


MISCONDUCT IN PUBLIC OFFICE

Why did so many thousands
die unnecessarily?

Summary report of the
People's Covid Inquiry

December 2021

PEOPLE'S
COVID
INQUIRY 

Learn lessons, save lives.

THE PEOPLE'S COVID INQUIRY

The People's Covid Inquiry took place fortnightly from 24 February-16 June 2021.

A panel of four, chaired by Michael Mansfield QC, heard evidence from over 40 witnesses including bereaved families, frontline NHS and key workers, national and international experts, trade union and council leaders, and representatives from disabled people's and pensioners' organisations.

1 December 2021

The full version of the report, including detailed accounts of all the sessions and more, is available at www.peoplescovidinquiry.com

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MICHAEL MANSFIELD QC

Chair of the Inquiry Panel



What was the point of it all?

The phenomenon of the ‘pandemic’ is hardly novel. There is a long history of the planet being plagued; they are regular occurrences beginning with the first recorded in 430 BC through to the notorious Black Death (1350), bubonic plague during the life of Shakespeare in the mid-16th century, the Great Plague (1665), Cholera (1817), a sequence of severe influenza outbreaks – Russian (1889); Spanish (1918); Asian (1957); Swine (H1N1-2009) – and most recently and highly relevant, Severe Acute Respiratory Syndrome (SARS – 2003) and MERS (2012, spread from camels).

Anyone in government responsible for health and safety must have been aware of the risk of a pandemic recurrence. This responsibility is well-recognised by the tenets of international and domestic law. Internationally it is embraced by a number

of different instruments – the Universal Declaration on Human Rights (1948 Article 25); the Charter of the UN (Article 1 1945); the Constitutional provisions of the World Health Organisation (WHO) and the World Health Assembly (1946/1948 – creatures of the UN and engaging over 190 states), both committed to countering cross-border health threats and giving rise to the International Health Regulations (IHR 2005).

Of especial interest is the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR). Articles 12 (1) and (2) read:

‘The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest standard of physical and mental health.

The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right SHALL include those necessary for ... (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases.’

The United Kingdom ratified this treaty in 1976.

Domestic law reflects these obligations via the Human Rights Act 1996 (HRA) s6, by which the government must act in a manner compatible with the European Convention Articles (ECHR), for example Art 2, the Right to Life. Even more specific is the National Health Service Act 2006 s2A which imposes a duty to protect public health from diseases and other dangers to public health, and indicates appropriate steps which may be taken. Public Health England (PHE) was the executive arm of the Department of Health and Social Care (DHSC) dealing with this along with the Minister who bore ultimate responsibility,

Secretary of State for Health, Matt Hancock. Both PHE and Mr. Hancock have gone. PHE was replaced by the UK Health Security Agency in the summer of 2020. According to the government website this agency will be responsible for planning preventing and responding to external health threats and providing intellectual, scientific, and operational leadership at national, local, and global levels. It will ensure the nation can respond quickly and at greater scale to deal with pandemics and future threats.

So what has been going on up to now? Or is this an admission of failure?

Besides the general historical context described above, there were far more specific warnings which were either ignored, or put on the back burner. In 2006, the Government Office for Science predicted a global pandemic within the next 30 years due to a virus mutating from a wild animal to humans (zoonotic disease). Ten years later, in 2016, there were two exercises, the full details of which have not been made public until recently – Cygnus and Alice.

The details of Cygnus were eventually leaked after threats of legal action. The Health Minister at the time in the House of Lords, Lord Bethell, in June 2020 asserted that Cygnus-style simulations should remain secret ‘so that the unthinkable can be thought’. More machinations from a government which had lost the trust and confidence of the people.

They did not want the public to know that three years earlier the Cygnus report came to this conclusion:

‘The UK’s preparedness and response in terms of plans, policies and capability, is currently not sufficient to cope with the extreme demands of a severe pandemic

that will have a nationwide impact across all sectors.’

What the Health Secretary Mr. Hancock failed to reveal was that on top of Cygnus, in the same year there had been a number of exercises modelling different scenarios. Ten in all: some were for Ebola, some for flu – but one was for coronavirus, deriving its basis from a MERS outbreak caused by this virus. This too was kept secret. PHE and the Department of Health and Social Care were both centrally involved.

The Government should, therefore, have been well prepared for the eventuality that presented itself at the end of 2019. The NHS and social care infrastructure should not have been neglected and run down; effective in-date Personal Protective Equipment should have been readily stored and accessible; track and trace provision should have been anticipated as vital to basic public health measures; extra NHS hospital space carefully planned; an adequate NHS trained staffing complement at the ready; quarantine conditions and support sorted; strict border controls and isolation facilities programmed in advance. None of this is hindsight, as we make clear. This People’s Covid Inquiry report is unequivocal – dismal failure in the face of manifestly obvious risks.

Even if distracted by Brexit – or Shakespeare – the Government went on to miss, overlook, or ignore the more immediate warning signs, which, if acknowledged, could have made a real difference to outcomes. On 31 December 2019 China alerted the WHO about a cluster of what was thought to be pneumonia cases in Wuhan.

Of itself this was not perhaps overly concerning. However, events escalated in a way that was not entirely unexpected – especially given the exercises undertaken.

On the 10 January 2020 the World Health Organisation issued a technical guidance package on how to detect, test and manage a potential respiratory pathogen (SARS and MERS). On 12 January 2020 China shared the genetic sequence for SARS-CoV-2. On the 23 January Wuhan and other cities were in lockdown. By 30 January 2020 the WHO declared a global emergency and the following day, 31 January, the first two cases were confirmed in the United Kingdom.

Yet it is not until the end of March that Mr. Johnson gets his act together. The Government was caught seriously on the back foot and remained that way for the rest of 2020, as detailed in the evidence. There has been no accountability in any form, and it cannot be offset by the vaccine distributed by the NHS throughout 2021.

There was no consistent, comprehensive and coordinated plan of public health strategy. What leapt off the press conference page was the dilatory initial response; the absence of any effective track and trace system; the sheer waste of taxpayers' money ploughed into the pockets of private cronies; the contradictory messaging; the abject failure to provide PPE; the albatross of Nightingale hospitals; the lack of trained staff; the failure to utilise NHS primary care facilities; the misrepresentations about care home ringed protection; the parlous state of the NHS in the first place. Above all is the utter distrust of the public and the disrespect for the frontline workers, who, once the claps and saucepan fanfares had abated, were offered a 1%, below-inflation, pay rise for their life-endangered troubles.

The UK remains near the top of the death and infection rate table. Mr. Johnson says (15 November 2021) he cannot rule out

more of the same on-the-hoof policy for winter 2021. Yet again he was advised months ago to implement a controlled raft of well-recognised public health suppression measures that accommodate the ongoing threat without resorting to the spectacle of see-saw lockdowns and disruption.

This Inquiry performed a much-needed and urgent public service when the nation was hit by a catastrophic pandemic coincident with an unprecedented period of democratic deficiency. It afforded an opportunity for the beleaguered citizen to be heard; for the victims to be addressed; for the frontline workers to be recognised; and for independent experts to be respected. When it mattered most and when lives could have been saved, the various postures adopted by government could not sustain scrutiny. This was especially so when initially the Government thought the best thing would be to ignore the virus because overreaction could do more harm than good.

The Prime Minister initially rejected the idea of an independent public judicial inquiry into the COVID-19 pandemic. Pressed by the bereaved and others, he eventually conceded in the summer of 2020 that there would be one – but not until later. Months went by and nothing more was said until earlier this year when the bereaved repeated their request. Again rebuffed, the time was not right, and it would interfere with government work. Once a bevy of notables lent their weight to the glaring and urgent need, Mr. Johnson relented and announced that there would be one 'launched' in the Spring of 2022. More silence thereafter. Despite continued requests – no definition of 'launch', no date, no judge, no terms of reference, no infrastructure. Nothing. Nor is there now, as we head towards

publication of our report having conducted a four-month People’s Inquiry in the Spring of 2021.

It was plain to Keep Our NHS Public (KONP), the organisers of the People’s Covid Inquiry, that Government words were bloated hot air, hoping to delay and obfuscate. Within this narrative lies a theme of behaviour amounting to gross negligence by the Government, whether examined singularly or collectively. There were lives lost and lives devastated, which was foreseeable and preventable. From lack of preparation and coherent policy, unconscionable delay, through to preferred and wasteful procurement, to ministers themselves breaking the rules, the misconduct is earth-shattering.

The public deserves the truth, recognition, and admissions.

For behaviour to be categorised in criminal law as misconduct in public office, it must be serious enough to amount to an abuse of the public’s trust in the office holder and

‘must amount to an affront to the standing of the public office held. The threshold is a high one requiring conduct so far below acceptable standards as to amount to an abuse of the public’s trust in the office holder.’ (A-G Ref No3 2003 (Attorney General))

The test for a jury has been said to be whether the conduct is worthy of condemnation and punishment:

‘Does it harm the public interest?’ (LCJ in Chapman 2015)

16 November 2021

PROFESSOR NEENA MODI

**MB ChB MD FRCP FRCPC
FFPM FMedSci**



The NHS was not well prepared for the pandemic. The UK COVID-19 death toll need not have been so high. The straitened circumstances of the NHS were an important contributor to what transpired.

The NHS entered the pandemic weakened by over a decade of austerity. Hospital capacity was among the lowest in Europe, staffing vacancies numbered 100,000, infrastructure had been allowed to decline, services were characterised by a poorly integrated patchwork of providers, including a growing number of for-profit providers, and staff morale had declined through years of underfunding, not having their voices heard, and the loss of colleagues as a consequence of Brexit. That the NHS was able to carry on during the pandemic was due to the commitment of front-line workers. Their sense of pride in delivering a vital UK service was restored by the recognition of the country.

This sense of pride has been under-recognised, and its worth under-estimated. NHS staff want, expect, and need decent salaries, but what sustains them is not the prospect of ever greater personal gain, but the knowledge that they provide a first-rate service, free at the point of need, available to all.

The acclaimed aspect of the UK pandemic response, the COVID-19 vaccine roll-out, was also largely due to the over and above commitment of NHS staff. However, instead of the pandemic being a wake-up call to invest in the NHS as a public service of vital importance to the UK population, and to strengthen the strong sense of united purpose and pride among the NHS workforce that is one of its greatest assets, the Government continued to favour and follow a policy of undermining the NHS by outsourcing to private providers.

The Government was well aware of the fragile state of UK health services. This led to the slogan 'protect the NHS'. Yet, instead of investing in NHS infrastructure that would be of value during and beyond the pandemic, for example by enabling general practitioners to provide telephone triage and on-line consultations with their patients, The Government side-lined primary care, by outsourcing to private providers of NHS 111 services. The lack of training of NHS 111 staff and reliance on untested algorithms contributed to the high numbers of deaths.

The UK COVID-19 death toll was also made worse by years of disinterest in, or deliberate neglect of the wider determinants of health. These inter-related factors encompass housing, education, child development, financial security, and work and environmental conditions, and act to increase or decrease an individual's risk of poor health. The failure to recognise and address health determinants has led to a

decline in the health of the UK population, a widening of health inequalities, and the consequent increased burden of COVID-19 mortality and morbidity falling upon the most disadvantaged sections of society.

The spread of the pandemic, and the death toll was also worsened by a poor public health response – the consequence of over a decade of reduced funding, loss of expertise, dissipation of services, and multiple reorganisations. However, the Government chose not to invest in strengthened public health systems, nor to redress past errors, or act on previous pandemic preparedness recommendations, including those of Exercise Cygnus in 2016, and chose not to restore a service that was once an international gold standard. Instead, the Government chose to outsource crucial test and trace operations, wasting £37bn on a failed system that exacerbated the spread of COVID-19, and increased the UK death toll, disbanded Public Health England and embarked, mid-pandemic, on yet another restructuring of public health provision.

Future resilience to health emergencies, no less the ability to cope with normal NHS requirements, requires a change in focus, direction, and strategy. The focus must be integrated investment in primary care, acute, community, mental health, public health, and social care services. The direction must be restoration of exemplary-quality, predominantly publicly provided and publicly delivered services. The strategy requires policies that address the wider determinants of health, and recognition that NHS workers want, deserve and need fair, stable, pay and conditions, but are driven to deliver their best by pride in the compassionate, equitable, public-sector service they provide.

10 November 2021

Michael Mansfield, chair of the panel

Michael Mansfield is an internationally renowned human rights lawyer. He has represented individuals, families, and groups in some of the most controversial legal cases the UK has seen: the Stephen Lawrence inquiry; the Bloody Sunday Inquiry; the Hillsborough disaster; Jean Charles de Menezes; the Marchioness inquiry and 'Shoot-to-kill' in N Ireland. He has chaired international people's tribunals on the Middle East; the Lewisham People's Commission on Lewisham Hospital and the North West London NHS Hospital Inquiry (Lewisham, Charing Cross and Ealing hospitals all saved from closure). He is currently heavily involved in the Grenfell Inquiry.



Professor Neena Modi, panel member

Neena Modi is Professor of Neonatal Medicine, Imperial College London and President of the British Medical Association. A leading researcher and fellow and member of council of the UK Academy of Medical Sciences, Neena has worked to improve children's health throughout her career. She is the immediate past-president of the UK Medical Women's Federation, and past-president of the UK Royal College of Paediatrics and Child Health.



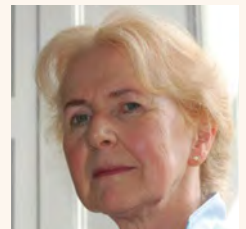
Dr Tolullah Oni, panel member

Tolullah Oni is an Urban Epidemiologist & Public Health physician at the Medical Research Council Epidemiology Unit, University of Cambridge and Fellow of Wolfson College, Cambridge and the African Academy of Sciences. Tolullah was born in Lagos, studied in London and worked in South Africa for over 10 years. Her research, focused on ways to improve health in cities, has been profiled in The Lancet journal. She sits on the editorial board of The Lancet Planetary Health, Cities and Health, and PLOS Global Public health journals, serves as commissioner on the Global Commission for Post-Pandemic Policy and is a member of Independent SAGE.



Dr Jacky Davis, panel member

Dr Jacky Davis is an NHS consultant radiologist at Whittington Hospital in North London. Jacky is a founder member of Keep Our NHS Public. She co-authored the books *NHS SOS: How the NHS Was Betrayed and How We Can Save It*, and *NHS For Sale*. Jacky is also a member of BMA Council.



Lorna Hackett, Counsel to the Inquiry

Lorna Hackett is a barrister and co-founder of Hackett & Dabbs LLP. She specialises in human rights and public law. She is committed to protecting the most vulnerable within society and has a strong track record in judicial review proceedings. She trains other barristers in advocacy and is a renowned public speaker on social justice and prisoners' rights.



ASCL	Association of School and College Leaders
BAME	Black, Asian and Minority Ethnic
BMA	British Medical Association
CAMHS	Child and Adolescent Mental Health Services
CCAS	COVID-19 Clinical Assessment Service; part of NHS 111
CHPI	Centre for Health in the Public Interest
Coronavirus	A family of viruses that cause illness in humans and animals; seven different types have been found in people, including the one causing COVID-19
COVID-19	The illness caused by being infected with SARS-CoV-2 virus
CQC	Care Quality Commission
DfE	Department for Education
DHSC	Department of Health and Social Care
DPH	Director of Public Health
DNACPR	Do Not Attempt Cardio-pulmonary Resuscitation agreement
DNAR	Do Not Attempt Resuscitation agreement
DPAC	Disabled People Against Cuts
DPIA	Data Protection Impact Assessment
DWP	Department of Work and Pensions
ECHR	European Convention on Human Rights
FFP2	Filtering Facepiece 2 PPE mask that filters at least 94% of airborne particles
FFP3	Filtering Facepiece 3 PPE masks that filters at least 99% of airborne particles
FRSM	Fluid resistant surgical masks; ineffective in filtering airborne particles
FTTIS	Find, Test, Trace, Isolate, Support
FOI	Freedom of Information
GDP	Gross domestic product (monetary measure of the market value of all the final goods and services produced in a specific time period)
HCW	Health Care Worker

HDU	High Dependency Unit
HSE	Health and Safety Executive
HMRC	Her Majesty's Revenue and Customs
ICNARC	Intensive Care National Audit and Research Centre
I-SAGE	Independent Scientific Advisory Group for Emergencies
JBC	Joint Biosecurity Centre
ITU	Intensive Therapy Unit
Long covid	Not recovering for several weeks or months following the start of symptoms that were suggestive of covid, whether you were tested or not
MERS	Middle East Respiratory Syndrome
MRSA	Methicillin-resistant Staphylococcus aureus
NAO	National Audit Office
NEU	National Education Union
NHSE	NHS England
NHS 111	Single non-emergency number for medical advice in the United Kingdom
NICE	National Institute for Health and Care Excellence
NIHP	National Institute for Health Protection
NPC	National Pensioners Convention; the principal organisation representing pensioners in the UK
NPI	Non Pharmacological Intervention
OECD	Organization for Economic Cooperation and Development
ONS	Office for National Statistics
PCI	People's Covid Inquiry
PHE	Public Health England
PPE	Personal Protective Equipment (masks, gloves, gowns, eye protection)
PTSD	Post Traumatic Stress Disorder
RCPsych	Royal College of Psychiatrists

R number	The number of people each case infected on average: an R number > 1 means exponential growth of cases
RIDDOR	Reporting of Injuries Diseases and Dangerous Occurrences Regulations
SAGE	Scientific Advisory Group for Emergencies
SARS-CoV	Severe Acute Respiratory Syndrome coronavirus
SARS-CoV-2	Severe Acute Respiratory Syndrome coronavirus 2 (the cause of COVID-19)
SMR	Standardised Mortality Ratio; quantity of increase or decrease in mortality of a particular group with respect to the general population
SPI-B	Scientific Pandemic Insights Group on Behaviours
SSP	Statutory Sick Pay
TUC	Trades Union Congress
WBG	Women's Budget Group
WHO	World Health Organisation
UKHCA	UK Home Care Association
UKHSA	UK Health Security Agency
YouGov	International internet-based market research and data analytics firm based in UK

Pandemic strategies terminology

Exclusion	Maximum action to exclude disease e.g. some Pacific island territories
Elimination	Maximum action to exclude disease and eliminate community transmission for a defined period of time e.g. mainland China, Taiwan, New Zealand
Suppression	Action increased in stepwise and targeted manner to lower case numbers and outbreaks e.g. most of Europe and North America
Mitigation	Action taken to 'flatten the peak' to avoid overwhelming health services and protect the vulnerable, but not to stop community transmission e.g. Sweden (initially)
Eradication	Global eradication of a disease (smallpox is a rare example)

2020

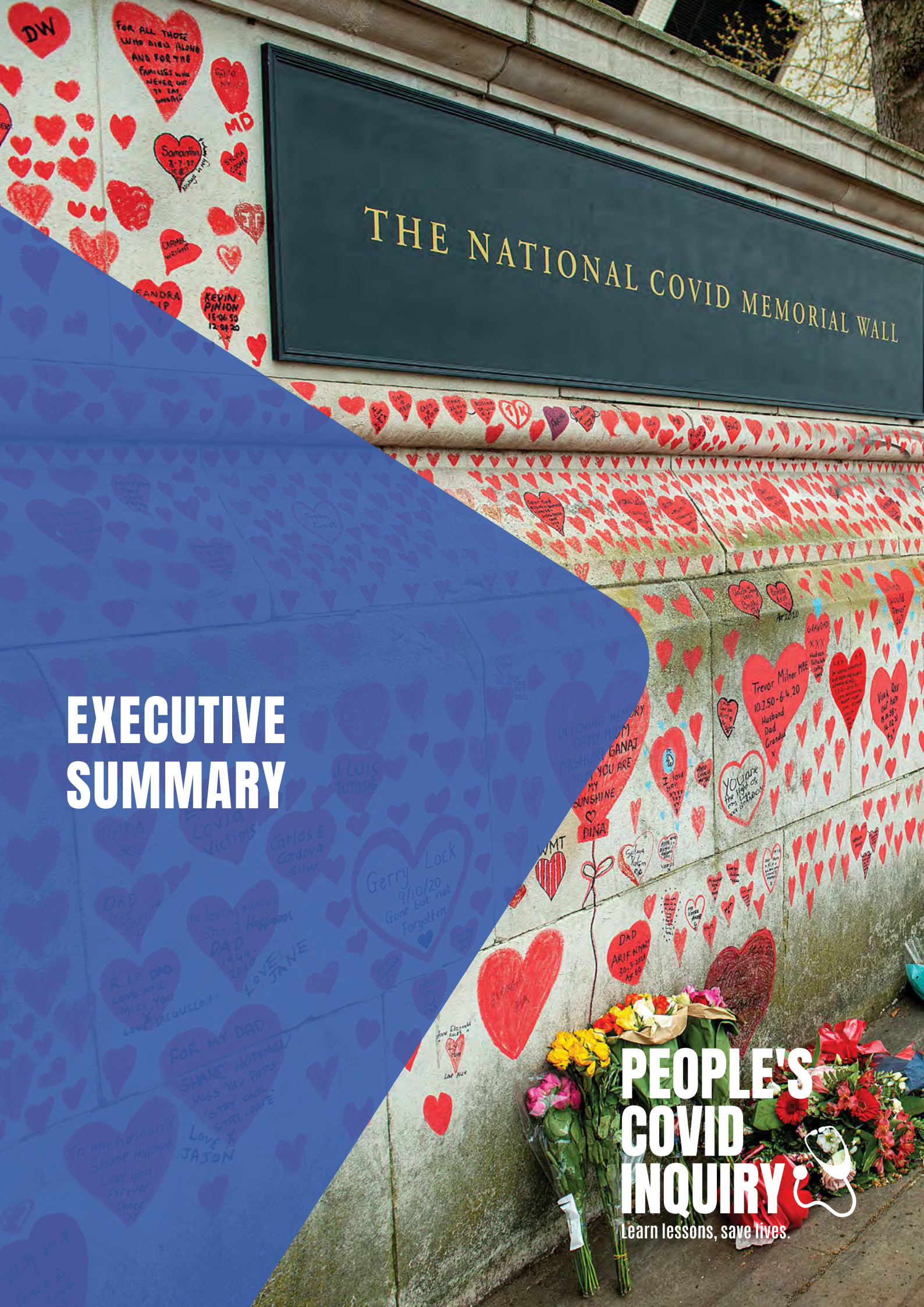
January 23	China lockdown of Wuhan, Hubei and other cities 2 months for UK government and Public Health England to prepare
January 24	Articles in The Lancet confirm evidence of dangerous new coronavirus in China
January 30	World Health Organisation declared global emergency
January 31	First UK case identified
February 28	First UK community transmission identified
March 10-13	Over 60,000 people per day allowed to mix at Jockey Club's Cheltenham Festival
March 11	World Health Organisation declared pandemic
March 11	50k allowed to attend Liverpool v Atletico Madrid football match at Anfield
March 12	initially rigorous testing and contact tracing abandoned
March 23	Imperial College London pandemic modelling suggested 200k deaths possible, prompting announcement of first UK lockdown
March 25	Coronavirus Act 2020 Royal Assent
March 25	Parliament suspended
March 26	First UK lockdown legally in force for three weeks (renewed 16 April)
April 21	Parliament reconvenes
June 23	First UK lockdown ends
July 4	First local lockdown – Leicester
September 2	Boris Johnson reiterates refusal to meet Bereaved Families for Justice
November 5	Second national lockdown in England announced
November 26	National Audit Office report: Investigation into government procurement during the COVID-19 pandemic
December 2	Second lockdown ends despite rising cases, notably in Kent
December 11	National Audit Office report: The government's approach to test and trace in England – interim report

December 26	Extension of Tier 4 restrictions across the country (from London and South East England announced 21.12.20)
December 21	Alpha variant of SARS-CoV-2 – B.1.1.7 (now VOC-20DEC-01) – identified as main factor in Kent, Southeast England and London (the ‘Kent’ variant’)
2021	
January 3	Prime Minister Johnson announces all primary children to return to school
January 6	Third England lockdown (reversing schools decisions) Milestone: ONS notes 150,000 covid-related deaths Report that £37bn spent on ‘test and trace’ has had no discernible impact on the pandemic
February 24	First session of the People’s Covid Inquiry (9 sessions to 16 June 2021)
March 8 & 29	Lifting third lockdown Step 1: schools, outdoor sports, social gatherings
March 10	Public Accounts Committee report: COVID-19: Test, track and trace (part 1) – no evidence Test and Trace investment had made any impact on virus spread
April 12	Lifting third lockdown Step 2: indoor leisure, outdoor attractions, hairdressers, outdoor hospitality, local holidays
April 15	Elective surgery waiting list reaches 4.7 million Bereaved Families for Justice Wall of Remembrance
May 17	Lifting third lockdown Step 3: social contact rules lifted, international travel
June 16	Ninth and final session of the People’s Covid Inquiry
June 21	Lifting third lockdown Step 4: nightclubs, theatre, weddings
July 7	People’s Covid Inquiry Preliminary Findings and Press conference
September 28	Boris Johnson finally meets Bereaved Families for Justice for the first time
October 12	Coronavirus: lessons learned to date. Report of the Joint Health & Social Care Committee and the Science & Technology Committee, House of Commons

- October 27** Public Accounts Committee report: Test and Trace update – ‘outcomes muddled ... a number of its professed aims ... overstated or not achieved.’
- October 31** Average daily UK deaths (within 28 days of Covid) rises from 111 to 169
- December 1** **People’s Covid Inquiry Report published**
- December 25** Deadline Boris Johnson set himself for announcing the chair of the public inquiry into the handling of the coronavirus pandemic

See also:

<https://www.instituteforgovernment.org.uk/sites/default/files/timeline-lockdown-web.pdf>



THE NATIONAL COVID MEMORIAL WALL

EXECUTIVE SUMMARY

PEOPLE'S COVID INQUIRY

Learn lessons, save lives.

DW
FOR ALL THOSE WHO DIED ALONE AND FOR THE FAMILIES WHO NEVER USE TO SAY WHAT
MD
SANDRA
KEVIN PINION 18-06-20 12-04-20

Gerry Lock
9/10/20
Gone but not forgotten

Trevor Milner MBE
10.250-6-4-20
Husband
Dad
Grandad

DAD
ARIE NINA
20-3-2019
Age 60

R.I.P DAD
LOVE AND MISS YOU
LOVE SALVATORE

FOR MY DAD
SHANE HORNBY
MISS YOU PAPA
STAY CALM
STAY LOSE
LOVE X
JASON



INTRODUCTION

'The first responsibility of any Government is to protect its citizens.'
(Matt Hancock, ex-Secretary of State for Health & Social Care, August 2020)

'We truly did everything we could, and continue to do everything we can to minimise loss of life and suffering.'
(Prime Minister Boris Johnson January 2021)

'How many more people need to die, how many more lives need to be lost to this virus before we start to learn lessons and prevent further deaths, further tragedies? We have a tragedy on a national scale, unprecedented in our times, and still the Government is dragging their feet.' (Jean Adamson, Covid-19 Bereaved Families for Justice)

By June 2020 the UK already had the worst per capita death toll from COVID-19 in Europe, despite being the sixth richest nation in the world. By January 2021, the Office of National Statistics noted that the UK had reached the milestone of 150,000 COVID-19 related deaths and throughout February and March 2021 Britain had the worst global per capita death toll. It is, therefore, undeniable that, among the richest nations in the world, Britain's overall response has been among the worst in terms of avoidable deaths.

In the face of these appalling figures, many had hoped that the Westminster Government would heed calls from organisations such as the COVID-19 Justice for Bereaved Families for a public inquiry. It did not. Faced with the Government's refusal to set one up, the national campaign organisation Keep Our NHS Public felt that a public inquiry could

not wait until the pandemic was over and launched its own.

The People's Covid Inquiry began in January 2021. The Inquiry set out to investigate the shocking scale of this tragic loss of life with the aim of learning lessons as quickly as possible in order to save lives and to better protect the population.

The Government was informed of the inquiry on 23 February 2021 and invited to take part. No response was received.

The first session of the People's Covid Inquiry began on 24 February and convened in live sessions fortnightly until 16 June 2021. The Government was sent further invitations to engage with the Inquiry on 29 March and 18 May 2021. No response has been received to date.

The Inquiry took evidence over nine sessions from over 40 witnesses including international and UK experts, frontline workers, bereaved families, trade union leaders, and representatives of disabled people's and pensioners' organisations. The evidence heard was sometimes shocking, sometimes moving and always informative. The main findings are summarised below.

THE DECADE PRIOR TO THE PANDEMIC

The Inquiry heard that following the change of Government in 2010, the new Government's ambition was to 'roll back the state'. Public spending fell from 42% to 35% of GDP between 2010 and 2019, and the Government's 'austerity' and deficit reduction policies resulted in a slowing down of the social progress made in the previous decade. This was particularly the case for lower income groups. As a result, health inequalities increased, and health

gains slowed down or even stopped – ‘we lost a decade with regard to health equity’ (Professor Michael Marmot; report para 1.2.1- 1.2.8).

Since health equity* is a good marker for the state of a society, this meant that the UK was vulnerable when the pandemic struck, and this was reflected in the structural inequalities which emerged (report para 8.17; 8.22; 8.27).

‘There was a very, very high differential mortality gradient where the most disadvantaged groups have clearly been most vulnerable both to contracting Covid and to getting seriously ill and dying from it... I think there’s a clear relationship between those two - between what happened in the run up to 2020 and what happened during the pandemic itself.’ (Professor Jonathan Portes)

SPECIFIC FAILURES OF PANDEMIC PREPARATION

In 2006 the Government Office for Science predicted a global pandemic within the next 30 years, due to a virus mutating from a wild animal to humans. Despite this the Government did not act on the recommendations of Cygnus, their own pandemic preparedness exercise conducted in 2016, which showed that preparations were inadequate (report section 1.4). In the past there had been a number of planning exercises for emergencies such as pandemics but all such contingency planning was ‘stripped

out’ after 2010 with ‘local agencies left to make their own arrangements’.

At the same time public health services had been decimated after the Lansley ‘reforms’ of 2010 (para 1.4.2 – 1.4.5).

Evidence from previous pandemics such as SARS and MERS was also ignored, in particular that FFP3 masks would be needed for healthcare workers in the event of a pandemic, rather than basic surgical masks (report sections 5.1; 5.2; 5.3; 5.4).

THE STATE OF THE NHS PRIOR TO THE PANDEMIC

Numerous witnesses referred to the crisis already affecting the NHS prior to the pandemic (see report section 1.2). After a decade of investment in the NHS (2000 – 2010), the following decade saw the policies of ‘austerity’ and marketisation drag the service down. As a result, targets were routinely missed, waiting lists rose, and by 2019 the NHS was short of 100,000 staff, leading to a heavier work load. The number of hospital beds fell drastically with the result that at the start of the pandemic the UK had ‘one of the lowest beds-to-patient population ratios in Europe’. At the same time social care was also in crisis.

Particular reference was made to the dire state of learning disability and mental health services, including child and adolescent mental health services (CAMHS) (report section 1.3; para 4.26.6-4.24.9). There were already long-term problems involving staff shortages and lack of beds and other resources, but ‘things had definitely gone downhill’ in the decade prior to the pandemic. For example ‘very often there had been no beds available for children at significant risk’. Thus these services were already

* Inequity refers to unfair, avoidable differences arising from poor governance, corruption or cultural exclusion while inequality simply refers to the uneven distribution of health or health resources. Marmot uses the term inequities to describe those systematic inequalities between social groups that are judged to be avoidable by reasonable means and are not avoided, hence unfair.

in crisis and could not meet the ‘surge of mental health referrals’ during the pandemic.

Reference was also made to the Government’s ‘just in time’ business model for procurement which delegated much of the procurement process to a ‘complex web of external companies...The Government had allowed the private sector to take over’ (report para 7.3.3). This meant that the system was too slow to respond when the pandemic arrived:

‘The last decade has seen funding stripped from public health, local Government and the NHS, leading to increasing levels of ill health. The end result has placed an impossible burden on the NHS.’ (Dr John Lister; report section 1.5)

‘We weren’t prepared. We didn’t have the PPE, we didn’t have the protocols, we didn’t have the rapid response systems, we didn’t have the infrastructure. I think that the NHS ...has been starved of funds for the last 12 years.’ (Dr Chidi Ejimofa; report section 5.11)

THE STATE OF PUBLIC HEALTH PRIOR TO THE PANDEMIC

Public health doctors and others noted that one of the reasons that the country was unprepared for a pandemic was because public health structures were ‘decimated’ after the Lansley reforms in 2010, when a new structure, Public Health England, was introduced. There was a ‘plethora of evidence’ that public health had been in decline in the subsequent decade, with a ‘significant shift away from public health, unprecedented in the last 100 – 150 years’. During this time many of the organisations and structures responsible for planning services relevant

to a pandemic were weakened or abolished:

‘Public health in general became a lesser interest of the Government. If the system had been operating well and run by public health people...we would have coped much better. We have Governments that have no real interest in the health of the population.’ (Professor Gabriel Scally; para 1.42 – 1.47)

THE STATE OF OTHER PUBLIC SERVICES INCLUDING SOCIAL CARE AND EDUCATION PRIOR TO THE PANDEMIC

The inquiry heard that other public services besides the NHS were also in crisis before the pandemic – ‘the system was already at breaking point’. Social care was estimated to have 110,000 vacancies at the start of the pandemic and in particular care homes had been struggling for some time due to underfunding and staff shortages. The National Pensioners’ Convention begged the Government for years to reform and properly fund social care but the ‘arrogant or incompetent’ Government had never replied to any of their letters (report section 2.8; 4.9).

At the same time school funding was cut ‘dramatically’ and the schools with the poorest children suffered the largest cuts. As Professor Marmot was prompted to ask when considering the social determinants of health: ‘What genius decided the best way to use public money would be to reduce spending per pupil on education?’ (section 1.2). Class sizes had to increase, with no compensatory increase in space, which meant social distancing was more difficult than in other countries during the pandemic (section 4.25).

NORMAL RESPONSES TO A PANDEMIC

Public health doctors and others were unanimous in their views on what constituted normal public health strategies in response to a pandemic (sections 2.1; 2.3; 3.2). Since it is not possible to eradicate the virus, the best strategy is to attempt to eliminate it through well-established public health measures. WHO advice about this was very basic – to find the virus, isolate those who have it, trace and test their contacts and to act fast. Lockdown may be used until a find test, trace, isolate and support (FTTIS) system is in place, and closing the borders would be part of that lockdown process. Other countries such as New Zealand, Australia and Greece did this early on, with returning citizens subject to strict quarantine.

Many Governments responded in this way after Chinese scientists published an article in *The Lancet* (23.1.20) with information about the virus, including the infectivity rate and death rate. The inquiry heard from a professor of public health in Otago (report section 2.4) that New Zealand started out with a strategy of mitigation, but quickly moved to elimination after seeing the success of many Asian countries. They instituted a lockdown when there were only 100 cases (and no deaths) in the country, and achieved elimination of the virus after 7 weeks. Since then they had enjoyed ‘zero covid’ (defined as 28 days without covid in the community against a background of high level testing) for most of the previous year. Those countries which refused to tolerate virus circulating in the community had much lower mortality rates than the UK and less economic contraction.

Experts felt that repeated lockdowns represented a failure to implement basic public health measures (section 2.1).

THE GOVERNMENT’S RESPONSE TO THE PANDEMIC

Many witnesses commented that one of the Government’s major mistakes was not acting quickly enough. They were not ‘engaged’ and they appeared to have no understanding of the risks the country faced. There was particular criticism of the Prime Minister, Boris Johnson, especially what was perceived as his cavalier attitude, boasting about shaking hands with Covid patients, and the fact that he didn’t attend the first 5 COBRA meetings. His attention seemed to be ‘elsewhere’:

‘The Government wasn’t on top of this in January/February. The Prime Minister wasn’t talking about it. And he’s a very strong leader of his party, and therefore the Government. And if he wasn’t engaged, I suspected the Government wasn’t engaged. Or it had a different agenda.’ (Stephen Cowan, leader of Hammersmith and Fulham Council; section 8.3)

‘My family had to sit and watch my Dad die for two weeks, and then you see the leader of the country stand up and make jokes about the fact that people are being robbed of their breath. He also called on (health care workers) to risk their lives and then decided not to provide the support they needed.’ (Lobby Akinnola, Covid-19 Bereaved Families for Justice; para 2.17; 4.52)

As a result they failed to establish a functioning FTTIS or to close the borders as other countries had done. They knew in February 2020 that there was a likely 80% infection rate and a 1% mortality for Covid and by the start of March 202 it was clear that cases were doubling every 3-4 days, but the UK only locked down on the 23 March 2020. One witness felt that if we

had gone into lockdown two weeks earlier then the spread of the virus would have been 'massively less' and far fewer lives lost (para 4.1.1). Meanwhile, large sporting events continued and several witnesses concluded that the Government originally intended to go for a 'take it on the chin' strategy of herd immunity, despite the predicted death toll if they did (sections 2.1; 3.3; 8.1). By April and May 2020 hospitals were being overwhelmed, which would have been much less likely with an earlier lockdown.

The Government was also criticised for 'exceptionalism', rejecting public health measures that other countries were taking to get on top of the virus as 'only appropriate for low and middle-income countries' and not following WHO advice, which was deemed to be only for 'developing countries' (para 8.2.13-15).

The Government acted from the beginning as though large scale deaths were inevitable, with Johnson warning in March 2020 (before the lockdown was announced) that many more families were 'going to lose loved ones before their time'. However, other countries including densely populated ones, managed to avoid the high death rate seen in the UK.

Witnesses criticised the Government's apparent willingness to trade off the nation's health against the nation's economy. They felt that it was better to take whatever measures were necessary to address the health crisis, even at the cost of economic output in the short term, because the alternative of not dealing effectively with it would lead to greater and longer term economic losses (section 8.1).

'The trade-off between the economy and public health is a false one. The smaller the mortality from Covid the smaller

the hit to the economy ...' (Professor Sir Michael Marmot, section 1.2)

One witness felt that the Government's response amounted to 'negligent manslaughter', in fact not even negligent in that the Government was fully informed of the risk to public health, of suffering and mass deaths, but went ahead anyway.

Finally there was concern that the Government had decided to 'put all its eggs in one vaccine basket', in other words to trust to vaccines alone to get the country out of the pandemic, rather than continuing with basic public health measures alongside a vaccination programme.

FAILURE TO SET UP A FUNCTIONING FIND, TEST, TRACE, ISOLATE AND SUPPORT (FTTIS) SYSTEM

'We have a growing confidence that we will have a test track and trace system that will be world beating and it will be in place by 1 June 2020.' (Boris Johnson to Parliament 20.5.20)

'From the beginning we have never had a proper FTTIS.' (Professor Sir David King)

A number of witnesses highlighted the importance of FTTIS and the consequences of its 'abysmal failure' (sections 2.3; 7.5). A successful FTTIS depends on early implementation, rapid identification of cases, rapid contact tracing and supporting people to isolate. This is a basic public health response to a pandemic but the Government had already abandoned widespread testing by March 2020, due to a lack of capacity.

For a long period there was no functioning FTTIS, the Government having failed 4 times to launch one. 'For some reason' the

Government persistently ignored 44 public health laboratories and finally employed private sector firms to set up a parallel system of testing sites. Companies were brought in who had ‘no experience of how to run these services’ (section 7.5):

‘We at iSAGE were simply amazed. In the middle of the biggest pandemic in over 100 years we set up private companies with no healthcare experience to run [the FTTIS] from scratch. I believe that was a disastrous decision.’ (Professor Sir David King)

There were many problems with this ‘bizarre and ineffective model’. The system was centralised and not integrated with primary care (section 2.3, 2.4). Patients were told to travel hundreds of miles for their tests and results didn’t get to GPs. It resulted in ‘unimaginable costs’ and yet witnesses said that it had never worked effectively:

‘Several multiples of funding of what primary care gets in a year have gone to Test and Trace which doesn’t seem to have helped at all.’

Witnesses including GPs felt that primary care, together with public health partners, could have taken on FTTIS if properly resourced. GPs are trusted by their communities and thus understand how to reach them and what messaging to use, especially with immigrant and lower socio-economic groups. They would also have had a better understanding of who to test when capacity was low.

Lack of testing early on meant frontline staff had to isolate unnecessarily, leading to acute staffing shortages in the NHS and in care homes.

Finally there was repeated criticism of the failure to support those who did have to

isolate, especially financially. This meant that often the chain of infection wasn’t broken when workers had to choose between isolating or food on the table for their families (section 8.2).

Witnesses contrasted the failure of the outsourced FTTIS system with the success of the vaccination programme, which had been run by the NHS.

LACK OF RESOURCES

‘The issue with PPE was so appalling, they (ITU) were receiving second-hand PPE, some of which had blood on it.’ (Michael Rosen, author)

The lack of essential resources was a recurrent theme throughout the inquiry. Stocks of personal protective equipment (PPE) were already ‘massively run down’ before the pandemic, and the Government did not take advantage of a short grace period to obtain more before the pandemic arrived in the UK. On the contrary it shipped quantities of PPE to China in February 2020 (section 7.8):

‘We thought – this is major, and waited for something to happen in the UK. We saw only absolute inaction.’ (Dr Michelle Dawson)

The consequence was ‘an abject failure’ to protect front line workers, including those in care homes, who were forced to see Covid patients without any protection. Staff were photographed wearing bin bags and other makeshift items, and this played ‘a significant role in hospital acquired infection’ at the beginning, both for staff and patients. (Bereaved Families for Justice for instance reported that their members estimated that 40% of their loved ones had contracted Covid in hospital). Many staff had to find their own PPE, and

described donations coming from local businesses. The Government eventually punished hospitals which were forced to source and pay for PPE outside the NHS supply chain by refusing to reimburse them for it, which put the hospitals out-of-pocket to the tune of ‘tens of millions of pounds’ per hospital (para 7.8.12).

Hospices and care homes have different supply routes and got no response from a promised ‘hotline’. One witness described being faced with having to send their ‘profoundly vulnerable dying patients’ back home (section 4.19):

‘We were talking to local businesses, veterinary practices, anyone we could think of because we couldn’t get them from Government. It was a complete dereliction of duty.’ (Dr Rachel Clarke)

Advice about PPE changed 40 times in 6 months and there was a strong suspicion that the Government ‘rationalised the rationing’ i.e. tailored the advice to avoid admitting to the shortages (section 5.4). There was criticism of the Government’s failure to distribute PPE more widely in the second wave, instead of which billions of pounds’ worth of PPE were ‘sitting in thousands of containers in Felixstowe docks’:

‘I can’t describe how desperate it was. Porters, who are usually on zero hours contracts, were still having to move infected bodies, with no body bag, no mask and no gown. Every single day, there was an NHS worker in tears in the changing room. We saw colleagues dying. And we were terrified we would be the next one. And you just have to keep going, keep working.’ (Dr Michelle Dawson; section 7.8)

COVID CLINICAL ASSESSMENT SERVICE (NHS 111)

Several witnesses talked of failures involving NHS 111’s Covid triage service (sections 2.7; 4.4; 7.4). The Government made a decision that all Covid calls would go through NHS 111, thus bypassing ‘one of the best primary care systems in the world’. Patients were told ‘very strongly’ to ring NHS 111 and not to trouble their GPs.

The Covid response service was outsourced at the beginning of the pandemic. There was very limited training for staff, with a steep learning curve and ‘inflexible scripted questions’ which didn’t take account of the very varied symptoms of Covid. It was not always understood that patients could be dangerously short of oxygen without being breathless. Particular mention was made of inappropriate questions about whether callers’ lips were blue (as an indicator of hypoxia), which was misleading and inappropriate for Black people.

Many who needed hospital treatment were told to ‘stay at home and take paracetamol’ with the result that some patients died at home without ever having seen a doctor:

‘I have a horrible feeling that if some patients had been passed on to their GPs we might have saved some lives. People died at home because they didn’t get the medical attention they needed quickly enough.’ (Dr Helen Salisbury)

LACK OF COHERENT GUIDANCE AND POOR MESSAGING

Witnesses felt that guidance from central Government was often lacking. When it did finally materialise, it was incoherent and 'not fit for purpose'. For instance, local Government 'found themselves in the front line' and had to take matters into their own hands in the absence of guidance from the centre, while on London Underground the unions eventually took charge of protecting workers when Government guidance was not forthcoming (sections 5.8; 5.11):

'We were having to create our own guidance, we weren't getting anything nationally.' (Dr Chidi Ejimofa)

'Eat out to help out' (Para 2.4.3) was mentioned as a policy that had made no sense to frontline workers (and had probably been responsible for a sixth of new Covid case clusters in the summer of 2020).

Government messaging was also heavily criticised as being 'woeful' (section 4.7). It was often unclear, confusing, contradictory or just plain wrong. For instance, 96% of people had understood the message to 'stay at home' but only 30% thought they understood 'stay alert', because 'what on earth does that mean?'. Witnesses also instanced the huge spike of avoidable deaths in January after opening up for Christmas, and because of the message 'Stay home, protect the NHS'. Many did stay at home, either because they didn't want to burden the NHS or because they were afraid of going into A&E departments. This resulted in excess deaths, either from acute illnesses such as heart attack and stroke, or late presentation of serious illnesses such as cancer. Experts warned

the Government about this but the Government ignored the warning.

Witnesses felt that messaging for minority ethnic groups had been 'poor to non-existent'. Minority ethnic patients have specific needs, in particular due to poor experiences in accessing health care and poorer health outcomes and communication with them throughout the pandemic had been 'wholly unacceptable'.

Finally, there was a feeling that the Government had tried to blame businesses, care homes, employers and individuals for Government failings (section 4.7):

'Now their narrative of "responsibility" is effectively saying "We wash our hands of this, it's over to you. And if things go wrong, it's your fault."' (Professor Steven Reicher)

FAILURE TO CONSULT OR TAKE ADVICE

Witnesses felt the Government had shown a blatant mistrust of professionals and experts (section 8.1). A wide range of individuals and organisations including public health experts, teachers' unions and local Government complained that the Government had never consulted them nor heeded their advice either before or during the pandemic. Prior to the pandemic the National Pensioners Convention (section 2.8) wrote repeatedly to the Government about reforming and funding social care but never heard back while health unions had drawn attention to problems with the NHS to no avail.

During the pandemic itself the Government did not consult staff involved in mental health care nor those responsible for at risk patients in the community about their special needs. At no stage did the

Government talk to or take advice from the teaching unions – ‘we were completely blanked by the Prime Minister’. One witness believed that if the Government had listened there would have been less disruption of education and fewer deaths.

Finally, the Government, having put their faith in technology rather than basic public health measures, did not consult the experts in those technologies.

FAILURE TO TRUST

Witnesses felt that the Government’s failure to consult and take advice was grounded in distrust of professionals and experts. For instance, they didn’t trust GPs, the NHS and public health to run FTTIS. They particularly regretted the Government’s failure to trust the public during the pandemic. Instead, the Government had viewed the public as ‘a problem’ with a poor grasp on reality and unable to deal with the crisis. In fact, research and evidence show that people tend to come together and support each other in a crisis, and that mutual support is critical to any public response (section 4.7). As a result of this distrust the Government never tried to mobilise the public, communities, or the 750,000 volunteers to take more control of the situation once the pandemic struck, but rather just told them what to do.

The Government also made a serious mistake in accepting advice early on ‘from non-behavioural scientists’ that the British public could not cope with a lock down, and delayed locking down, resulting in tens of thousands of avoidable deaths (section 4.7):

(The Government’s) paternalist psychology, that people are weak and frail and can’t do things for themselves,

their positioning of their best asset, the public, as a problem, is one of the fundamental failures of this whole pandemic.’ (Professor Steven Reicher)

FAILURE TO BE HONEST

Several witnesses mentioned the fact that the Government suppressed or manipulated data in their dealings with the public. There was also concern about a ‘data grab’ in which it was felt that the Government hadn’t been transparent with the public (see below).

PRIVATE SECTOR PRIORITISED OVER NHS

We have already described the Government’s ‘disastrous decision’ to bypass the NHS and use the private sector to run the FTTIS system (section 7.5). This has thus far cost the tax payer £37 billion without, according to the Public Accounts Committee, making a measurable difference to the pandemic despite its ‘unimaginable’ costs. But this is not the only instance of the Government turning to the private sector either because it had run down the NHS to the point where it couldn’t respond to the pandemic adequately or because they preferred to use the private sector even when the NHS could have stepped up.

Austerity and marketisation had already weakened the NHS over the previous decade, so that it went into the pandemic with too few beds and staff and a crumbling infrastructure (section 1.5). As a result the Government had to arrange for extra hospital beds to deal with the anticipated demand, and took out a contract with 26 private health companies to block book the entire capacity of their hospitals (section 7.2).

The inquiry heard that there was ‘a real problem of transparency’ about how much the Government paid for the contract and how much of the capacity had actually been used. The think tank CHPI estimated that on average there was one Covid patient per day in the private beds, while the contract was thought to be costing the tax payer between £170 million and £400 million a month. While being very poor value for money the contract allowed the private hospitals to survive the effects of the pandemic so that they were now in a good position to deal with the backlog of non-Covid work, both via the NHS and via private demand:

‘What we’ve seen is a subsidy going into the private hospital sector to help it survive the initial effects of the pandemic, and now, potentially, to help it thrive as a result of the increased demand for health care.’ (Professor David McCoy)

To this end the Government will continue to set aside money to pay for NHS patients to be seen in the private sector to the tune of £2.5 billion a year for the next four years, double the amount spent in 2018 and 2019. Witnesses said this money should be going to boost the capacity of the NHS rather than the private sector.

The Government also built 7 Nightingale hospitals to deal with Covid patients, at a cost of over £530 million, at least £50 million of which went to private companies (para 2.8.6; 5.11.11). They didn’t discuss them with NHS staff, who could have pointed out that there was no one to staff them. As a result they only treated a handful of patients between them.

A Labour MP described how the Government had launched the Leamington ‘Lighthouse Project’ to build a ‘megalab’ in his constituency (the latest of 9-10

such megalabs contracted to private and private public partnerships parallel to the NHS; section 7.6). He questioned why the Government had chosen to set up a brand-new laboratory instead of expanding local NHS pathology services, and expressed concerns about the quality standards of the facility. There had been a total lack of transparency around the project, and the contract was awarded without going out to tender:

‘There have been too many failures and too much taxpayers’ money squandered by this Government for us to allow ministers to avoid accountability in the way they are at the moment.’ (Matt Western, Labour MP)

CORRUPT CONTRACT PROCESSES

Witnesses also expressed dismay about the lack of transparency around the awarding of contracts during the pandemic. As with the Lighthouse Project described above, some were awarded without being put out to tender and to people who had little or no relevant experience. A witness who set up a charity to obtain PPE described how the Government failed to take up contracts she had managed to negotiate for millions of items of PPE, with the result that at a time of acute shortage the items were sold to other countries (section 7.8):

‘We spoke directly to the Cabinet Office, we sent them the correct paperwork. And I followed it up a week later, and nothing had happened. Those masks could not be held and so they were sold to Germany, because they were fit for purpose... I wasn’t a VIP, I didn’t have access to the VIP lane. And it wasn’t followed up.’ (Dr Michelle Dawson)

Over 70 companies contacted the BMA to say they could supply high quality PPE but had received no response from the Government (section 7.8). The BMA forwarded these offers to the Department of Health but had no reply. Money spent on the procurement of PPE was clearly ‘hugely wasteful and occasionally corrupt’:

‘They opened up high priority lanes that led to fast-track contracts. It wasn’t what you knew but who you knew in Government...contracts were handed out to firms that had no history of making PPE or medical grade equipment. There is a clear history of lack of transparency, waste and cronyism surrounding the Government’s contracting process throughout the pandemic.’ (Dr David Wrigley)

THE COVID-19 DATA STORE

The inquiry heard about ‘an unprecedented collection of NHS data’, collated nationally and held in a single place, called the COVID-19 data store (section 7.10)*. This had been set up in March 2020 through contracts with US tech giants like Google and Amazon. The Government had released no details, but it was believed that all GP records would go into the store unless patients opted out. Unfortunately, most patients know nothing about it as there has been very little publicity and no consultation:

‘The data protection laws require your explicit consent to what happens with your data. The obligation is on the Secretary of State and NHS digital to seek your consent and to notify you about this proposal. Currently their notification is simply a web page, and

a link to how you can opt out.’ (Rosa Curling)

NHS data is extremely valuable to the commercial sector, who know that the NHS, with its highly centralised system, and its unique mass of health data, provides extraordinary opportunities from which to profit.

There was significant concern about how secure people’s confidential health data would be with these tech giants, who would be able to access it and whether the public could prevent their data from being used for private profit. (Since the Inquiry, NHSE Digital have been forced to postpone from 1st July to 1st September and then postpone again without a date; para 7.10.9).

THE EFFECTS OF THE PANDEMIC ON PARTICULAR GROUPS

The Inquiry heard from a wide range of individuals and organisations representing groups who had suffered particularly badly during the pandemic (section 5.5).

Witnesses testified to the fact that there was ‘an abject failure’ to protect NHS workers (section 5.1). The principal determinant of dying from the disease was catching it, and therefore depended on exposure to the virus. Unforgivably there was a failure to provide adequate PPE to those exposed with the result that front line NHS workers had a seven-fold increase in their risk of getting (and thus dying from) COVID-19 (over 850 died between March and December 2020). Guidance around PPE had changed frequently.

The NHS started the pandemic 100,000 staff short. This, combined with a lack of testing in the early days, meant that

* <https://www.england.nhs.uk/contact-us/privacy-notice/how-we-use-your-information/covid-19-response/nhs-covid-19-data-store/>

staffing was at times ‘the worst I’ve ever seen it’, with instances of one nurse to 21 patients. As the pandemic progressed some of the work force who had ‘been in the trenches’ for months, and seen colleagues severely ill and dying from Covid, would no longer accept the dangerous working conditions.

Others suffered burnout, moral injury and post-traumatic stress disorder (sections 5.1, 5.12). Burn out involved emotional exhaustion and arose from working long hours in stressful conditions. Moral injury gave rise to feelings of distress and guilt as a result of being asked to do a job to a standard that was not acceptable:

‘I feel hugely let down by the Government, cannon fodder absolutely nails it.’ (quoted by Sumner, para 5.12.1)

‘You care about your job, you want to do it well, you don’t go into nursing to potentially harm people, but that’s how it feels sometimes. You’re put into situations where you can’t do a decent job, and it isn’t safe.’ (Kirsty Brewerton)

One witness felt that staff would give up the ‘insulting’ 1% pay rise offer if they could only get the resources to do their jobs properly:

‘We worked for peanuts with our flimsy PPE, crossing our fingers, we can beat it, the Government sicken me with their lack of empathy. 30% pay rise for them and a clap for us. What a mug I was for being a nurse.’ (NHS nurse)

Despite the widespread burnout and moral injury there was little or no attempt to offer routine risk assessments or support for mental health or other problems, and when risk assessments were instituted after a ‘groundswell’ of protests they were

criticised as tick box exercises (section 5.12):

‘When we asked our participants during the interviews, how they were doing, many of them said, “God, that’s the first time somebody’s asked me that”, and really broke down, were really, really emotional.’ (Dr Elaine Kinsella)

Many frontline NHS staff are poorly paid, women and/or minority ethnic workers on minimum pay and conditions, and don’t have the luxury of working from home and many felt they couldn’t afford to self-isolate (section 3.8; 6.0; 6.7). There was also particular concern about minority ethnic NHS staff who were dying at much higher rates. It was already known before the pandemic that they were more at risk of discrimination, bullying, and harassment and therefore knew that if they raised concerns once the pandemic began, they were the least likely to be heard or acted upon:

‘It’s hard and dangerous work. And for people to do that hard and dangerous work every day, they need to know that it’s worth it and that it means something. But they are starting to feel hopeless, they are starting to feel that they have lost the point, they’ve lost the drive to keep working.’ (Dr Rachel Sumner)

FRONT LINE WORKERS LET DOWN

The pandemic exposed who the real ‘essential workers’ are in a crisis – teachers, transport workers, care home staff, hospital porters, supermarket shelf stackers (section 5.8). As with the NHS, many are poorly paid, living in deprivation, some on zero hours contracts and unable to work from home. Not only were they exposed to Covid on the front line, often with inadequate or no PPE, but many fell

into other risk categories such as poverty, co-morbidity, obesity, ethnicity, and living in crowded accommodation (sections 6.1 – 6.5).

If asked to self-isolate they were faced with having to live on £95/week and many felt they couldn't afford to stay at home (section 4.8). One private contractor was refusing to pay even minimum wages to any worker testing positive. The Government was severely criticised by many witnesses for not giving financial support to poorly paid workers who needed to self-isolate (section 8.2):

'The biggest obvious policy error has been the failure to raise sick pay or to put in place an effective system of sick pay that incentivises people ... to take time off work to self-isolate. That has been a real false economy, which has undoubtedly inhibited the effectiveness of Test and Trace, and therefore probably led to more people getting sick than needed to be, prolonging the pandemic unnecessarily.' (Professor Jonathan Portes)

Often employers shirked responsibility for making work places safe, and it was up to trade unions to establish Covid safe environments and to look at risk assessment especially for minority ethnic workers (sections 5.8. 5.9). For example bus drivers working for private companies had to take their own safety measures such as erecting plastic screens and closing access via the front doors of buses. One employer, Aviva, sent out a notice saying these measures had not been agreed and threatening disciplinary action if they continued

'Bus drivers told me they were just totally abandoned. The lack of any safety measures to protect the drivers was quite astonishing ...the horrific death toll

of London bus drivers was tragic.' (Unjum Mirza)

Workers on London Underground (section 5.8), largely in public hands, still had to fight for fundamental protections such as masks and hand gel, and to get their cabs cleaned properly. Finally they had to threaten that they would not take the trains out if they weren't supported in these basic public health measures. Once again there was little or no attempt to do any risk assessments

The consequences have been shocking: in London alone, within a month of lockdown, 21 transport workers had died from COVID-19.* Sadiq Khan said 88 transport workers, including 51 bus drivers had died from COVID-19 (May 2021**).

There were concerns about confusing guidelines for the reporting of covid contracted through occupational exposure and a fear that not only were the numbers of health workers with Covid underreported but a vital opportunity to investigate such cases had been missed (section 5.7). Even so HSE received about 25,000 such reports, the vast majority of which hadn't been investigated:

'The employer has an obligation to take steps to protect their workers. People who take this burden (of Covid exposure) by virtue of their work on behalf of society, deserve that level of protection as a precondition and the right levels of personal protection, as well as the vaccine, as a fundamental right.' (Professor Raymond Agius)

* <https://www.standard.co.uk/news/london/transport-london-21-coronavirus-deaths-mayor-sadiq-khan-a4413431.html>

** <https://www.london.gov.uk/questions/2021/1345>

CHILDREN AND YOUNG PEOPLE

The inquiry heard that the UK had had the longest periods of closure or near closure of education (section 4.2.4). As noted above the Government failed to consult the profession and ignored its recommendations for dealing with the crisis:

'Our schools were largely closed for much the longest period, and I think that is a record of failure by this Government.'
(Kevin Courtney)

School funding was cut 'dramatically' after 2015, and the schools with the poorest children had suffered the largest cuts. As a result, class sizes increased to where they were 40 years ago, without any compensatory increase in space. Thus, social distancing was much harder than in other countries, and schools suffered more disruption. There was inadequate ventilation in most schools, with no moves to improve the situation and there was a shortage of PPE for teachers, who felt vulnerable.

Other problems had interrupted children's education, including the failure to deliver laptops and broadband, and the determination of exam grades by 'mutant algorithms', which had been 'a farce' and very stressful for pupils. Children from poor homes had been particularly badly affected by the pandemic as they typically had little space and few resources at home, and their parents were less likely to work from home:

'Teachers see the differential impact that social class and inequality has had. It's a fundamental issue that has to be addressed. There are massively discriminatory impacts of the school closures, the school disruption. The Government has to work with us to put

those things right, not only as a result of Covid, but also the inequality that existed pre-Covid, that was shown up during Covid.' (Kevin Courtney)

The pandemic exacerbated many mental health problems in children and adolescents, and following the first lock down there was a surge of mental health referrals. These commonly involved eating disorders, depression and self-harm, problems which thrive on isolation. Many children were also very stressed over missing so much schooling. Unfortunately Child and Adolescent Mental Health Services already had too few resources and were not able to cope with the increased demand:

'[They impact on] generations to come. We know that what a young person experiences today is going to have an impact on how they parent their children.'
(Rachel Ambrose)

Finally there was harsh criticism of the Government's response to a request for the funding needed to address the damage done to children's education during the pandemic (section 4.25). It had been estimated by the Institute for Fiscal Studies that this could represent a cost to the country of £350 billion over the next 40 years, but when the Education Policy Institute proposed an initial catch-up programme of £15 billion the Government's response had been to offer 10% of that ie £1.5 billion. Given the economic and social case for funding catch up, especially for the most disadvantaged, it was 'almost impossible' to see what the justification for that decision was. Government appointee Kevan Collins had resigned in protest.*

'I really find the Government's decision on this almost incomprehensible from

* <https://www.thetimes.co.uk/article/downing-st-must-take-the-blame-say-critics-as-kevan-collins-quits-7sl879mvw>

almost any perspective.' (Professor Jonathan Portes)

AT RISK GROUPS

'We all face the same storm but we are not all in the same boat.' (Dr Sonia Adesara, after Damian Barr)

The elderly (sections 4.8, 419), the disabled and those with mental health problems and learning difficulties (section 4.20, 423) were all especially at risk during the pandemic and they died in disproportionate numbers.

Witnesses emphatically rejected the Government's claim that they put a 'protective ring' around care homes. On the contrary, elderly people living in care homes were 3 times more likely to die of COVID-19 than those living in the community, and it was estimated that 25% of Covid deaths had occurred in care home residents.

'The devastation that care home residents have suffered, are still suffering, is unacceptable. It shouldn't have happened, needn't have happened and should never happen again.' (Jan Shortt)

When the pandemic threatened, older people were discharged from hospital back to their care homes without being tested for SARS-CoV2. Care home staff didn't have adequate PPE or testing available, and consequently were catching Covid and moving between homes. Care homes, like prisons and cruise ships, were 'institutional amplifiers' and once introduced, infection spread very quickly in them (para 4.10.3):

'In our modern economy prisons, care homes, and immigrant detention centres are a means of monetising the storage of human beings. They have a different set

of objectives and the idea that they're there to look after people is missing the point. They are essentially financial vehicles, which happen to have people in them.' (Professor Martin McKee)

While the disabled make up 20% of the population, they have also been disproportionately affected by Covid, accounting for almost 60% of deaths by November 2020 (section 4.20. 4.23).

Many older disabled people and those with learning difficulties live in care homes or supported living settings. Like the elderly they suffered because patients were discharged from hospitals into these settings without being tested for Covid, and also because of a lack of PPE and poor social distancing. In addition there is a historic link between disability and poverty. Disabled people are three times more likely to live with severe material deprivation, and as a result those who worked couldn't afford to stay at home and shield.

Lastly, long standing unequal access to healthcare for the disabled was exacerbated by the pandemic. The clinical frailty score was used 'overzealously' to limit disabled people's access to hospital and ITU because the Government wanted to avoid images, such as those that came out of Italy, which suggested that they had lost control of the pandemic. Withholding treatment and keeping people out of hospital was one way of doing that:

The inquiry heard that the learning difficulties/mental health needs communities were also largely forgotten about in the pandemic:

'It makes me angry. Boris Johnson has forgotten this whole group of people who have died at six times the rate of their peers in the general population.' (Clare Phillips)

The disabled and those with mental health problems and learning difficulties were fearful and were driven to creating 'hospital passports' in order to persuade medical professionals that they deserved admission to hospital and life-saving treatment (sections 4.21.3). These explained the diagnosis, medications and needs of individuals, some of whom would not be able to advocate for themselves if separated from their usual support worker who knew them well.

Finally there were concerns from Covid-19 Bereaved Families for Justice that there had been a 'lack of transparency and honesty' when they sought answers about what had happened to their loved ones. In particular they felt very let down by the Care Quality Commission (CQC), who had refused to release the number of Covid-related deaths in individual care homes. They felt they CQC had sought to protect the interests of the commercial sector at the expense of the interests of the public, and in choosing to hide behind Freedom of Information exemptions their position had become 'untenable':

'We all share the one thing in common, we were looking for answers. I needed to understand, and our members need to understand why our loved ones died in a place where we expected them to be safe.' (Jean Adamson)

Adamson eventually succeeded in getting this information released by the CQC in July 2021.* The report states 39,017 people died from COVID-19 related causes in care homes from April 2020 to March 2021. This represents over 30% of the total 126, 670 deaths by end of March 2021.

* <https://www.cqc.org.uk/news/releases/care-quality-commission-publishes-data-showing-death-notifications-involving-covid-19>

MINORITY ETHNIC COMMUNITIES

We have already mentioned that Black, Asian and minority ethnic communities were more at risk, and by April 2020 30% of those admitted to ITU were of 'non-white ethnicity' despite making up only 14% of the population. The disproportionate impact of Co.vid on this population was due a combination of factors including increased exposure through crowded living circumstances and occupation, poor access to health care and a high rate of co-morbidities such as obesity, cardiovascular disease and diabetes (sections 6.1-6.7).

BMA surveys had already shown that Black, Asian and minority ethnic doctors were more at risk of discrimination and bullying and they were thus less likely to raise concerns especially around lack of PPE. Once again risk assessment had not been adequately addressed.

Dr Latifa Patel told the inquiry that minority groups were also disadvantaged when virtual platforms became the norm for the NHS (section 6.8). They didn't necessarily have good WiFi or good English and privacy was a problem in multigenerational families, with people resorting to consultations in cars and bathrooms in order to find privacy.

Finally vaccine hesitancy was commoner in this group due a historic lack of trust in the Government, combined with disparities in access to healthcare and poor messaging during the pandemic:

'Structural discrimination is an issue underlying all of this. And this is pre-pandemic. Inequitable systems, such as housing, education, employment, earnings, benefits, credit. All of this is structural discrimination that puts people

at a disadvantage – ethnic minorities and non-ethnic minorities, but more so ethnic minorities.’ (Professor Kamlesh Khunti)

WOMEN DISADVANTAGED FURTHER

The inquiry heard the conclusions of a report (Lessons Learned: Where Women Stand at the Start of 2021*). This found that while men were more likely to die from COVID-19, women had suffered a greater social and economic impact. They were more likely to be made redundant, more likely to be furloughed, had suffered a vast increase in their unpaid work, and were more likely to be in significant debt (section 6.12). There had also been an increase in domestic violence, a problem which predated the pandemic and is ‘massively underreported’.

It was also known that women were more likely to be poor, to work in sectors such as hospitality that would be affected by the pandemic, and that they carried out 60% more unpaid work than men, and that closing schools and nurseries would increase that burden. In other words, the pandemic had exacerbated pre-existing gender inequalities in society.

When Dr Clare Wenham raised concerns based on pandemics elsewhere, she was told ‘London is not Liberia, we won’t have the same problems’ (para 6.12.3):

‘Covid has highlighted problems that existed long before the pandemic... We don’t want to go back to the way things were, we have an opportunity to do things differently, and this is the moment to do that.’ (Dr Mary Ann Stephenson)

MIGRANTS IN A HOSTILE ENVIRONMENT

Between 800,000 and 1.2 million people in the UK are classed as ‘undocumented’, also labelled by the Government and right wing press as ‘illegal immigrants’; (section 6.10). Their immigration status is checked whenever they need to access any of the services that are needed ‘to live a dignified and normal life’.

This means they are ‘incredibly fearful’ about approaching these services even when in need. The NHS for example charges some migrants up to 150% of the cost of care, and some instances of non-urgent treatment require payment upfront – i.e. if you can’t pay, you don’t get the treatment. Of particular concern to undocumented migrants is the fact that the NHS shares patient data with the Home Office.

The inquiry heard about several examples of undocumented migrants who were too fearful to seek help despite being ill with COVID-19 and who died at home as a result. The irony of this was that they were entitled to free care for Covid, but they didn’t know this as the Government didn’t publicise it.

There was also concern about the abysmal and traumatising conditions in which some asylum seekers are kept, with no possibility to socially distance and no ready access to GP services. Covid had ‘ripped through’ some of these communities:

‘The hostile environment, makes life incredibly difficult for people who don’t have the right immigration papers. And as we know, this affects not just those who don’t have legal status, but can affect people who are unable to prove that they have legal status, such as those from the Windrush scandal.’ (Aliya Yule)

* <https://wbg.org.uk/analysis/reports/lessons-learned-where-women-stand-at-the-start-of-2021/>

PUBLIC RESPOND DESPITE WRONG MESSAGING

Several witnesses talked of the Government's mistaken views of the public, including treating us as the problem and not the solution and failing to exploit a strong sense of community that people felt, including the 750,000 who volunteered to help out. Government talk about 'pandemic fatigue' and their claim that the public were 'really tired of restrictions' was nonsense – in fact the public were always 'ahead of the Government' in wanting to do the right thing. They had been observant of the rules, they had just been 'the wrong rules.' (section 4.7)

The public were generally prepared to behave 'heroically' as long as they trusted the Government but did lose faith once the messaging became confused, and trust evaporated when they saw egregious rule-breaking going unpunished.

There has also been a strong public sector ethos during the pandemic which the Government on occasion exploited, undermined or ignored.

LEGAL CONSIDERATIONS

The inquiry heard from a human rights lawyer about the legal aspects of the Government's actions during the pandemic (para 8.2.44-48). There are international laws which require states to be prepared for pandemics and to take appropriate steps when they occur. There was a question mark over whether the UK's response actually complied with some of these laws, in particular the lack of PPE and ventilators, the discharge of untested patients into care homes and the protection of patients in hospitals and homes.

Under the European Convention on Human Rights (ECHR) the Government has a duty to protect the public at large, frontline workers and at-risk groups. There was also a duty on employers to ensure the health and safety of their employees at work by providing a safe work place with necessary training and equipment (such as PPE), and that a breach of those regulations could be a criminal offence. Claims against breaches of ECHR could be brought in UK domestic courts

On the possibility of prosecuting those felt to be responsible for failings during the pandemic, the Inquiry heard that individuals can't be charged with corporate manslaughter, but an organisation, such as the Department of Health and Social Care, could be. There had been a recent opinion in The Guardian from a QC that the discharge of patients infected with coronavirus back into care homes raised 'some serious questions about whether there is liability for that department for corporate manslaughter'.

One union (the GMB) is already calling for justice for the families of workers who died, many unnecessarily, and for those who contracted long Covid through their work:

'People who think that our pandemic strategy has been a success must look at the number of deaths, the number of people suffering with long covid, but also the impact on our economy and the fact that we've had restrictions for 16 months, three lockdowns, four months of children being out of education. How is this even remotely a success?'

'The media never actually discuss the response in other countries...so people aren't aware that life could be so different had we adopted the elimination strategy last year, or even learned much later and adopted it more recently. It's very, very clear that countries that valued life,

that treated deaths as preventable are the same countries that have done best economically.'

OUR CONCLUSIONS

The Government was not prepared for a global pandemic despite warnings that one was coming. When it arrived, they ignored clear warnings of the dangers and did too little too late.

During the decade before the pandemic successive Conservative Governments had run down public services, including the NHS, public health and care services, with the result that they were already in crisis when the pandemic struck. The pandemic then shone a light on long term problems in society around inequalities and discrimination and exacerbated them. The poorest and most vulnerable were hit the hardest and died in disproportionate numbers.

The Government failed to protect its frontline workers, at risk groups and the public. It made disastrous decisions about FTTIS and NHS 111, and consistently favoured the private sector over the NHS. There was lack of transparency around these dealings and huge sums of money have been wasted.

The Government failed to consult or to heed the advice of professionals, experts, civil society including unions and the public and, what's more, actively distrusted them. They have shown themselves unwilling to learn from their mistakes and change course where appropriate. They have ignored calls for an urgent inquiry in order to learn lessons and prevent further unnecessary deaths.

The scale of deaths has inevitably invited questions about accountability. In a much-quoted BMJ editorial Dr Kamran Abbasi proposed that the UK Government had shown a 'premeditated and reckless indifference' to human life when it accepted tens of thousands of premature deaths in the hope of achieving 'herd immunity' or for the sake of propping up the economy. He used the term 'social murder' to describe 'the lack of political attention to social determinants and inequalities' which was uncovered by the pandemic, and which led to disproportionate death rates amongst the poorest and most disadvantaged.

Abbasi asked who is to blame if avoidable deaths result from politicians wilfully neglecting historical experience, scientific advice and their own statistics and modelling. Should public health malpractice count as a crime against humanity, both nationally and internationally? Some will argue that the UK was not the only country that fared badly but low death rates in countries such as New Zealand and Taiwan show that it didn't have to be like that, and to make matters worse the Government has shown no sign that it is ready to learn any lessons or accept any responsibility for (at the time of writing) 167,000 deaths.

Matt Hancock was right when he said that 'the first responsibility of any Government is to protect its citizens'. But they failed miserably and as a result tens of thousands of people died avoidable deaths. Politicians must at some stage be held to account – by legal and electoral means – for their fatal failures. A properly conducted public inquiry will be an important part of that reckoning.

During the intervening months from July until now, the People's Covid Inquiry

has continued to gather and examine evidence, including the fiercely critical House of Commons Health and Social Care and Science and Technology Committees report, 'Coronavirus: lessons learned to date' published 12 October, the recent joint report 'Building a consensus for health, care and support services fit for the pandemic era' from Independent SAGE and Keep Our NHS Public, the National Audit Office report on the Government's preparedness for the pandemic, and much more.

There has been no indication from the Government that it is prepared to learn lessons from this tragedy and the significance of the ongoing death toll in the UK is currently played down in official circles. We can only agree with the words of the House of Commons Joint Select Committee report, that the pandemic has proved to be 'one of the UK's worst ever public health failures'.

That report, while outlining some mistakes in the Government's early response, attributes most of the blame to public health bodies rather than the Government itself. The attitude of Government was perhaps most clearly expressed recently when Cabinet Office minister Stephen Barclay declined to say sorry 11 times for the Government's handling of the COVID-19 pandemic.

WHAT NEXT

Since the Inquiry concluded its evidence gathering, the infection rate and death toll are going up again. On 7 July 2021 the average daily death toll from COVID-19 in the UK was 35. In late November at the time writing, the average sits at 141 COVID-19 deaths per day.

Our key findings and recommendations are based on contemporary evidence from the front line. They are even more urgent now than when the Inquiry reported preliminary findings in July 2021. This winter is predicted to be the worst ever for the NHS, with every indication that COVID-19 infection rates and deaths remain high, already NHS and care services under enormous and unsustainable pressure.

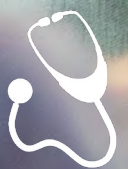
The Government's handling of the pandemic was grossly negligent and has unquestionably led to significant loss of life that could and should have been avoided. Those in charge during the pandemic showed a wilful disregard for public safety and a callousness toward the numbers of people who have died and their bereaved relatives. We ask that the Government accepts and acts on our findings, and implements the recommendations set out in our report.

It is not too late for some good to emerge from the pandemic. Lessons are clear, and can and should be learned. With political will and public support, social and health inequalities could be tackled. We could see the NHS and other public services properly funded saved from the brink of collapse. Only in this way can we keep the nation safe and protect it from a repeat of the current catastrophic public health disaster we have documented here.



FINDINGS AND RECOMMENDATIONS

**PEOPLE'S
COVID
INQUIRY**



Learn lessons, save lives.

1. CONDUCT IN PUBLIC OFFICE AND DUTY OF CANDOUR

Findings

- F1.1** There have been serious governance failures of the Westminster Government, in breach of all of the Nolan Principles: Selflessness, Integrity, Objectivity, Accountability, Openness, Honesty and Leadership. These contributed to tens of thousands of avoidable deaths and suffering, and they amount to misconduct in public office.
- F1.2** Recommendations from previous pandemic planning exercises were ignored.
- F1.3** The Government failed to conduct risk assessments or act to protect key populations at increased risk.
- F1.4** An equality impact assessment of all the policies was not carried out and measures taken to address risks identified as should have happened.
- F1.5** The Westminster Government treated bereaved families with disrespect and ignored their questions for over 12 months.

Recommendations

- R1.1** Breaches of the Nolan principles by the Westminster Government during the pandemic must be addressed. Egregious breaches must have consequences.
- R1.2** Consideration should be given to charges of Misconduct in Public Office given the evidence available of the Government's breaches and failures and the serious consequences for the public.
- R1.3** For the future, the Nolan principles should have a statutory basis.
- R1.4** Government must acknowledge to the public and bereaved families the mistakes made in its management of the pandemic.
- R1.5** Government must make public the details of private-sector procurement during the pandemic. The NHS and public health services should publish and justify private-sector procurement data each year.

2. PANDEMIC PLANNING AND CONSEQUENCES

Findings

- F2.1** The UK has one of the highest death rates in the world from COVID-19 despite having a renowned national health service and a world reputation in public health.
- F2.2** 167,000 deaths have COVID-19 on the death certificate (ONS 5 November). Many of these deaths could have been avoided.
- F2.3** The Government failed to address the seriousness of the pandemic for several vital weeks from 23 January 2020 (Wuhan lockdown and Lancet articles published) to first lockdown on 26 March despite very clear indications this was urgent.

Recommendations

- R2.1** There must be prompt institution of standard pandemic control measures in the event of any future pandemics.
- R2.2** Pandemic planning in the NHS needs to be urgently reviewed for the future, including: the review of hospital protocols on transmission in the early stages, the NHS 111 service, the role of GPs.
- R2.3** Representatives of care homes, disabled people's organisations, relevant health, care and education trade unions, schools and bereaved families should be asked to contribute on the basis of their knowledge and experience gained during the pandemic
- R2.4** The role of behavioural scientists should be recognised in formulating clear government messages.
- R2.5** There should be an urgent review of pandemic planning for the care sector, including care in domiciliary settings. Staff, representatives of care homes and care settings, and unions should be involved in future pandemic planning.
- R2.6** There should be an urgent review of pandemic planning for disabled people in the community, in their homes and in hospitals, including representatives of disabled peoples' organisations, including those on the ground.
- R2.7** Recommendations for PPE should follow a precautionary principle and improving workplace ventilation (including schools) should be a priority.
- R2.8** The SAGE should have a gender expert, adequate public health expertise and equality impact assessments should be carried out on all future policies.
- R2.9** Public-sector infrastructure, expertise, and capacity needs to be rebuilt.

3. THE NHS HAD BEEN UNDERMINED PRE-PANDEMIC

Findings

- F3.1** The NHS had become an undermined, fractured and fragmented public service by the time it went into the pandemic, severely weakened after a decade of austerity. There is a risk of impending collapse. The NHS should have been in a position to protect the people but was not able to do so; instead, the NHS itself was in need of protection.
- F3.2** The NHS had insufficient capacity for resilience during a pandemic and was forced to become a Covid service during the first and second pandemic waves.
- F3.3** The severe weaknesses in the NHS included 100,000 staff vacancies, ITU, bed and equipment shortages, and the running down of laboratories.

Recommendations

- R3.1** Investment must urgently strengthen NHS hospital, community, mental health and primary care services, diagnostics and public health, and social care and support for independent living.
- R3.2** The NHS must have built-in capacity for continuity of emergency and elective services, including cancers and life-altering health issues, during a pandemic or other emergencies.
- R3.3** The NHS must be strengthened to a state of pre-pandemic preparedness including adequate staff, beds, equipment, testing facilities, and PPE.
- R3.4** Restoration of NHS and public health capacity must start immediately to achieve safe NHS care of all patients, to restore decayed infrastructure and increase workforce numbers, eliminate waiting lists, and improve services year-on-year in a manner fit for the 21st century.
- R3.5** It is urgent to restore the morale of NHS and care staff with a statement of commitment to public services, publicly provided and publicly delivered, backed by urgent real terms restoration of level of funding to expand the workforce and address lost real value pay.
- R3.6** Government must ensure long-term funding plans for the health and social care system are commensurate with need.
- R3.7** Specific provision must be made for assessment and management of patients with long covid.

4. AUSTERITY AND THE PANDEMIC

Findings

- F4.1** The UK Government failed to uphold its 2010 election promises to address the wider determinants of health and wellbeing. Its policies widened health inequalities, laying the basis for an increased UK COVID-19 death toll.
- F4.2** Deep social inequality contributed to a more vulnerable UK population, with increased hospitalisations, deaths and, during the first 5 months of 2020, the highest excess mortality rate across Europe.
- F4.3** The UK has the lowest sick pay in the OECD, except for Malta. Lack of sick pay and low sick pay played a role in spreading infection by forcing people to go to work to feed their families even when they had the virus.
- F4.4** Financial and other support for people needing to isolate has never been sufficient to be effective in reducing spread of infection.

Recommendations

- R4.1** The deep health inequalities heightened during COVID-19 must be addressed with focus on investment in health and social care and further research and action to correct the disproportionate impact on our Black, Asian and ethnically diverse population.
- R4.2** The social determinants of health must be tackled as a priority across all policy areas in order to reduce health inequalities.
- R4.3** Statutory sick pay should be at least at levels equivalent to European countries .
- R4.4** Statutory sick pay should be available to people having to self-isolate.
- R4.5** The £20 uplift in Universal Credit must be restored, especially in the light of escalating food and energy costs and ongoing rates of viral infection.

5. INEQUALITIES AND BLACK, ASIAN AND ETHNICALLY DIVERSE COMMUNITIES

Findings

- F5.1** The existing disparities suffered by Black, Asian and ethnically diverse NHS staff (as well as female NHS staff generally) have been highlighted and exacerbated by the pandemic.
- F5.2** When the increased risk to people from ethnically diverse backgrounds was recognised, the response was slow and insufficient to protect workers and communities adequately.
- F5.3** It is plausible that existing inequalities, and the experiences in the pandemic contributed to vaccine hesitancy.
- F5.4** There is a lack of knowledge of differential exposures and risks relating to urban living, which disproportionately affects Black, Asian and ethnically diverse groups.

Recommendations

- R5.1** There is an urgent need for research into how to prevent higher death rates in people from minority ethnic backgrounds.
- R5.2** More investment is needed into research on the health needs of BAME populations.
- R5.3** Cultural and targeted messaging must be improved, and relevant public health interventions should be directed at communities where such multi-generational households are highly prevalent.
- R5.4** The 'hostile environment' for migrants should be abolished.
- R5.5** Double tax for foreign national healthcare workers through annual health surcharges and income tax and NI contributions should end.

6. PUBLIC HEALTH RESPONSE

Findings

- F6.1** The UK Government's delay in issuing advice to healthcare professionals and subsequent advice to the public to rely on NHS 111, contributed to the COVID-19 death toll.
- F6.2** NHS 111 should not have replaced primary care for COVID-19 patients. The outsourced NHS 111 COVID-19 triage had inexperienced, undertrained staff who were unable to safely interpret patient symptoms. The inadequate community and emergency NHS response to the pandemic (including NHS 111) contributed to people dying without the care they needed.
- F6.3** GPs were wrongly side-lined and could have played a greater and vital role in caring for patients, working with local public health, and assisting with measures to control the spread of infection. This was a grave error.
- F6.4** The bypassing of NHS and university laboratories delayed the required level of testing and contact tracing, which never caught up with what was needed.
- F6.5** The Government chose to ignore organisations with relevant expertise, including local authorities, local Public Health, professional bodies, trade unions, disabled people's and pensioners' organisations, all of whom had experience to offer.
- F6.6** Public health capacity and capability has been undermined at all levels, by policy decisions and funding cuts. The result is the worst public health disaster.
- F6.7** Regional public health services were progressively dismantled following the 2010 General Election, with the loss of vital expertise in England.
- F6.8** UK public health policy was out of step with the WHO, ignored information from China in January on infectivity and mortality. It displayed complacency and 'English exceptionalism'. The Government's responses during the pandemic have been slow and costly of lives and not routinely 'based on the science' as they should have been.
- F6.9** Westminster policy was wrongly based on a misplaced application of 'herd immunity'.
- F6.10** The Government failed to establish the core public health measures of 'Find, Test, Trace, Isolate, Support' (FTTIS). In England there is still no effective coordinated system, the WHO bedrock of pandemic response. A privatised Test and Trace was and is a costly failure.
- F6.11** Delay in declaring each of the three lockdowns resulted in the deaths of tens of thousands. Despite being a precondition of ending lockdown, each was lifted without an effective FTTIS being in place.

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- F6.12** Several countries that responded with rigorous tried and tested public health measures avoided lockdown or had shorter periods of lockdown and school closures.
- F6.13** The UK government followed an incoherent and dangerous pandemic strategy, failing to learn valuable lessons from other parts of the world (e.g. South Asia; New Zealand) where more effective strategies were pursued.
- F6.14** The UK Government did not impose border controls in time. They encouraged large sporting events to go ahead facilitating spread of infection.
- F6.15** Government messages were often confused and contradictory, and sections of the population were wrongly blamed.
- F6.16** The government was secretive about the existence and findings from potentially mass life-saving pandemic modelling: several exercises had been conducted for both flu and coronavirus pandemics, two key ones were Exercises Cygnus and Alice in 2016.
- F6.17** Ignoring pandemic planning exercise findings meant that stocks of PPE, testing capacity, border controls and contact tracing were not in place when coronavirus appeared. These measures would have saved lives.
- F6.18** Vital time was wasted in establishing essential measures: the sourcing of PPE, creating and distributing diagnostic tests, creating guidelines for sections of the population most at risk.
- F6.19** There was, and remains, a misplaced over-reliance on vaccines alone. The WHO policy is one of vaccines plus public health measures.

Recommendations

- R6.1** There needs to be recognition that much is to be learned from the WHO and from other countries in terms of best practice in fighting a pandemic.
- R6.2** The UK must support a global vaccination programme including waiver of intellectual property agreements for COVID-19 related technologies, and help poorer countries with their pandemic response if the pandemic is eventually to be brought under control.
- R6.3** The pandemic is not over. A broad public health strategy must be agreed and initiated in conjunction with the vaccination programme in the UK.
- R6.4** GPs and primary care must be resourced and empowered to look after their own patients in a future pandemic or health crisis, working closely with local public health.
- R6.5** GPs and local public health teams must be put at the heart of any pandemic response and given the necessary funding to fulfil this role.

- R6.6** The UK government should commit to reinstate and adequately fund a comprehensive public health service, led by public health experts independent of government.
- R6.7** All pandemic advisory bodies should be led by those expert and trained in public health.
- R6.8** Resilience must be built into public services to meet future health emergencies.

7. POLICY OF PRIVATISATION AND OUTSOURCING

Findings

- F7.1** 'Just-in-time' procurement failed the NHS and other services and showed itself to be fundamentally unsuitable for public health emergency planning.
- F7.2** The emergency situation demanded that decision-making and the usual tendering processes be streamlined, but public sector experience was recklessly neglected. Centralised decision-making without transparency has cost lives.
- F7.3** 'Find, Test Trace Isolate and Support' was never adequately established. The outsourced 'NHS' Test & Trace Service should have been an NHS and local public health-led service from the start – publicly provided and led by clinical teams with sufficient expertise and resources, and supported to integrate and coordinate nationally.
- F7.4** Public service responses have been exemplary, always going the extra mile. In contrast, private testing companies did not send results to GPs because it was not in their contract and outcomes have been very poor.
- F7.5** Pandemic strategy was to outsource contracts rather than to invest in public services. 'Eye-watering' payments for private contracts sit badly alongside the need for investment in NHS and care services. This has not been in the public interest.
- F7.6** The NHS is undermined by the Westminster relationship with the private sector which appears to have been based on ideology.
- F7.7** The pandemic has been used to underwrite the private healthcare sector with public funds, in preference to building NHS capacity.
- F7.8** Pandemic private contracts relating to patient data have been secretive and deeply flawed, with absent safeguards against breaches of data protection and commercial exploitation. This has damaged public trust.

- F7.9** Government contracting to the private sector during the pandemic has been tainted by cronyism and conflicts of interest, and has heightened the risk of profiteering.
- F7.10** The NAO has confirmed that contract processes have been poorly monitored, indefensibly costly, and at times unlawful.

Recommendations

- R7.1** National policy in England should return to one based on public provision for essential services: the NHS, public health, social care and supported living.
- R7.2** Public health planning and services at regional and local level must be publicly provided by public health teams, the NHS, primary care, and local authorities and not be outsourced to private contractors.
- R7.3** Public health capacity nationally and locally must be rebuilt as an integrated public service.
- R7.4** Public reaffirmation in the NHS as a national, integrated and publicly provided health service will restore NHS morale.
- R7.5** The preferential funding of private hospitals in place of building NHS hospital and primary care capacity must stop.
- R7.6** NHS and public health procurement for the NHS and pandemic planning should be returned to public hands.
- R7.7** Just-in-time procurement must end. Pandemic planning must never again rely on 'just-in-time' supply management.
- R7.8** Personal health data must remain under the control and ownership of public bodies to retain public trust, and must not be used for commercial exploitation
- R7.9** Outsourcing of health services to the private sector should end and public funds should be preferentially directed towards public sector providers of health and social care services, including clinical support such as pathology and diagnostics.

8. NHS, CARE AND FRONTLINE WORKERS

Findings

- F8.1** Health and safety risks for key workers were not addressed in timely fashion. Frontline staff were inadequately protected and supported and as a consequence suffered greater illness and death rate than the general population. In the NHS and care sector, over 1500 staff have died from COVID-19.
- F8.2** The failure to maintain the NHS and social care meant that services were already understaffed and under stress before the pandemic hit.
- F8.3** The NHS responded to coronavirus but was unable to maintain usual elective and some emergency services; it did not cope.
- F8.4** Staff have been faced with clinical situations where, through no fault of their own, they were unable to provide the standards of care they knew to be safe. Staff witnessed greater deaths and injury and were unable to respond. Many experienced 'moral injury' and their mental health suffered.
- F8.5** The dangerous level of low staff morale, stress and burnout is apparent. This results from exhaustion, moral injury, burnout and PTSD. After nearly two years of intense pressure and contradictory responses from Government and some members of the public, any sense of wellbeing has been steadily eroded.
- F8.6** There is immediate danger that many exhausted staff are leaving or waiting for the opportunity. Morale is further impacted by the below-inflation pay offer, cutting real pay value further. Staff note in contrast the unprecedented diversion of funds into the private sector.
- F8.7** In many cases there were inadequate risk assessments and failure to listen to staff concerns and involve staff in improving workplace safety. The well-established 'precautionary principle' (take no risks) was abandoned, resulting in unavailability of appropriate PPE; failure to acknowledge the importance of airborne spread of virus and to implement mitigating safeguards; failure to adequately report and investigate infection possibly acquired at work, meaning there were missed opportunities to learn lessons.

Recommendations

- R8.1** Comprehensive policies to protect key workers in their workplaces must be developed to protect against future pandemics, learning from the experience of COVID-19, and working with the trades unions to develop these. COVID-19 should be classed as industrial disease.
- R8.2** Workplace union safety representatives should be actively involved with regular review of safety measures and risk assessment.

- R8.3** The supposition for high-risk workers who contract COVID-19 should be infection has been acquired at work rather than in the community, and notification made to the HSE for further investigation.
- R8.4** HSE need to be funded to the level needed to investigate the volume of reported cases fully so that important lessons can be learned.
- R8.5** Support services must be provided to support the long-term mental health difficulties faced by many staff and the long covid symptoms they have.
- R8.6** Health and care staff must have a way to report conflict and stress from 'moral injury' and managers must respond.

9. SOCIAL CARE

Findings

- F9.1** Lessons from pandemic exercises were not implemented for care settings. There was a lack of adequate foresight and planning for a fragmented and privatised care service. Barriers were created to accessing hospital treatment.
- F9.2** There was a failure to ensure care homes were adequately prepared for the pandemic with sufficient staff, isolation capacity, testing, PPE and training. This also applied to those receiving care at home.
- F9.3** The discharge of 25,000 untested patients into care homes played a major role in the deaths of the 47,000 residents who died in care homes. Provision for testing and isolation only took place after most outbreaks had already occurred.
- F9.4** The underfunded, fragmented and privatised nature of social care played a key role in allowing viral transmission. Many staff are on zero hours contracts and work across multiple residential or domiciliary settings increasing the risk of contracting and spreading infection.
- F9.5** Care workers on very low rates of pay were expected to work without PPE and take risks with their own health and that of their own families and those they cared for.
- F9.6** As a result, in the first 18 months of the pandemic the UK experienced the highest number of care home deaths in Europe. Thousands of people also died at home without medical care, both from COVID-19 and non-coronavirus conditions.
- F9.7** To reduce pressure on hospitals, some older people in some care homes and hospitals were restricted from access to critical care and life-saving treatment by application of blanket DNAR policies, until this was challenged.

Recommendations

- R9.1** Social care services should be urgently overhauled and restructured, towards a national service that can provide care, support and independent living with training, career structure and pay to support care staff.
- R9.2** Collection and utilisation of data for those who receive social care at home should be funded and improved.
- R9.3** Review of pandemic planning must address the failures to protect the elderly requiring care and support during this pandemic.

10. PALLIATIVE CARE AND HOSPICES

Findings

- F10.1** The hospices, who rely on charity funding, fell between the definitions of NHS hospitals and care homes, and were denied PPE supplies via the NHS. They were immediately on the point of running out of PPE. Government help lines went unanswered and they had to source their own PPE.
- F10.2** Patients requiring palliative care were terminally ill, sometimes acutely unwell. Many felt abandoned.

Recommendations

- R10.1** Palliative care should be funded by government as an essential public service and part of the NHS.
- R10.2** Sufficient palliative care specialists and beds should be funded to meet the needs of an ageing population and to allow people to die in a dignified manner of their choosing.

11. DISABLED PEOPLE

Findings

- F11.1** There was a shockingly high differential death rate for disabled people: six out of ten deaths (59.5%) involving COVID-19 in England from March to November 2020 were disabled people. Disabled people form only 16% of the working age population, and represent 45% of people over pension age.
- F11.2** There was a lack of planning to address the health risks for disabled people in the community, in their homes and in hospitals, even though these could have been anticipated.
- F11.3** Disabled people were severely affected economically by the pandemic; many were on legacy benefits and were excluded from the £20 uplift given to those on Universal Credit.
- F11.4** Access to community support, shopping, and PPE for disabled people was very delayed and often remained unavailable to those not connected digitally.
- F11.5** Some disabled people were restricted from access to critical care and life saving treatment through the application of DNAR policies.
- F11.6** In order to try and ensure that medical staff understood their needs and saw them as valuable members of society who deserved equality of treatment, disabled people had to take 'passports' into hospital with them.

Recommendations

- R11.1** Inequalities in benefits available for disabled people must be addressed.
- R11.2** Benefits uplift during a pandemic should equally be added to benefits received by disabled people.
- R11.3** Digital access for disabled people, particularly older people in the community should be reviewed and their needs assessed.
- R11.4** Do Not Attempt Resuscitation notices must not be automatically applied to disabled people but good practice processes followed.
- R11.5** NHS staff training must be updated on the human rights of disabled people.

12. IMPACT ON WOMEN

Findings

- F12.1** The existing disparities suffered by women have been highlighted and exacerbated by the pandemic.
- F12.2** The differential impact on women of pandemic conditions, including lockdown, is known from research: the impact of increased caring responsibilities, childcare responsibilities, forfeiture of paid work, increase in vulnerabilities to mental health issues and domestic violence. This was not adequately considered by Government.
- F12.3** The Government and its advisers did not consider or anticipate the impact that the closure of schools and nurseries would have had on women's ability to carry out paid work.

Recommendations

- R12.1** The differential impact on women in pandemic conditions must be addressed in emergency planning and policy. The SAGE should include an expert on gender inequality.

13. MENTAL HEALTH

Findings

- F13.1** The levels of mental health distress and referrals have outpaced available resources for all ages, putting even greater stress on services poorly resourced pre-pandemic.
- F13.2** Referrals of children and young people to mental health services for crisis and non-crisis treatment soared because of the pandemic with resources failing to match the need. This affects not only children and young people, but also their families.

Recommendations

- R13.1** Expansion of provision to meet the mental health needs of children and young people should be urgently addressed.
- R13.2** Funding and support for child and adult mental health services must match the expansion of need.

14. SCHOOLS AND CHILDREN

Findings

- F14.1** The consequences of schools being effectively closed for most students – between 25 March to September, and January to March 2021 – were disastrous, particularly for the least advantaged.
- F14.2** The school system has been fragmented through academies and the political aversion of Government to local authorities. This left an unwieldy, over-centralised communication route via the DfE, undermining the potential for local coordination to control the pandemic in schools.
- F14.3** The Westminster Government failed to sufficiently liaise with Local Authorities and large education unions who were ideally placed to understand the very varied situations of schools throughout England.
- F14.4** Schools have acted as ‘institutional amplifiers’ of coronavirus infection, with large groups of children and staff gathered in unventilated places (most recently November 2021). The Government has downplayed the risks of both long covid and repeated school absence.
- F14.5** National guidance for mask wearing in English secondary schools, introduced in March 2021 and standard in most European countries, was ended in May 2021 without any scientific explanation.
- F14.6** School space is finite and often cramped, yet no attempt was made nationally by the DfE to attempt to reduce transmission of the virus: by the adoption of additional space where possible, the introduction of ‘half and half teaching’ on alternate weeks, or to fund schools to install better ventilation.
- F14.7** Many schools could not afford to fund safety measures: spending per pupil in England had fallen by 9% in real terms between 2009–10 and 2019–20, the largest cut in over 40 years.
- F14.8** The Government initially refused to provide meals for children on Free School Meals during lockdown and school holidays, then moving to hard-to-use voucher system, before a U-turn after a campaign by the footballer Marcus Rashford.
- F14.9** A faster, fully achieved laptop roll out and connectivity provision could have played a more significant role in preventing increased isolation and the further growth of inequalities for many pupils. Provision was slow and patchy, taking until June 2021 to reach its target.

Recommendations

- R14.1** WHO and European health guidance for mitigation of virus spread in schools should be adopted immediately.
- R14.2** Mask-wearing should be re-introduced into secondary school for the duration of the pandemic.
- R14.3** National Education Union guidance for safe schools and emergence from the pandemic, should be considered immediately by Government.
- R14.4** Planning for future pandemics should include specific measures for schools including rotation teaching, mask-wearing, outside teaching, expanding space by use of non-school buildings.
- R14.5** Local authorities and local public health should be part of future pandemic planning.
- R14.6** Financial support should be provided for schools to install ventilation and carbon dioxide monitoring equipment for classrooms.
- R14.7** Funding should be allocated to schools to supply laptops and wireless routers for all children who need them for use at home.
- R14.8** Children who receive Free School Meals should receive them during school holidays, as of right.
- R14.9** School funding should be increased to help schools reduce class sizes, employ extra teachers and teaching assistants, and ensure the possibility of children catching up in the broadest sense.

15. GOVERNANCE IN THE PANDEMIC

Findings

- F15.1** The public was not well served by the Westminster Government. From outcomes in deaths and economic decline, it is clear that the UK got things badly wrong in managing the pandemic.
- F15.2** Public messaging was confusing, unclear, contradictory and lost public trust. The Chancellor's disastrous 'eat out to help out' scheme in summer 2020 ignored scientific advice about the risk of airborne spread.
- F15.3** The population very largely abided by the rules in spite of rather than because of Government messages, and the rule-breaking behaviour of prominent individuals.

- F15.4** The Government's communications throughout the pandemic have not been inclusive enough to reach higher risk communities.
- F15.5** Westminster cabinet government failed to impose limitations on prime ministerial power.
- F15.6** The Westminster Government's own public health advice was inadequate: it was coming from spokespeople for public health who were civil servants and therefore not independent. Too often they colluded with edicts from the centre, rather than representing the best available public health advice.
- F15.7** The Chief Medical Officer was not an experienced and independent public health voice at the beginning of the pandemic.
- F15.8** The willing appearance of the top scientists alongside political leaders in Government briefings diminished their independence from political messaging.
- F15.9** Independent scientific advice to government was compromised in the early part of the pandemic and not routinely made public for the first six months.
- F15.10** The scientists on the SAGE did use their freedom to speak publicly, aided once meeting minutes were made public.
- F15.11** Senior civil servants were found wanting in fulfilling their role of 'speaking truth to power'.
- F15.12** There was an ignorance of, or failure to apply, the lessons from the past.
- F15.13** Back office civil servants, notably in HMRC and DWP worked hard to deliver rapid responses to the urgent need to support the incomes of millions of people.
- F15.14** Arm's length bodies like the CQC and the Health and Safety Executive failed to act independently to protect those vulnerable people they were established to protect.
- F15.15** A cadre of local authority leaders played a crucial role in protecting the population, despite the decade of drastic cuts and downgrading of local government (an indication of how things might have been done better).
- F15.16** The hollowing out of the role of local government in school education over the last decade could not be filled by the DfE centrally with few contacts to rely on to protect children in the pandemic. Many schools served their communities despite rather than because of the DfE.

Recommendations

- R15.1** The future public inquiry must investigate the Cabinet Government's failure to counter a decision-making model centred on the prime minister and whether the Whitehall model for the civil service is so broken that it needs to be fundamentally changed.

- R15.2** A parliamentary committee for national emergencies should be set up before which the Prime Minister should be required to appear at least annually.
- R15.3** The independence of scientific advice must be strengthened. The appointment of the Chief Scientific Adviser and the Chief Medical Officer should be subject to Select Committee approval and their advice published.
- R15.4** The centralised public health structure in England should be reviewed and should be headed by a senior and respected public health specialist, independent of government, leading a team which includes public health doctors and specialists working at local and regional level, and whose primary allegiance is to the public health agency.
- R15.5** In the light of misconduct in relation to contract allocation, the public inquiry must examine whether civil servants were asked or instructed to act against the law.
- R15.6** Persistent failure to comply with the requirements of the Public Accounts Committee or the other relevant committee on national emergencies and resilience should lead to their resignation.



POSTSCRIPT: EVENTS SINCE THE END OF THE PEOPLE'S COVID INQUIRY

**PEOPLE'S
COVID
INQUIRY** 

Learn lessons, save lives.

INTRODUCTION

This section is Chapter 9 of the People's Covid Inquiry report. The full report is available at www.peoplescovidinquiry.com

No judicial inquiry yet in sight

9.01 At the time of this report going to press (end of November, 2021) there is still no news on the appointment of a chair for the promised judicial inquiry into the management of the pandemic or an indication of when this might begin its deliberations. This reflects an ongoing reluctance in the Government to be scrutinised and held to account. It does, however, make the contemporaneous account of the pandemic highlighted in the People's Covid Inquiry report and its findings and recommendations even more important given this absence of action by those in positions of power.

9.02 Although the scope of the People's Covid Inquiry was limited by availability of resources and its voluntary basis, the investigation was wide ranging and an excellent example of a 'citizens' tribunal' – part legal proceedings, part theatre, part publicly speaking 'truth to power' – aimed at raising issues to more visible levels than governments or the media are prepared to do on their own.^{9.1}

Ongoing death toll

9.03 The pandemic continues in the UK with lethal consequence. At the time of writing (15 November 2021) the average daily deaths have been over 120 per day for four-weeks and rose to 169 at the end of October.^{9.2} The pandemic has continued worldwide. Known deaths from COVID-19 have surpassed five million, out of 253 million confirmed cases.^{9.3}

Internationally, the UK has fared badly for the 6th richest economy with 214 deaths per 100,000 along with the USA (233 deaths per 100,000). Countries of various geographies and economic wealth have fared better, some remarkably so (Portugal 178, Germany 118, Ireland 113, Canada 78, Vietnam 24, Australia 7, China and New Zealand less than one death per 100,000).^{9.4} There has been no sign that the Government wants to learn lessons from this tragedy and the significance of the ongoing death toll in the UK is played down in official circles.

9.04 Coronavirus cases and deaths are rising again in Europe. In the UK 69% of the population is fully vaccinated; in Portugal it is 87%, and Ireland 76%. Much of the world has not received anything like the quantities of vaccine needed to protect billions of people. In the UK the pandemic is very much alive, and it remains true that the basic public health measures such as mask-wearing in public places and improving ventilation are required alongside the vaccination programme.

9.05 The fact that a judicial inquiry is still urgently needed cannot be doubted (as we called for on 7 July 2021 in our urgent findings [see Appendix]) given the current challenges posed by the ongoing pandemic and the huge pressures being faced by the NHS.

9.1 'ONE OF THE UK'S WORST EVER PUBLIC HEALTH FAILURES'

9.1.1 The management of the pandemic has been explored by parliamentary representatives in a report published on 12 October 2021, from the House of Commons Health and Social Care, and Science and Technology Committees.^{9.5} The outstanding take-home message from

this report is summed up in the conclusion that this was 'one of the UK's worst ever public health failures'. This is a hugely powerful statement, particularly given that one of the committee chairs (Jeremy Hunt) was a former Secretary of State for Health with responsibility for the NHS from 2012-2018. However, the report is framed in a way that avoids attributing blame to politicians for the consequences of their actions including the dire state of the NHS at the start of the pandemic – and in this sense must be considered a whitewash.

9.1.2 Despite this, the report contains scathing criticisms^{9.6} of Government management: the initial response was delayed, care homes were abandoned, the 'world-beating' test and trace system had marginal impact. The report describes^{9.7} how comparisons with flu and a fatalistic view of the inevitable spread of infection impeded reaction to the pandemic. While clearly condemnatory of the delay in the first lockdown for reasons including lack of testing capacity and doubts about public compliance, the explanation is presented uncritically in terms of the nebulous concepts of 'groupthink' and 'British exceptionalism'.

9.1.3 The higher death toll is attributed to delay in initial lockdown and lack of targeted financial support for individuals seen as having been a huge barrier to people isolating. While little negative attention is focused in the select committee's report on the delay in triggering the second lockdown, senior scientists now feel this was an even more serious error, leading to tens of thousands of unnecessary deaths.

9.14 Rather than incriminating 'groupthink', the main problems^{9.8} were seeing the public as a problem, failing to value public health at a local level, and

seeing the private sector as the best way to run a test-and-trace system.

Bereaved families excluded

9.15 The select committees report is also notable for the absence of the voices of those who lost loved ones to COVID-19. A representative of the Covid-19 Bereaved Families for Justice^{9.8} group commented:

'The report ... is laughable and more interested in political arguments about whether you can bring laptops to Cobra meetings than it is in the experiences of those who tragically lost parents, partners or children to Covid-19. This is an attempt to ignore and gaslight bereaved families, who will see it as a slap in the face.'

9.16 Not only were they not invited to give evidence to the committees, when they were finally seen by the Prime Minister 398 days^{9.9} after he first agreed to meet, the date of the promised judicial inquiry into pandemic management had still not been specified.

9.17 Hunt outraged bereaved relatives in a radio interview by describing the account given in the select committees report as portraying 'a game of two halves', using a jarring football metaphor to imply that whatever sins resulted in over 150,000 deaths, these were absolved by the vaccine rollout programme.

9.18 Astonishingly, he also claimed to know nothing of Exercise Alice,^{9.10} a pandemic modelling exercise only recently made public. This was commissioned in 2016 where the pathogen in the spotlight was not influenza, but rather the coronavirus that causes Middle East Respiratory Syndrome (MERS-CoV). Senior health officials who war-gamed the impact of this coronavirus hitting the

UK, warned four years before the onset of the current pandemic of the need for stockpiles of PPE, a computerised contact tracing system, and screening for foreign travellers.

9.19 The select committees report lends enormous weight and urgency to the call for a full judicial inquiry. The recurring excuse that this would divert attention and resources from fighting the pandemic has worn very thin, given both the evident need to learn and apply lessons to manage the current surge in infection, and the time being found for both a major reorganisation of public health structures and the NHS as a whole.^{9.11}

9.2 OUTSOURCED 'NHS' TEST AND TRACE AND PATHOLOGY SERVICES

9.2.1 The failure to build a strong public health test and trace system was reviewed by the Public Accounts Committee in its update report 27 October 2021^{9.12} on the outsourced NHS Test and Trace (see para 7.5), summarised as:

'One of the most expensive health programmes delivered in the pandemic ... allocated £37bn over two years ... outcomes muddle ... aims overstated or not achieved.'

9.2.2 The Leamington Lighthouse mega-lab referred to in section 7.6 of this report finally opened in July 2021, as the Government continued its rollout of private or private-public partnership outsourcing of NHS pathology capacity. In the same policy direction, Sajid Javid announced £5.9 billion spending on 199 community diagnostics hubs, with many companies already approved for these contracts.

9.2.3 In October 2021, the concerns expressed through the Inquiry about the

lack of governance in the awarding of contracts outsourcing important health responsibilities became all too real. Immensa Health Clinic was founded in May 2020 by Andrea Riposati. In August 2020 Immensa was awarded a £119m PCR testing contract without tender and a further £50m contract in July 2021. The UK Health Security Agency announced that Immensa Lab had wrongly given negative SARS-CoV-2 test results to over 43,000 people who in fact were infected. Their contract was temporarily suspended though they continued to process private travel-related tests.^{9.13} The laboratory had never been accredited. This contributed to the spread of coronavirus by unsuspecting people and may have led to illness and possibly deaths.

Virus transmission crisis

9.24 The Government's SAGE has warned of the need for a possible winter lockdown if measures are not taken now to tackle rising infections. The Chief Scientific Adviser to the government advised to 'go hard and go early' with coronavirus restrictions if cases surge (as they are doing), but the Government continued to paint an optimistic picture, wishing to give the impression that there is no cause for concern. In contrast, local public health chiefs in England are beginning to break away from government guidance^{9.14} and at least a dozen have called on their population to go back to mask wearing and working from home. Cases among younger (unvaccinated) school pupils aged 5-12 and 13-17 have doubled from September to end October 2021 with infection rates of almost 6%.^{9.15} Figures suggest that this rise among children has driven a surge in cases across all age-groups in the community, but particularly in households with children (adults aged 35 – 54). While

deaths are low amongst children, there are concerns about the growing number of cases of children with long covid.

9.3 WORST EMERGENCY EVER FOR THE NHS AND SOCIAL CARE

9.3.1 The NHS, mental health and social care services have been left devastated after 21 months of the pandemic, faced by frontline staff already struggling with 100,000 vacancies, insufficient beds and ITU capacity, at least 7000 GPs short, close to 1000 health and care staff dying from COVID-19, social care settings in disarray with staff vacancies rising from 6% to 10%, and care homes unable to take new referrals due to staff shortages.

9.3.2 The NHS is under severe pressure (acknowledged by its Chief Executive Amanda Pritchard) and expecting worse to come as winter, influenza and Respiratory Syncytial Virus return. Necessary infection control measures during the pandemic have seen another 9,000 beds taken out of commission, making it even more difficult for the health service to catch up with the backlog of work. This cannot be fully compensated for by expensive contracts put in place to use some of the 8,000 private hospital beds (see report section 7.2), which fund the private sector and fail to build the extra capacity the NHS needs.

9.3.3 In the 30 years before the pandemic, numbers of NHS hospital beds have more than halved giving the UK one of the lowest numbers of beds for its population in Europe. Half the acute hospitals in England are averaging 95% bed occupancy (85% being regarded as the acceptable safe maximum), with around 5% taken by COVID-19 patients (around 8,000 patients at any one time).

9.3.4 The proportion of patients attending A&E departments and being seen within four hours has fallen to 64% (with a national target of 95%). Recently, every ambulance service in the country^{9.16} was on the highest state of alert due to such pressures. Build-up in hospitals has back-flowed causing intense pressure in A&Es and worse than ever delays in ambulance handovers to A&E, leading to deaths of patients in the back of ambulances trapped in delayed handover queues. This has exacerbated the availability of ambulance crews for new calls, and delayed responses to 999 calls have resulted in deaths before paramedic teams arrive.

9.3.5 Figures show^{9.17} further increases in numbers of patients waiting for treatment, standing now at nearly six million while NHS staffing shortages are leading to cancelled operations. Thousands more patients are not yet coming forward as predicted, for example with cancers. The wider health consequences of the NHS having to divert its entire focus to coronavirus are only slowly becoming clear.

9.3.6 General practitioners have dealt with 196.8 million appointments so far this year – up 12% on 2019 – but have been vilified as lazy^{9.18} in some of the national press. This campaign has generated verbal and physical abuse of staff and been supported by Sajid Javid, the Secretary of State for Health. GPs are now considering industrial action while other health trade unions are already balloting members over strike action^{9.19} in relation to a below-inflation pay offer.

Care support and mental health services deficits

9.3.7 300,000 adults are waiting for care support,^{9.20} 55,000 for assessment, and over a million people are not getting the care and support they need.^{9.21, 9.22} Care staff vacancies have risen from 6% to 10%. In addition, care homes^{9.23} are now refusing to take patients from hospital to free up beds because of their own staffing shortages. These have been needlessly exacerbated by the Government's policy of 'no job – no job'.^{9.24} The Care Quality Commission has warned of a 'tsunami'^{9.25} of people without the care they need this winter unless staff shortages are tackled. The tsunami of unmet need includes 1.6 million people who are without the mental health support they need and mental health care is in deep crisis.^{9.26}

9.3.8 The chief executive of the NHS Confederation (a membership body for organisations that commission and provide NHS services) made a heartfelt appeal to the Government^{9.27} saying:

'You have got to recognise that we need a national mobilisation. You've got to recognise there is a health and care crisis coming over the next three or four months and accept it, acknowledge it and encourage the public to do everything they can to help.'

9.3.9 The head of the British Medical Association representing doctors has said the Government is being 'wilfully negligent'^{9.28} in not reintroducing mandatory mask wearing indoors and encouraging work from home.

9.3.10 Meanwhile, having returned from a holiday break in Spain (October 2021), the Prime Minister insisted the only effective way of combating the pandemic

was to press ahead with the booster vaccination programme, that everything was under control and there was nothing to worry about. The leader of the House of Commons, Jacob Rees-Mogg^{9.29} then wrongly assured people that you could not catch the virus from friends.

9.3.11 Despite all the above, Sajid Javid stated in a recent press conference^{9.30} on coronavirus (the first for five weeks):

'We don't believe that the pressures that are currently faced by the NHS are unsustainable.'

He argued that the NHS is in fact coping, while predicting daily coronavirus cases might rise to 100,000. Nowhere are there consistent public health messages to be heard about reducing infection other than through vaccination, and little attention has been given to improving ventilation in buildings, for example with only 8% of schools reporting having received promised carbon dioxide monitors.

9.4 INCOMPETENCE, INDIFFERENCE OR DEMOCIDE?

9.4.1 The present pandemic management policy in Westminster is indifferent to the loss of life, the long-term complications of COVID-19 in survivors, and the impact on NHS staff and other frontline workers. The question is raised as to whether this amounts to democide ('the killing of members of a country's civilian population, as a result of its government's policy, including by direct action, indifference, and neglect'), 'social murder',^{9.31} gross negligence manslaughter, or misconduct in a public office?

9.4.2 Campaigners who have raised such possibilities have watched with interest as French police searched the homes and

offices of officials including the former prime minister as part of an investigation^{9.32} into that government's handling of the coronavirus crisis. Current and former ministers of the French Government have been targeted by at least 90 formal legal complaints from civic groups and members of the public over their response to the health emergency. In addition, a Brazilian congressional panel has recommended that President Jair Bolsonaro be charged with 'crimes against humanity',^{9.33} asserting that he intentionally let the coronavirus rip through the country and kill over 600,000 people in a failed bid to achieve herd immunity and revive Latin America's largest economy.

9.5 GOVERNMENT DIRECTION IS APPARENT IN THE HEALTH AND CARE BILL

9.5.1 Mid-pandemic, the Government produced a White Paper proposing a major national reorganisation of the NHS in England. This was followed by the Health and Care Bill, currently going through Parliament^{9.34}. The legislative plans are consistent with the decisions taken and policy direction during the pandemic. The decision makers have had much extra freedom during the pandemic, with less scrutiny over contract distribution. The Health and Care Bill will centralise extraordinary powers in the hands of the Secretary of State for Health and Social Care, will deregulate a great deal of contracts awarded in the NHS, and facilitate the current policy direction of embedding private interests in the NHS. It contains proposals that will diminish the powers of local authorities and the ability of local populations to have access to NHS plans and proposals and a chance to challenge. The Bill does not end the

policy of procurement through private contracting that has been awash with conflicts of interest. There are therefore genuine concerns that the new Health Bill will facilitate that culture rather than repair it.

9.5.2 Events such as Immensa in October and Owen Paterson in November (although not directly related to the pandemic, one of his paid jobs was with the private laboratory company Randox^{9.35}, a major pathology contractor in the Government's outsourced parallel pathology system – he has since resigned as MP) have reinforced the concern that there is a serious loss, if not a total breakdown, of governance and integrity in public life – sleaze is in the headlines. This is in itself a threat to the public's health.

9.5.3 The lessons to be learned from the pandemic have not been learned by Government and ministers. We hope that the findings and recommendations in this report will prompt further discussion and challenge. It was a further shock to hear in November that Johnson has paid Deloitte £900,000 to prepare evidence for the inquiry in the spring, an inquiry which will, amongst other issues, look into Deloitte's handling of the Test and Trace failed services.^{9.36} If and when the judge-led public inquiry calls for evidence, we will make our report and supporting documents available for scrutiny.

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APPENDICES AND FURTHER INFORMATION

**PEOPLE'S
COVID
INQUIRY**



Learn lessons, save lives.

APPENDIX 1: TERMS OF REFERENCE FOR THE PEOPLE'S COVID INQUIRY

The People's Inquiry is tasked to look at the urgent lessons to be learned from this coronavirus pandemic. At the time of writing (January 2021), the total of excess deaths from COVID-19 since the start of the pandemic has exceeded 100,000. The shocking scale of this tragic loss of life was avoidable. We need to know why. The Government has failed to learn from mistakes and has not agreed to a public inquiry. Mistakes are being repeated and more avoidable deaths are lost.

The Inquiry will examine the events of the pandemic and identify the lessons to learn, both positive and negative. It will look at the context for the NHS and social care at the outset from January 2020. Both successes and the failures will be explored, so that the important lessons can be learned and the consequences avoided in future.

The NHS when fully funded, well-staffed and equipped has been the pride of Britain. The NHS and public health as previously conceived should have been in the best position to support the safety and health of the population.

The Inquiry will look at:

- a) the extent to which the NHS, including public health, based on its founding principles would have been enabled to respond differently.
- b) Issues on health inequalities, community and GP services, mental health and social care will also be examined, including the extent to which vulnerable sectors of society have been protected or let down.
- c) The impact of the pandemic, policies and decisions at government level and their implementation.

The evidence will provide the basis for conclusions and recommendations on the provision of health and social care in England, including the future funding and organisation of the National Health Service and the need for a national service for care, support and independent living.

January 2021

APPENDIX 2: PEOPLE'S COVID INQUIRY WITNESSES GIVING ORAL TESTIMONY

The YouTube links go to the start of each individual's testimony.

Jean Adamson, Covid-19 Bereaved Families for Justice

https://youtu.be/_MmH8ABPAIw?t=6665

Raymond Agius, Professor Emeritus of Occupational and Environmental Medicine, University of Manchester

https://youtu.be/bRtKxm_5lno?t=2954

Oluwalogbon 'Lobby' Akinnola, Covid-19 Bereaved Families for Justice

<https://youtu.be/ReR5LtgyPpk?t=3209>

Rachel Ambrose, NHS nurse in CAMHS (Child and Adolescent Mental Health Service), convenor Nurses of Colour, Nurses United

<https://youtu.be/cp4tqXWOS3I?t=4441>

Rehana Azam, National Secretary GMB Union

<https://youtu.be/g1z6PNCGL5I?t=504>

Michael Baker, Professor of Public Health, University of Otago, New Zealand

<https://youtu.be/g1z6PNCGL5I?t=4586>

Michael Bimmler, Barrister in public law

https://youtu.be/_MmH8ABPAIw?t=7995

Kirsty Brewerton, NHS Clinical Sister, and founder of Sitting Rooms of Culture

https://youtu.be/bRtKxm_5lno?t=4489

Rachel Clarke, Consultant in Palliative Medicine, Christopher House and NHS, author

<https://youtu.be/Tb0UNPPIGik?t=5885>

Ellen Clifford, National Steering Committee, Disabled People Against Cuts, author

<https://youtu.be/Tb0UNPPIGik?t=324>

Anthony Costello, Professor of Global Health and Sustainable Development, University College London; former Director at WHO, member of Independent SAGE

<https://youtu.be/g1z6PNCGL5I?t=2451>

Kevin Courtney, Joint General Secretary National Education Union

https://youtu.be/_MmH8ABPAIw?t=2161

Stephen Cowan, Leader of Hammersmith & Fulham Council

https://youtu.be/_MmH8ABPAIw?t=4560

Rosa Curling, Lawyer, co-founder of Foxglove, formerly of Leigh Day Solicitors

https://youtu.be/NrS6_GCXtDE?t=4050

Dr Michelle Dawson, NHS Consultant Anaesthetist, trustee Healthcare Workers' Foundation charity (previously 'Heroes')

https://youtu.be/NrS6_GCXtDE?t=5990

Dr Chidi Ejimofe, NHS consultant in Emergency Medicine

https://youtu.be/bRtKxm_5lno?t=5711

Jo Goodman, Co-founder Covid-19 Bereaved Families for Justice

<https://youtu.be/UVIPRxdRx7Y?t=434>

Deepti Gurdasani, Clin. epidemiologist & statistical geneticist, Snr Lecturer in Machine Learning, QMUL

https://youtu.be/_MmH8ABPAIw?t=586

Phil Hammond, NHS doctor, journalist, and comedy writer/performer

<https://youtu.be/35tdMRcznbU>

Janet Harris, Sheffield Community Contact Tracing Group

<https://youtu.be/g1z6PNCGL5I?t=5847>

Professor Sir David King, Chair of Independent SAGE

<https://youtu.be/ReR5LtgyPpk?t=620>

Kamlesh Khunti, Prof. of Primary Care Diabetes & Vascular Medicine, University of Leicester, member government advisory body SAGE; Chair of SAGE Ethnicity Sub-Group; member of Independent SAGE

<https://youtu.be/CE0-QfCOMXw?t=2300>

Elaine Kinsella, Chartered psychologist, lecturer in psychology, University of Limerick, Ireland (with co-researcher Rachel Sumner)

<https://youtu.be/cp4tqXWOS3I?t=2710>

Dr John Lister, academic, author and campaigning health journalist

<https://youtu.be/UVIPRxdRx7Y?t=5870>

Professor Sir Michael Marmot, Director, UCL Institute of Health Equity, Dept of Epidemiology and Public Health, UCL

<https://youtu.be/UVIPRxdRx7Y?t=1361>

David McCoy, Professor of Global Health Medicine, Institute of Population Health Sciences, QMUL; Centre for Health and the Public Interest

https://youtu.be/NrS6_GCXtDE?t=733

Martin McKee, Professor of European Public Health, member of Independent SAGE

<https://youtu.be/Tb0UNPPIGik?t=1929>

Unjum Mirza, Secretary, Victoria Line Branch of ASLEF union

https://youtu.be/bRtKxm_5lno?t=553

Latifa Patel, NHS doctor, deputy chair BMA representative body (Personal Capacity)

<https://youtu.be/CE0-QfCOMXw?t=4187>

Clare Phillips, operations manager supported living services for adults with learning disabilities

<https://youtu.be/Tb0UNPPIGik?t=4505>

Jonathan Portes, Professor of Economics & Public Policy at King's College London, and former senior civil servant

<https://youtu.be/cp4tqXWOS3I?t=5384>

Stephen Reicher, Professor of Social Psychology, University of St Andrews; participant in SPI-B (SAGE) and Advisory Group to Scottish CMO on Covid-19; member of Independent SAGE

<https://youtu.be/cp4tqXWOS3I?t=505>

Michael Rosen, author, poet, broadcaster, former Children's Laureate, Covid-19 survivor

https://youtu.be/NrS6_GCXtDE?t=198

Dr Helen Salisbury, NHS GP, columnist for BMJ, Oxford University, teacher/trainer undergrad medical students and postgrad doctors

<https://youtu.be/ReR5LtgyPpk?t=5835>

Gabriel Scally, President Epidemiology and Public Health Section, Royal Society of Medicine, Visiting Professor of Public Health, University of Bristol, member of Independent SAGE

<https://youtu.be/UVIPRxdRx7Y?t=4669>

Jan Shortt, Gen. secretary National Pensioners Convention

<https://youtu.be/ReR5LtgyPpk?t=4730>

Mary-Ann Stephenson, Director, Women's Budget Group

<https://youtu.be/CE0-QfCOMXw?t=672>

Holly Turner, NHS children's mental health nurse, CAMHS service, GMB union rep

<https://youtu.be/UVIPRxdRx7Y?t=4019>

Rachel Sumner, Snr Lecturer in Psychology, School of Natural & Social Sciences, University of Gloucestershire (with co-researcher Elaine Kinsella)

<https://youtu.be/cp4tqXWOS3I?t=2710>

Matt Western, MP for Warwick & Leamington – statement read out by Counsel

https://youtu.be/_MmH8ABPAIw?t=6324

Dr David Wrigley, GP in Carnforth, North Lancashire, Deputy Chair BMA, co-author 'NHS for Sale' and 'NHS SOS'

https://youtu.be/NrS6_GCXtDE?t=2491

Aliya Yule, Access to Healthcare organiser, Migrants Organise

<https://youtu.be/CE0-QfCOMXw?t=5585>

Zahra Ali (Fatima Az- Zahra Ali) School student

<https://youtu.be/cp4tqXWOS3I?t=7078>

APPENDIX 3: ADDITIONAL VIDEO TESTIMONY SHARED WITH THE PEOPLE'S COVID INQUIRY

Our thanks to the following contributors:

Sandra Daniels, Chair of Reclaim Social Chair (now renamed Action 4 Inclusion): 'During the pandemic, there was very little acknowledgement of the impact the pandemic restrictions were having on disabled women'

<https://youtu.be/Tn10sjyhF6I>

Greg Dropkin, Merseyside Keep Our NHS Public activist and statistician, discusses the reasons he believes Government inaction caused thousands of unnecessary deaths.

<https://youtu.be/AqtN4-OXNRo>

Dr Lola Fakoya-Sales GP registrar, who also worked shifts in A&E during the pandemic, talks about her heart-breaking experiences as the COVID pandemic hit.

https://youtu.be/3Rc_1laqIYs

Dr Phil Hammond, NHS doctor, journalist and comedy writer/performer talks about what the Government could have done differently and the need for the public inquiry.

<https://youtu.be/35tdMRcZnbU>

Janet Harris talks about her experience as one of the founder members of the Sheffield Community Contact Tracers, a voluntary group.

<https://youtu.be/fqKwpX8drwY>

Jatinder Hayre talks about his experiences as a medical student on the wards during the pandemic and where he thinks the Government went wrong.

<https://youtu.be/eGctehtZ26E>

Lisa, social care worker, shares her reasons for stopping work as a social care worker. Shared with the Inquiry by the Stand Up For Social Care campaign organised by Unison North West.

<https://youtu.be/AcfVdgYvCqk>

Marielle shares her experiences as a care worker. Shared with the Inquiry by the Stand up for Social Care campaign organised by Unison North West.

<https://youtu.be/k1v89kUsmdQ>

Stacey Richardson, a paediatric nurse working in the NHS in the Northeast, talks about her experiences during the pandemic.

<https://youtu.be/mOFpNYizgZ0>

James Skinner, Campaign and Programme Lead for Medact, a membership organisation for health professionals, talks about a range of issues impacting on migrants during the pandemic.

<https://youtu.be/SohhSN3JmAE>

Judy Stewart tells us about her experiences as part of a locally run initiative called the Sheffield Community Contact Tracers.

<https://youtu.be/88DNvZ8yPWY>

Dr Aaminah Verity who qualified as a GP during the pandemic, shares powerful testimony about life as a GP working in community and hospital settings.

<https://youtu.be/41-iAas2SKQ>

Bob Williams-Findlay, disabled activist, gives his view on the Government's failures during the pandemic.

https://youtu.be/zeOWk8_lmhE

Aliya Yule, Access to Healthcare organiser for Migrants Organise, talks about how deep distrust of the government and fear of data sharing is affecting take up of vaccines.

https://youtu.be/2oYg_KNUIAQ

FURTHER INFORMATION

The full version of the report, including detailed accounts of all the sessions and more, is available at www.peoplescovidinquiry.com

Summaries, witness statements and supporting evidence are available session by session at: www.peoplescovidinquiry.com/join-our-sessions

Further evidence in the public domain is collected at: www.peoplescovidinquiry.com/evidence

Media coverage of the inquiry is available at: www.peoplescovidinquiry.com/press

Further enquiries can be addressed to:

Samantha Wathen, Press and Media Officer press@keepournhspublic.com

Secretary to the Inquiry, Olivia O'Sullivan inquiry@keepournhspublic.com

Keep Our NHS Public can be contacted via:

Tom Griffiths, Head of Campaigns campaigns@keepournhspublic.com

Co-chair, John Puntis John.puntis@yahoo.com

Co-chair, Tony O'Sullivan co-chair@keepournhspublic.com

ACKNOWLEDGEMENTS

Keep Our NHS Public warmly thanks the many people who gave their support in numerous different ways to the People's Covid Inquiry:

First and foremost, Chair of the Inquiry, Michael Mansfield, panelists Neena Modi, Tolullah Oni and Jacky Davis, and Counsel to the Inquiry Lorna Hackett.

Our thanks to Susan Michie, Professor of Health Psychology at UCL and member of Independent SAGE and Savannah Simons at Indie_SAGE for their reliable help and patience.

Sincere thanks to the Keep Our NHS Public national team, led by Head of Campaigns Tom Griffiths, with Press Officer Samantha Wathen, National Administrator Max Leak, Website Editor Hannah Flynn, Campaigns Officer Amy Merrigan and Campaigns Officer Lewis Baker. Our thanks also to Social Media Strategist Chloe Howard (PLMR).

Special thanks to Olivia O'Sullivan, secretary to the Inquiry, liaising with witnesses and collating testimony for the Panel.

We are grateful to the chairs introducing each session for Keep Our NHS Public, before handing over to the Inquiry Chair Michael Mansfield QC: Sonia Adesara, NHS doctor; Alia Butt, KONP Executive, NHS Psychotherapist, NHS Staff Voices, Louise Irvine, KONP Executive, John Puntis, co-chair KONP, Professor Sue Richards, KONP Executive, Professor Wendy Savage, Life President KONP, and Tony O'Sullivan, co-chair KONP.

Our thanks also to:

Leila O'Sullivan, report design
Rose O'Sullivan, proof reading

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THE PEOPLE'S COVID INQUIRY

The People's Covid Inquiry took place fortnightly from 24 February-16 June 2021.

A panel of four, chaired by Michael Mansfield QC, heard evidence from over 40 witnesses including bereaved families, frontline NHS and key workers, national and international experts, trade union and council leaders, and representatives from disabled people's and pensioners' organisations.

The full version of the report, including detailed accounts of all the sessions and more, is available at www.peoplescovidinquiry.com

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