

Witness Name: Alasdair Donaldson

Statement No.: 1

Exhibits: AD/01-06 (see annex)

Dated: 15/12/2024

## UK COVID-19 INQUIRY - MODULE VI

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### WITNESS STATEMENT OF ALASDAIR DONALDSON

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I, Alasdair Donaldson, of Personal Data will say as follows: -

#### 1 Introduction

1. I worked as an official at the heart of the Government's Covid response, from April 2020 until the end of the crisis in 2022.
2. I have been asked to confirm my professional background, qualifications, and current employment. I graduated from Oxford with a degree in PPE, then trained and briefly practiced as a commercial barrister, before switching to public service. I should stress that I have no academic background in science or epidemiology.

3.

**Irrelevant & Sensitive**

4. In 2020 I was working as the Senior Policy Advisor at the British Council. I volunteered for Covid response work and, more or less by accident, found myself posted to DHSC's Adult Social Care (ASC) Policy team, just at the moment when

it started to become clear that this was at the center of the major crisis over Covid in care homes.

5. I worked first on care home policy at DHSC (April-October 2020), then on the 'Moonshot' strategy at NHS T&T (October-June 2020-21), and finally as Chief of Staff to the Director General, Strategy and Policy, within the new UKHSA (June 2021-October 2022)<sup>1</sup>. In the latter role (at UKHSA), I was involved in helping to establish the new agency, including planning for future pandemics. In the first role (at DHSC), I was the official responsible for creating the Vivaldi Project.

## 2 Introduction to Vivaldi

6. When I arrived at DHSC on 30 April 2020, there was complete chaos in the department. Hundreds of staff had just been parachuted in, like me, with no relevant knowledge or experience. Nobody seemed to know who was doing what, or even in some cases who we worked for, beyond our immediate managers. There were no accurate organograms, then or throughout the crisis, and even after UKHSA was established I was in senior meetings (with Dr Jenny Harries) in which it was admitted that HR were unsure of our number of employees *to the nearest thousand*. I started each meeting by asking people what they did, where they thought they sat in the system, and who else they thought were important to talk to.
7. Shortly after joining the ASC Policy Team, I was able to negotiate a split reporting line into the 'Pillar Four' surveillance study team, in what became NHS T&T.
8. Unlike the ASC Policy team, the Pillar Four team was effective and well run, overseeing the big ONS infection survey and other studies, which were one of the UK's success stories during the pandemic. The split reporting (to the ASC Policy team and the Pillar Four team) allowed me a degree of freedom of

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<sup>1</sup> Respectively the Department for Health and Social Security, NHS Test and Trace, and UK Health Security Agency.

manoeuvre which enabled me to achieve things which simply would not have been possible in the pre-existing structures at DHSC.

9. Furthermore, as head of Pillar Four, Sir Jeremy Farrar put me in touch with academics, ONS statisticians, and private sector data experts outside the civil service, who were able to achieve things that were proving impossible within DHSC and PHE. Put simply, whenever the system tried to stop us acting - which it did throughout the summer - I was able to say, in effect, 'but the other team want this', and then proceed to get it done outside the system.
10. The month I joined (April 2020) witnessed massive casualties in UK care homes<sup>2</sup>. This was beginning to be dimly perceived by those in charge of care home policy at DHSC and PHE, I think partly from anecdotal evidence from care home managers, and was of great concern to Jeremy Farrar and his colleagues, from their understanding of how the disease was likely to affect vulnerable people in closed settings. However, the existing ASC data from PHE was so poor, and the level of testing so low, that the true scale was not obvious; and it was not a palatable conclusion that the relevant officials particularly wanted to hear.
11. Indeed, it was only when the 'Vivaldi' team I set up began to improve and analyse that data from the 'Pillar 2' testing and other sources in May that we began to see the true scale of the outbreaks and fatalities (I remember messaging my DHSC ASC line manager to say that the first true data cut had come through and was 'catastrophic').
12. When I joined I was tasked by the then Deputy Director of the ASC Policy team (he was moved to another role a few weeks later) to conduct a small scale research project in a small sample of care homes. The exact size of the sample was never finalised, and nor was the budget, although it would likely have been under £500K and involved only a few thousand tests in a handful of homes. The

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<sup>2</sup> Our Vivaldi data and subsequent ONS analysis, based on excess deaths, suggests there were probably between 25,000 and 30,000 Covid deaths in care homes in the first wave (mostly March-May 2020). That was thousands more than those with Covid on the official death certificate - though for reasons I set out below they were highly likely to have been caused by Covid - because at that time there wasn't enough testing to establish for certain that they had the disease. See, for example, ONS report in Annex AD/01 [INQ000551799].

tests would have to be sources separately from the mass, one-off care home testing round that had just been announced. This was soon abandoned, after I argued that it would cause unnecessary logistical complexity and that it would be better to piggy-back off the mass test, which would also allow us to potentially gather data from all the homes, not just a handful. However, seeing the chaos and the urgent need to do something about care homes - and with vital sponsorship from Jeremy Farrar and his Pillar 4 team - I set about significantly expanding my remit.

13. Working at the fastest possible pace, I put together a team of non-civil servants who I was pointed to by Jeremy Farrar. These included Professor Laura Shallcross from UCL and her Doctoral student, Maria Krutikov, Gemma Hallatt from Palantir, and 4-5 statisticians from the ONS led by Owen Abbott (these ONS personnel changed over time). Together, the team and I created what I named the Vivaldi Project (which still exists today). Although my work on Vivaldi was theoretically reporting to DHSC via the ASC Policy team, at first this work had to be done largely without DHSC cover, and in some cases against direct instructions from more senior officials (see below).
14. The work was also initially done at risk, including by me. At first I had no significant accessible budget for most of Vivaldi, and indeed was not myself being paid (see below). By the end of the summer it had become clear how important Vivaldi was, and I managed to acquire a budget of c.£12 million, thanks to Farrar's Pillar Four team. Nevertheless, I was still operating without any other civil service staff, despite weekly requests to DHSC for reinforcements throughout the summer. The vast bulk of the work on Vivaldi had to be done outside the Civil Service, and indeed I have come to believe it probably only succeeded because it was.
15. In essence the aim of Vivaldi was to try to work out what was happening with Covid within the care homes, in terms of how much Covid was spreading and what the factors were which were likely helping it to spread, in order to work out how to stop it.

16. It seemed clear that care home managers knew what was going on better than anyone at DHSC or PHE. Therefore we decided to ask them – all of them - and rapidly to organise a questionnaire to send to all the care homes in England. The response was overwhelming (some two thirds of the c.9,000 old peoples' homes in England responded).
17. We aimed to cross-refer this with the results that we knew should soon flow from the single round of whole care home testing that had just been announced, along with all the other relevant data that we could get our hands on. This was to include mortality and infection data, testing data, data about staff sickness and movement, numbers and movement of residents and staff, even – if we could get it – the design and ventilation of the homes: in short, any and all data which would build a picture of possible risk factors and – by linking all the data together – allow analysis of which were most closely associated with the spread of the diseases.
18. We were the first to collate, de-duplicate, match up, analyse, and present all the data, and to set about fixing the serious problems which we realised were affecting the data feeds. From this work we expanded into creating a more accurate care home data dashboard (see below).
19. Finally, Vivaldi undertook to conduct regular repeat antibody, and T-Cell testing of residents and staff across (initially) c.100 sample care homes (later rising to several hundred), and linked this information to the results of the national PCR testing (using the previously mentioned data structures that Vivaldi was instrumental in setting up).
20. From all this we aimed to produce, as fast as possible, proper data and a rigorous analysis of what was happening in the homes, and then use that to inform improved policies to stop the spread of Covid in those settings. It was hoped that this would help to stop the unfolding tragedy, and prevent it from being repeated in any second wave.

21. In this, Vivaldi was extremely successful. Vivaldi was able to produce its first report within eight weeks<sup>3</sup>, based on the questionnaire and initial data. We were then (early July) able to force our resulting recommendations to be taken into account and acted upon with improved national policies. These recommendations formed the basis for the mass regular repeat testing regime of all staff and residents in all care homes that continued through the rest of the pandemic, as well as other critical policy changes such as preventing inter-home staff movement, and paying staff sick pay. Finally, we created what became the official UK care home data dashboard, to give ministers and officials detailed, comprehensive, granular, and real time data on every care home in the country, along with the latest overall local authority (LA), regional, and national statistics<sup>4</sup>.
22. These policy and data improvements in turn helped to prevent a repeat of the tragic situation in the homes. In the second wave that winter, which in all other respects was worse than the first in terms of fatalities, the care homes were significantly better protected<sup>5</sup>. Despite the many thousands of fatalities in care homes during the first wave, our data revealed that more than half of homes had not suffered any outbreaks by the end of summer 2020, and so remained 'sitting ducks' with no natural immunity. In spite of this, far fewer fatalities occurred in care homes during the second wave (Winter 2020-21) than had occurred during the first. In other respects, many of the mistakes that led to catastrophe in the first wave were repeated in the second, but fortunately a repeat of massive casualties in the care homes did not occur. I do not think it has been fully appreciated how close things came to that not being the case. I believe the evidence suggests that it is highly likely that Vivaldi and the policy changes that it forced on a sometimes resistant system probably helped to save thousands of lives<sup>6</sup>.

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<sup>3</sup> See Vivaldi 1 Project initial report in Annex AD/02 [INQ000551800].

<sup>4</sup> See Vivaldi data dashboard examples 1-7 in Annex AD/03.1-7 [INQ000551805; INQ000551806; INQ000551807; INQ000551808; INQ000551809; INQ000551810; INQ000551811].

<sup>5</sup> See Vivaldi dashboard chart 'Care Home Deaths' in Annex AD/04 [INQ000551801], which gives a good visual indication of the broad pattern of mass care home mortality, clearly showing the first and second wave spikes, though NB the first wave deaths stats are vulnerable to the early data issues described in detail below.

<sup>6</sup> See ONS data in Annex, *ibid*, estimating that *excess* deaths in care homes were 27,079 in the first wave, and just 1,335 in wave two.

23. I do not claim credit for this. The intellectual credit for the success of Vivaldi belongs to the lead academic on the study - who was awarded an MBE for her efforts - to her team at UCL, to the ONS and Palantir staff who did the key work on the data, and to others. I was very fortunate in finding myself in the right place at the right time, at the very centre of the key battleground of care home policy. I was not the brains of the operation, but rather the civil service 'muscle'. I was necessary (but not sufficient) to create it, and to force its consequences through an often unhelpful and obstructive Whitehall system.

24. I have set this out in detail because I believe it is vital background to the central importance of the Vivaldi Project and what flowed from it in the fight against Covid in care homes.

25. This in turn is crucial to understand the systemic failures and obstructions created by parts of the public health system to help carry out this work, or to follow through its implications, or to use its data, or correctly to interpret its findings. Vivaldi turned out to really matter, so those problems really mattered, and I happened to be in the best place to observe them.

26. In turn, I believe that understanding those problems can help to clarify the wider systemic issues that contributed to the tragic failures of 2020-21 – and to analyse how to prevent similar failures in future.

### **3 Hospital Discharge into Care Homes**

27. Finally, Vivaldi is also important because its findings have consistently been used (e.g. by then SoS Matt Hancock) to suggest that hospital discharge into care homes was not responsible for significant numbers of infections.

28. Mr Hancock reports getting the first Vivaldi results on 16/07/2020<sup>7</sup>, after they had worked their way up the chain of command to his desk. He states: 'In my box tonight was one particularly startling note relating to the way Covid has been getting into care homes. The main takeaway is that the virus is primarily being

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<sup>7</sup> In his 'Pandemic Diaries: The Inside Story of Britain's Battle Against Covid', entry for 16/07/2020.

brought in by staff, not by elderly people who've been discharged from hospital.' Later he concludes: 'The most important lesson to draw is that there should not be staff movement between care homes... Instead, most of the debate focuses on the wrong lesson: the movement of patients out of hospital into care homes... the evidence shows it was a very small part of the problem.'

29. Unfortunately this is untrue. The Vivaldi findings showed nothing of the sort. Vivaldi explicitly looked at a period of time (May) many weeks after the mass hospital discharge in March, and made no attempt to analyse – because by that stage it could not – the impact of untested mass hospital discharge into the vulnerable settings. As should be obvious, it cannot be used – as it has repeatedly been by Mr Hancock as well as other politicians and press commentators – to try to suggest that the hospital discharge into care homes had a less significant impact than is often alleged.
30. What the study really found was evidence for the common sense proposition that the infection was being seeded into care homes by people coming into those homes without being tested, and often themselves infected, but pre- or a-symptomatic. By May the only people doing so were staff (visitors were by then banned). The study found clear evidence that agency staff moving between homes were still spreading the disease. By that stage Covid prevalence within care homes was significantly higher than in the wider community, so staff movement between homes was particularly dangerous.
31. But, again, the study suggested how the disease was being spread within and between homes in May. Our data was not able to give definitive insight into how the virus got into many homes in the first place back in March, for the simple reason that there had been little or no testing back then. Indeed, staff movement between homes would not have been so dangerous if the homes themselves had been genuinely protected in the first place, rather than full of the virus.
32. I believe this is very important because - perhaps in a psychologically understandable effort to absolve themselves of their responsibility for the original decision to discharge thousands of people from hospitals into homes without

quarantine or tests, our study has been used to suggest that such a policy was not dangerous - when in my view as a matter of basic epidemiology and simple common sense it probably was very dangerous indeed. Absence of evidence cannot be claimed to be evidence of absence, and there is no good data for the period when the main hospital discharge occurred for the same reason it was potentially so reckless: because there was no testing. I must therefore respectfully disagree with the ex-SoS's claim that the debate is 'focussing on the wrong lesson'. It is most important that the right lesson is learned for next time.

33. Again, in his second Witness Statement, at para.49, Mr Hancock uses the Vivaldi evidence - and the policy change which came out of it with regard to staff movement and repeat testing of all staff as well as residents - to justify his claim that hospital discharge had not been a major cause of the catastrophe. He rightly points out that the policy changes reduced the spread within care homes. But this misses the point that they reduced it from the level it had fallen to *after* the end of the first wave had already ripped through many care homes.

34. Mr Hancock also refers to a retrospective PHE study. I believe this study relies on the same PHE outbreak and pillar 1 data on which PHE had been relying through that period, and the major weaknesses of which I explore below. I would therefore urge extreme caution about relying on it. Furthermore, PHE staff had a significant self-interest in showing such a result, as the same people responsible for the initial advice (or lack of it) about the dangers of hospital discharge were exactly the same people responsible for this data and were, in effect, marking their own homework. That homework had potentially involved the possibly unnecessary deaths of thousands of people, and they were extremely conscious that they would come under scrutiny. I am no epidemiologist, but having worked with and discussed these issues with experts who are, I cannot understand how any such study could conceivably find that '1.6% of cases were identified as potentially resulting from hospital associated Covid-19 infection'. It is my belief that such a low and such a specific figure is inherently implausible in the context where most of the cases for the crucial period of the first wave were never tested and never sequenced.

35. Again, at para.353 of Mr Hancock’s second witness statement, he claims that ‘Clinical experts, such as Jenny Harries and data released since this time have shown that the seeding of infections in care homes came from care home staff rather than from hospital discharge.’ This goes to the heart of the matter. The fact is that this, and subsequent claims by Dr Harries and PHE, relies on the Vivaldi findings - but is a complete misreading of those findings, which can support no such claim.

36. Nor was the seeding of Covid into care homes from March 2020 a minor issue, as has sometimes been suggested (for example, by Fraser Nelson in the Telegraph and the Spectator, referring explicitly to Vivaldi, though it’s unclear if this was as a result of briefing from Government sources<sup>8</sup>). At that stage, before vaccinations or natural immunity from prior infections, the R0 for the spread of the virus in a freshly affected population was estimated to be around 3 – and probably higher in closed settings with often shared facilities and poor ventilation - and the case fatality rates for those symptomatic patients testing positive in old age care homes was being discussed at the time by those working in the field as perhaps as high as 30%. Over those few weeks after the mass hospital discharge, the sector experienced perhaps between 25,000 and 30,000 excess deaths. The data showed these tens of thousands of excess deaths correlated closely with the shape of the first wave across the country, and also that they were concentrated in homes with known outbreaks. It is highly likely that the vast majority of them were caused by Covid, as many care home managers told us at the time. The reason why so many thousands of those deaths were not reported as Covid at the time was precisely the result of there not being enough tests to establish that these were Covid infections in the first place.

37. Mr Hancock has said that ‘outbreaks rose sharply long after we had enough tests’<sup>9</sup> – but again this is wrong. By definition, outbreaks were *defined* by testing. In March and April, before there were significant numbers of tests, we were

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<sup>8</sup> See link (unable to annex as behind a paywall):  
[https://www.telegraph.co.uk/news/2020/07/09/real-story-behind-britains-covid-care-home-crisis-is-nt-think/?utm\\_medium=email&utm\\_source=CampaignMonitor\\_Editorial&utm\\_campaign=LNCH%20%2020200810%20%20House%20Ads%20%20SM+CID\\_090a209b59b7a892301959cafe3c50e8](https://www.telegraph.co.uk/news/2020/07/09/real-story-behind-britains-covid-care-home-crisis-is-nt-think/?utm_medium=email&utm_source=CampaignMonitor_Editorial&utm_campaign=LNCH%20%2020200810%20%20House%20Ads%20%20SM+CID_090a209b59b7a892301959cafe3c50e8)

<sup>9</sup> Ibid, entry for 14/05/2020

unable to detect many or most of the outbreaks, even where they resulted in fatalities and were strongly suspected by care home managers. Even when there was outbreak testing, there was a fixed limit to the numbers of tests used. Excess deaths suspected to have been from Covid were not then counted towards outbreak data, where no testing had been conducted. Comprehensive mass testing wasn't happening across all homes until September, as the Vivaldi data showed. Earlier attempts were plagued with data collection problems (see below – many tests were not even labelled to distinguish between staff and residents). Even the early Vivaldi data from PCR testing, which showed more cases than the PHE testing, still only found infection in 4% of staff and 11% of residents. But Vivaldi also showed that the true figures for infections were far higher than that, as the antibody testing showed a significantly higher percentage of those tested had had Covid. Furthermore, we were of course only able to test survivors.

38. Mr Hancock is also on record as saying that PHE data has suggested that only a small proportion of Covid cases in care homes could be traced back to hospitals<sup>10</sup>. It is not entirely clear what data this refers to (there was an initial

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<sup>10</sup> Ibid, p.512 and 554, where he refers to 'PHE data' (with no reference) which showed that only 1.2% of cases in care homes in 2020 could be traced back to hospitals, then states that the cases were mostly introduced by staff movement. This sounds like an elision of the Vivaldi insight (that by May 2020 *after the initial mass mortality and the end of hospital discharge*, the staff movement was the major problem), with flawed PHE data tracing entry routes, presumably based on analysis involving sequencing.

The flaws in this approach are obvious: ignoring the time frame (the second half of the year is irrelevant to the question at hand of what caused the mass mortality in care homes in the first wave), the tracing analysis can only be based on inadequate foundations – perhaps the 6 home study methodology – for the simple reason that there was hardly any testing and so hardly any sequencing for the key period of March/April 2020 when the massive infection numbers were seeded into the homes. Indeed, many of the deaths from that period were not even recorded as Covid deaths because there were no tests available to confirm the diagnosis (though the deaths were concentrated in homes reporting outbreaks). It cannot be inferred from the small proportion of infections that *were* traceable back to hospitals at that time that a very large number of those infections which were *not* tested or sequenced did not also come from hospitals, which is what Mr Hancock seems to imply.

See also para.44 of Mr Hancock's second witness statement to the Inquiry, where he states that 'research has found that the vast majority of infections came into care homes from the community, not from new residents'. Again, it is not clear of what 'the research' is that this refers to, but it certainly cannot be a legitimate reading of anything produced by Vivaldi, which he elsewhere used as the source of this argument. I also cannot see how it can be

PHE-led analysis of just six care homes, but the inadequacy of this early study in terms of methodology and sample size was obvious at the time and indeed was one of the reasons why Sir Jeremy Farrar and his colleagues involved in commissioning and running surveillance studies were so insistent on the importance of Vivaldi; there were also post-facto analyses put out by PHE a lot later, but these relied on the very PHE data whose serious flaws I discuss in this statement).

39. Great caution is needed in interpreting 2020 PHE care home data. I repeatedly witnessed how relevant members of PHE and SAGE, who had overseen and failed to warn against or properly mitigate the tragic initial errors, consistently used inadequate methods and extremely faulty data which played down the seriousness of the problem in care homes (see below). Vivaldi successfully challenged these methods and that data, revealing a great deal many more cases. Further PHE-led evidence, including that produced on the day after Dominic Cummings gave critical evidence to the Parliamentary Select Committee in spring 2021 (I am unable to locate this evidence at this remove, although I clearly remember the Vivaldi lead epidemiologist calling me at the time to discuss its methodological inadequacy), did not tally with what Vivaldi had uncovered, and carries a substantial risk of the system 'marking its own homework'. It was not being checked by independent epidemiologists with no 'dog in the fight' or intellectual or professional interest at stake.
40. Any such studies certainly should distinguish carefully between the first mass untested hospital discharge, in late March 2020, and prior and subsequent hospital discharges (including a further significant discharge which the Vivaldi data dashboard showed happened in mid-January 2021, when hospitals were again starting to be overwhelmed at the peak of the second wave). Prior discharges would have left before the hospitals were full of Covid patients, and later discharges would have been tested. The relevant moment of danger was late March 2020. To dilute evidence (or lack of it) from that time with data from other periods is in my view seriously to distort the evidence.

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based on wide-scale sequencing data from the crucial period in question, given that, again, there were very few tests then being undertaken in care homes.

41. The studies should also distinguish carefully between which infections were known (presumably through sequencing) to have come from a particular identifiable source other than a hospital discharge, and those which were simply not known. Given that the whole problem with the early hospital discharge is that there was no testing (and could therefore be no sequencing), it is likely that the exact chains of infection for most outbreaks early in the first wave will never be known. The sources of subsequent outbreaks are irrelevant to that issue. Mr Hancock himself points out that, as of mid-April, he knew that only 0.5 tests had been taken per care home<sup>11</sup>. That was not conceivably enough testing to prove that hospital discharge had not caused significant numbers of infections and fatalities at the start of the first wave, in the context of huge numbers of excess deaths.
42. Finally, Mr Hancock also says that the Vivaldi evidence on the risks posed by staff movement explains why care home deaths came so much later than if hospital discharge had been the cause. Again, I take issue with this point. If someone was discharged from hospital in late March and was asymptotically infected with SARS-COV2, it could be another two to three weeks before there were any deaths from those unwittingly infected by them, and a further period before deaths from anyone that *those people in turn* might have infected. The peak for care home deaths in the first wave appeared to be a close match with the peak for the rest of the population, in April. Albeit deaths stayed higher for longer because of the unique challenges experienced by those settings, and the difficulty of getting the virus out of homes once it had taken hold.
43. In short, I was at the centre of collecting, analysing, and improving the first data from the mass testing in care homes – I saw it the first moment it arrived and immediately reported it as ‘catastrophic’. I also created and led the leading study on what was happening with Covid in care homes, which the then SoS has consistently cited as the main evidence against the alleged dangers of hospital discharge. As such I can state with reasonable confidence that the evidence does not support the claim that hospital discharge wasn’t responsible for

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<sup>11</sup> Ibid, entry for 16/04/2020.

significant numbers of unnecessary infections and deaths in March-April 2020. Indeed, I believe that it was probably was.

44. To be clear, without comprehensive testing and sequencing data from March 2020, it is not possible to prove this was the case. But it is also not possible to disprove it for the same reason. Further, the principle of Occam's Razor suggests untested people coming into care homes was dangerous – as does the Vivaldi evidence about untested staff - and that the decision to do so was likely to have risked catastrophic consequences. To argue otherwise is to use one failure (the lack of tests) to obfuscate another (reckless hospital discharge into unprotected care homes).

45. When I joined in late April, the lengthy guidance for care homes had only recently been changed to mention quarantine (02/04) and testing (15/04) in care homes, and was not to mention the movement of agency staff between different homes or the dangers of asymptomatic transmission (which were widely understood and discussed at the time within DHSC) until July (09/07), after and as a direct result of the Vivaldi findings. Given the R0, the high proportion of Covid sufferers who were asymptomatic, and that it was difficult to quarantine discharges in care home settings (and there was not yet guidance to do so), a missing factor would be necessary to explain why a policy of untested hospital discharge such as existed in late March, would *not* seed thousands of cases within care homes. The most obvious missing explanation is that it did, but there were no tests to identify the resulting cases. This would explain the huge spike of excess deaths in care homes in the following few weeks and the higher prevalence of Covid in care homes in May, as shown by the Vivaldi study. I do not believe that the shape of that spike could be explained merely by the movement of staff between homes, since that movement continued well into the summer, until the policy changes forced through by Vivaldi.

#### **4 Policy Failures and Obstacles to Necessary Improvements**

46. In early May 2020 I witnessed what seemed to me to be a degree of psychological denial within the system about the scale of the unfolding disaster in the care homes and of the centre's failure to know or control what was

happening. In the SAGE Social Care Sub Committee, which I attended regularly from May 2020, PHE colleagues would regularly say words to the effect of 'we just haven't got the data', without acknowledging that it was their responsibility to get it.

47. I dealt directly with relevant people within DHSC, PHE, and SAGE, who had been in place as the disaster occurred, and had arguably been partially responsible – whether by commission or omission – for overseeing or advising on the policies and guidance which helped allow it to happen. They were, perhaps understandably, hesitant to acknowledge what was going on, and reluctant to undertake - or even allow - the urgent work that was necessary to analyse and mitigate it.

48. To be clear, I do not believe that this reluctance was conscious, deliberate, or malicious. But I can find no other explanation for the extreme obstructiveness that I encountered when trying to launch Vivaldi and then, perhaps even more surprisingly, to ensure that its findings were acted upon.

49. Having been given my instructions on joining at the end of April 2020, I was told that I needed to get PHE involvement with any care home study, which DHSC had by then been requesting for three weeks, without success. I immediately set about trying to get it myself. This indeed proved to be mysteriously difficult. I was passed backwards and forwards in PHE, where nobody seemed to know who was responsible for what, and to my surprise PHE as a whole appeared to be being deliberately obstructive. Specifically, when I asked colleagues who I subsequently came to understand were leading on care homes within PHE who I should work with to get PHE endorsement for the care home study I was supposed to be organising, I was told by everyone I spoke with that it wasn't really for them, passed to other people who would say the same thing and pass me back to the original contacts, and so on. This went on for several days.

50. After working through the first weekend of May (2020), I was conference-called after 23:00 on the Sunday night by the relevant care home policy lead from PHE,

and the Chair of the SAGE Care Home Sub-committee<sup>12</sup>. I explained again what I was doing, and that I needed PHE sign-off to do it. I was promised this first thing in the morning. In the event, however, I was to waste another important week chasing this sign-off, before finally being told that it would not be forthcoming after all. The relevant PHE lead, Professor Julia Verne, and the SAGE Care Home Committee Chair Professor Ian Hall, claimed that cases had been 'plateauing' for 'three weeks', and 'hospital to (care) home mortality was actually low'. They therefore queried whether a study would be 'worth it'<sup>13</sup>. Given the complete absence of decent data at the time, and given what we subsequently discovered about the mass mortality then going on across the sector during this period, this reaction was unhelpful and – I believe – inappropriately defensive.

51. There was also some civil service scepticism about whether the political pressure (from then SoS Matt Hancock) for mass testing in care homes was actually necessary, or whether (as Dr Jenny Harries said in a SAGE meeting on care homes on 08/05/2020 which I attended), 'policy (may be) getting ahead of the science.' The relevant PHE lead also expressed concerns about other possible policies that might impact care home staff: for example working mothers would find it difficult to be isolated in care homes if they were asked to do so during the worst of the crisis. Professor Sir John Edmunds, as he had throughout the early stages of the crisis, urged more caution, saying how important it was that all hospital discharges be tested before being moved into care homes, even if they were not thought to have Covid, and that allowing the virus to spread through the remaining unaffected care homes 'should not even be contemplated: if it goes through all the homes, death numbers will be unthinkable'.

52. Eventually Sir Jeremy Farrar and Sir John Bell told me in a meeting<sup>14</sup> that the Vivaldi study would 'one of the two most important studies in the UK' at that stage (along with the nationwide ONS Covid survey), and that 'resources should not

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<sup>12</sup> It is worth pointing out that these hours were entirely normal while we were on a war footing. I didn't take a single (even weekend) day off for many weeks. I was by no means alone in this. Even colleagues who were otherwise obstructive were undoubtedly working very hard indeed, albeit not always terribly effectively.

<sup>13</sup> In a meeting on 05/05/2020.

<sup>14</sup> On 10/05/2020

limit it', but that there was no point 'getting tangled up with Government', so we should put together a team of the best people outside Government to circumvent the centre and 'force it through'. I considered this to give me scientific and ethical (if not professional) cover, and proceeded to do exactly that.

53. The only professional cover I had was an email from Chris Whitty to someone else that was eventually forwarded to me, saying that this was a 'top priority' (I'm afraid I no longer have access to my DHSC emails and no longer have access to this message). I must admit that I doctored this (to remove the long chain by which it got to me) and used it as a sort of carte blanche to wave at people whenever I came up against bureaucratic obstructions, which were numerous.
54. Even when I had thus been enabled to side-step the obstructions from PHE, the following gives a flavour of the further bureaucratic obstructions that Vivaldi then faced over the next few months:
55. The new Director of the DHSC ASC team, Professor Dame Jane Cummings, apparently after an angry intervention from our opposite numbers at PHE, asked me 'who's telling you to do all this?'. Vivaldi and I were then excluded from many of the relevant meetings. It was difficult to progress the work with my own director trying to block it or play it down. In the end we had to go round her direct to David Pearson (the newly appointed care home 'Tsar'), and/or use cover from Pillar 4, in order to make people aware of our important findings.
56. Again I suspect after complaints from PHE, in June Ros Roughton, the then Director General for Adult Social Care within DHSC, with whom as a junior member of her staff I had no other contact, phoned me on my personal mobile to ask why I was doing what I was doing (launching Vivaldi) and, effectively, to tell me to stop doing it. I can think of no other reason why this was done in the form of a call to my personal mobile phone (rather than, say, an email or minuted meeting), except out of a desire to avoid a paper-trail. The DG had had overall responsibility for care home policy during the relevant period, and may have guessed that my study was likely to uncover serious problems and suggest immediate policy changes. Given the importance of what I was working on, I

decided I had no choice but to ignore what the DG said, in the hope that I might be able to continue the project for a few more days, before anyone noticed that we were still going and finally shut us down. At that stage each day was bringing in more valuable data, which was being shared with Pillar Four. Fortunately for us, during those next few days, she was replaced as DG. As I did not tell my line management chain about the conversation, nobody knew about the stop order, so nobody followed it up to stop me. For what it is worth, this was one of several occasions where I felt forced by the moral dilemma I found myself in to risk my career in order to continue with the fight against the virus. Fortunately, due to a series of administrative errors (see below section on HR), I wasn't being paid properly anyway, and had only received £4 pay that month. I therefore felt that I had less to lose than I otherwise might.

57. The Ethics Committee that needed to sign off the Vivaldi methodology in order for us to be able to conduct the study told us we would have to wait for a fortnight before they could next meet to review our urgent proposal. We had already made clear that such a delay would have been catastrophic in the context of what was happening every day in the care homes, where many people were still dying of Covid every day, and that it would have made it impossible for our findings to have any chance of influencing upcoming policy decisions due to be made at the start of July. In the end I persuaded them to meet the next day by pretending to know and be delivering direct orders from Chris Whitty.
58. Even after I made it widely known that we had launched a huge study which was giving the Vivaldi team access to unique data and insights into Covid in care homes, we were consistently not invited to important meetings, including the SAGE care home sub-committee, by the existing insiders. At one stage in June we had to gate-crash a SAGE care home meeting, do the virtual meeting equivalent of seizing the microphone, and quickly share our screen and present our data to the group so that it was too late to stop us. To be fair, having made this nuisance of ourselves, this forum did eventually come to accept and indeed support us, but our findings would not have been presented had we played by the book.

59. We raced successfully to produce our initial Vivaldi findings just in time for them to be useful to the key moment of decision: the SAGE advice in early July on which the updated care home policies and 'Winter Plan' for the sector were going to be decided. The relevant meeting was, presumably deliberately, brought forward 24 hours without telling us, so that we missed it, and hence missed our chance to input our fresh findings into the key recommendations. Given that ours was known by all to be by far the biggest study of Covid in care homes in the country, and indeed we believe in the world at that time, this was unlikely to have been a mere oversight.
60. When, next day, I delivered our results to my own Director and Deputy Director at the expected deadline, they said it was now too late to use them, albeit they might be taken into account 'next spring.' When I protested, and pointed out the important and urgent implications of the results, they said would only listen to the conclusions of Vivaldi (which was after all at least technically their own study) once it had been pushed through SAGE and re-presented back to them by SAGE, although of course we had now missed our opportunity to do so. This was not because they wanted it checked, but explicitly because, as they said to me in terms, 'this needs to be SAGE advice so we don't get criticised'. In other words, the DHSC ASC policy leadership were not comfortable taking responsibility for acting on the implications of their own study to make major policy changes, despite the large numbers of lives at stake, without senior scientific cover telling them to do so.
61. I therefore had deliberately to obfuscate the degree of senior support I had from my ASC colleagues - which in reality was non-existent - to confront SAGE with the Vivaldi findings, explain why they were incompatible with the draft advice, and thereby force SAGE to re-write its advice overnight to take into account our recommendations. I did this by, in effect, pretending to the SAGE Sub-Committee that I had permission from my senior colleagues within the DHSC ASC team to challenge the original SAGE advice by insisting that it take the new Vivaldi findings into consideration and include them in the advice before it was published. Because of the importance and nature of those findings, which were incompatible with the then advice, this required the advice to be re-written.

Only then, with the SAGE advice re-written, could I get the relevant decisions to be adopted in turn as policy by the DHSC ASC team (I obviously did not tell them that I had allowed SAGE to think I had DHSC ASC seniors' backing for insisting that Vivaldi feed into the advice).

62. These decisions were big ones. They included the payment of sick pay to care home staff (to incentivise sick staff to stay away from vulnerable residents), the stopping of agency staff moving between different homes (although, even then, the subsequent advice from my bosses the following week about stopping this dangerous practice was described as 'extremely weak and disappointing'<sup>15</sup> by then SoS Matt Hancock), and, crucially, the recommendation of regular repeat asymptomatic testing for *all* residents and *all* staff in *all* care homes for the elderly. SAGE, based on their inadequate, modelling-based analysis, were initially only recommending repeat testing in the largest homes, leaving many thousands of smaller homes (around two thirds of all homes) inadequately protected going into the second wave. Our evidence-based analysis demonstrated that staff and residents in small homes were likely to be at just as much risk, per capita.
63. If I had not taken a risk, ignored my bosses, and effectively shamed SAGE into changing its advice in order to overcome the resistance of my own manager and Director, I believe the testing regime for care homes would have been very much less protective as we went into the (in other respects more dangerous) second wave. The results could have been a great deal worse. This was another of several occasions on which I had to risk my career in order to force the system to do what the data showed was necessary.
64. Having tried to stop the Vivaldi study going ahead, having refused to share data with it, and having tried to avoid its results being reported, shared, or acted upon, I discovered from a colleague who had attended it that the relevant senior PHE personnel then presented our findings in a senior forum (I believe it was a meeting with senior officials and the newly-appointed 'Care Home Policy Tsar'), as their own work. They even presented our summary slide-pack, which I had

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<sup>15</sup> Ibid entry for 29/07/20

shared with them, having taken our name off the front and replaced it with their own (they made no other changes). This was so clearly unprofessional and plagiaristic that I called the senior official in question (Director Eamonn O'Moore) to confront him about this, and to be fair he offered me an apology (though no explanation). In fact I was secretly happy about the incident, as my main concern was that our results get widely reported, and I was relieved that at least they were now being used. But I believe it does give a flavour of the territorialism and sometimes even professional dishonesty of parts of PHE and some senior officials at the heart of the care home crisis.

65. In August 2020, with the connivance though not the official sanction of senior officials in pillars 4 and 5, I personally undertook to redirect thousands of blood samples from care homes across the country, by courier, to Birmingham University, to be tested for T-Cells whilst they were still fresh, at a cost of several hundred thousand pounds. I had to do this without official civil service authorisation or contractual or budgetary cover (although I should say we did have the relevant *ethical* cover and permissions), organising it personally with help from my Vivaldi colleagues. For many months I received invoices for tens of thousands of pounds for testing in private laboratories, addressed to me personally at my home address (I did not pay them). I did this because I knew that the department would eventually agree – as indeed it did – that this was an important and highly desirable use of resources, but was quite incapable of officially approving it in time, whilst the bloods were fresh enough to be useable. This was yet another occasion in which I felt I had to put my career on the line to do what it was clear needed to be done. To be fair, I was subsequently praised for doing this (although this is the first time I have revealed the full extent to which I had had to go out on a limb to do it). I understand that the results which flowed from this proved to be important, including to determining the extent to which care home populations had been exposed to the virus and the extent to which they were still highly vulnerable, and relevant to the then live question of how much natural protection there was in the population in advance of the expected second wave.

66. I was in several meetings where senior civil servants said, in these words: 'Minsters / Cabinet Office / Number 10 must not be told...' (X/Y/Z). This was most often in the context of ongoing embarrassing problems with the care home data. [I usually made it my business to use back channels to ministers' private offices and colleagues at Number 10 immediately but surreptitiously to report upwards exactly what was being kept back, so that they could ask the right questions of the system, although it took time for me to build contacts in the right places higher up the system.] E.g. In August and September 2020 I several times contacted Minister for Social Care's Private Office to set up meetings with the Minister, cutting out all the officials senior to me in the team and requesting that they not be informed, in order that I might brief the minister (who was very grateful and was asking for it) with the latest from the dashboard. The Minister would then ask my bosses questions which were designed for them to have to call me in with Vivaldi data in order to be able to answer.
67. My Deputy Director told me that I was being 'too helpful', should 'stop writing 'helpful' emails with data answers', and should stop responding to ministerial requests for data. She added: 'Just because we know the answers, doesn't mean we should always give them.' Particularly, it seemed, where those answers either showed up previous errors, contradicted PHE data, or suggested existing problems which would then become our team's responsibility to solve. Since the Vivaldi dashboard did exactly that – by consistently showing higher figures for outbreaks and infections in care homes – this was a chronic, on-going issue.
68. I was explicitly told by my Director not to share the vital data summarised by the Vivaldi dashboard with the Minister for Social Care, even when she had specifically asked for it. In the end (in late August) I had to give briefings to the minister in secret, without my own senior managers knowing, until my data became recognised as too valuable to stop (see below section). This was yet another occasion in which I had to risk my career in order to force through the right thing. When it was eventually discovered, I was reprimanded, although fortunately by that time I had just gained a promotion into another team, so was about to move anyway and avoided further punishment.

69. The Inquiry may be interested to note that I was in many meetings from as early as the summer of 2020 which began, not with a focus such as ‘what more can we do to fight the pandemic?’ but with a defensive or reactive reminder such as ‘*come the Inquiry*, we’ll have to be able to say’, or ‘the Inquiry will ask us...’, with the clear implication that a priority should be covering ourselves, or distancing ourselves from responsibility, for example because ‘that is for (PHE/Local Authorities) to solve, not us.’ Indeed, whether or not care homes being a LA responsibility is a good idea for wider policy reasons, it certainly seemed to complicate the response, and allowed the centre to shift responsibility away from themselves at the crucial moments<sup>16</sup>.
70. I’m afraid at this distance I cannot give specific dates and times of specific meetings. But it certainly happened more than once, including in meetings with the Director and Deputy Director of the ASC Policy team in the summer of 2020, that senior officials said ‘we need to be careful for when there the Inquiry’. This was not said in jest, but was also not (consciously) sinister: it was culturally acceptable and accepted that officials had a legitimate interest in ensuring that they and their teams would not be held responsible for bad decisions or situations when – as everyone thought was inevitable – the Inquiry started. The implicit impact of this on crucial decision-making – or more likely the incentive to seek to avoid taking actions or making policies which would then become those officials’ responsibility – was never openly acknowledged.
71. The above examples may give the misleading impression that all parts of the system were obstructive, or that all policymaking at that time was incompetent, or that those who were trying to do the right thing were forced always to be effectively renegades within a department that has been described<sup>17</sup> as ‘a smoking ruin’. That impression would be both over-critical and perhaps over-romanticised; though some of my senior colleagues must certainly have found me difficult to work with at this time. Many of my colleagues were

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<sup>16</sup> Again, see Hancock, *Ibid*, entry for 13/04/2020: (Minister for Social Care Helen Whately’s) ‘view is that LAs should take ultimate responsibility for people who don’t need to be in hospital, but do need to be quarantined.’

<sup>17</sup> By the Prime Minister’s then Chief of Staff, Dominic Cummings, in his evidence to the Parliamentary Select Committee.

excellent. Almost all on the strategy, policy, or scientific side (although less so in other functions such as HR) were very hard-working through the crisis. Plenty of good decisions were taken by them (and plenty of bad ones by me). Parts of the system at times worked well.

72. However, I hope that the selection of incidents just discussed give a flavour of how other parts of the system were extremely chaotic, dysfunctional, and obstructive during the crisis - both within DHSC and SAGE and particularly with PHE. I hope they help to paint an accurate picture of some of the systemic problems that were undoubtedly a constant constraint on competent and timely action across the system.

73. My general approach, whenever we hit a blockage, was simply go up a level and call in an intervention to unblock things. This uncollegiate tactic must have made me unpopular with some colleagues. There may well have been occasions when I did so mistakenly or unnecessarily. But it is also true that it was often undoubtedly necessary in order to get necessary things done. Ministers and Number 10 have (in my view rightly) been held to account for the many errors made during the pandemic. But I am forced to conclude that they were also at times a necessary corrective to a Whitehall machine that was certainly sluggish and often actively obstructive at every level.

## **5 Issues with Data and Data Sharing**

74. Data, or lack of it, was at the heart of the tragedy of the care homes during the first year of the pandemic. On Vivaldi, I was in a position to witness some of these failures at first hand, and to try to fix them. I believe it may be helpful to the Inquiry for me to focus in some detail on what went wrong and then right with care home data, which I believe was representative of wider data failures.

75. As already discussed, the initial disaster in care homes in the first wave was partly the result of a severe shortage of testing. This meant that people (hospital discharges, staff, etc) were going in and out of care homes without being tested, potentially carrying the virus with them asymptotically into those highly

vulnerable settings. Bizarrely, this failure to have anticipated the need for mass tests was then used in an attempt to argue that things weren't as bad as in fact they were: without the tests there was no proof of how many people had caught and died from the virus. This is still sometimes used as a defence today (see above section).

76. To help combat this, then SoS Matt Hancock announced the target of 100,000 daily tests by the end of April 2020, and a one-off round of testing for the whole population of the country's care homes. As well as jolting a reluctant and sluggish system into a necessary massive expansion of testing capacity, and any morale-boosting or political motives, the main purpose of these tests as deployed in care homes was two-fold. The first was finally to enable staff to identify who in their homes might be infected, so that they could be isolated and treated appropriately. The second was effectively surveillance: to build a much-needed picture of what was happening across the sector, including crucial epidemiological data, such as prevalence and incidence of the virus, that were vital in order to be able to make adequate policy.

77. The initial round of whole home testing was undoubtedly important for helping with the first purpose, and will almost certainly have saved lives. Unfortunately, however, the second purpose was, in the words of an epidemiologist colleague at the time, 'a disaster'.

78. Firstly, there was distortive political pressure to hit the target by the end of the month, with the count focussing on tests sent out, not tests taken. Since they were sent out in bulk boxes, there was inevitably significant misallocation and over-counting.

79. Second, there were no proper identifiers attached to many of the test results, or way of knowing exactly who (resident, staff, etc) had been tested where and when, or whether some people could have been tested more than once.

80. Worse still, there were three different portals and data flows which did not join up or talk to each other, so the data flow for the test results was over-complex and

dysfunctional<sup>18</sup>. The new 'Pillar Two' (DHSC/T&T) whole home testing was not properly linked to the existing 'Pillar One' (PHE) in hospitals and care homes with outbreaks (and, as later emerged, the NHS App only collected the former and not the latter). There was no real way of knowing if people had been tested through both routes, one, or neither. It was impossible to build an accurate denominator against which the tests could be compared.

81. This all meant that it was very difficult to use the results to build an accurate picture of what was happening, and most of the initial tests conducted were – from a surveillance or national policy perspective – largely useless. The results could be used to identify individual cases within the homes where they were being deployed, but they could not build up any accurate picture of prevalence and incidence of the virus across the social care system.

82. This was no doubt partly the result of the extreme speed at which these systems were set up. But I believe the problems were exacerbated by the fact that the different parts of this complex system were highly reluctant to talk to the other parts, in order to sort out the data flows once the problems emerged. PHE was institutionally suspicious of the new mass testing that it did not control, and refused for many months to properly report it in its results (even though it showed many cases which PHE had not picked up), or conversely to share the full details of its own Pillar One data flows, so that they could be analysed and combined with the Pillar Two data at our end.

83. In PHE's case, it turned out that they were using nothing more sophisticated than an old Excel spreadsheet, which was a long way from fit for purpose<sup>19</sup>, and that those crunching the data at their end were unable to do so accurately. At one point in July, after weeks of territorialism and evasions, the person in charge at PHE – in spite of being on the other side of what as she saw it was by then a major data dispute with Vivaldi - rang me in tears, to say that she was due to present her data to a minister, but simply didn't understand it because of the

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<sup>18</sup> See Data flow diagrams 1 & 2 in Annex AD/05.1-2 [INQ000551802; INQ000551803].

<sup>19</sup> This was symptomatic of wider problems. On 2/3/2022 Dr Harries admitted (in a meeting I was minuting) that 'PHE failed (sic) because (of) unstable infrastructure around its IT systems, data, etc.'

inaccurate ways it was being collected and recorded. PHE also changed the definition of 'outbreak' during this time, which further confused their own figures.

84. As a result of these failings, for months throughout the summer of 2020, PHE was reporting highly flawed and inaccurate data to ministers, that significantly under-estimated the prevalence of the virus in the nation's care homes. Since the failings were legacies of the early period of the crisis, these failings and under-estimations undoubtedly projected backwards to the period of the mass hospital discharge in March, and forwards to subsequent PHE-sponsored analyses purporting to report care home cases over the period as a whole, which would have been forced to rely on PHE data for the entire period up to when Vivaldi was cleansing and reporting the Pillar Two data.
85. When I had first heard about the whole home testing round in late April, I had unilaterally decided to abandon the limited study I had been tasked with, which was to have relied on specifically allocated tests to be conducted in a small handful of representative homes, in favour of piggybacking on the nationwide results of the whole home testing. This undoubtedly gave Vivaldi a massively greater and more representative scope and amount of data. But it also meant that Vivaldi would have been vulnerable to the data problems mentioned above.
86. Fortunately, I had access to private sector data experts from Palantir working (for free) in the 'NHS Foundry' data lake (effectively, the final repository for all the data once it had flowed through the data system). I also had a team of statisticians working on cleansing and analysing the data for the purposes of the Vivaldi report. I realised that my team occupied a unique position of having access to the most care home data, and the expertise to combine and improve it.
87. Therefore – again I had to do this unilaterally and without proper cover – I asked my team to collate and present all the data we could get our hands on that was relevant to care homes, and to follow the data feeds backwards to unblock, de-duplicate, identify, and generally fix the problems with the data flow. This was extraordinarily painstaking work. It was only possible because there was sufficient technical knowledge from external parties (Palantir, UCL, ONS) to

understand and problem-solve the data flows. [That this expertise was not available within the Civil Service or PHE is a serious point to consider when planning for future pandemics.]

88. At one stage, for example, the team had to use postcode analysis to identify hundreds of care homes in order to work out what tests must have been conducted where. We had dozens of meetings with confused and/or obstructive colleagues across the system, as we fixed the data flows and cleansed the data, although we were fortunate in gaining some sympathetic and helpful colleagues within DHSC. Again, however, perhaps due to institutional defensiveness and territorialism - along with a pathological reluctance throughout to system to share data, even in the midst of a national emergency - this was all extremely slow and frustrating. For example, getting PHE and NHS D to share their data streams into the Vivaldi data lake (in NHS Foundry) proved impossible without ministerial pressure and difficult even after we had arranged for that pressure by asking Minister for ASC to intervene.

89. It was as a result of this process that, by July, we were able to present significantly improved data to senior officials and ministers. These data showed a variety of serious on-going problems within the care homes. It also revealed how inaccurate and inadequate were the PHE data. Effectively, the Vivaldi data showed lots of cases and outbreaks that weren't being captured or reported by PHE. Thanks in part to my raising these data difficulties at high levels, there was at this time increasing frustration and pressure from Ministers on PHE to improve their official data reports. The urgent need for accurate data, accurately presented, was, by now, painfully clear.

90. Therefore – once more unilaterally and without cover – in late July I asked my team to build an interactive care home data dashboard. I commissioned this from my outside partner at Palantir, with help from some re-directed consultants I managed to borrow whilst everyone else was on holiday, without really telling people what we were doing until we had a final product to show for it.

91. This work was deliberately duplicative, in that PHE and NHSD were separately trying to create the same thing, having seen from our presentations to SAGE in July the power of our approach of cleansing, combining, analysing, and presenting of all the different data feeds. PHE and NHSD controlled some of these feeds, and refused to share them (despite multiple requests and interventions I had called in from above). Moreover, the more senior staff within DHSC were backing their efforts and were reluctant to use the Vivaldi data to create their own as it would give them responsibility over the issue. It might therefore be thought that I was wrong to deploy resources – even ones working for free – to make this attempt.
92. However, everything I had seen so far about the respective speed and competence of the Vivaldi team versus the relevant officials in PHE and NHSD, plus the galvanising effect our efforts were having on other parts of the system, led me to suspect that we were best placed to create the best product, and that such a product would be crucial in the fight against the second wave that the Vivaldi data was soon starting to predict. This turned out to be correct.
93. Having developed it in quasi-secret, my team were able to complete and demonstrate the power of our dashboard to senior officials and the Minister for Social Care, who sure enough chose it over the competition. She was soon asking for daily updates, and then for direct access to the dashboard herself. I deliberately spread the word as far as possible. Then – against direct orders from my Director not to share it with ministers, LAs, the Cabinet Office, or Number 10 (on the grounds that it was ‘not our job’, etc) – I granted access to everyone in local or central Government who requested it. In some cases I also dropped heavy hints that they should make the request. Again I did all this at significant professional risk, as I had already been reprimanded for sharing the initial data with the Minister.
94. The dashboard was able to show national and regional prevalence, fatalities, trends, etc, but also (with the right permissions) to drill down to the level of individual care homes. Towards the end of August we were able to use it to brief the Perm Sec, Minister for Social Care, and the DSHC Lords Minister, Lord

Bethel, on the low take-up of whole home testing by many (now identifiable) care homes, and show exactly which homes still didn't have sufficient PPE, weren't paying staff to stay away, etc. As such it was a very powerful tool which allowed ministers and people on the front line in Local Authorities to identify where there were still problems and, where necessary, to intervene directly.

95. This became the official care home data dashboard that was used right through the second wave. I believe it helped to save significant numbers of lives. I draw attention to it because I believe it is instructive that it had to be developed in semi-secret, outside the civil service, against significant blocking attempts by PHE, NHSD, and others, and shared against the express orders of my own managers, at significant professional risk to me personally. I believe that was symptomatic of wider problems.

96. In a final bit of territorialism, in September the new JBC<sup>20</sup> tried to close down the Foundry, or at least stop data from flowing into it (which would have disabled the dashboard). I was only able to resist this with direct assistance from the Minister. There was an ingrained hostility to the NHS Foundry and my data experts because they were from Palantir – a private company that created and ran the Foundry – despite the fact that they were working for me entirely for free and were significantly better than anything the Civil Service had<sup>21</sup>.

97. This detailed analysis of some of the chronic data problems faced in the battle to protect the care homes is, I believe, instructive as an example of wider system issues. For example, despite explicit prior warnings from me and my team, the Pillar Three antibody testing subsequently made exactly the same mistake as Pillar Two, and in autumn 2020 sent out a million tests to hospitals with no identifying markers or means meaningfully to analyse the results. Perhaps fortunately, by that stage we knew that it was possible to catch Covid again, so the entire purpose for which the antibody tests had been purchased in such huge

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<sup>20</sup> Joint Bio-Security Centre.

**Irrelevant & Sensitive**

numbers<sup>22</sup> was no longer valid anyway. In other words the mistake didn't matter much because those tests didn't matter much either. But because a huge team had been set up with a huge budget, this Pillar Three work continued under its own momentum. I myself witnessed the team mislead the relevant minister (Lord Bethell) about the potential significance of what was really by then largely pointless. The resources would likely have been much better re-deployed elsewhere at a time when other teams, including ours, were crying out for reinforcements. But large teams can become effectively 'a solution looking for a problem' to justify their existence and sunk costs. I understand they continued for another year and a half before they were finally shut down.

98. A key lesson for the future is that the reason care homes were so vulnerable was that there was no routine surveillance or data infrastructure. It is imperative that this problem is fixed (and I believe that Vivaldi is still operating in this space, aiming to do just that). Care homes need near real-time sentinel surveillance of infections in 'peacetime' to ensure that disease and pandemic threats can be quickly detected and acted upon during a crisis.

## **6 Preparations for the Second Wave in Care Homes**

99. Baroness Harding, then CEO of Test and Trace, has been on record as saying that 'nobody could have predicted the start of the second wave in September 2020'. This is clearly not true. It was predictable and predicted, including by her own experts and staff before it happened. Our Vivaldi data, which we were presenting to ministers from late August, clearly showed the rising tide of infections in care homes and the fact that most had no immunity. More importantly, the Data De-brief Group Chaired by Jeremy Farrar which met every Thursday<sup>23</sup> through that period was warning of the coming wave before it stuck. They were clear that seroprevalence at the end of the first wave was only around 10% (or in other words that, despite all the casualties already suffered, 90% of the population still had no immunity). Worse still, they were starting to see that it was possible to catch the disease twice.

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<sup>22</sup> To allow health workers or others to get some sort of 'freedom pass', if they could show that they had already had and recovered from the virus.

<sup>23</sup> To discuss and report on the latest surveillance data from all the national studies. See 'Spike', *ibid*, p.177.

100. It would be more accurate to say that most of the experts and senior public health officials were entirely aware that we faced the prospect of a larger, more dangerous second wave beginning in the early autumn, probably when schools and universities returned, whilst other departments including BEIS and HMT seemed to believe the wishful thinking that the virus was going away and would be unlikely to return. Hence the advice and incentives to go back in to offices and 'eat out to help out'.

101. I assume the comment by Baroness Harding was an innocent mistaken retrospective memory, to justify the near collapse of test and trace capacity that September. In fact the real reason for the collapse was the care home testing regime which Vivaldi had helped to bring in in August and perfect in September<sup>24</sup>. Once this was brought in and (by September, after some delays in delivery the cause of which I am unaware) fully implemented across the sector, it was sucking up a massive proportion of the overall national testing capacity, which took a few weeks to be further expanded.

102. With the new policy Vivaldi had helped to force through and then (using the data dashboard) ensured was being implemented, we had effectively caused so many tests to be diverted to care homes that, in Sept 2020, the whole T&T system started to break. There were a few key weeks when the turnaround time for tests for the general public was too long to be of much use – as was widely reported in the press at the time. This in turn helped to speed up and potentially exacerbate the second wave.

103. I have to admit my share of responsibility for this. Indeed, I have been concerned about it ever since that month, and worried about the role I may have played personally in effectively undermining the general testing system at a time when it was extremely important to the country. I clearly wasn't in any position to conduct any epidemiological, cost-benefit, economic, or QALY (Quality Adjusted Life Year) analysis about whether it made sense to test care home inhabitants at

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<sup>24</sup> Thanks to our data dashboard's ability to find which individual homes were still not testing as they were supposed to.

the expense of the rest of the population at that time. But I knew full well it was happening at the time, and that I bore significant initial responsibility for it. I cannot pretend that I ever attempted to point this out to anyone senior, in case it undid the incredibly hard work we had done to get the system to test the care homes properly.

104. In my defence, however, senior leaders should have been conducting such analyses, and making these decisions was clearly well above my level. Also, I had no way of knowing that the leadership of T&T had not been expecting the second wave that those of us lower down were already detecting and reporting up on. Nor did I know that public reassurances about testing capacity being sufficient were untrue. And I *did* know that both prevalence and vulnerability was significantly higher in care homes than in the wider population. Furthermore, epidemiologists including Jeremy Farrar had warned me that unprotected care homes could act as reservoirs for re-seeding infection back out into the community. But I cannot be sure that the testing prioritisation was right at this time, I'm conscious I am not an objective observer on this issue, and I remain concerned about my role and its possible impact at this point in the crisis.

105. It is worth stressing again that the massive casualties experienced by the general UK population in the second wave were perhaps twice as bad, overall, as the first. These did not peak until much later (in January). And, as already discussed, in care homes the casualties ended up being very significantly lower as a result of the testing regime that we had put in place<sup>25</sup>.

106. Given the vulnerability of the still unvaccinated care home population, and the numbers (over half) which we knew had still not yet experienced the virus at that stage, I am confident that the overall (non-QUALY-adjusted) UK death toll would have been significantly higher had we not diverted so much testing into care homes before and during the second wave. Furthermore, by the time the second wave peaked in January, the testing capacity had significantly increased, and largely caught up with the increased demand.

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<sup>25</sup> See ONS data in Annex AD/01, *ibid*.

## 7 Conclusions

107. In describing what I witnessed in the battle against Covid in the care homes, I have tried to be as objective as possible. It is hard to write this evidence without sounding like I am indulging in retrospective self-defence, self-aggrandisement, or score-settling. I have been asked by the Inquiry to give conclusions and recommendations for how we could better prepare for the future. I should flag that my following attempts to do so necessarily involve elements of personal judgement.

108. Analysis of disaster response has highlighted the importance of middle management in understanding failures in civil contingencies<sup>26</sup>. I was one of hundreds, perhaps thousands, of middle managers, and definitely do not wish to give a false impression of my personal importance in the fight against the pandemic. However, many more senior people have reported a significant ‘fog of war’, chronic confusion about what was actually happening on the ground, and an experience of pulling policy levers which seemed to have ‘nothing on the end of them’<sup>27</sup>. From my mid-level position at what turned out to be the very heart of the battle, I believe I therefore may have some useful insights into what was happening on the ground, which may be of use to the Inquiry in fleshing out its overall view of what went right – and what went wrong.

109. I repeat that the important work was done by others in my team, not by me. However, it is clear to me that if I had not decided to ignore PHE, SAGE, and the DHSC ASC policy team leadership, and taken substantial professional risks, we probably would not have tested all the staff in all the homes every week, or brought in the reforms we did on staff movement and sick pay, or have accurate data and an effective data dashboard. We would then have stumbled into the second wave in the autumn and winter of 2020 not much better prepared than we had been the previous spring, and I believe we would have experienced another catastrophe in the many care homes that had not yet experienced Covid (as, sadly, the wider population did experience).

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<sup>26</sup> See, Richard Feynman on the Challenger Inquiry, as discussed in Niall Ferguson’s ‘Doom: The Politics of Catastrophe’, p.270.

<sup>27</sup> See, for example, Sir Jeremy Farrar in ‘Spike, The Virus Versus the People, the Inside Story’, p.126.

## **Bureaucratic Incentives**

110. That this was avoided was thanks to what was effectively a team of academics, private sector data experts, and statisticians, initially working at risk and outside the civil service, with help from someone (also myself mostly unpaid throughout) who had been forced to become effectively a rogue unit within DHSC, and who had on at least five, possibly six occasions had to disobey direct instructions, or act in secret, at serious risk of losing my job.
111. In summary, we had to create Vivaldi because PHE and DHSC ASC Policy teams had failed to do so. We had to use outsiders because they wouldn't and perhaps couldn't do it themselves. Parts of PHE and DHSC ASC effectively tried to stop Vivaldi happening, then tried to stop it reporting, then tried to avoid acting on the results, then tried to stop the creation and use of our data dashboard. Having tried to stop our initial report, PHE first tried to ignore it, then tried to steal it and present it as their own, then tried to re-interpret it as justifying its own previous policy failings. DHSC refused to share data, even when ordered to by ministers, and regularly proposed not telling ministers important information. I believe that all this suggests a pattern of disfunction that helps to explain why things were so bad with care home policymaking at the start of pandemic, and gives broader clues as to the systemic problems Covid revealed.
112. In my view none of this was because of bad faith or malicious or lazy individuals (although I believe it is imperative that the same people are not given free rein to plan the future of surveillance in care homes). It was, rather, part of a wider problem of systemic bureaucratic inflexibility; lack of ambition, creativity, or problem solving; reluctance to take risks or responsibility; and a chaotic breakdown of basic functionality within crucial parts of the public health architecture, including PHE and DHSC ASC. In a way, the total chaos within the department was sometimes helpful to Vivaldi, because we were able to operate more freely, and get on with what clearly needed to be done, without too many

people noticing until it was too late to stop us. More often, however, it was highly problematic.

113. From what I saw, I believe that the incentives to the individual public servants were misaligned with the wider interests of the general public. This was likely due to the reluctance of people within the system to take responsibility for positive recommendations or proactive action. Wherever risks could be shifted from traceable to general, it seemed that they were, even if that increased their size and severity.

114. Relatedly, it is impossible to emphasise enough how inadequate were the relevant HR systems in the Covid-facing areas of DHSC, NHS Test and Trace, and later UKHSA, that I saw, and what a negative impact that had on staff, productivity, and Governmental performance. I directly witnessed multiple examples of catastrophic failings. At one stage I was also tasked with compiling a summary of these problems, which convinced me that they had been widespread throughout the existence of T&T and UKHSA<sup>28</sup>.

115. These HR inadequacies created a demoralising and extremely time-consuming drag on the functioning of the Covid response teams. It led to good people leaving, unpaid or in despair, or never being able to join in the first place, or waiting at home for months to join teams who were issuing desperate weekly calls for reinforcements. It exacerbated the misallocation of human resources that may be to some extent inevitable as an unprepared system shifts to crisis mode. Perhaps most seriously, it made it extremely difficult for good managers to build good teams within the Civil Service, reward hard work and success, or replace points of failure.

116. The HR systems set up were shambolic and highly bureaucratic. For long periods, as I witnessed first-hand, senior management had no idea how many people were working for them, even to the nearest thousand, or exactly what all those staff were doing. Despite multiple requests from the highest levels, there

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**Irrelevant & Sensitive**

were no accurate organograms for the organisations, even when asked for by the CEO. This made it extremely difficult for people to identify who they should be working with, and exacerbated the chronic problem of work being conducted that was either contradictory to or duplicative of work underway elsewhere in the system. This was particularly problematic in the context of a crisis driven by a natural opponent (SARS-COV2) which moved at exponential velocity and required a fast and flexible response. I believe that the UK Government, and hence people, suffered as a result of these hidden failures and the poor civil service performance which arose from them.

117. I myself was in the unique position that my civil service career seemed likely to be ended any day, due to a series of (surprisingly common) HR problems that meant that I had no contractual protection or regular salary throughout the entire first year I worked on the crisis (April 2020 – May 2021; indeed I am still trying to recover my pension contributions for this period). The system (in the form of the ‘sponsoring’ department I had moved from when I volunteered for Covid response work) even tried to get me made redundant, simply because the respective HR departments had apparently failed to share the relevant records of my employment with each other, but proved incapable even of managing that, so that I had to face and win a personally expensive (it cost me several thousand pounds in legal fees, although most of these were eventually recovered) and (worse) time-consuming formal procedure in order to demonstrate that I had been legitimately appointed into the DHSC role in which I was already working – this went on for weeks during the worst of the crisis at a time when hundreds were dying every day in the ASC sector on which I was working. There would have been no way of replacing me quickly, and if this process (the result of a typical bureaucratic error) had succeeded, Vivaldi would never have happened, and vital care home policy reforms may well never have been made.

118. Although this meant that I had to spend a lot of time and my own money successfully challenging these attempts, it had the perverse effect of liberating me from over-caution. Frankly, I did not consider I had much to lose by trying to do the right thing for the care homes and the country. My daily hope was that I not be sacked quite yet, so that I could spend another day helping enable my

team to do more to save lives. I was amazed to survive the summer, successfully launch the various Vivaldi products, and be promoted (twice) to a position of greater safety. I say this because others were not in that position, and I don't want to give the impression that I was somehow morally braver than them. They did have a great deal to lose from a system that I believe disincentivises initiative, risk-taking, proactivity, and responsibility.

119. My work often encountered obstacles within a Governmental response which I came to conclude was in some respects grossly inadequate. Mistakes were made by many people, including me. However, I am keen to avoid criticising individuals, or defending particular decisions. In my personal view the priority should be to learn the correct lessons from this pandemic, in order to prepare for the next one.

### **No Fault Approaches**

120. One good way of doing this may be to take a 'no fault' approach, like that which has been so successful in improving airline safety. Indeed, I later proposed this, with limited success, within UKHSA. My experience led me to conclude that there was a system-wide failure of the UK's Public Health response during the pandemic, in part because of a chronic antipathy within Whitehall towards taking responsibility. Many mistakes were therefore errors of omission not commission. It might be that singling out individuals for censure for specific actions could therefore have the perverse result of further disincentivising robust action in future, and exacerbating the underlying problem.

121. Furthermore, the vast majority of individuals who played important roles worked extremely hard and cared deeply about the public interest. When questionable and even disastrous decisions were made, it is my belief that they were usually made in good faith, but were the result of systemic problems within Government. Unfortunately, having subsequently worked within the heart of UKHSA, including closely on attempts to be prepared future epidemics, I do not believe these problems have yet been adequately addressed.

## Understanding Exponential Threats

122. Throughout the crisis it was apparent that the virus moved exponentially, whilst the civil service was moving linearly (and sometimes glacially). Indeed, the exponential movement of the virus was not properly understood by Government at an institutional level. There were many conversations with senior officials which seemed to be premised on the false assumption that we might easily trade off a bit more prevalence here for fewer tests or restrictions there, or that the relentless progress of the disease as it ripped through families and communities would wait for policymaking to catch up at its normal speed.
123. Where the word 'exponential' was used, it was often used incorrectly as a synonym for 'fast', and even then it was not widely appreciated quite how fast the virus would move once it was allowed to get going. The fact that a handful of cases can turn into millions of cases within weeks, and that the growth will be very slow at first and very fast indeed at the end, with massive increases concentrated in the last few days, was insufficiently appreciated. If there is only one lesson to take away from the crisis, it is that the UK Government machine is not capable, as currently configured, of responding to or even understanding an exponentially moving contingency.
124. Politicians and officials need to be better educated in basic statistics and balancing risks, and better incentivised to do so. I witnessed ministers and officials were too easily bamboozled by 'science' and (worse because not empirical) 'modelling'. Even when - to take one notorious example from SAGE care home modelling - the inputs were taken from Wikipedia<sup>29</sup>. Though, in my experience, the ministers often interrogated the data more than did senior officials.

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<sup>29</sup> Professor Ian Hall, then deputy chair of the SAGE subgroup SPI-M, against whose models our empirical evidence from Vivaldi was pitched when he was Chair of the SAGE Care Home Sub-committee, told BBC's Panorama in November 2020 with admirable honesty that: 'The public may be surprised that we were using Wikipedia to get data very early on in the pandemic, but that was really the only data that was publicly available that we could access.' (See e.g. <https://metro.co.uk/2020/11/19/sage-experts-relied-on-wikipedia-to-model-impact-of-covid-crisis-1361999/>)

## Public Trust

125. There was also an institutional reluctance to trust the public. This was ironic, as the public largely trusted the public health officials, but the former arguably proved much more deserving of trust than the latter. It is true that there was no way of ensuring that self-tests had been correctly administered or accurately reported. It took far too long for regulatory approval for their use in different self-test settings to come through. Again, counterfactuals (it's better to trust that most people will test and tell the truth about their results than not to have them test at all) did not always seem to be adequately considered.

## Information Sharing

126. Relatedly, within the civil service as elsewhere, knowledge is power. In a Whitehall system where many people lack genuine expertise, marketable and career-enhancing power comes from discovering, and then ideally hoarding, knowledge. This was in my view the systemic cultural issue behind the catastrophic and chronic reluctance to share data. My approach and my orders to my teams were 'if in doubt, share everything with everyone.' But this often got me into serious trouble. Worse, my attempts to get other parts of the system to share data with us *and even with ministers*, were incredibly difficult, and frequently thwarted. Bad and perhaps fatal policy decisions resulted from this systemic failure to share vital information.

127. To take one example (discussed in more detail above), PHE's data on care home outbreaks was badly flawed. This was well known. But it took months of ever escalating requests (I had to go all the way to Number 10) before they released the underlying data so that we could sort it out. NHSD continued to refuse to share data with DHSC even after that. And, within DHSC, I was ordered *not* to share vital data with ministers, Number 10, or Local Government on the front lines. Eventually I had to brief the Minister for Social Care (at her request) in secret from my own line manager and head of team, at serious

personal risk to my career. I do not want to single out individuals, however, because from what I could see the problem was chronic and system wide.

128. I always told my teams to 'share all information'. It became clear that this was an unusual approach. I believe, particularly in a national emergency, that it is the right one. Yet all too often it was an eccentric, even professionally disadvantageous, thing to do. This cultural habit will have to be addressed if future pandemics are to be dealt with better than Covid.

### **Overall Conclusions**

129. The Inquiry will no doubt struggle with the evidential burden in its investigations. A vast amount of documentation was generated. But many of the most important decisions will have been taken off the record, as civil servants have an ingrained, almost pathological obsession with avoiding paper-trails that might leave them personally exposed.

130. The Government system will continue to line up and insist in bland terms that it didn't do badly. Against this is the undeniable fact of over 200,000 dead UK citizens, not including the tens of thousands more who died of other causes because they were unable to access healthcare or due to the long lockdowns that were the (in my view necessary and inevitable, but unfortunate) consequence of other policy errors<sup>30</sup>. Also undeniable is the unflattering comparison with many other countries, particularly in the first year of the crisis, in spite of our subsequent, life-savingly fast, vaccination programme.

131. There were well known political failures in the UK, but also undoubtedly system failures in Whitehall. There is a great danger that the (entirely fair) focus on the former lets the latter off the hook. We can and do change our politicians. But the civil service carries on. Whether or not there is ever a reckoning for any of the often catastrophic blunders I witnessed it making, or the wider failures of which they were a part, it is vital that we learn and apply the right lessons for the future.

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<sup>30</sup> Much higher than any other public health disaster in the century since Spanish Flu, which caused a roughly similar death toll in the UK.

132. Occasionally Kafka-esq and even grimly amusing as some of these bureaucratic struggles may seem in retrospect, it is worth being conscious - as we were painfully at the time - of the tragic backdrop of all of this. For example the fact that, as our Vivaldi data confirmed, many thousands of residents and hundreds of staff died of Covid in English care homes in the spring and summer of 2020. Then in the wider population, many tens of thousands of people died in the second and third waves in autumn 2020 to spring 2021 and summer to winter 2021. All three waves were predictable and predicted. But in spite of its failures in the first wave, Government again failed to do things (institute NPIs, get tests out of warehouses into the hands of workers, put in place proper border measures to slow the ingress of VOCs, etc) which might have mitigated the scale of the disaster.

133. My reluctant personal conclusion from what I directly witnessed is that the Civil Service I am proud to be part of catastrophically let down the people it was supposed to serve. Whitehall and policymakers should not shy away from the fact that they presided over something that was more than a natural disaster, inevitably exacerbated in places by a few incompetent or reckless errors. Rather, the Government public health response to Covid involved a series of catastrophic policy errors, and an overall system performance that was - with notable exceptions – a profound failure, perhaps the greatest Governmental policy failure of modern times. This failure resulted in the unnecessary deaths of tens of thousands of British citizens<sup>31</sup> – including a generational slaughter within care homes - many of those victims dying horrible deaths, often without the solace of their loved ones. Understanding the true causes of this failure is I believe owed to the victims, their families, to history, and to the future.

134. Worse still, having gone on to help build the new UKHSA and work with colleagues there on preparing for the next pandemic, I have come to believe that we have not yet learned all the right lessons, or made all the necessary improvements.

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<sup>31</sup> Again, Jeremy Farrar in Spike, p.128: ‘That people died needlessly is, alas, unarguable from any insider’s perspective’. A conclusion that from what I saw is sadly very hard to disagree with.

135. Put simply, I do not think we are ready for next time.

### Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: \_\_\_\_\_ **Personal Data** \_\_\_\_\_

Dated: \_\_\_\_\_ 23/04/25 \_\_\_\_\_

Annexes

<b>Exhibit</b>	<b>Para</b>	<b>Internal Reference</b>	<b>Inquiry Reference</b>
AD/01 – ONS Deaths Data Report	10		INQ000551799
AD/02 – Vivaldi 1 Report	21		INQ000551800
AD/03.1-7– Vivaldi Data Dashboards	21		INQ000551805 INQ000551806 INQ000551807 INQ000551808 INQ000551809 INQ000551810 INQ000551811
AD/04 Vivaldi Care Homes Deaths Data	22		INQ000551801
AD/05.1-2 Data Flow Diagrams	80		INQ000551802 INQ000551803
<b>Irrelevant &amp; Sensitive</b>			