack of coordination that created the impacts outlined above – namely a lack of PPE and equipment that cost lives, wastage and damaged public trust.

(i) <u>*Inadequate emergency procurement planning*</u>

66. Throughout the evidence heard in Module 5, it has been clear that the government lacked any adequate emergency procurement plan or strategy. As a consequence, the government was acting like "*rabbits in the headlights*" (Lord Agnew) [**10/117/7**] and established new systems

[6] M1 Interim Report p.3

and processes in the heat of the moment. These systems and processes failed to adhere to the principles for managing public money (see above) and failed to deliver the supplies that were needed.

67. Lord Agnew described the "*chaos*" that came about because "*we hadn't had a civil contingencies infrastructure in place in this country to my knowledge for years. Not of any scale*." [**10/114/10-12**]. He also recalled that government lacked a strategy when he was appointed in February 2020, by which time "*it was too late*" to rectify [**10/115/24**].

68. We invite the Inquiry to consider the extent to which this was caused by the absence of pre-pandemic involvement or oversight from DHSC in health procurement. As Jonathan Marron stated: "*Prior to the COVID-19 pandemic, the Department was not directly involved in the procurement or distribution of PPE for the health and care system*" [**INQ000528391_0042, §145**]. Had there been some involvement or oversight, the vulnerabilities in the system should have been known and a robust emergency plan could have been put in place. Instead, government ministers and officials were ignorant of this critical challenge that would arise when facing a health emergency such as Covid-19. Setting policy, oversight, accountability, and "*acting as guardians of the health and care framework*" are the express responsibilities of the DHSC[7], so the Department's abdication of responsibility with respect to PPE is both incomprehensible and inexcusable.

69. This failure is all the more inexcusable given that the importance of this issue arose repeatedly in pandemic preparedness exercises, including Exercise Silver Swan (pandemic influenza in Scotland) [**INQ000147883_0017**], Exercise Iris (MERS-CoV in Scotland) [**INQ000147839_0008**], and Exercise Alice (MERS in England), which made plain that at the earliest stages of such an outbreak, suitably trained professionals, with access to PPE in sufficient quantities, sufficient bed capacity and specialised clinical equipment, were critical [**INQ000090431_0009**].

70. However, despite this criticality, there was a failure to consider the procurement aspects of this challenge. As stated by Prof Sanchez-Graells, Exercise Cygnus in 2016 "*did not consider crucial aspects of preparedness in relation to the procurement of PPE and other consumables because it was assumed that, in addition to the strategic PIPP stockpile, arrangements were already in place for procuring these items, including through the NHS Supply Chain…*" [**INQ000539153_0060, §193**]. This flawed assumption led to a critical failure in procurement preparedness when the pandemic struck.

[7] https://www.gov.uk/government/organisations/department-of-health-and-social-care/about

71. Chris Hall stated that he does "*not believe anyone could have drawn up a detailed, useful strategy before the pandemic. It would have been very difficult to predict how much equipment would be needed and the unique market conditions which were generated by the pandemic.*" [**INQ000536421_0002, §9**]. This completely misses the point of an emergency plan. Government should have had a strategy in place that could *respond* to the needs and market conditions of a global health emergency, *whatever* precise form they took. The very suggestion that planning is impossible is not only ludicrous but dangerous. The Inquiry must say so.

72. Poor resilience and emergency planning did not only affect the procurement of supplies, but also logistics and distribution. As Brigadier Prosser told the Inquiry: "*some of the exercises prior to the pandemic just hadn't gone far enough in terms of the scale at which the demand signal would go up and the intensity*" [**15/159/25**].

(ii) *Inadequate stockpiles*

73. There was a failure to stockpile adequate levels of the correct PPE to respond to the Covid-19 pandemic. There was a singular focus on influenza preparedness and a consequent failure to stockpile suitable PPE for a Disease X pandemic scenario. The point of preparedness is to be ready to respond to the unforeseen and the unknown unknowns – by stockpiling only for an influenza pandemic, the government failed to adequately prepare.

74. The inadequacy of the Pandemic Influenza Preparedness Programme "PIPP" stockpile was multifaceted: it did not include the correct items of PPE, it did not contain sufficient quantities of PPE, there were data and logistical issues accessing it, and there was no distribution plan or strategy.

75. It must also be borne in mind that the term 'stockpile' can be misleading. Not all of the PPE considered to be 'in' the stockpile was physically available to SCCL – large portions were reliant on Just-in-Time (JIT) contracts being fulfilled.

76. Because the PIPP stockpile did not contain the types of PPE needed in the Covid-19 pandemic, the procurement teams were "*playing catch up*" as explained by Gareth Rhys Williams:

> *"…the fact that the pandemic PPE stock did not contain the right types of product for dealing with Covid (e.g. gowns) meant that the specifying and procurement teams were always going to be playing catch up…"* [**INQ000536362_0036-0037, §114**].

77. As of 18 February 2020 [**INQ000057507**], the PIPP stockpile contained a fraction of the target volumes of all PPE lines – including FFP3 Masks (27%, but of which only 2 million were physically held in the stockpile, with the remaining 5.7 million dependent on JIT contracting),

IIR Masks (34%) and clinical waste bags (24%); and contained 0% gowns despite the recommendation of the NERVTAG sub-committee on PPE to add gowns to the stockpile the previous year [**INQ000528391_0055, §204**]. Procurement of gowns, as the Inquiry has heard, became a critical challenge in the early stages of the pandemic.

78. But it is also clear that, even if the stockpile had contained target volumes, it would have been wholly insufficient. Jonathan Marron stated that "*PIPP stockpile targets are based upon the estimated requirements for products over the first 15-weeks of a RWCS pandemic flu outbreak, excluding BAU demand*" [**INQ000528391_0054, §198**] but this stock level was clearly inadequate to meet demand over the first 15-weeks of the Covid-19 pandemic. To give just two examples of this insufficiency:

    a. Demand for FFP3 masks increased from 87,000 to 286,000 per week in mid-February (representing an increase equivalent to around 10 weeks of the circa 2 million FFP3 masks physically available in the stockpile, even at this very early stage in the first wave). This increase in demand led to SCCL placing order limits and having only 1.44 weeks supply by 3 March 2020 [**INQ000528391_0072, §269 and _0074, §276**].

    b. Demand for IIR Masks during Covid-19 far exceeded that which had been estimated for a flu pandemic, with estimated 32-week demand as of 26 March 2020 being 481 million as against 197 million for a flu pandemic [**INQ000528391_0115, §429**].

79. In addition to the inadequacy of stock actually available in the PIPP stockpile, the failures to plan and prepare were further compounded by a lack of data and the stockpile being in 'deep storage' and therefore difficult to access. Matt Hancock stated in his Pandemic Diaries that, as of 14 January 2020, he was aware that "*paperwork is all over the place. There's no clear record of what's in the stockpile, and some kit is past its 'best before' date*" [**INQ000569777_0002**].

80. Mr Hancock also explained in evidence that this lack of data and poor recordkeeping "*wasn't the only problem. The bigger problem was that it wasn't pickable*" [**11/57/7-15**]. Similarly, Gareth Rhys Williams states that the PIPP stockpile "*was in "deep storage" in a warehouse in the north-west, rather than in a distribution warehouse. The pallets were stacked so that they were not immediately accessible, and pallets needed to be moved to a distribution centre so that loads could be broken up to send to individual hospitals and other customers*" [**INQ000497031_0140, §4.285**].

81. There is also no credible explanation or justification for the failure to properly stockpile suitable PPE for a non-influenza health crisis. This was even identified as the route to ensure appropriate PPE in the 2016 Exercise Alice (MERS-CoV) report which stated that "*Access to*

sufficient levels of appropriate PPE was also considered and pandemic stockpiles were suggested as a means to ensure sufficient quantities were available" [**INQ000090431_0009**]. Sadly, it seems that little action was taken in the years that followed to ensure this would be the case.

82. As Chris Stirling told the Inquiry: "*stockpiling is always going to be part of the answer*" to ensure that supplies are maintained in a pandemic [**9/81/17-18**]. Given its central importance, it is inexcusable that government failed to adequately prepare and plan for the stockpiles that were needed in advance of the Covid-19 pandemic. Lessons must be learned to ensure that this does not occur again in the future.

(iii) <u>*Lack of centralised data*</u>

83. Prior to the pandemic, there was a total lack of data preparedness, in particular there was no centralised system for recording stocks of PPE and other medical equipment. As Professor Sanchez-Graells stated "*The importance of having accurate and updated data to inform the response to an emergency, including through procurement, can hardly be overstated.*" [**INQ000539153_0040**].

84. This had a profound effect on the response in the initial stage of the pandemic, as the Inquiry found in Module 1:

> *"The decisions that were taken early in the Covid-19 pandemic rested on having "fast and reliable data". If decision-makers and advisers lack access to such data, they are "essentially driving in the dark.""*[8]

85. The UK was a long way from having 'fast and reliable' data at the outset of the pandemic. As Professor Manners-Bell told the Inquiry, we were "*nowhere near*" having a single UK-wide complete inventory of items such as PPE, describing instead "*a huge fragmentation of data*" [**5/22/14**].

86. The NHS had no inventory management and stock ordering system, meaning that there was no centralised record of PPE stocks held at the NHS frontline. Gareth Rhys Williams, stated that *"… at the start of the pandemic, there was no central record of what existing stocks of PPE were held by each Trust."* [**INQ000497031_0140, §4.285**]. Similarly, the minutes of a Daily Procurement Meeting on 20 March 2020 state that: *"Emily Lawson added that the data on PPE*

[8] M1 Interim Report p.97

stock is really poor. They don't know what is being held with Trusts. They don't know what is coming into the country…" [**INQ000233775**].

87. The issue wasn't just that data was held separately, but also that it was practically impossible to integrate data held across the devolved nations and in individual health Trusts or organisations, with Professor Manners-Bell explaining that this meant there was no means for "*interrelation or integration or the ability to integrate those different data silos*" [**5/23/3-4**].

88. According to Gareth Rhys Williams, "*The difficulty experienced in forecasting demand was probably the single largest issue*." [**INQ000535017_0014**].

89. In his evidence, Chris Hall explained that structured data is difficult to achieve, suggesting "*You wouldn't get something like that right first time. You probably wouldn't even attempt it in the middle of a crisis*" [**4/115/11-13**]. This is precisely why this should have been part of government's emergency planning – in order to build resilient systems and have access to necessary data when a crisis hits.

90. Professor Manners-Bell considers the need for centralised data to be "*absolutely crucial in any supply chain*" as it "*would definitely forearm the people in charge of the supply chain, whether that sits [in] the NHS Supply Chain or within the Department of Health and Social Care or even the politicians, to give an accurate view of what inventory is being held, what types of PPE are being held, the volumes that are being held and where they are being held*" [**5/24/10-18**].

91. A related issue was the sharing of information on offers amongst the procurement teams, with Chris Hall describing that "*before the introduction of Mendix, most caseworkers had very limited information with which to work*" [**4/100/13-14**]. It is remarkable that during this period of extreme urgency and intensity, the government lacked any usable data management system to record offers and their progression.

92. The Cabinet Office's 'Spreadsheet of PPE Offers' [**INQ000534813**] has 55,215 rows of data. That they resorted to the use of spreadsheets to store and track this information shows a dire state of preparedness and plainly created a real risk of crucial data being lost or missed. We urge the Inquiry to highlight the gravity of this failure, and make recommendations to prevent its recurrence. Lacking data is a serious omission, but a failure to hold and present data effectively through appropriate IT systems is a serious systemic failure.

(iv) <u>*Lack of civil service expertise and readiness*</u>

93. When the pandemic hit, government officials were not ready or prepared to respond. Civil servants lacked the expertise, capacity and readiness to respond to the procurement

challenges. Attempts were made to plug this skills and capacity gap by private sector consultants who were drafted in to assist. Civil servants were also seconded to DHSC or the Cabinet Office from across government, which created additional unnecessary challenges such as IT systems that were incompatible between departments.

94. The use of private consultants was borne out of necessity but came with new challenges as they generally did not have any experience of government systems and procedures, or specialist knowledge of PPE or relevant medical equipment. As Tim Jarvis stated "*Some of those leading these teams, had little or no experience of government. They had extensive experience of private sector supply chains but, particularly in the early days of my involvement, did not know where to go for advice or specialist knowledge within government or how to navigate the regulatory and approvals processes within government.*" [**INQ000527570, §2.10**].

95. Chris Hall described there being "*a very, very small group of people in the UK that buy PPE for a living*" and went on to suggest that "*it's not a difficult thing to buy. It's a commodity. It's usually bought through wholesalers. I'm not trying to diminish the skill and application of my former colleagues who came from SCCL, that's quite a small cohort, and all of those people worked in the PPE Buy Cell. All of them.*" [**4/152/4-15**].

96. The assertion that PPE was "*not a difficult thing to buy*" must be assessed against previous and continuing failures to purchase PPE that was suitable for real world use and met the particular requirements of the workforce that needed it and not just whether it met a technical specification. While it might be correct to observe that PPE *ought not to be* a difficult thing to buy, the evidence before the Inquiry reveals that, even pre-pandemic, apparent difficulties had neither been identified nor addressed.

97. Hall spoke about the contract with Ayanda. In that case, the lack of knowledge meant that government sourced ear looped facemasks that "*did meet the specification for which there they were contracted against but, as we learnt more, those ear loops, I think, were uncomfortable and so then the requirement changed to a different type of mask*" [**4/81/3-8**]. This is an example of PPE, at great cost to the public purse, being wasted as a direct result of procurement officers lacking the necessary understanding about what products ought to be purchased.

98. We also challenge whether "*all of those people [who buy PPE for a living] worked in the PPE Buy Cell*". As the Inquiry has heard, PPE procurement pre-pandemic was largely devolved to individual hospital Trusts. We question whether this frontline experience was sufficiently consulted in relation to PPE requirements, given their relevant expertise and experience.

(v) *Lack of understanding about product requirements and sources of supply*

99. Finally, at the heart of the failure to prepare, was a lack of understanding about the particular products that would be required or from where they could be sourced.

100. Those working in procurement often did not understand the real world use of the products they were buying, nor appreciate the subtle but important differences between products in the same category. This is apparent in the context of PPE from the lack of understanding about fit testing and Rosemary Gallagher's statement recalling one of her members saying: "*When I have fed back to cabinet office that [masks] don't fit, I was told any mask was better than nothing.*" [**INQ000553817_0007, §23a**].

101. However, this issue did not just affect PPE but also ventilators and other medical equipment The government's response to the shortage of ventilators was to launch the 'Ventilator Challenge' and called on manufacturers, many of whom had no experience in clinical technology, to develop new designs.

102. This approach was misconceived. The issue was one of supply, not innovation. Instead, the government ought to have acquired the existing IP or legislated where necessary to allow more manufacturers to build additional machines using existing designs. Such an approach would have been quicker, cheaper and more familiar for clinicians, as Prof Moonesinghe said "*I think that better planning and preparedness could have avoided at least some of the challenges that we had. If we had, for example, the surge in ventilator demand, if that could have been met with equipment that people were more familiar with, then yes, that would have helped.*" [**9/167/3-7**].

103. Because pre-pandemic PPE procurement was the responsibility of individual NHS Trusts, those in DHSC also lacked the necessary direct relationships with manufacturers or larger reliable wholesalers that were needed in order to scale up supply.

104. Into that void, aided and encouraged by the 'Call to Arms', stepped numerous opportunistic business people, intermediaries and agents. Whereas some were public-spirited, many were focused on profit and personal advancement. Many were the "*crooks and cranks*" identified by Lord Agnew [**10/168/13**]. These new entrants into the PPE market moved quicker than the UK government to locate the manufacturers and secure supply, sometimes gazumping the government in the process, further contributing to global supply pressures and price increases, while enabling those intermediaries to make massive profits from the pandemic.

IV. POLITICAL & INSTITUTIONAL FAILURE

105. As the pandemic arrived on our shores in early 2020, the consequence of the failure to prepare became all too real: supplies were exhausted, institutions were unable to cope, and systems collapsed. Procurement and logistics systems were simply overwhelmed. Professor Manners-Bell told the Inquiry that "*the supply chain and the logistics in the UK just wasn't able to cope with the demands which were being placed up on it. The systems were not set up, whether they were the warehousing systems or whether they were the procurement systems.*" [**5/18/5-9**].

106. Johanna Churchill stated that: "*SCCL, PHE and the NHS all had substantial issues… The lack of interconnectivity between the organisations and the lack of consistent technology meant that the bodies failed.*" [**INQ000533311_0009, §32**].

107. This '*lack of interconnectivity*' was further exacerbated by the fragmented, complex and potential competition between centralised procurement agencies, such as NHS Supply Chain (SCCL), National Services Scotland (NHS NSS), NHS Shared Services in Wales (NHS SSW), Business Services Organisation Procurement and Logistics Service in NI, individual NHS Trusts, care providers and other public sector bodies such as prisons and local authorities.

108. The pandemic exposed existing institutional weaknesses across DHSC, NHSE and SCCL. These weaknesses were the consequence of a failure to plan and prepare to provide critical healthcare equipment and supplies in an emergency, and of having no capacity or infrastructure whatsoever, to cope with anything other than business as usual.

(i) Delay and false reassurance

109. In the initial stages of the pandemic, the government's response can be characterised as one of inertia, incompetence and false reassurance. This fundamentally undermined the PPE procurement drive and compounded the problems that the UK would face.

110. There was an unacceptable delay before government recognised the scale of the challenge it was facing and the institutional failures that were undermining the response. As Jonathan Marron stated:

> "*PHE and SCCL were initially confident that their procurement efforts together with the PIPP stockpile placed the UK in a strong position in early February. However, over February and March 2020 it became clear in the reporting to the supply chain cell that there was significant manufacturing disruption due to lockdowns and export controls in China, a logistics freeze due to international border closures and massively increased*

international demand. Pre-existing contracts to augment the PIPP stockpile failed to deliver as did new contracts made by SCCL and private wholesalers to supply increased demand as the health and care sector prepared for COVID-19 arriving in the UK." [**INQ000528391_0004, §11**]

111. It is inconceivable that PHE and SCCL actually believed that the UK was in a strong position at any point, and the Inquiry should view these assertions as deeply problematic and lacking in candour.

112. Assurances that PPE procurement was under control continued into March and even early April. In Module 2, Dominic Cummings told the Inquiry that "*…on 26 March, Hancock told us that PPE procurement was 'under control'. On 31/3 Hancock told the Cabinet Room that there was 10 weeks stock for most PPE (minutes). This proved false.*" [**INQ000273872_0072, §338**]. Similar assurances that "*we have plenty of PPE*" are recorded in the Daily Procurement Meeting minutes from 20 March 2020 [**INQ000233775_0002**] and a DHSC document from 1 April 2020 maintains that "*existing stockpiles and resupply routes are extensive*" [**INQ000551580_0005**]. None of this was correct.

113. Similarly, although PPE supply into care homes was a significant issue and concern in early April, as confirmed by the minister Helen Whately in her evidence to the Inquiry [**8/49/19**], the minutes of a Health Ministerial Implementation Group meeting on 7 April 2020 refer to PPE but make no mention of the supply issues [**INQ000083702**].

114. Assurances over PPE supply were made despite warnings from Professor Jonathan Van-Tam and others as early as 24 January 2020 that there was insufficient PPE to respond to an airborne High Consequence Infectious Disease (as Covid-19 was then classified) [**INQ000047541_0003**]. Similarly, Johanna Churchill stated that "*I made it clear to others that there was a need for procurement processes to speed up at the outset of the pandemic. … It became apparent within days of the pandemic beginning that there was a serious issue in respect of PPE. It became obvious that there was a shortage of items of which there was a finite supply.*" [**INQ000533311_0012-0013, §43-44**].

115. It is clear that the UK was not "*in a strong position in early February*" as Marron recalls PHE and SCCL stating. These false reassurances led to a missed opportunity to resolve issues and put sensible strategies in place before the situation became critical. As Lord Agnew said, by the time of his appointment later that month "*it was too late*" to rectify the lack of strategy [**10/115/24**].

(ii) *Collapse of SCCL*

116. By mid-March 2020, it had also become apparent that NHS Supply Chain Coordination Limited (SCCL) could not manage the increase in supply and demand. It had effectively collapsed.

117. After being instructed to increase PPE purchasing in February 2020, SCCL was soon unable to meet demand from the NHS and other health and social care bodies. Matt Hancock records in his diaries that:

> "*…the government-owned company that gets supplies to hospitals across the NHS has effectively collapsed. The increase in demand for PPE was so enormous that they couldn't fulfil it. This is a total disaster. I'm absolutely furious that the people who are meant to be experts in logistics have been unable to cope because there are too many actual logistics*." [**INQ000569777_0012**]

118. Brigadier Prosser states that he was informed on 21 March 2020 that SCCL and its logistics partner Unipart was "*incapable of meeting the distribution challenge facing it*" [**INQ000560895_0011, §32**] and expanded in his oral evidence that "*there was something blocking it … digitally they couldn't do it, their systems couldn't expand. Physically, they weren't presenting options about extra warehousing*" [**15/147/13-16**].

119. The stock managing and ordering system within SCCL also had no spare capacity for more than very few additional users without risking crashing, requiring users to remain on their own, fragmented systems. According to Gareth Rhys Williams, "*The NHS Supply Chain IT infrastructure was at breaking point before the pandemic and could not handle the extra users that we needed. There were similar issues with access to the DHSC/SCCL systems*." [**INQ000535017_0047**].

120. Lord Bethell also recalled in his evidence that SCCL was "*completely eviscerated. It had no warehouses, no database, the staff didn't have the names of any of their suppliers*" [**11/28/16-19**].

121. It is clear that SCCL had simply not considered resilience in the event of a global pandemic, as Paul Webster stated: "*SCCL did have its own plans in place for a range of events including in relation to the disruption of supply but, again, the modelling for these did not envisage the sort of worldwide pandemic that was experienced during 2020*" [**INQ000492085_0029, §9.4**].

122. The government resorted to the ultimate back-stop solution: enlisting support from the military. A formal MACA (Military Aid to the Civil Authorities) request was made on 22 March 2020. Notably, the request included the statement that "*Commercial solutions have been explored*

but are unable to deliver in the immediate timeframe" [**INQ000049775_0002**]. However, the Inquiry has heard no evidence of DHSC, NHSE or SCCL actually exploring any alternative commercial solutions at this time. The system had collapsed at the first sign of challenge, and those in charge had stuck their heads in the sand.

123. Within a matter of hours, the MoD was able to identify a new commercial logistics partner: Clipper Logistics. It is notable that this came about without an open procurement process, that no other companies were contacted (despite it being known that "*many*" would have spare capacity [**INQ000560895_0013, §37**]), and that Clipper was only approached due to a personal relationship between their CEO and a member of the Engineer and Logistic Staff Corps.

124. While there are significant grounds for criticism of that contracting process, we acknowledge Brigadier Prosser's candour that it would "*absolutely not*" [**15/177/3**] be good practice in normal times and we recognise the urgency and effectiveness with which the MoD were able to resolve this critical challenge.

125. Even still, the simple fact is that this should never have been necessary. It is inexcusable that SCCL and Unipart became completely overwhelmed and was unable to scale up its operations to respond to the logistics and distribution requirements of the pandemic. Any resilient logistics system ought to have foreseen the possibility of periods of increased supply and demand, or a major upheaval such as during a health emergency. Spare capacity should have been built into SCCL's operating model (including for digital systems, warehousing and transport), or an emergency plan in place to allow them to scale up when required. This failure had the potential to undermine the entire healthcare response to the pandemic.

(iii) *Failure of Just-in-Time contracting and lack of UK manufacturing*

126. At the start of the pandemic, the UK was almost-exclusively reliant on sourcing PPE from overseas. Contracting was largely on a 'Just-in-Time' (JIT) basis, including for significant portions of the PIPP stockpile. This made the UK especially vulnerable to global supply chain disruption.

127. Jonathan Marron stated that "*continuity of supply was recognised as a key concern given the location of the primary outbreak in China (the country that manufactures the most PPE) and the resulting disruption to clinical consumable manufacturing caused by Chinese regional lockdowns, closure of international borders and export controls introduced at the end of January 2020*" [**INQ000528391_0060, §223**]. But this was not recognised in advance and prepared for.

128. It should have been foreseeable that global supply chains would come under enormous pressure in the event of a global pandemic. But the UK appeared oblivious to that obvious risk until the pandemic struck.

129. As Matt Hancock explained, the reason for this is a drive "*in normal circumstances for value for money and efficiency*" but "*when the pressure of a radical increase in demand met with a radical constriction of global supply, because everybody else's demand was going up too, the idea of having this just-in-time delivery system collapsed, and with it SCCL*" [**11/63/2-8**].

130. There was a complete collapse of the Just-in-Time ('JIT') approach to contracting at the onset of the pandemic: the first JIT order for 6.8 million FFP3 masks was placed on 31 January 2020, but all but one company stated they would not be able to meet the requirement, and that one remaining company reported an inability to fulfil the order four weeks later. As Jonathan Marron stated: "*No suppliers on framework able to deliver*" [**INQ000528391_0079**].

131. Similarly, the lack of domestic PPE manufacturing meant that the UK had nowhere else to turn to ensure continuity of supply. There were efforts to encourage domestic manufacture through UK Make, but the absence of advance planning or frameworks meant that vital time was lost activating domestic manufacturers.

132. Chris Stirling stated that, in addition to stockpiling, "*I think, increasingly, if we're looking for a longer-term and more sustainable answer, on or nearshore manufacturing opportunities, particularly in flexible production capabilities, potentially offers a more cost-effective and sustainable route of [ensuring that supply is maintained in a pandemic].*" [**9/81/17-23**]

133. We agree with Tim Jarvis's suggestion that a "*potential lesson from the pandemic is whether we should retain some residual capacity to stand up manufacturing of PPE at scale for critical goods in a future emergency. This was not in place prior to the pandemic and the PPE that was in short supply globally had not been considered critical.*" [**INQ000527570, §4.1**]. The obvious problem with this however, is that it requires significant investment for which there will be no return other than in an emergency. We submit that such an investment is essential to ensure that the UK is adequately prepared to provide sufficient life-saving PPE in the event of a future pandemic.

(iv) *Parallel supply chain*

134. In response to the collapse of SCCL and JIT contracting, the government set about establishing a parallel supply chain. But because this had not been planned for, with no oven-ready framework or structure to implement, and limited insight into what was required, the parallel supply chain was ineffective.

135. As Gareth Rhys Williams stated: "*The lack of detailed contingency planning and supply chain mapping of where PPE products were produced / where the raw materials came from, to protect in the event that the existing distributor fed supply chain failed, cost us a number of weeks at the beginning of the pandemic.*" [**INQ000536362_0038, §116**]

136. Chris Hall described the work of the PPE Buy Cell as "*like drinking from a fire hose*" in which a "*large proportion of these offers were completely unsuitable*" and "*very time-consuming*", with the perception risk of viable offers being "*lost in a bureaucratic swamp*" [**INQ000536369_0004; §3.5 & §3.7**].

137. Mr Hall also raised these concerns with Gareth Rhys Williams in an email on 13 April 2020: "*I dream about this stuff*", in which he said: "*We have designed the least efficient process possible*", explained that "*IT is killing us – I spent most of yesterday going back over old cases on stuff I had missed especially gowns*" and observed that "*there are limited gains in just working a fundamentally broken system*" [**INQ000534626**].

138. Gus Wiseman, the Head of Operations for the Joint Assistance Coordination Team (JACT) raised similar concerns in an email later that month, stating that "*the current system [for PPE] is broken. 7,000 leads in a backlog, 3 week waiting times for companies, very poor responsivity from Cabinet Office to issues and challenges in consistently engaging on long-term change*" [**INQ000489625_0002**].

139. We agree with Mr Hall's and Mr Wiseman's description of a system that was broken. The parallel supply chain was a creature of necessity, but it was established on-the-fly, without proper advance consideration of what would be required, the systems that were needed, training of staff or processes to ensure the effective triage and efficient response to offers.

140. This was likened by Lord Agnew to a "*hamster wheel … so we never had a strategic conversation…*" [**10/118/1-2**] and he said "*the country has to get angry about this sort of incompetence … People think it's all being done in a marvellously organised way, and it's not. It certainly wasn't then.*" [**10/130/25-131/4**]

141. The families we represent <u>are</u> angry about this incompetence. It is inexcusable that there was no strategy in place before the pandemic to increase supply of life-saving PPE. The country should never have been in the position of requiring a parallel system to be established, but if that was required then it should have been properly planned for, underpinned by a strategy, and designed in an efficient and transparent manner. In particular, from its inception it should have robustly countered corruption, cronyism, and profiteering.

(v) *Self-gazumping*

142. One of the adverse consequences of the fragmented and uncoordinated procurement efforts was that it risked creating direct competition between multiple buying efforts – whether the existing UK and devolved NHS procurement bodies, the parallel supply chain, or private intermediaries and agents – with the effect that this further drove up competition and prices in an already challenging market.

143. These issues were particularly apparent as middlemen and intermediaries entered the market. As Andrew Mitchell said, the intermediary market (in the context of ventilators) was "*much riskier*" than procuring directly from manufacturers; and said the "*guidance instructed officials conducting triage to "be cautious" of new suppliers entering the market and claiming to have stock. This was due to an increase of 'middlemen' offering stock on behalf of companies*." [**INQ000527714, §13.12 & §4.10**].

144. In some cases, this competition between UK buying efforts led to 'self-gazumping', as identified in a May 2020 'lessons learned' report from the China Team, which said: "*An intermediary approach failed to deliver, particularly on ventilators*" and "*it would be useful to consult teams here before giving orders, which could help to improve the understanding regarding the availability of products and realistic amount of the required production, not least as much production led back to China. This may also have helped to mitigate self-gazumping in the context of procurement not recommended, or even known about, by the China Network.*" [**INQ000494034_0003**]

145. This issue was addressed by Andy Wood in his statement: "*One of the issues which we were aware of was that we were usually dealing with intermediaries while the China team in the UK and Beijing was also trying to negotiate directly with the manufacturers. It was important to ensure, where possible, that the Opportunities Team was not competing against the China team for the same production capacity or supply.*" [**INQ000540488_0024, §4.6**]

146. An email on 1 May 2020 from Frank Clifford (JACT) describes this as "*approaching a Rubicon moment … We even have the ludicrous situation of a manufacture being identified some time ago, sending information into he [sic] .gov system and now being asked to undertake due diligence on a middle man who is offering items from that company*". The risk, as Mr Clifford identified, was that *"[t]he PPE team [was] adding no value*" [**INQ000493919**].

147. These conflicting activities undermined the wider procurement effort. This should have been identified as part of an emergency procurement strategy – it should have been obvious to anyone looking at the PPE market that the vast majority of manufacture was located in China

and there was a finite amount of capacity in the system. The use of middlemen and intermediaries did not increase the sources of supply, but rather increased the competition for that same limited supply.

(vi) *Call to Arms*

148. The issue of middlemen and intermediaries was further exacerbated by the government's 'Call to Arms', which only increased the overwhelm faced by the PPE Buy Cell. We suggest that it also had the effect of encouraging intermediaries and middlemen (often with no prior PPE experience) to enter an already crowded and competitive market, further exacerbating the global supply pressures.

149. The evidence from those closest to the government's commercial function at the time can leave little room to doubt that the 'Call to Arms' was counterproductive and a mistake. As Gareth Rhys Williams said: "*it had some very, very serious ripple - well, more than ripple, it caused huge problems, and a lot of the problems that the Inquiry is rightly looking into, I think, flow as much from that as they did from our lack of stock to start with*." [**2/197/10-14**]; and Chris Hall said simply that it "*made matters a lot worse*" [**4/115/18**].

150. Jonathan Marron agreed in his evidence that the preferable approach would have been to "*actively go out to seek manufacturers and to try to get down to the bottom of the supply chain*" because "*the more intermediaries there are in the supply chain, the higher the price of the goods become*." [**3/172/23**].

151. There can be no doubt that the UK's procurement resilience would have been greatly improved by building stronger relationships directly with manufacturers or major healthcare distributors (as identified by Andrew Mitchell, known as state-owned enterprises, or SOEs, in China [**INQ000527714, §13.21**]), rather than simply waiting for offers to be received into government or through middlemen that would inevitably be operating at profit.

(vii) *Devolved Administrations*

152. In April 2020, the UK Treasury agreed an uplift to the PPE funding envelope for DHSC expressly on the basis that it was to "*meet the UK's demand for PPE, including the NHS, social care and other public services*." [**INQ000551597**]. This was to include the procurement of PPE for the devolved nations as well as community providers and other public services. The funding envelope was further increased subsequently, again on that basis.

153. However, the DHSC failed to deliver. Just two weeks after the UK-wide funding envelope was agreed, on 12 May 2020, the Finance Ministers of all three Devolved Administrations wrote to

Steve Barclay MP (Chief Secretary to the Treasury) to express their "*collective concerns in regards to the limited supply of PPE currently being delivered through the proposed UK-wide procurement approach. This has resulted in the devolved governments incurring significant costs to secure sufficient PPE to protect our frontline workers.*" The letter stated that "*DHSC cannot currently guarantee the UK Government led PPE procurement can meet the needs of the devolved administrations*". [**INQ000336538**]

154. In the following days, the devolved administrations were asked by DHSC to consider a proposed four-nations approach, but emails at the time show the DAs remained concerned: "*experience of how this has worked during the Covid-19 emergency is that each of the 4 nations has had to set up its own supply lines and there has been a lack of transparency about procurement decisions taken by DHSC on behalf of UK nations.*" This led to an alternative proposal to "*revert to a standard consequentials approach*" but establish a new Four Nations PPE Procurement Group, in which each nation would be an equal partner but could plan future PPE expenditure and coordinate on contracts where needs overlap [**INQ000377395**].

155. The consequence of DHSC's failure to procure PPE for all four nations in accordance with the agreed funding envelope, was that the DAs sought reimbursement from HM Treasury for existing purchases in accordance with the Barnett Formula, which Steve Barclay MP described as "disappointing" [**INQ000109535**].

156. The confusion and delay in establishing an effective four-nations procurement arrangement will have inevitably caused further distraction and disruption to efforts to secure adequate PPE supplies. There ought to be a clear framework for future civil emergencies that would enable all four nations to cooperate and coordinate their efforts, but with clarity as to where responsibilities lie and assurance over funding provision.

(viii) <u>*Community providers and PPE for non-healthcare organisations*</u>

157. In a similar vein to the issues affecting Devolved Administrations, it became apparent to HM Treasury by July 2020 that the DHSC had failed to meet the commitment under the PPE funding envelope to provide sufficient PPE free of charge to community providers in the care sector, primary care and other public services.

158. Jonathan Marron notes that, with the move to a centrally funded PPE procurement scheme, DHSC was "*concerned about the ability for smaller providers, such as primary care, social care, and NHS community-based services (e.g. dentistry and community pharmacy) to access PPE*" [**INQ000528391_0170, §636**]. The clear inference from this concern is that, yet again, the government had failed to properly prepare for this eventuality.

159. However, the response to that concern by the DHSC was inadequate. Rather than providing PPE free of charge directly to community providers or via Local Resilience Forums, the DHSC (through PHE) sold 337 million items of PPE to private wholesalers at cost, which the wholesalers were then able to sell on to community providers on a commercial basis for profit.

160. As the Treasury itself recognised, this arrangement did not represent value for money and was contrary to the agreed PPE procurement funding principles. In a letter on 16 July 2020, Steve Barclay MP chastised Matt Hancock and expressed his disappointment and frustration about this arrangement:

> *"2. It is therefore disappointing to hear that the police, LAs, some parts of the NHS and prisons have all incurred costs buying their own PPE [...] Furthermore, these organisations have been buying from the wholesale market, at inflated prices which DHSC has been supplying at cost price.*
>
> *8. I am concerned that supplying wholesalers with PPE purchased by DHSC does not represent value for money and expect to see this halted as a route to supplying public services and the wider PPE supply chain. It is not acceptable that wholesalers both benefit from low prices secured via Government's significant efforts and from a margin on sales to wider public services.*
>
> *"10. It is deeply frustrating that these issues have surfaced so far after the initial period of constrained supply..."* [**INQ000109535**]

161. The DHSC was told to refund community providers and public services for the additional costs that they had incurred through this botched distribution arrangement. This means that DHSC will have paid twice for the same PPE, whilst private wholesalers made a profit.

162. This failure by DHSC to provide sufficient PPE to community providers, despite having been provided the funds to do so, did not only have financial impacts — it also cost lives. Many of the families we represent report a lack of PPE in social care and other community settings, which contributed to the death of their loved ones:

163. Basil Elliott, the brother of NICBFFJ member Anne Elliott, passed away after contracting Covid in his care home in Enniskillen. Anne had been vocal, both to the home and to entities such as the Regulatory and Quality Improvement Authority, in raising concerns that there were inadequate measures to guard against Covid 19 in the home, including inadequate use of PPE. Anne believes that this cost her brother his life.

164. Femi, the father of CBFFJ UK member Lobby Akinnola, died from Covid-19. He had been in previous good health. Femi worked in social care and was a support worker for a learning disability charity. He reported a distinct lack of available PPE.

165. CBFFJ UK member Laura Cairns' mother Sue was a care worker for autistic adults at a care home. The company she worked for did not give staff adequate PPE during the first lockdown and told staff they would be breaking contracts if they did not work as normal even without appropriate protection. Sue died after becoming infected with Covid-19.

166. Prof Naomi Fulop lost her mother, Christina, to Covid-19: she had been receiving domiciliary care. Naomi believes that her mother contracted Covid-19 from a visiting carer because they had been provided with insufficient PPE, including masks. It is of particular concern that the carers were only given one surgical face mask, as per Public Heath England guidance, to wear per eight-hour shift and so went from one frail, vulnerable person to the next wearing the same mask.

167. We are concerned that lessons have not yet been learned from this failure. An April 2022 Capabilities Review from the Pandemic Diseases Capabilities Board indicates that the failure to consider PPE supply arrangements for non-health sectors is an ongoing issue:

> "*Given the importance of this area and the current gap in non-health sector preparedness, there is therefore a need for cross-government work to consider the demand and supply arrangements for non-health sector PPE with a view to preparing a secure and proportionate PPE supply for future pandemics.*" [**INQ000087205_0003**]

168. It is vitally important that, should the UK face another pandemic emergency, adequate systems are in place to ensure an adequate and accessible supply of PPE to all necessary settings – whether hospitals, primary care, social care or other community providers and public services.

V. CONFLICTS AND CRONYISM

169. In early 2020, the government faced a choice. It was a choice whether to follow a rules-based, transparent and accountable process with a principled and consistent approach to inviting, managing and processing offers; or to establish a system that threw the constraints of good procurement practices overboard and paid lip-service to the principles for managing public money. Disappointingly, they chose the latter.

170. The establishment of the HPL or VIP Lane turned the UK Government's ordinary rules on handling conflicts of interest on their head. Rather than being a reason to more carefully scrutinise a contract, personal relationships now *resulted* in suppliers gaining preferential treatment through the VIP Lane – greatly increasing the chance of them obtaining a contract. As the UKACC observed in their evidence, these personal links between a referrer of an offer and a supplier in the VIP Lane were, at least in principle, capable of constituting a conflict of interest [**2/150/20**].

171. However, many of the politicians and officials that the Inquiry heard from failed to recognise this. They simply could not accept that this may be a conflict of interest, nor understand why that posed a problem. In some cases, their answers revealed a shockingly poor grasp of the concept of a conflict of interest, let alone how it should be treated. During the course of evidence, attempts have been made to narrow the definition of such conflicts (discussed in detail below at §220-227). The Inquiry must give short shrift to these try-ons, which are little more than brazen attempts to defend the indefensible: that those with connections and conflicts were afforded preferential treatment through the VIP Lane.

172. The advantage afforded to VIP Lane suppliers was a simple one: speed.

173. In a fast-moving global supply chain, where demand outstripped supply on a daily basis, speed is of the essence. Unless stock could be secured from manufacturers at pace, it would be lost to another buyer. That is the principle that middlemen and intermediaries operated on, as revealed by the evidence the Inquiry has heard throughout Module 5 — intermediaries identified manufacturing capacity, agreed in principle to make a purchase, then contacted the government to say they could obtain X supplies, but awaited a contract or advance payment before proceeding. They had hours or days to make these transactions work, not weeks or months.

174. By getting their offers to the front of the queue, via a political referral or intervention, these middlemen and intermediaries stood a far greater chance of meeting that timeframe and securing a contract.

175. This benefit is borne out from the data. Although the Inquiry has heard differing interpretations of the data on VIP Lane contracts, there are some clear truths:

- **The VIP Lane accounted for just 2.75% of all suppliers in the Parallel Supply Chain**

  *Of those suppliers who made offers to supply PPE: 430 were in the VIP Lane and 15,194 were non-VIP [**1NQ000528391_0192, Table 11**].*

- **Almost a third (30.83%) of all contracts awarded were to those in the VIP Lane**

  *Of the 393 contracts awarded, 115 were via the VIP Lane and 258 were non-VIP (20 unspecified) [**INQ000575086**].*

- **The chance of securing a contract was <u>at least</u> 10x greater if a supplier was in the VIP Lane**

  *This figure is almost certainly higher if assessed on the basis of offers made (c.25,000 [**INQ000497031, §1.29**]) as opposed to suppliers, given that many suppliers made multiple offers. But the government has failed to provide a figure for the number of individual offers made by VIP Lane suppliers and so therefore the calculation cannot be made on the available data.*

- **Contracts awarded on the VIP Lane represented 48% of the total spend by the Parallel Supply Chain**

  *Of the total spend on PPE by the Parallel Supply Chain of £8,626,368,106, the cumulative value of contracts to VIP Lane suppliers was £4,192,833,447 and to non-VIP Lane was £4,433,534,658 [**1NQ000528391_0192, Table 11**].*

- **Despite accounting for almost half of the contract spend, the VIP Lane only accounted for 37% of the quantity of PPE supplied**

  *Of the total number of items of PPE procured through the Parallel Supply Chain (20.84 billion), 7.795 billion of these were in the VIP Lane whereas 13.045 were non-VIP [**1NQ000528391_0192, Table 11**].*

176. In simple terms: VIP Lane suppliers were 2.75% of the total, but received 30.83% of the contracts, at 48% of the value, for only 37% of the goods. The conclusion is inescapable: a VIP Lane supplier was significantly more likely to secure a contract at the expense of value for money.

177. Of course, government needed a way of triaging suppliers to enable the quick identification and activation of legitimate offers. Companies that already supplied the NHS, already made PPE or were large global suppliers of goods, would have made it to the front of any sensible triage. The choice instead was to create a VIP Lane that allowed politically exposed people to jump to the front of the queue. No other country thought this a good idea, or indeed an acceptable process. The undeniable truth is that the establishment of a VIP Lane opened the door to corruption, cronyism, and profiteering.

178. So, why did this happen?

(i) *Establishing the 'VIP Lane'*

179. Despite the obfuscation from many of the witnesses during Module 5, we suggest that the Inquiry can be clear about the reason the VIP Lane was established: it was to provide a bespoke route for political and VIP referrals – no more, no less.

180. Witnesses such as Darren Blackburn have attempted to claim that the VIP Lane served two purposes: looking at the most credible offers and dealing with the "*noise*" generated by feedback requests [**4/69/14-18**]. But this *ex post facto* claim is undermined by contemporaneous email correspondence that Darren Blackburn himself sent on 8 April 2020, which is detailed in Max Cairnduff's witness statement:[9]

> "*On 8 April 2020 a Deloitte consultant raised a query as to whether the HPL could be used to process a high value offer, and Darren Blackburn replied 'No. VIP route is facing a backlog and is for MPs who can make life painful and shout loudly. If they are existing suppliers then they go through SCCL. If they are new suppliers – they go through the hopper and they are triaged accordingly like everyone else. If their volumes are such that they are high priority they will be contacted quickly and should fly through the system.*'" [**INQ000536351_0022, §7.15**]

181. Similarly, an email from Mr Cairnduff on 9 April 2020 stated that "*highly credible offers of large volumes of kit*" should go through the standard route [INQ000534699]. This is the truth of the matter: the VIP Lane was a process to deal explicitly with referrals from MPs, Ministers, Peers and other senior officials. It existed only to service those who had political connections and could utilise their influence to get to the front of the queue.

182. This is supported by Max Cairnduff's email on 29 October 2020 titled "Origins of the 'VIP' Cell", in which he explained:

> *"The public response to the call to arms to provide PPE was overwhelming. The PPE Cell received thousands of offers of PPE, so many that a large backlog quickly developed.*

[9] We note that the email itself does not appear to have been disclosed to the Inquiry. We are concerned at this omission of a crucial and clearly relevant communication which ought to have formed part of the evidence in Module 5. Although the content is available in Mr Cainduff's statement, the Inquiry is left unaware of who received this email, what prompted it, or any reply.

"Emily Lawson's office started being chased by ministers / senior officials for progress on offers they thought particularly valuable. The Cell had to create a way to deal with those offers, and avoid senior enquiries distracting the Cell's wider work.

"This led in mid-to-late March to the creation of the "VIP" team." [**INQ000496857**]

183. As Mr Blackburn stated in his 8 April 2020 email, any other new supplier — even if their offer was 'high value' or the volumes were 'high priority' — was required to go through the standard process. The term "hopper" is not one which has been used extensively during Module 5, but can be inferred to mean the general PPE Buy Cell backlog of offers, as apparent in other emails at around the same time in early April 2020 (e.g. [**INQ000475311_0023**]). This is despite it being known that high-quality offers "*were lost, or at risk of being lost*" due to delays in that process, as Mr Blackburn himself stated in his witness statement [**INQ000536359_0013**].

184. It is clearly correct that there was a risk of good offers being lost. But the VIP Lane was not the right solution and was not designed to solve that problem.

(ii) <u>*Role of politicians in procurement process*</u>

185. The only remotely credible excuse for a bespoke process that was proffered by witnesses was the need to deal separately with the "noise" or feedback requests from politicians who had made referrals, thus protecting the wider procurement team from being distracted or influenced by these requests.

186. As Max Cairnduff acknowledged in his statement, "*perhaps as is inevitable human nature, if a caseworker received an email saying that there was particular interest in an offer from a very senior minister, then they might be more likely to open up that case and see what had happened to it...*" [**INQ000536351, §9.6**].

187. The Inquiry heard a great deal of evidence about the "noise" in the system. There may have been merit in removing that noise from the system in order to avoid the risk of improper influence over the procurement process. But the politicians did not agree. Michael Gove told the Inquiry that having a system that "*protected civil servants from ministerial interference*" would be "*counterproductive*" and "*misunderstands democratic accountability*" [**5/154/4-6**]. This is nothing more than a political ploy to conflate two issues.

188. No one is criticising responsible ministers from exercising appropriate oversight over their departmental functions and the civil servants under their purview. Rather, civil servants in the VIP Lane were receiving referrals and interventions from MPs, unelected Peers and other

Ministers who had no democratic responsibility over those functions, such as was the case when Mr Gove himself intervened in relation to Meller Designs.

189. Mr Gove had no ministerial role or oversight in PPE procurement, which was a DHSC responsibility, yet he chivvied and chased on behalf of his "*great personal friend*" [**5/157/4**] David Meller, who had donated to his leadership campaign and given more than £68,000 to the Conservative Party [**INQ000493360**].

190. Mr Gove explained in his oral evidence that Mr Meller was in direct contact with his Private Office and Special Adviser, who knew of the close friendship [**5/158/7-19**]. That direct relationship with Mr Gove and his office led to Meller Design's first offer on 19 March 2020 being passed directly to senior officials including Gareth Rhys Williams and Emily Lawson within just a couple of hours of Mr Meller's email [**INQ000563687**]. It is unfathomable that this would have occurred if the offer had gone through the 'hopper', given that Meller Designs hit no obvious priority supplier markers.

191. Thereafter, Mr Gove became personally involved in chasing up the Meller Designs offer, providing for Mr Meller a literal direct line into the heart of government, with a call on 26 March 2020 [**5/159/20**], and a powerful and influential ally (and his office) who could navigate the civil service and procurement process on his behalf. Mr Gove's Private Office continued to chase for progress "*as a matter of urgency*" [**INQ000533868**]. These approaches caused Max Cairnduff to make a direct intervention on 4 April 2020 to discourage the constant chasing:

> "*I understand you're both being chased by a Mr David Meller of Meller Designs for updates on his offer of masks. Mr Meller is presently in our payment process. There's been multiple conversations with Mr Meller which are ongoing but he keeps separately contacting private offices even while conversations with our team are continuing. Unfortunately, that means he's generating a lot of noise in the system.*" [**INQ000534695**].

192. But even this did not stop the chasing or additional noise: within just 36 minutes of Mr Cairnduff's email, a response was sent from the Cabinet Office (sender's name redacted) to ask how long the appraisal would take and express frustration for the delay by "*putting myself in his shoes*" [**INQ000534695**].

193. Thereafter, further requests for intervention were made to Lord Bethell who on 6 April 2020, despite knowing of the personal relationship with Mr Gove and being "*a hundred percent*" aware of Mr Cairnduff's stated position "*that although there might be pressure to act, it was essential to check the deal*" [**11/34/22-24 & 11/35/5**], gave "*assurances*" that the offer would be "*actioned ASAP*" to issue "*a letter of intent **today***" (original emphasis) [**INQ000497141**].

194. Lord Bethell justified his role in this on the basis that "*many [civil servants] were genuinely paralysed by the system - by the situation. The system had been put in place for a hundred years to stop us from doing this kind of thing. The system put in checks and balances and rigour and audit and regulations…*" [**11/35/10-16**]. In a similar vein, Mr Gove dismissed these civil servants following due process as "cautious Charlies" [**5/156/9**]. But subverting the civil service to force action to be taken before due process was followed, and to throw away 100 years of procurement safeguards, was not the right approach and was not in accordance with the principles of good governance. A failure to have an emergency procurement plan or strategy must not be allowed to be used as an excuse to junk all safeguards and normal processes.

195. None of the chronology detailed in the preceding paragraphs can be said to amount to proper ministerial responsibility or oversight. This was Mr Gove and his staff affording preferential treatment and proactive support to a "*great personal friend*" — treatment that would not have been available to a supplier without those political contacts and which assisted Meller Designs to move more quickly through the procurement process than other suppliers could have done, thus affording the crucial benefit of speed.

196. There are many more examples of this improper involvement of politicians: Lord Chadlington and his referral of SG Recruitment (detailed below at §224-226) and Baroness Mone and her involvement in PPE Medpro (detailed in our CLOSED M5 Closing Submissions) to name just two.

197. Mr Gove's claim that he was merely a "*postbox*" [**5/161/10**] is so disingenuous that it would be laughable, if this were not such a serious issue. In Mr Gove's world it seems bold denial trumps rational explanation, and the bolder the better.

198. Setting aside the appropriateness or otherwise of politicians demanding updates or chasing up offers, if the process had in fact been designed to achieve the aim of protecting procurement officials from any direct or implied pressure from politicians to prioritise an offer, then that may have been admirable. That may have amounted to the "*legitimate operational requirement*" identified by Prof Sanchez-Graells [**2/73/13**]. But it was not. The VIP Lane did not achieve that aim, it achieved the opposite.

199. The VIP Lane was not merely a stakeholder engagement or communications function, as some witnesses sought to imply. Rather, it was an integral part of the PPE procurement process and was staffed by some of the most senior and experienced procurement officers operating within government.

200. As Prof Sanchez-Graells said "*they addressed a challenge in the worst possible way in a procurement context*" [**2/73/16-17**].

(iii) *Patronage and political support*

201. The cronyism, preferential treatment and patronage described above was not limited to the VIP Lane for PPE. It also extended to Dyson's involvement in the ventilator challenge.

202. As Matt Hancock records in his pandemic diaries:

> "*Our [ventilator challenge] competition is proving a mixed blessing. Some participants are a little over-enthusiastic. James Dyson, the vacuum manufacturer, has been contacting numerous people in high places to ensure he has a prominent role. He's continually on the phone, including to Boris, pushing to take part. He's an amazing innovator and engineer and he's completely right to turn to this – after all, we put out the call – but it's becoming awkward. … Michael texted asking to talk urgently about what to do about Dyson. It's a fine line between enthusiasm and getting in the way.*" [**INQ000569777_0011**]

203. This political support and focus on Dyson is of great concern to our clients. The evidence shows that political patronage began even before the Ventilator Challenge was launched, with Claire Gibbs explaining in her statement:

> "*I am aware that there was a call between the then Prime Minister and Sir James Dyson on 13 March 2020. In a message sent on the morning of 13 March 2020 by Gareth Rhys Williams to Steve Oldfield of DHSC and Patrick Vallance, Gareth suggested getting a group of engineers together in order to make ventilators urgently. Dyson was cited as an example of a company which the design consultants might be able to work with Gareth forwarded this email to Munira Mirza and Ben Warner who worked in No 10. Later that morning Steve Oldfield reported that his phone number had been given by the Prime Minister to Sir James Dyson and Lord Bamford of JCB.*" [**INQ000528389_0106**]

204. This was followed by exceptional treatment, prioritisation and political support throughout the process. Ministers were eager for Dyson to be awarded a contract for the prototype ventilator, despite it being less advanced than other models in the Challenge and had not yet secured clinical approval [**INQ000233775**].

205. For example, in a meeting on 25 March 2020, despite advice that Dyson's units did not meet specifications and would fail clinical tests, Michael Gove "*acknowledged he was under political pressure to ensure we have followed up with Dyson*" [**INQ000535017_0041**] and was described as "*INSISTENT*" (original emphasis) that an order be placed [**INQ000496699**].

206. This culminated in a decision to provide a contingent order to Dyson for its model, a decision made by Mr Gove that went against commercial advice and was exceptional in light of the fact that it was an entirely new design [**INQ000497031_0077**]. Sir John Manzoni, expressed concern that "*indirect pressure was being placed on the MHRA to approve the supplier's design at the stage of selecting suppliers to progress in the Ventilator Challenge*" [**INQ000536361_0013**]. While witnesses who attended the Inquiry disputed that there was ever any pressure to approve a design that would not otherwise have passed regulatory approval, we observe that the effect of this pressure would, at the very least, have been a distraction for the MHRA and very likely have prevented other models or equipment from utilising limited testing capacity, despite those other models offering better prospects for use.

207. The exceptional treatment of Dyson continued even after it has become apparent that government would not pursue their model, with Lord Agnew warning Gareth Rhys Williams that "*we are going to have to handle Dyson carefully"* and making the incredible suggestion that:

> *"I suspect we'll have to buy a few machines, get them into hospitals so that he can then market internationally being able to say they are being used in UK hospitals… we both need to accept that it will be a bigger decision than we can both make. Remember he got a personal call from the PM. This can't be ignored.*" [**INQ000512992**]

208. The fact that a serving Minister was prepared to buy and supply ventilators that had not been deemed suitable or necessary for UK hospitals simply because the supplier was politically connected (or even contemplate doing so) speaks to an environment and a culture in which political patronage was prioritised above all else.

209. Further, as Prof Sanchez-Graells sets out, decisions made in relation to Mr Dyson would likely have been in breach of the applicable procurement rules:

> *"In my view, the inclusion of Dyson in the 'Ventilator Challenge' and, in particular, the award of a contingent contract were driven by industrial policy considerations-or, in other words, were decisions that sought to favour Dyson's position on grounds that were irrelevant to the procedure at hand. This not only was a breach of the limits on the direct award of extremely urgent contracts… but also an award on non-objective grounds and criteria that could not have been used to justify an award under the procurement rules… At the very least, if implemented within a standard procurement procedure, this intervention would have been a breach of the duty of equal treatment and potentially the materialisation of an impermissible conflict of interest. The fact that this took place outside the remit of the procurement rules on the basis of a non-compliant approach to the direct*

award of contracts does not reduce its affront to those principles." [**INQ000539153_0130-0131**]

210. This form of patronage and political support had no place in the procurement process, whether in the VIP Lane or in the Ventilator Challenge. Indeed, it was an "affront" to all proper procurement principles.

(iv) *The benefit conferred by the VIP Lane*

211. Various witnesses in Module 5 have sought to claim that the advantage of the VIP Lane was negligible or minimal – affecting only the initial opportunities stage and providing no significant benefit beyond an email inbox.

212. Even if that were so, this position ignores the most significant constraint of the global supply chain pressure in that period: time. The quicker an offer could progress through the procurement process, the more likely that it could be completed before the manufacturers sold stock or production slots elsewhere.

213. As Max Cairnduff stated, "*you were often asked to submit things before we would otherwise choose due to senior pressure*" [**INQ000536351_0025, §7.20**]. He also acknowledges the consequence of this: "*that if my team were quicker or more responsive, then suppliers would get different treatment*" [**§9.7**].

214. That approach is brought into sharp relief by the explanation sent by Dawn Matthias-Jackson, apparently to a new recruit onto the HPL Team. Asked, not unreasonably, to identify what "a VVIP case" is, Ms Matthias Jackson offered the explanation: *"They are Very, Very Important People. Basically suppliers who have made contact with us directly via a MP, Lord, Lady, PM Private Office etc. As such, Cabinet Office are keen that they receive a speedy response from us in terms of taking their potential offers of support forward"* [**INQ000565104**].

215. By avoiding the backlog in the 'hopper', by *"receiv[ing] a speedy response"* and being "*submit[ted] before we would otherwise choose*", those suppliers with a political or influential referrer were able to jump the queue. They were able to make swifter progress that allowed them to move through the system and gain immediate market access to lock in the manufacturing supply before their competitors, thus securing the contracts.

216. However, Prof Sanchez-Graells has also debunked the suggestion that "*this was an opportunity stage issue only, but then VIP offers were sent for technical assurance like any others*", because in fact "*technical assurance ended up appointing a specific person to deal only with VIP offers. So it's not accurate to say all offers were treated the same from a technical*

assurance perspective because technical assurance was taking time and having a dedicated person for technical assurance of VIP offers would have accelerated things." [**2/74/9-19**].

217. One example of this was Ayanda. Darren Blackburn received a text message from Andrew Mills on 17 April 2020 asking for an update and emailed [**INQ000534566_0003**] internally saying "*Can we expedite this one please? … Our contact has close ties to DIT so wouldn't be a good outcome [if we lost the opportunity].*" The email was replied to by someone in the MOD saying they will "*check where it is in QA*". The effort to "expedite" was through technical assurance. This is clear evidence that the benefit did not end at the opportunities stage but continued throughout the process.

218. Similarly, the Inquiry also heard from Sarah Collins of the UKHSA that a Supplier Triage Analysis conducted in January 2022 revealed 50 suppliers who were identified as a priority for "*entry routes for testing contracts and associated governance procedures*" [**INQ000383567**] on the basis that "*they had had a reference from an MP or a senior person in government, or it was someone who was sort of a known person, it was basically - it was not about whether they should be prioritised, it was more about who had referred them*" [**8/83/2-11**].

219. We also must observe that the Inquiry has not heard the full picture. No witnesses from the technical assurance stage were called to give evidence, nor has the Inquiry heard from anyone involved in the latter stages of the procurement journey (due diligence and the closing team). The manner in which VIP Lane offers were handled at those later stages remains unclear on the evidence, but it can be inferred from the Meller Designs interventions (as detailed above) that the interference of Ministers and the additional hand-holding from the VIP Lane opportunities team continued to have a role to play and, we suggest, the Inquiry can clearly infer that a continuing benefit and preferential treatment were afforded throughout those stages of the process.

(v) *Conflicts of interest and due diligence*

220. The evidence has revealed a shocking misunderstanding and misapplication of the regard to conflicts of interest.

221. It is clear from the evidence that the government were operating with an extremely narrow definition of a conflict of interest. This overlooked the risk of conflicts arising in the referral process itself and, in many cases, failed to identify what ought on any view to have been regarded as an actual conflict of interest requiring further investigation and additional due diligence.

222. This narrow interpretation is apparent from Gareth Rhys Williams's explanation that: "*As part of the due diligence, the directors of potential suppliers were checked by the Markets and Suppliers team using an HMRC tool that flagged whether they were Politically Exposed Persons. The results of these checks (positive or negative) were recorded on the Due Diligence report forwarded to the Closing team.*" [**INQ000497031_0182, §4.442**].

223. But, as Prof Sanchez-Graells states:

> "*While this is a potentially helpful check, it does not suffice to ensure that a company does not create potential conflicts of interest in relation to PEPs, as their holding a directorship is a very narrow and probably rare circumstance. Where a due diligence check concerning PEPs was concerned, especially in the context of the 'VIP Lane', a more thorough investigation may have been appropriate and there could have been ways to go beyond the HMRC tool, such as explicitly asking the company and the referrer to complete a conflict of interest declaration form. However, where conflict of interest declarations were required as part of the Closing Team's due diligence (through a new supplier form), they referred to possible conflicts of interest between the supplier and DHSC (id, para 4.456). This also left routes for potential conflicts unexplored, especially in relation to PEPs involved in the referral the 'VIP Lane' but unrelated to DHSC.*" [**INQ000539153_0110**]

224. One example of this is Lord Chadlington's involvement in the SG Recruitment contract. Lord Chadlington accepts that, as Chairman and a shareholder of Sumner Group Holdings, he stood to gain "indirectly" from profits made by SG Recruitment. He also received payments of director's fees for his role as non-executive Chairman and for consultancy services. [**INQ000530462_0019, §78**]. Yet, this was not regarded as a conflict of interest when the contract was awarded.

225. We suggest that the Inquiry can conclude that SG Recruitment — which had no experience in PPE supply — received a benefit and preferential treatment owing to Lord Chadlington's involvement, along with the support of Lord Feldman, Mr Hancock and Lord Cameron. As Lord Feldman said in his evidence, "*it didn't really enter my consideration*" [**7/192/15-16**] that Lord Chadlington may have benefited from the contract and considered that "*because it's disclosed*" it failed to be a conflict or a concern [**7/192/19**].

226. The suggestion by Lord Feldman that he referred SG Recruitment because he "*had a slight soft spot for someone who told me they had served in the military [David Sumner] and was ex-SAS and credentialised themselves in that way*" [**7/190/18-21**] is as striking as it is alarming. It beggars belief that this was thought to establish SG Recruitment as a suitable company to be

prioritised for PPE procurement contracts, especially in the context of hurried due diligence and an overlooked conflict of interest involving Lord Chadlington as Chairman of the parent company.

227. Another alarming insight into ministerial awareness and understanding of conflicts of interest came in the evidence of Lord Bethell, who stated that "*I think that if someone has put something in their register of interest and are utterly transparent about it, then it doesn't qualify as a conflict*" [**11/40/13-15**]. This is fundamentally wrong. A conflict of interest doesn't cease to be a conflict when it is declared elsewhere. There are no passes for complying with the rules on declarations. This flawed understanding is insightful as to the approach of government ministers at the time and may help to explain why so little regard was had for conflicts actual or perceived during the pandemic.

228. The due diligence process as a whole was also not robust and was capable of being undermined. In the example of Andrew Mills and his offer, initially through Prospermill Ltd, to supply PPE, due diligence was undertaken and Prospermill was yellow rated. But then, only after the products had passed technical assurance and the contract was at the final stages, Andrew Mills informed Darren Blackburn that he intended to contract instead through another company Ayanda Capital. Further diligence was undertaken and Ayanda Capital was red rated. Despite this the offer was progressed [**INQ000536359_0030, §85**]. We suggest this was an example of the due diligence process being completely unfit for purpose. By the time Mr Mills informed procurement officers of the change, the offer had been through the majority of stages in the procurement process. Mr Mills had the upper hand and was able to dictate terms even if that meant government accepting greater risk.

(vi) *Alternatives to the VIP Lane*

229. As we say above: the VIP Lane was a choice. It was not a necessary or required response to the procurement pressures.

230. The Inquiry's expert, Prof Sanchez-Graells stated that:

> *"The reasons for [the VIP Lane's] creation are unpersuasive, as there were alternative measures that could have been put in place without creating preferential treatment at triage stage. There was no consideration given to the risk of de facto differential treatment that the pressure stemming from regular requests for updates and the labelling of offers as 'VIP' could have, or potential confusion as to what 'VIP' signalled. There was no consideration of the fact that a referral by Ministers, MPs, or Senior Officials was not a justification for preferential treatment."* [**INQ000539153_0121**].

231. Rather than reflect with candour about the failures of the VIP Lane, ministers such as Matt Hancock have lined up at this Inquiry to justify its existence and describe as "*wholly naïve*" [**11/99/24**] the idea that another more appropriate, robust and transparent process could have been established.

232. Yet, none of those ministers have identified any other country in the world to have introduced a process akin to the VIP Lane, nor did any of the devolved nations feel the need to adopt something similar. As Karen Bailey of BSOPaLS (the Northern Irish Procurement and Logistics Service) told the Inquiry, other than prioritisation of specific items such as FFP3 masks, all offers received were dealt with on a sequential basis "*first in, first served*" [**15/22/2**].

233. Another alternative was that identified by Chris Hall, to "*take an approach which is closer to the one taken by the Ventilator Challenge. The Ventilator Challenge proactively went out and found people that they thought could design and build ventilators in a hurry*." [**4/114/14-18**]

234. Either approach — a sequential triaging of all offers, or a proactive approach to manufacturers and reputable suppliers — would have adhered to the principles for managing public money, would have maintained trust and confidence in the government's procurement approach and would have ensured the UK could obtain sufficient supplies without cronyism, profiteering and preferential treatment.

235. There is no credible explanation for why the UK — the sixth-largest economy in the world, with the oldest national health service in the world and a supposed beacon of democracy — was so out of step with every other nation on the planet, that the only way it could source sufficient PPE and medical equipment was to turn to the personal friends and contacts of its politicians. There is no credible explanation because it simply cannot be justified.

236. We endorse the conclusion of Prof Sanchez-Graells that "*the reasons given for the creation of the 'VIP Lane' are not persuasive because there was no genuine legitimate need for different processing of referred offers simply on the basis of the referral*" [**INQ000539153_0101**]. Patronage and cronyism had no place in this process.

VI. PROFITEERING

237. The net effect of the preferential treatment, institutional failure, cronyism and corruption outlined above was the ability of unscrupulous businessmen and women to take advantage of the pandemic to make huge personal financial gain.

238. We note that the Inquiry has steered away from calling evidence of profit levels and profiteering in Module 5, despite much of this information already being in the public domain and calling for answers from those responsible. We maintain that the Inquiry ought to have heard from those suppliers who made these profits, in order that they could be asked to justify them. Similarly, those ministers and officials involved in the approval of these contracts ought to have been asked to explain why such enormous profit margins for intermediaries and middlemen were considered appropriate.

239. As it is, the Inquiry has the evidence to observe that excessive profits were made. For example, according to the Good Law Project: "*Firms like Uniserve, Ayanda Capital, and Meller Designs all saw profits leap after the pandemic, with earnings surging by 500%, 2,600%, and 9,000% respectively*" [**INQ000493360**].

240. In the case of Ayanda Capital, the man behind the company Andrew Mills (who secured contracts due to his prioritisation on the VIP Lane, having been an adviser and member of the Board of Trade at DIT) is reported to have profited £32.4 million, with his business partners Mr Horlick also profiting £20.3 million and Nathan Engelbrecht profiting £11.6 million. Those profits combined (£64.3 million) represent more than 25% of the total value of contracts secured, of just over a quarter of a billion pounds (£252,500,000) [**INQ000497969**].

241. In the case of Meller Designs, David Meller (the "*great personal friend*" of Michael Gove, who obtained contracts following repeated direct intervention from Mr Gove's private office) and his brother are reported to have profited £16.4 million from his contracts [**INQ000497969**].

242. In another case of massive profiteering, SG Recruitment (a company with no experience of manufacturing PPE and a pre-pandemic turnover of under £500,000) is reported to have made £1.1 million in profit from two contracts collectively worth just under £50 million [**INQ000493439**].

243. But this was not intended to be the end of the story for SG Recruitment. As an email obtained by the Inquiry reveals, David Sumner and Lord Chadlington intended to use this government procurement as "*a key stepping stone that generates cash reserves and then affords us the luxury of sector analysis (Healthcare, Defence, Security) to see how the group can evolve with its own high yielding product lines*" [**INQ000510480**]. Despite this, shortly after the pandemic, SG Holdings Ltd entered liquidation and media reports suggest that the UK government is unlikely to recover any money for £20 million of unusable PPE supplied by SG Recruitment.[10]

[10] Government likely to lose millions in dispute over PPE contract awarded via 'VIP lane'

244. This egregious profiteering was enabled by the VIP Lane and its prioritisation of offers based on who was making the referral and whether it was therefore a 'trusted' offer. It allowed middlemen and intermediaries to make a quick profit while the country suffered. This, along with so much else revealed in Module 5, is simply inexcusable, indefensible and unjustifiable.

VII. NORTHERN IRELAND SPECIFIC ISSUES

245. The issues with procurement and supply in NI had significant overlap with the flaws in the UK system as a whole. The devolved administrations, including NI, were no more prepared for the pandemic than the UK Government had been, as was apparent from several aspects of the NI response.

246. Before considering those aspects, it is important to emphasise the distinction between process and outcome in order to ensure that correct lessons are learned for the future. This is particularly significant in the NI context, as witnesses repeatedly suggested that procurement in NI had not suffered from the flaws associated with procurement in England and conducted by central UK government. For example, it has been suggested that NI did not see the same level of shortages of PPE as in England, and it has been highlighted that the cronyism of the VIP lane was not witnessed in NI procurement.

247. NICBFFJ reject the idea that flaws and failures in English procurement are benchmarks against which to measure Northern Ireland's comparative 'successes'. Even where NI appeared to have better outcomes than England, the evidence heard in this module makes clear that these were not product of some grand procurement strategy which was well-prepared and carefully implemented, or even a product of a coherent and considered response to an emergency. Instead, there was a large measure of "the luck of the Irish" associated with those positive aspects of NI procurement. Self-evidently, relying on good fortune is not a proper strategy for meeting a pandemic. Self-congratulation on the part of NI entities in this Module therefore suggests a misunderstanding of the purpose of the Inquiry, which is to meaningfully reflect on past actions and to learn lessons which can be implemented in the next pandemic.

248. A preference for self-congratulation, on the part of the NI DOH in particular and a failure to reflect on what occurred and to identify what went wrong, has been a recurring feature of these hearings. The recurring lack of self-reflection on the part of NI entities in advance of Inquiry hearings, ensures that the evidence to the Inquiry is not as informed as it should properly have been, thereby hindering the efforts by the Inquiry in identifying what went wrong and drawing lessons for the future. Instead, there seems be a passive approach, and a policy of 'wait and

see' what errors the Inquiry can identify from their decisions, against a clear knowledge that the Inquiry's consideration of NI specific issues has been and will continue to be 'high-level' and non-specific. To that end, the Inquiry risks being used by NI entities as both an excuse for historic inaction and meaningful reflection and a cover for future failures to implement NI specific change.

249. By way of example, Mr Matthews of the DOH candidly admitted that they had not yet completed work on identifying what lessons could be learned in general from modelling, with such work apparently still going on, but emphasised "*we would look to any recommendations made by this Inquiry around modelling because I think it is fiendishly complicated…*" [**15/90/1-3**]

250. Ms Bailey identified that BSO PaLS considered it was too soon to draw lessons learned from the pandemic even at this stage:

> "*we still feel that we're not really finished at the point where we could pool all of the lessons learned because some of that will be about disposal and some of the initiatives, for example, we're involved in at the moment in terms of putting them into energy and into waste initiatives. So we want to make sure it's a full picture before we actually do a final lessons learned. But happy to take any recommendations that the Inquiry makes to us in that respect.*" [**15/44/22 – 15/45/6**]

251. This attitude was not confined to civil servants. Former Minister of Finance Conor Murphy, when asked about the limits of his Department's consideration of lessons learned, again effectively identified that devolved entities would wait for the Inquiry to identify what went wrong:

> *"I do think there are, of course, in any of these experiences there are lessons to be learnt and I would hope that the experience of the pandemic is, through the work of the Inquiry, and the analysis that will come from that then, applied to make sure that we are in a better prepared state, should such a situation arise again. I don't think that the administration in Northern Ireland is unique in terms of not being fully prepared for the extent of a pandemic that faced us. But I think, of course, the experience, the analysis that will come through this Inquiry and the kind of suppose, self-examination across each of the administrations then hopefully will make people in a better state of preparedness should such a situation arrive again. At the very least, we will have the experience of that to draw on in terms of a response.*" [**15/130/14 – 131/5**]

252. Whilst the Inquiry's recommendations should obviously inform lessons learned and any future response, it is simply not acceptable for NI entities to attend at the Inquiry and for their evidence

to be that they still have not identified or sought to identify what went wrong and would like the Inquiry to identify this for them. It is also difficult to argue that it is too early to complete any work to learn lessons and identify what went wrong on the part of individual entities such as BSO PALS, given that each entity is dealing with a much more detailed set of issues than this Inquiry itself is considering.

253. It is glaringly apparent from the evidence that there were significant process failures with respect to procurement and supply. Despite this, the Department of Health's closing submissions did not appear to acknowledge any of these failings:

> *"It should now also be apparent that, in general terms, the items obtained, including their specification, quality, and volume, were sufficient to meet the needs of the people of Northern Ireland, and that all relevant organisations worked together to ensure that these materials were effectively distributed to those who needed them.*
>
> *"Now, my Lady, the department does not want to pat itself on the back or appear in any way self-congratulatory, as has been suggested earlier this morning. But objectively, we contend that the department has demonstrated that in the relevant period, its public procurement processes met with the highest standards of integrity, transparency, and good administration."* [**16/91/21 – 92-10**]

254. This approach misses the point and fails to acknowledge important concerns about the significant problems with procurement and distribution in NI which will require to be addressed and resolved for any future pandemic. In particular:

(i) It fails to acknowledge that the Department and devolved entities were initially slow to react to the inevitable procurement needs in the initial stages of the pandemic, thereby ensuring they were on the back foot when seeking sufficient supplies of PPE and critical care equipment;

(ii) It fails to acknowledge the lack of any coherent strategy or planning to obtain adequate supplies of PPE, or the fact that the relative success was founded on a significant degree of good fortune;

(iii) It fails to acknowledge the very limited safeguards which were imposed to prevent cronyism/corruption;

(iv) It fails to acknowledge that supplies obtained by NI were obtained at higher cost than those in other jurisdictions, a factor which should properly be addressed in order to identify the reasons and to prevent recurrence;

(v) It fails to acknowledge the failures in relation to material that was purchased, and which must be addressed in any future pandemic, due to failures in modelling and failures in safeguards imposed in relation to those purchases;

(vi) It fails to reflect on how procurement and supply arrangements require to fundamentally change in order to be prepared and resilient for future pandemics.

(i) *Lost time in February and early March*

255. The Inquiry will recall evidence from previous Modules which suggested that the response to the pandemic in NI was slow, to the extent that the "lost month of February" could have been regarded as extending into much of March. The procurement response does not appear to have deviated from that approach, with the evidence suggesting that action in earnest to purchase PPE was only taken in late March rather than in late January/early February when it was plain that the pandemic was coming. For example, the statement of Karen Bailey of BSO PaLS identifies that 50 purchase orders for critical care equipment to support the response to the pandemic were placed between 23 March and 13 January 2021. Strikingly, although there were apparently no purchase orders made before 23 March 2020, it appears that 45 of these 50 purchase orders were placed between 23 March 2020 and 30 April 2020. **[INQ000514103_0016/38]**

256. The delay in the NI response also appears to have been the fundamental reason that a proposed joint purchase with the Irish Government to obtain urgently needed PPE in late March 2020 did not proceed. Those responding to questioning on this issue did not accept expressly that a failure to act promptly had scuppered this proposal, however this reality is clear from the explanations provided.

257. Conor Murphy, then Minister of Finance, made clear that the joint procurement was proposed because "*the economic agency in the south of Ireland was further ahead in perhaps securing*" PPE, and discussions were therefore held about "*the possibility of adding …an order from Northern Ireland into that and having a joint procurement exercise.*" **[15/116/16-21]** This plainly suggests that the NI authorities were late to react, and were, understandably, attempting to make up for their late reaction by piggy-backing on the southern Irish efforts which were, as a consequence, further developed.

258. That this is what occurred was also evident from the testimony of Mr Losty, who described a zoom call with the Irish Ambassador to China, who confirmed that they had discussed the issue with their PPE suppliers and "*they had basically exhausted all the amount that they were able to get at that time.*" **[11/178/3-13]**

259. It is apparent from this explanation that the Irish Government had already reached an agreement on the amount of PPE they were able to obtain and were unable to increase this as a result of Northern Ireland's belated request to join the venture or to be considered in the distribution of the PPE obtained. The logical inference is plainly that if proactive steps had been taken sooner, then joint procurement may have been achievable.

260. The slow reaction to the pandemic and its consequence for procurement of PPE was also apparent in the failure to acknowledge that independent care providers would be required to rely on state resources given the worldwide difficulties in sourcing necessary PPE.

(ii) *Failure to Ensure Access to Supplies for Independent Care Providers*

261. It is striking that the DOH position in closing appeared to be that the issues with PPE provision for independent care homes appeared to be about messaging, describing the "*perception that there was confusion around the messaging in relation to how the independent healthcare providers would procure PPE at the early stages of the pandemic.*"

262. That characterisation of the issue is unhelpful and appears to deny or downplay what was a significant issue with the risk that lessons will not be learned for the future. The difficulties that independent care providers had in accessing PPE at the outset of the pandemic were not only real, but they also held significance both for those reliant on care homes, and for society as a whole, given the extent to which infections in care homes had the potential to drive numbers in the pandemic. The Inquiry has seen repeated emails evidencing the increasing concern of the IHCP and others about the failure of the DOH to act promptly and with responsibility in ensuring that the independent care home sector, and those providing domiciliary care, had access to sufficient PPE [e.g **INQ000536196**]. Such were the frustration of providers of home care in Northern Ireland, that a joint letter was issued on 23 March 2020 setting out individual and collective frustrations and dissatisfaction at the leadership of the DOH and Trusts in responding to the pandemic, noting their respective limited attention for anything other than the Acute and Primary Care sector meaning that home care workers were continually overlooked in policy guidance and requested to deliver care without masks or visors to symptomatic clients [**INQ000536197**]. This was not, as the DOH now suggests, confusion around messaging. This was an early abdication of responsibility for the independent and home care sector, with catastrophic results.

263. That Independent Health and Care Providers (IHCP) had made *"considerable representations" during February 2020 and March 2020 to DOH about PPE shortages, but that the Department had maintained that procurement rested with ISPs"* was noted in the NAIO report on procurement of PPE. The NAIO records that *"DOH acknowledges that discussions with ICS*

[Independent Care Sector] *representatives took place in March 2020, during which issues associated with access to PPE were raised.*" Unsurprisingly, the NIAO reports that Independent Service Providers (ISPs) had "*inadequate PPE supplies in the early stages of the pandemic, with particular shortages of FFP3 masks and eye protection.*" **[INQ000281185_0033, §3.7]**

264. It is also apparent that the needs of these care homes were not even considered in early modelling of demand, which focused only on hospital-based care **[15/36/9-16]**.

265. It is not disputed that steps were thereafter taken to ensure that independent care providers had effective access to PPE obtained by the DOH, but the significance of these early failings should not be denied or downplayed. The Inquiry will be well aware from previous Modules, as well as statements provided for the forthcoming Module 6 focusing on the care system, that many of our members have concerns that inadequate PPE in care homes in the early stages of the pandemic cost their loved ones their lives. This should have been acknowledged by the DOH. In any event, steps must be taken to ensure that, in the future, independent care providers are not effectively forgotten in any pandemic response undertaken by the state.

266. It can be inferred that one reason that these independent care providers appear to have been forgotten from early procurement and supply of PPE is that there was no coherent plan in place to deal with the pandemic. That this was the case is apparent from the extent to which procurement efforts relied on good fortune.

(iii) *Lack of Plan or Strategy for Procurement*

267. The slow reaction of the NI authorities effectively meant that the ultimate success of the NI executive in procuring adequate PPE, for example, was not based on any considered plan which can be adopted and utilised for the next pandemic, rather it relied on a large measure of good fortune, particularly in securing supplies of PPE from China Resources.

268. When it was put to Conor Murphy that the China resources shipments were founded on a large measure of good fortune, he suggested that this characterisation underplayed Mr Losty's role, noting that he "*was very critical in securing supply for us.*" **[15/118/10-11]** That is not disputed; it is in fact the point. Mr Losty had no professional background in healthcare equipment procurement, nor did the Executive Office (where he was placed) or the NI Bureau have any authority over or formal role in procurement **[11/155/4 – 156/24]**. As Karen Pearson identified in the Corporate Statement provided for the Executive Office, with which Mr Losty agreed, his critical role in securing supplies was borne from circumstances/opportunity. **[11/155/21 – 156/13]**

269. This context reinforces the conclusion that the DOH emphasis on whether NI managed to obtain the necessary amounts of PPE to meet demand in the pandemic are misplaced in the context of this Inquiry. They confuse process with outcome.

270. That is not to say that NICBFFJ's comments are wholly critical. Rather there are important positive lessons which can be drawn from this particular procurement exercise.

271. Firstly, and very obviously, it provides a demonstration of the effectiveness in practice of one of the alternatives to implementing a VIP lane which we have identified above, namely of a proactive approach being made by those responsible for procurement to reputable suppliers.

272. Secondly, it is significant that the purchase of PPE from China Resources was made possible by the positive relationships which had been developed by Mr Losty and the NI Bureau in Beijing. Notably China Resources was not included on the "White List" of companies permitted by the Chinese authorities to export PPE, however Mr Losty and his colleagues did not know any company on the list, and did not know anyone who did, leading them to approach China Resources, a company which Mr Losty did have previous experience relationships with. In simple terms this tends to provide a practical example of the importance of the recommendation made by the Inquiry's expert on supply chains, who, in Recommendation 22, emphasised that decision-makers including the DAs should cultivate "*longer term relationships with Chinese, and critically, non-Chinese suppliers must be maintain or developed, even taking into account the possibility that these channels may be rendered ineffectual in a pandemic.*" **(INQ000474864_01378)**

273. Mr Losty's historical relationship with CR in this case appears to have been a game-changer. As Mr Murphy emphasised:

> *"Tim Losty used his own personal connections that he had built up as the Northern Ireland Executive's representative in Beijing for a number of years at that point and managed to secure us a contract, which -- I think when you see some of the exchanges from Scotland and Wales, they were, you know -- and indeed from London -- that we had managed to secure that ourselves was a matter that raised some eyebrows, given how small we were in the international stage."* **[15/118/15-24]**

274. This tends to provide a practical example of how a recommendation which appears to be simple and somewhat obvious may have critical importance in a pandemic.

275. It is possible to acknowledge these positives whilst still cautioning against drawing the wrong conclusions from the process and outcome. There are consequently a number of lessons which should be identified.

276. Firstly, for the reasons identified above, this procurement exercise was founded primarily on good fortune. That self-evidently is not a strategy for any future pandemic. The fact that, because one person was in the right place at the right time, NI escaped a much worse fate should not lead to a false sense of security about the slow response to the pandemic which was apparent from the DOH submissions.

277. Secondly, the extent to which this shipment, arranged through a single Chinese company, was critical to NI obtaining adequate supplies of PPE at the time tends to emphasise the lack of options available to NI either in or outside of China. The good fortune which permitted this procurement exercise must not be permitted to allow neglect other aspects of Prof Manners-Bell's recommendations, including the importance of developing other relationships inside and outside of China (as well as developing domestic capacity).

278. A third factor which should be considered is the fact that NI was required to engage in such an exercise on its own, through the NI Bureau as opposed to the UK Embassy (albeit using contacts within the Embassy). It is clear that the FCO and the DTI were engaged in sourcing PPE on behalf of the DHSC prior to the initiation of the China Resources procurement. Whilst NI has bureaux in Beijing, Brussels and Washington, these are limited entities, reflecting that there are some international activities that have an impact on areas that are devolved **[11/152/21-253/3]**. International trade and international relations are excepted matters, over which the UK Government departments retain responsibility. The fact that Tim Losty and the NI Bureau were so essential to obtain this shipment of PPE, as opposed to the UK China Embassy, the FCO or the DTI, suggests a breakdown in the constitutional arrangements and the devolution settlement, as well as a lack of coherence in procurement between the devolved entities and the UK Government. This is not merely an abstract legal concern about the constitutional settlement and democratic accountability. Whilst this procurement exercise was ultimately successful, it appears that the lack of coherence in the system permits a very real risk of self-gazumping. This is one obvious reason that a coherent response on procurement issues is required in future.

279. That is also not to say that the answer to such concerns is that procurement should be centralised and governed by UK departments. A single procurement route would, on the evidence that the Inquiry has heard, inevitably lead to a lack of consideration by Westminster of the unique requirements of the DAs, it would also undermine the democratic accountability that comes with devolution. Moreover, the evidence in this Module suggests that the UK response was more chaotic, more prone to inappropriate cronyism, and less effective, than the devolved administrations, characteristics from which the Devolved Administrations understandably would wish to be distanced.

(iv) *Limited safeguards which were imposed to prevent cronyism/corruption*

280. NI did not adopt anything equivalent to the VIP/High Priority Lane which was implemented by the UK Government. Instead, Karen Bailey of BSO PaLS described how offers were triaged, and treated on a first come, first serve basis, irrespective of who had referred the offer or whether these were followed up by any politician. Prioritisation of offers was on the basis of need, such as the separate triage stream which prioritised offers of FFP3 masks in particular given the concerns about shortages of such masks **[15/20/24 – 22/2]**.

281. This is significant as it undermines the suggestion from UK Government witnesses to the effect that those who criticised the establishment of the VIP lane were not being realistic or living in the real world. As observed in closing oral submissions, the number of offers dealt with by NI appears to be equivalent to the number of offers being dealt with by UK Government (once population size is factored in). The NI experience (and the experience of other devolved administrations) suggests not only was the VIP lane inappropriate and ineffective, it was unnecessary.

282. However, the mere fact that NI did not suffer from the implementation of a VIP lane approach, does not mean that the NI approach can be lauded as an example of a process characterised by transparency and effective safeguards against abuse. Rather there are significant improvements in terms of both practical safeguards as well as organisational culture which are required.

283. It is accepted, for example, that BSO PaLS had not identified any conflicts of interests in contracts awarded during the pandemic **[15/40/15 – 41/2]**. However, that in itself is insufficient to justify the claim by the Department in closing submissions that "*the department has demonstrated that in the relevant period, its public procurement processes met with the highest standards of integrity, transparency, and good administration.*"

284. Most notably, the NI Audit Office observed that, while it is objectively correct (and it may be subjectively the position), that BSO PaLS has not identified any conflicts of interests in contracts awarded during the pandemic, their process relied exclusively on relevant officials self-declaring conflicts of interest and is therefore unlikely to detect any undisclosed conflicts **[INQ000348882_0048-49]**. Accordingly, the process adopted was not effective as a safeguard in practice. In her evidence Ms Bailey of BSO PaLS confirmed that despite this observation of the NIAO, no changes have been implemented to ensure a more robust or proactive approach to identifying or safeguarding against such conflicts, and no such steps appear to be envisaged. This is apparently because BSO PaLS consider that there are already sufficient safeguards in

place to guard against such conflicts, primarily because decision-making rested with three different agencies. There are two points to note about that response.

285. Firstly, this fails to acknowledge that this does not in fact remove the risk of an undisclosed conflict of interest operating as an influence on the process. For example, such a conflict could lead to an offer being prioritised by one decision-maker out of sequence. The fact that other decision-makers are involved subsequently would not undo the consequence of preferential treatment of this nature.

286. Secondly, this multi-agency process was known to the NIAO when these critical comments were made. That suggests that the NIAO were not of the view that these processes served to remove any further risk. The position of BSO PaLS appears to simply be that the NIAO were wrong to take that view. No proper basis has been provided to support that conclusion, which has ensured that effective safeguards have still not been developed and implemented. We invite the Inquiry to make this clear.

287. Quite aside from the formal safeguards in place, there are also concerns at a culture which failed to recognise the importance of transparency and therefore to prioritise data retention in relation to procurement. That there has been a cultural failure to recognise and act upon the importance of such data retention was glaringly obvious in the explanations provided for the inability of the Inquiry to access data contained on Mr Losty's devices and accounts, which were variously the subject of "the dog ate my homework" type explanations. For the avoidance of doubt, we are not in a position to criticise Mr Losty for the loss of this data, nor do we suggest that there is evidence of anything nefarious being concealed. However, what these chains of events do make clear, is that there was a cultural failure to appreciate the significance of data retention for the purposes of government transparency and oversight, and relatedly the importance that this holds for safeguarding against maladministration and corruption.

288. One reason that such transparency is required is that it may be necessary to explain particular aspects of procurement. That is significant, as there remain aspects of NI procurement which do require explanation. One obvious aspect is the fact that NI appeared to pay more than other devolved entities for similar items of PPE.

(v) *Higher Cost*

289. The evidence appears to suggest that NI paid a higher price as compared to other devolved administrations for the PPE that was purchased. For example, the NIAO report on NI costs shows that NI was paying £0.99 per mask in April 2020, at a time when Wales was paying £0.40 - £0.73 (NIAO Report INQ000348882_0053 Fig 17). Evidence from Scotland suggests

that the most the Scottish authorities paid for a Type IIR was £0.75. Similarly for gloves, the most authorities in Scotland paid was £0.17, in March 2020. In contrast, the NIAO report shows that NI paid £0.22 in April and £0.25 in September for gloves, whilst in the interim, in June 2020, Wales paid £0.14 per glove. These figures again suggest that DOH self-congratulation over procurement is, again, misplaced. Whilst the NIAO report identifies that BSO PaLS suggested this may be due to a variety of factors, including additional transportation costs, and may relate to the volumes purchased by each entity, it is not at all clear that there has been any comprehensive exercise conducted to examine whether these factors could explain the entirety of these differences in costs. It is just as likely, particularly given the limited statistics above, that the timing of purchases was a feature, which suggests that failure to plan or to purchase in advance was a failing. In any event, it is not at all clear that the differences in prices can be explained by the factors identified by BSO PaLS. This also reinforces concerns at the lack of lessons learned exercises undertaken by BSO PaLS, which hinders efforts to identify the reason that NI appeared to pay more for similar PPE items than their devolved counterparts.

290. Higher prices were not the only example of apparently wasted funds associated with NI procurement. There was also significant over-purchasing and consequent waste, resulting from inaccurate modelling.

(vi) *Issues with Modelling*

291. There are two features of modelling PPE needs in NI that we would wish to emphasise.

292. Firstly, it appears that devolved entities were misled at the outset of the pandemic by the suggestion that modelling of demand for PPE would be undertaken by NHS England and Public Health England for the UK as a whole. This suggestion apparently originated from the DHSC itself, which established the WN Covid Supply Chain Group and at the inaugural meeting "*it was identified that RWC modelling was being worked up*" by NHS England and Public Health England to trigger PIPP Just in time supply. DA representatives raised the need for such modelling at subsequent meetings, but "*no demand modelling information was forthcoming through this group prior to its closure at the end of March 2020.*" **[INQ000514103_0029§69]**

293. Clearly informing DA's that modelling was forthcoming, and not then providing that modelling, was a failing which had the potential to hinder efforts to obtain and supply necessary PPE. That this occurred is further evidence of chaos and the lack of a coherent response to the pandemic. Steps should be taken to ensure that such chaos is not a feature of any future pandemic response.

294. The evidence of BSO PaLS is that the DOH and PHA then established a Silver Command commissioned "modelling cell", which was chaired by the PHA. BSO PaLS then received three sets of modelling:

- Demand figures provided in March 2020 which took into account only hospital led demand (thereby omitting the care system and needs in the community);
- Modelling of RWCS in July 2020 which overstated demand;
- After the overstated demand had been identified, a revised RWCS model was provided in July 2021. Although this predicted lower demand than the previous model, actual demand from July 2021 again did not reach predicted levels.

295. These failures in modelling demand were significant. Initial modelling apparently failed to take into account the majority of end users, which may have been a factor in the failure to ensure that all end-users were able to access the PPE that was available.

296. Overstated demand was also significant in terms of the ultimate cost to the health service because wasted funds necessarily mean less funds for other healthcare priorities, resulting in loss of resources which would otherwise be available. The extent of the overstated demand appeared to go beyond what was required for the pandemic. By way of example, evidence suggests that the cost of NI write offs from surplus stock since 2022 was 33% greater than in Wales despite the NI population being roughly 2/3 of that of Wales [Contrasting **INQ000536425, §230** with **INQ000514103_0070, §215].**

297. It is therefore a matter of significant concern that there has not been any effective analysis of NI modelling conducted by the DOH or the PHA. As noted above the evidence of Mr Matthews of the DOH identified for example, that they had not yet completed work on identifying what lessons could be learned, stating: "*there is a piece of work going on at the minute to look at modelling in general, and to look at what lessons can be learned…*" **[15/89/23-25]**

298. It is not at all apparent from the generalised phrasing that the work which appears to be ongoing is in fact examining the modelling which was conducted to identify what went wrong and how this could be corrected in the future.

299. Nor does the evidence from the PHA on modelling provide any more comfort, rather the reverse. Despite chairing the modelling cell, the PHA statement provided to the Inquiry for the purposes of this Module made passing reference to the issue of modelling in a single paragraph **[INQ000538438_0009, §27]**. Their statement acknowledged that they chaired the PPE Regional Modelling Group which was established to support the effective planning,

provision and utilisation of PPE across the NI HSC system, but does not mention that the modelling overstated demand, twice, leading to significant loss of public funds, nor does it comment on whether these errors were considered in any way so that the reasons for this could be identified to try to ensure such mistakes to be avoided in future. It does not even suggest that they await the Inquiry's conclusions on these issues.

300. It is respectfully suggested that the Inquiry's recommendations should emphasise the importance of accurately modelling demand in any future pandemic and should also include recommendations that work is conducted to identify what went wrong with modelling of such demand in NI, and how this could be corrected in future.

(vii) *Issues with PPE purchased*

301. A further concern at waste associated with NI procurement was associated with the purchase of material which was later discovered to be unusable. Concerningly, the most significant issues of this nature related to a purchase of masks from the Welsh government.

302. One feature of the explanation provided for this failing has been an apparent attempt to suggest that some PPE equipment which was purchased was rejected as a result of user preference and not for reasons for public health. The oral evidence of Karen Bailey of BSO PaLS about the decision not to use was to the effect that they were "*technically perfect but just did not meet the user preference.*" **[15/26/4-6]** That evidence was somewhat surprising, as Ms Bailey's witness statement appeared to suggest that the decision not to use the masks were taken by professionals responsible for Infection Prevention and Control:

> "*Complaints were received from Trusts about the fit of the masks, and they withdrew them from use; in particular getting a snug fit around the wearer's nose and cheek were causing concerns for the staff in using the mask.* ***Infection Prevention and Control (IPC) leads within the Trusts made the decision not to use the masks.*** *Upon investigation by MOIC, it was found that the noseband was made of a plastic material which was not as malleable as other masks in use and that the masks may not be suitable for use in higher risk areas, but that they might be used in instances where MRI scanning was taking place as there was no metal content in the noseband.* ***Subsequently members of the IPC cell reviewed the masks and rejected them for use in clinical areas…"*** (Emphasis added in bold) **[INQ000573993_0005, §10]**

303. Given her evidence that the masks were rejected twice by IPC professionals, the basis Ms Bailey has for suggesting that the masks were "*technically perfect*" but rejected as a matter of "*user preference*" is not clear. It is not apparent whether this evidence was intended to

downplay the ultimately wasteful purchase, costing approximately £3.3m, but this comment was concerning for separate but related reasons.

304. Firstly, for the reasons identified above, in particular the involvement of IPC professionals in the decisions not to use these items, it is not at all clear from the evidence that these items were rejected solely because of "user preference".

305. Secondly, if the items were in fact "*technically perfect*", this tends to suggest that their disposal was unnecessary and was itself a wasteful act. If this was the case, it is also not clear why steps were not taken to sell these masks to other jurisdictions. The evidence is that they were obtained by NI at cost in a purchase from the Welsh executive. This was not a case of oversupply, with excess being identified after the conclusion of the pandemic, rather the decision not to use these masks was taken during the pandemic. If the masks were in fact technically appropriate, it is not at all clear why they could not have been sold on to others rather than disposed of.

306. Finally, we have spent some time on this issue because it discloses a misplaced attitude on the part of those responsible for purchasing and supplying the PPE that they were better placed to identify what was "*technically perfect*" than those on the frontline who were relying on these products to protect their health and lives, and the health and loves of those they were caring for. In any future pandemic those who are required to rely on the PPE must have a say in what amounts to appropriate and effective PPE.

307. A further reason this apparently misplaced focus is significant is that the apparently congratulatory attitude adopted by the DOH appears to place too much weight on whether they obtained adequate PPE, and too little weight on whether they were successful in their role of ensuring that the end-user who required PPE received the right PPE at the right time.

(viii) *Issues with Supply to the end user*

308. The Inquiry has evidence from the various Health Trusts, as well as of the supply issues to various care providers, about issues of PPE provision to those on the front line. The position of the DOH in this Module was to the effect that there was always sufficient PPE to meet demand, however Chris Matthews accepted that, at least in the early stages, there were issues with distribution:

> "*What I understand is that in the early stages, even though there were sufficient supplies of PPE, because of the initial kind of pull system, some of the PPE was in the wrong bits of the system and then had to be kind of moved to other areas.*

Q. So a distribution --

A. So I think it was a distribution and logistics problem rather than a supply problem, in those kind of early stages where demand was essentially exponential and the system, I think as you've already heard, the business-as-usual system could not cope with the demands being placed on it at that point.

Q. But from the perspective of a healthcare worker on the ground, they might not have had -- (overspeaking) --

A. I accept that."

[15/81/5-24]

309. This acknowledgement by Mr Matthews was a necessary acknowledgment in light of the weight of the evidence about PPE shortages on the front-line. The point no doubt being made in over-speaking in that latter question on the transcript was no doubt one made by the Inquiry's supply chain expert, Prof Manners-Bell, about the importance of the six "Rs", (right products in the right place, at the right time, in the right condition, of the right quality, and at the right price). He noted:

> "*in supply chain terms, not getting the PPE to the right place means a critical supply chain failure. You may not have bothered to have had those goods in the first place If you're not able to get them to where they're needed at the right time, to the right people."* **[5/11/10 -12/2]**

310. Mr Matthews' evidence reinforces the conclusion that obtaining the correct PPE was necessary but was not sufficient on its own to protect our clients' loved ones. The acceptance that PPE supplies were in the wrong bits of the system and so did not reach those who needed them is in reality, an acknowledgment of failing which is not at all consistent with the Department's suggestion in closing that the PPE items obtained:

> *"were sufficient to meet the needs of the people of Northern Ireland, and that all relevant organisations worked together to ensure that these materials were effectively distributed to those who needed them."*

311. The concern on the part of NICBFFJ is that failures in supply to the end user have not been properly considered and addressed by the Department.

(ix) <u>*Resilience in the Future*</u>

312. It is apparent that one of the key features of PPE procurement was the lack of resilience of supply chains, resulting in the need to rely on a large measure of luck during the pandemic. As noted above, that cannot be a strategy to meet any future pandemic. Improvement in the resilience of procurement and supply chains will be essential to effectively respond to any future pandemic.

313. Prof. Manners-Bell, the Inquiry's expert witness on procurement and supply chains, has made a significant number of recommendations and emphasised that a multi-faceted approach was required. We have already noted his comments above in relation to developing and improving international links. He also emphasised the strategic impact of migrating from a linear to circular supply chains, as they could not only ensure increased resilience, but also held out the prospect of associated benefits such as reduced environmental waste (INQ000474864_0053-_0054, §217-225). Among those recommendations he considered to be essential was to "*develop a domestic UK PPE supply chain.*" (INQ000474864_0127§543).

314. A number of these conclusions and recommendations appear consistent with the approach outlined by the former Minister of Finance in his own evidence about the changes initiated in response to the pandemic. What is not clear is the extent to which the approach has a prospect of being implemented successfully and whether sufficient resources have been put towards it so that there is such a successful implementation. For example, it is notable that Mr Murphy also referred to the fact that, although there is a strong manufacturing base, he suggested that we do not have natural materials in terms of supplies *"so that will always be a challenge for us."* **[15/122/1-9]** That read as an implicit acceptance that resilient domestic supply chains are a practical impossibility, however Mr Murphy's statement does not provide any evidence that there has been comprehensive work undertaken to examine the extent to which a lack of natural resources is a factor that would prevent establishment of domestic supply chains which would be resilient in a future pandemic, consideration, for example, whether any issues relating to the natural resources available can be avoided through innovation.

315. We respectfully suggest that ensuring resilience in supply chains is an essential lesson which must be drawn from this module of the Inquiry. It is essential that devolved authorities do not simply pay lip service to that aim but undertake comprehensive steps to ensure that realistically possible methods of ensuring resilience through domestic manufacturing have been properly considered.

VIII. RECOMMENDATIONS

316. We urge the Chair to make the following recommendations in the Module 5 report.

317. **Recommendation 1a:** The preparation of a comprehensive UK pandemic procurement strategy and emergency plan, which must include:

a. A detailed governance framework for emergency procurement procedures under the Procurement Act 2023, that is based on making proactive approaches to accredited manufacturers and suppliers with a transparent framework and selection criteria that reflects the importance of circular supply chains, shorter supply chains and diverse supply chains. This governance framework must robustly protect against preferential treatment and political referral outside of those criteria.

b. A plan for the training, exercising, and redeployment of staff from across the civil service to support emergency procurement functions.

c. Systems readiness including CRM tools for tracking triage and validation of all contract stages; and IT systems that are accessible for all procurement teams (including redeployed staff).

d. Clear identification of data sources, including for medical equipment across the NHS, live PPE stock levels, usage rates and specific local requirements (such as relates to FFP3 fit testing).

e. Availability of detailed specifications for all approved types of PPE and critical medical supplies, and indicative identification of those which will be required for different pandemic scenarios and different healthcare settings. Specific regard to be paid to provision for a diverse workforce and patient population.

f. A wholesale review, with ministerial oversight, of the demand modelling frameworks across the four nations, to ensure that ongoing and future purchase of PPE and critical supplies include for both business as usual (BAU) and reasonable worst case (RWC) scenario usage.

g. A plan for supply of PPE and critical supplies to community providers and other public services outside of BAU healthcare procurement structures.

h. List of accredited suppliers and manufacturers for all critical supplies, with pandemic exclusivity agreements reached to prevent self-gazumping.

i. A four nations emergency procurement framework agreement, to enable all four nations to cooperate and coordinate their efforts, but with clarity as to where responsibilities lie and assurance over funding provision.

318. **Recommendation 1b**

a. A similar arrangement to be put in place in each of the Devolved Administrations, together with regard to the four nations framework.

319. **Recommendation 2**: Adequate physical stockpiling of all types of PPE that could be required in any HCID or Disease X pandemic, sufficient to provide a minimum of 15 weeks supply at pandemic demand levels (without having to rely on JIT contracts, assuming global supply chain disruption), rotated for BAU usage to replenish and maintain in-date stock, and stored in warehouses suitable to be drawn upon for distribution within 48hrs notice.

320. **Recommendation 3**: Review the design and fit of all PPE to ensure suitability for all health and social care workers (especially women, those from ethnic minorities and those with disabilities) and all workers to be fit tested for FFP3 masks with data held centrally to ensure an adequate local supply of correctly fitting RPE is provided to all health and social care establishments as part of both BAU and an emergency response.

321. **Recommendation 4**: Supply chain distribution and logistics entities that can be scaled up to meet increased demand across both the NHS estate and community providers, with spare warehousing and delivery capacity built into the system or commercial contingency contracting in place for additional capacity to come online within 48hrs of activation.

322. **Recommendation 5**: Build resilience in the domestic production of PPE and critical supplies, leading to an identified list of domestic manufacturers capable of responding to increased demand of PPE and critical supplies, with detailed product specifications and templates that meet regulatory approval available to be utilised at pace. Draft legal provisions to facilitate emergency production of patented products by other manufacturers.

323. **Recommendation 6**: Duty of candour on politicians, senior officials and institutions to promptly raise where shortcomings and anticipated failings are identified, to avoid issues of false reassurance and delayed remedial action when issues do arise.

6th May 2025

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