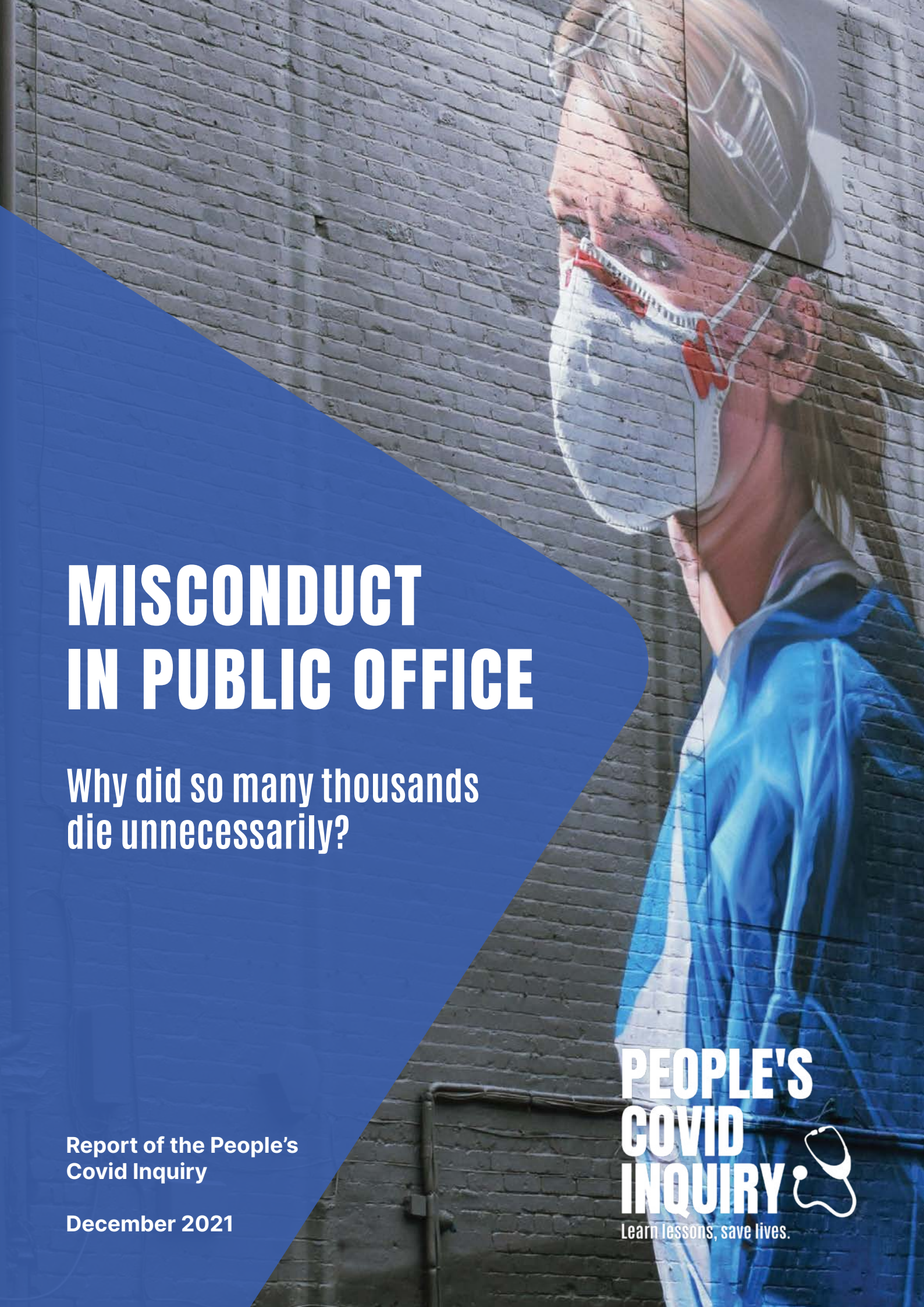


# MISCONDUCT IN PUBLIC OFFICE

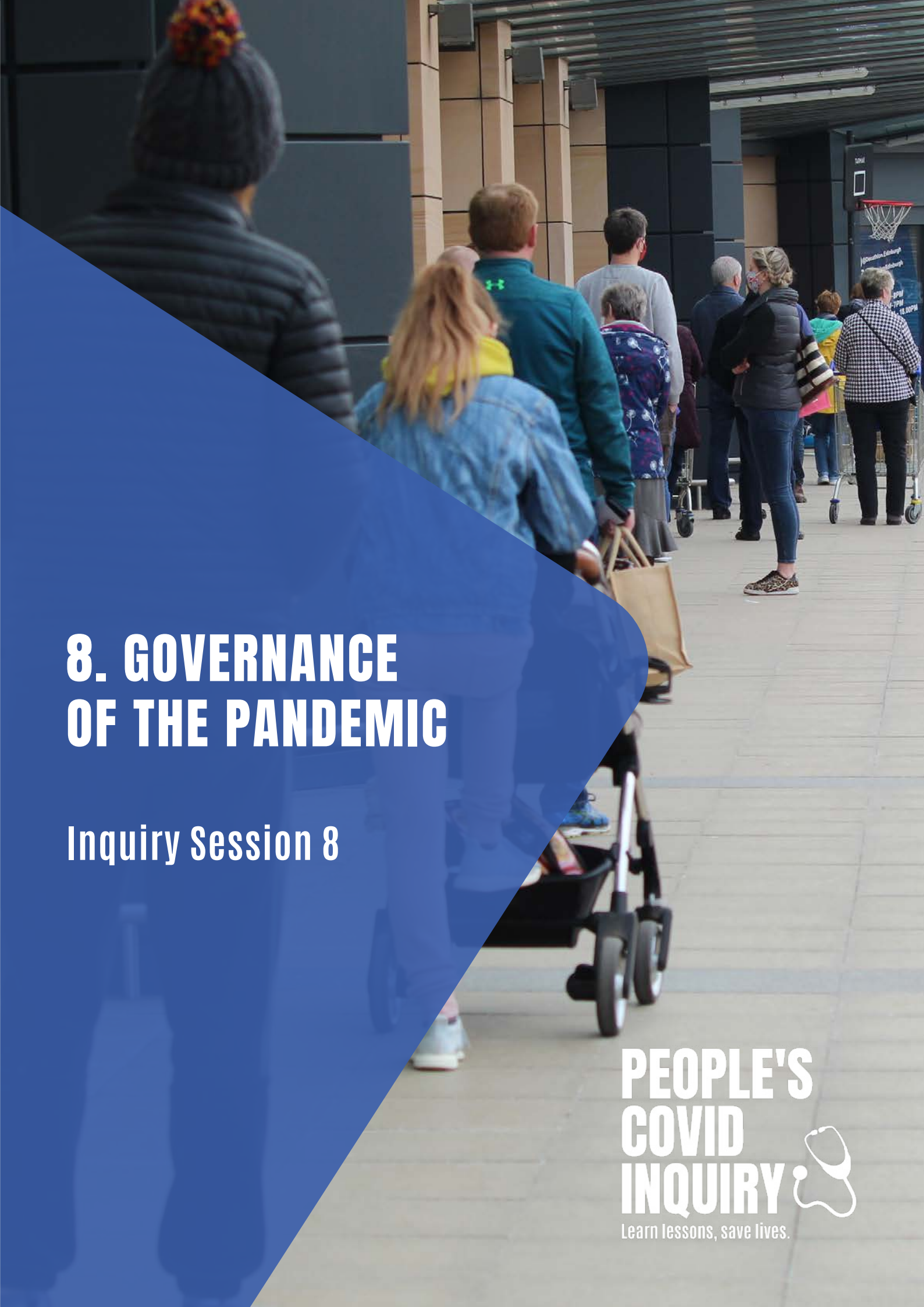
## Why did so many thousands die unnecessarily?

**Report of the People's Covid Inquiry**

**December 2021**

PEOPLE'S COVID INQUIRY

Learn lessons, save lives.



# 8. GOVERNANCE OF THE PANDEMIC

## Inquiry Session 8

PEOPLE'S COVID INQUIRY

Learn lessons, save lives.

# 8.0 INTRODUCTION

8.0.1 This chapter draws primarily on testimony given by Dr Deepti Gurdasani, Cllr. Steve Cowan, and Ms Jean Adamson (Session 9), Professor Jonathan Portes (Session 8) and Michael Bimmler, a barrister specialising in public and human rights. Additional points are incorporated from Professor Gabriel Scally (Session 1), Sir David King (Session 2), Janet Harris (Session 3), Professor Stephen Reicher (Session 8), Mr Kevin Courtney (Session 9) and Professor Raymond Agius (Session 5).

8.0.2 In this chapter, our focus is on how the system as a whole operated in pursuit of strategic goals, and in particular how it was led from central government, how the governance of institutions involved contributed to success or failure, and how those occupying senior positions can be held to account for their actions and inactions.

8.0.3 We know a lot about the political ideas (and how they related to Covid) which were occupying the Prime Minister in early February 2020 through a speech he gave in the Painted Hall of the Royal Naval College at Greenwich:[8.1]

> *'This country is leaving its chrysalis. We are re-emerging after decades of hibernation as a campaigner for global free trade. And frankly it is not a moment too soon because the argument for this fundamental liberty is now not being made ... Free trade is being choked and that is no fault of the people, that's no fault of individual consumers, I am afraid it is the politicians who are failing to lead ... and in that context, we are starting to hear some bizarre autarkic rhetoric, when barriers are going up, and when there is a risk that new diseases such as coronavirus will trigger a panic and a desire for market segregation that go beyond what is medically rational to the point of doing real and unnecessary economic damage, then at that moment humanity needs some government somewhere that is willing at least to make the case powerfully for freedom of exchange, some country ready to take off its Clark Kent spectacles and leap into the phone booth and emerge with its cloak flowing as the supercharged champion, of the right of the populations of the earth to buy and sell freely among each other ... and here in Greenwich in the first week of February 2020, I can tell you in all humility that the UK is ready for that role.'*

8.0.4 This ideological orientation combined with the character that fails to connect the big ideas to practical action, his tendency to work shorter hours and to take more holiday than prime ministers normally do, and the strong distractions of a chaotic personal life come together to make Prime Minister Johnson supremely ill-fitted to lead the governance of the Covid crisis. The fact he failed to attend the first five COBRA meetings on the pandemic is well-known. The evidence for these assertions is well documented through published material.[8.2] No 10 declined our invitation for the Prime Minister to give evidence to the Inquiry about this, so for a more detailed account taken from testimony under oath we must await the promised full judicial inquiry.

8.0.5 So we turned instead to looking at what evidence there was on the functioning of the various organisations and institutions close to the Prime Minister, to see whether they were able to compensate for the character flaws and balance the ideological predilections to cope with the circumstances. We are citizens of a modern democracy rather

than the subjects of a medieval monarch to whose inadequacies we must simply submit. While it is true that executive power has become more and more concentrated in the centre of central government, there are institutions with independent embedded values which make up the ecology of governance, which we draw on our evidence to explore.

8.0.6 Witnesses varied in how far they were willing to point the finger of blame at Government. Some were very tough:

> *'It's been a strategy of – I would say – negligent manslaughter, but I think that is far too generous because it's not negligent. Essentially it has been a policy where they have been fully informed on the risks – mass deaths, the risk of suffering, but have gone ahead anyway … The Government's policy has focused on a herd immunity narrative, acceptable deaths … We know now that there have been over 150,000 deaths and a million people suffering with Long Covid, which we do not understand … and unforgivably, 30,000 of those are children.'* (Gurdasani)

> *'The health of the people became a lesser interest of Government [from 2010 onwards] than it had [previously] been … There is a plethora of evidence that . . the public's health has declined and equalities decreased … and that is because we have been unfortunate enough to have a government which has no real interest in the public's health.'* (Scally)

8.0.7 Others may have been less outspoken, but there is common recognition from witnesses that our system and some of those who lead it have fundamentally failed us, as demonstrated by our high death rate and poor economic performance compared with many other countries of equivalent wealth, population density and science base. Our report concludes that a highly centralised system of government such as ours has become may be able to provide good leadership in such a national emergency, but that since such leadership is unlikely to be available all of the time, we need to ensure that there are effective institutionalised supports and constraints to ensure that the pressures for good crisis decision-making are firmly in place. Below we set out in some detail the evidence that leads to this conclusion

## 8.1 HOW SYSTEMS OF GOVERNANCE CONTRIBUTED TO OUTCOMES

### The centre of the centre – sofa government again

8.1.1 As Cllr. Steve Cowan observed, this country has a very centralised system of governance, and the elevation of Boris Johnson to the role of Prime Minister was accompanied by a further ratcheting up of centralisation, most spectacularly in the prorogation of Parliament where even the monarchy was enrolled in the programme (which was subsequently found to be unlawful by the Supreme Court).

8.1.2 How did this tight centre perform in the battle to beat the pandemic? We have no direct witnesses who were at its heart as the Prime Minister and the Secretary of State for Health and Social Care did not respond to our invitation to be witnesses, so we must make what judgements we do on the basis of the observations of other knowledgeable witnesses. We recognise that the analysis will be incomplete unless a full public inquiry is able to cross-examine the key players in those central institutions. The centralisation

of decision-making in a pandemic is not necessarily the wrong approach, but the less that leadership is distributed the more important it is that it be highly effective because of the greater impact of failure. If we look at the performance of the centre of the centre, there do seem to be a number of recurrent lessons.

8.1.3 The Prime Minister in Cabinet is meant to be the setting where the contested questions and policy priorities are resolved, but the issue of the balance to be afforded economic matters and the pandemic was not fully confronted and resolved in the early part of the pandemic.

8.1.4 It was clear from published statements of key players that the idea of herd immunity, whereby the economy continued as normal and the population fell victim to the infection with assumed immunity for those who recovered was the favoured option for weeks.[8.3] Advisors to the Prime Minister seem to have deluded themselves into believing herd immunity was an acceptable way forward in order to accommodate the Prime Minister's policy preferences.

8.1.5 It seems unlikely that the full implications of this approach were tested in front of full Cabinet and that they gave their consent. Had it been put to Cabinet we would almost certainly have seen leaks which expressed reservations. In this case, the absence of evidence probably does constitute the evidence of absence. So we have some reason to believe that the institution at the very core of government, Cabinet, was sidelined and ineffective – a return to the 'sofa government' described in the Chilcot report on the Iraq war as disastrous for good decision-making.[8.4]

8.1.6 It is also the case that Boris Johnson had taken the precaution of removing from Cabinet the experienced MPs of standing who might have been expected to have an independent opinion after he succeeded Theresa May as Prime Minister, excluding most of them from the Conservative Party so that by the time of the pandemic they were not even in Parliament. The remainder were on the backbenches and doing useful work following the crisis through select committees, but even the second order ministers who were in the Cabinet would surely have been briefed about the consequences of a herd immunity strategy and also about the delay to essential action that was taking place while such a strategy was being considered, which became all too evident in the high death rate experienced in March, April and May 2020.

8.1.7 Professor Jonathan Portes has pointed out to us that almost all economists take the view that public health has to be restored and that the economy can take the hit of going into lockdown in order to stop the spread of the virus. Because of the success of the job replacement scheme – putting aside any reservations about the level of fraud – working from home and support for business, better off members of the public were building up savings that when spent after the all-clear was sounded would cause a big economic bounce back. The constant flirting with the idea of riding out the infection and building up herd immunity was not an economic but a political idea, straight from the Prime Minister.

8.1.8 The strong view of the public health profession, as expressed by many of our witnesses, is that infection must quickly be found and eliminated for an effective response.[8.7] The periodic resurgence of a strategy of letting the economy run explains not only the late initial lockdown in the first wave, the financial incentives to go out and mix in the summer of 2020,

the late lockdown in the Autumn of 2020 despite the clear and published advice from SAGE on 21 September and the intention of having Christmas 2020 off from the pandemic, etc.

8.1.9 This led directly to a very large number of deaths, as noted by Dr Deepti Gurdasani (para 8.0.6). Had Cabinet endorsed a coherent strategy of suppression of the virus and using effective testing systems to find any outbreaks it seems very likely that we would have experienced far fewer deaths and incurred less economic damage (including the debt incurred to pay for furlough and other benefits for an extended period). A Cabinet that worked would have been a better guarantee of that than one man's whim.

## 8.2 POLICY ERRORS

8.2.1 Further errors arose out of the chaotic decision processes in the centre. Public health experts use the mantra 'find, test, trace, isolate and support' as the recipe for overcoming an epidemic, but one section of the community were not supported despite the fact that they were at high risk of becoming infected and infecting others. Although the centre had been willing to provide relatively generous support for many millions of people in the secure employment where furlough became a possibility, people whose employment was more precarious could not be supported through furlough because they worked in the gig economy, possibly on zero hours contracts and with no employment protection and sometimes not even access to statutory sick pay.

8.2.2 Professor Portes reported that not only was the level of statutory sick pay below any comparable country in the OECD (see report section 4.8), but it was massively below at just over £90 a week. The knock-on consequences of the failure to pay an adequate amount were that the Test and Trace system underperformed because people were not prepared to name their contacts, that in any case people did not pick up the phone when Test and Trace called, and that large numbers of people with transmissible infection carried on working and therefore spread the virus. What kind of strategic centre fails to consider such an obvious option? Probably one that is overwhelmed, populated by people who tell the boss what he wants to hear, and where key voices are drowned out.

8.2.3 There is then the larger question of the Test and Trace system itself and the choice to set something up de novo, with most operations run through outsourced contracts and leadership from a person with no relevant experience of the field (see report sections 2.3, 3.3 and 7.5). There was in fact plenty of capacity available already – not in the one and only laboratory of Public Health England, but in a variety of settings such as major hospitals and universities and existing private sector labs. Some effort would have been necessary to bring about a surge in capacity but that would have been done building on a sound foundation rather than on thin air, as with what happened. How can a system which has at its disposal some of the finest minds around not have come to a better decision about how to take this forward? The answer is probably panicked 'sofa government' rather than considered and well-supported decision-making.

## Contempt for standard operating procedures or protocols

8.2.4 Managing something as big and complex as government is not like managing the corner shop or the local pub. Large organisations develop procedures to help give due weight to factors which it is best to consider in different types of activities. One such is procurement procedure, which had developed protocols over time to achieve the best value for money for the system. These standard procedures will have been developed when urgency was less of a factor than during the pandemic, but the evidence published by the National Audit Office shows a failure to understand the significance of such things and their apparent replacement with the principle that it is not what you know but who you know, as the NAO's discovery of fast-tracked bids to provide service from friends of ministers, who were 10 times more likely to be awarded Government contracts than bids that came through in the normal way (see report section 7.3).[8.5]

8.2.5 The evidence shows that the contracts awarded to friends had a high failure rate. This is not surprising if key parts of the process such as whether the potential contractor had a track record of delivering similar services, seems to have been over-ridden. This retreat into a courtier culture should have been addressed by departmental permanent secretaries, who are personally responsible to the Public Accounts Committee of parliament for the propriety and value for money of the spending in their department. The Permanent Secretary of the Department of Health and Social Care has questions to answer about this.[8.6] We discuss below the implications of permanent secretaries not having control over departmental expenditure. Not only was there some evidence of corruption but there was plenty of evidence of poor outcomes from the procurement process.

## Hitting the jackpot

8.2.6 In the light of this litany of incompetence and malfeasance, it is hard to explain why the commissioning of the vaccines was so different. Dominic Cummings in his evidence to the Health and Social Care/Science Select Committee inquiry[8.7] suggests that he and the Chief Scientific Adviser, Sir Patrick Vallance, took control of the process. Sir Patrick had until very recently been a senior executive at GlaxoSmithKline and was himself a clinical pharmacologist, very relevant experience for the task.

8.2.7 Someone with strategic experience in the pharmaceutical industry was found to lead the work and seems to have had an enclave protected from the chaos in which to gather resources and create the necessary relationships. The recently published story of the development of the Oxford/AstraZeneca vaccine certainly suggests that crucial risk capital to finance the development of the vaccine was available at an unusually generous level.[8.8] The official public inquiry may tell us more and see how far positive lessons might be learned for the functioning of Government but the contrasting examples of Test and Trace and vaccine development and procurement are stories which shout out about the importance of relevant specialist knowledge and the need for decision-making which uses it.

8.2.8 The primary message that comes out of this section is that the leadership of our response to a pandemic is the most stretching and challenging role, even for someone who has the character to

undertake it. When the electorate chooses someone as Prime Minister who clearly does not have that ability, that way lies disaster – as demonstrated in the death toll for the UK. Lucky the country led by politicians who understood the issues, worked hard and with determination to follow the right strategy in a timely manner and were able to build their political resources to allow them to continue. A key feature of our constitution is that the Prime Minister in Cabinet is at the apex of decision-making, a collective system which allows for the frailties of the human beings who occupy the post of Prime Minister. For the second time in two decades, that system has failed and we urgently need to ensure that it works in the future.

## The national public health function was not up to the job

8.2.9 For over a century, public health physicians have been at the core of the UK's response to epidemics and national emergencies, indeed the art and science of public health was invented in the UK slums of the nineteenth century. It had become a well-established career with a capacity for training and experience at a number of levels so that there was a talent pipeline of public health leaders able to come to the fore to provide leadership when needed. This changed from 2010 onwards. As Professor Gabriel Scally (see report section 1.4) said:

> *'The capacity for emergency planning and resilience at regional and local level had been systematically stripped out since 2010, leaving central government incapable of dealing with what was a very predictable, and predicted, national emergency.'* (Scally)

8.2.10 The Health and Social Care Act of 2012 changed the NHS, including Public Health, into a system for commissioning and contracting rather than a comprehensive service for ensuring the public's health, and with that change the system's capacity for strategic public health leadership was eviscerated completely at regional level, and downgraded with reduced funding at local level as it was passed over to local government.

8.2.11 At national level, PHE was set up; however, the national authority previously exercised by the regional directors of Public Health, who depended for their effectiveness on their capacity to speak with professional independence, was not replicated in PHE. It was set up as a part of the DHSC, having no separate governance or statutory powers and responsibilities.

8.2.12 The chief executive of PHE since its origin and until 2020 was Duncan Selbie, whose background was as an NHS Trust manager and chief executive of one of the now defunct Strategic Health Authorities. He had no professional qualifications and no work experience in public health. His background fitted him for the role of leading a public health improvement service, doing useful work on a number of priorities, but did not fit him for being a professionally authoritative voice on epidemic control. Developing and running a programme for health improvement is not the same thing at all as having the personal credibility to come to the fore in a pandemic. This would depend on knowledge of the field of public health, experience of earlier epidemics, and the personal leadership style and capacity to confront obstacles to success

8.2.13 Those professional public health specialists who occupied senior positions in PHE were, in effect, civil servants, and unprepared for the senior leadership roles

they were suddenly faced with. Deputy Chief Medical Officer Dr Jenny Harries, until 2019 a relatively obscure public health doctor in PHE's regional office structure, showed her inexperience by failing to remain separate enough from ministers and the Prime Minister. She was used in a televised 'fireside chat' with the Prime Minister and, encouraged by him, gave false reassurance to the public.[8.9]

8.2.14 Whereas in the past, public health officials spoke on their own account as experts and were careful to guard that independence so that the public would see them as truth-tellers whose opinion could be trusted, what we see in this example and others is someone with a public health leadership role who regards it as her job, like any other civil servant, to serve the government of the day.[8.10]

8.2.15 No 10 Press conferences held with senior PHE staff on the podium alongside ministers or the Prime Minister led to them providing justification for government policy rather than saying what a top public health professional would say, as several of our witnesses have pointed out. Dr Jenny Harries (now the head of PHE's successor body, the UKHSA), for example, justified the abandonment of testing in March 2020 despite the advice of WHO:

> *'I remember watching with some disbelief when the deputy CMO, Dr Jenny Harries, was asked by the BBC reporter why we had not followed the advice of WHO. She said that advice is for developing countries. Frankly, that is absurd. It is a very dangerous way to respond.'* (King)

8.2.16 Dr Harries' co-deputy CMO, Professor Jonathan Van-Tam may have managed to keep more of a distance. In the final question of the Downing Street press conference held on 30 May 2020, following a question from *The Observer*'s Toby Helm which pointed out that more than a million people had signed a petition calling for the sacking of Dominic Cummings and asking whether people in authority should give a lead and obey the rules, Jonathan van Tam answered slowly and deliberately:

> *'... in my opinion, the rules are clear and they have always been clear. In my opinion, they are for the benefit of all, and in my opinion, they apply to all.'* (Van-Tam)

It is notable that he did not appear again in the No 10 press conferences for a very long time.[8.11]

8.2.17 The destruction of independent public health capacity may have had its most significant impact in the absence of this discipline as an independent voice on SAGE. Now that the minutes of the early SAGE meetings have been published we know that senior staff of PHE were present at those meetings, and in the minutes were described as part of the group of scientific advisers. Actually, as civil servants, they were unable to express independent scientific advice, but this meant there was no independent public health advice, leading to an over-reliance on the other disciplines such as epidemiology – important though that was.

8.2.18 The under-provision of proper public health advice was a major problem in the early days. It is not surprising that many of the people who agreed to serve on indie_SAGE (the parallel voluntary body chaired by Sir David King) were the very people who constituted the independent strategic capacity which was so clearly needed by Government. Had more of those people been present on SAGE in the early stages of the pandemic, it seems unlikely

that WHO advice would have been ignored, testing dismantled, and international travel permitted.

## Chief Medical Officer and Chief Scientific Advisor

8.2.19 Was Professor Chris Whitty, the Chief Medical Officer, not a strong enough advocate of the case for public health? It is worth noting the following comments made by Professor Scally:

> *'Only one of the four national Chief Medical Officers was a fully trained and experienced Public Health physician.'* (Scally; see report section 1.4)

And this was not Professor Chris Whitty. Prof. Scally expanded on this point later in the press.[8.12] Whitty is an eminent scientist and a person with many relevant qualities, but in the early stages of the pandemic clearly lacked the practical wisdom that is at the core of the field of public health. A senior public health leader always makes sure that they protect their right to give their independent professional opinion, because so much depends on people trusting their advice and therefore following it.

8.2.20 As the former chief scientific adviser, Sir David King, said, referring to the Phillips Report into government handling of the BSE crisis (of which Phillips was very critical),

> *'The scientific community was never allowed to communicate with the public directly. Openness, honesty, and transparency with the public as well as with government ministers is vital.'* (King; see report section 2.1)

8.2.21 The Chief Medical Officer was fairly new in post but had occupied the role of departmental Chief Scientific Officer in the Department for International Development and then the DHSC. He was therefore well-versed in the Whitehall routine of seeing experts as 'on tap but not on top'. Of course the elected government of the day has the final say, but the public has a right to know that the decision was in spite of advice rather than, as was claimed in the 'following the science' refrain, because of it.

8.2.22 It is fair to say that a rather more robust stance developed as we moved into the Autumn of 2021, as evidenced in the published advice of the September 21 meeting of SAGE shows:[8.13]

> *'A package of interventions will need to be adopted to reverse the exponential rise in cases. Single interventions by themselves are unlikely to be able to bring R below 1. The shortlist of ... interventions that should be considered for immediate introduction includes:*
>
> *a. A circuit breaker to reduce incidence to low levels*
>
> *b. Advice to work from home for all who can*
>
> *c. Banning all contact within the home for members of other households*
>
> *d. Closure of all bars, restaurants, cafes... etc*
>
> *e. All university and college teaching online*
>
> *The more rapidly interventions are put in place ... the faster the reduction in incidence and prevalence ... the greater the reduction in Covid-related deaths.'*

Despite the unequivocal nature of this advice, it was not followed for a further five weeks.[8.18]

8.2.23 The Chief Scientific Officer, Sir Patrick Vallance, was newer to Whitehall and more used to being listened to with respect by those at the top of a major pharmaceutical company whose top leaders knew their future as a company depended on good scientific advice being followed. Both the Chief Medical Officer and the Chief Scientific Adviser should be guaranteed their independent status in the future. Governments may choose not to follow their advice, but they will then face the court of public opinion if they over-ride it and disaster follows. The only way to retain their independence rather than conforming to Whitehall 'groupthink'[8.14] is for them to have the right and the duty to speak for themselves to the public.

## The role of top civil servants

8.2.24 In our un-codified constitution, the convention is that policy advice to ministers is confidential and not to be made public. The main reason for this convention is to protect the anonymity of civil servants so that they will feel able to offer tough advice to ministers – 'speaking truth unto power'[8.15] without their future career under a government of a different persuasion being compromised, thus giving our system of governance the benefit of continuity of expertise and knowledge.

8.2.25 Governments are accountable to the public through Parliament for the decisions they take and civil servants are accountable to ministers – so goes the argument, rather than directly to the public. Civil servants, according to this convention, can be ordered by ministers to do most things, although not to break the law, and they should resign if they feel they cannot follow the order.

8.2.26 Continuity of expertise and knowledge should have been important advantages for the UK in responding to this pandemic as during the previous 15 years we had experienced the foot-and-mouth epidemic in 2006, where many of the same principles of epidemic control applied and also a very extensive Foresight project in 2006 where a huge amount of work went into setting out what would need to be done if the most pressing risk on the UK national risk register came about, a novel virus which had crossed the animal/human barrier and created a pandemic:

> *'This was the single biggest Foresight programme that I ran. We met for just over two years on that programme.'* (King)

There had also been the more recent Exercise Cygnus in 2016 and, as we have recently been told Exercise Alice, which unlike Cygnus with its focus on influenza, worked on what needed to happen if we were struck by a coronavirus pandemic.

8.2.27 Nonetheless we were clearly not prepared. This was not only, as Professor Portes said, because the wrong balance had been struck since 2010 between sustaining the public institutions that we need in an emergency and the policy of austerity but also because something clearly was wrong in how the heart of government functioned. Some of this failure is explained by the misfortune of being led by a prime minister who is widely reported by many of those who have known him throughout his career as not fit to govern. From time to time, the electorate will bring someone to the office of Prime Minister who does not have the ability to fulfil the role of crisis leader. So what does our constitution offer in those circumstances? A tough and experienced

civil service capable of ensuring that ministers fully consider all the issues in making their decisions.

8.2.28 The Whitehall model of confidentiality and continuity depended for its strength on the mutual interdependence of civil servants and ministers, but over the last several decades that relationship has been undermined by the presence of an ever-growing army of political advisers, appointed by ministers and working directly to them, bypassing top civil servants. The question the pandemic raises is whether the relationship between ministers and civil servants has been so undermined by the use of special advisers that it can no longer put tough questions to ministers and expect to be heard? It is certainly the case several very senior civil servants, including the Cabinet Secretary and head of the civil service, were removed from their posts before or during the early months of the pandemic, thus reducing top level capacity to provide challenge to the strategic direction being taken.

8.2.29 The Cabinet Secretary Sir Mark Sedwill, appointed to that role in 2018, resigned in June 2020 at the age of 55. Such early resignations rarely happen from the post of Cabinet Secretary and it is therefore possible to surmise that this was the work of Dominic Cummings, who had made no secret of his desire to bring about fundamental change in Whitehall. He clearly saw a raging pandemic as no hindrance to getting on with his agenda. The chosen successor, Sir Simon Case, was one of the youngest ever to hold the post and his most demanding role previously had been as Private Secretary to Prince William. The appointment must have raised eyebrows amongst the select group of past cabinet secretaries. A weakened civil service could still do administrative tasks well, as discussed below, but the core function of the top of the civil service to 'speak truth unto power' seems to have been eroded too far to be safe.

## Use of scientists

8.2.30 We need to consider the role of scientific advice and advisers and whether or not they were well used. There are two different codes of legitimacy involved in interactions between the science community and government. The actions of government are legitimate because they are the elected government of the day, chosen by the people. Scientists get their legitimacy from their research, opening their ideas to challenge through peer-review and the judgement they bring to their conclusions. How could such different codes of operating co-exist?

8.2.31 What seems to have happened in the early days of the pandemic with SAGE is that they were regarded as subservient to the will of the Government of the day. Minutes were not published until some months had elapsed, the group consisted at first of a mixture of scientists and government advisers. Professor Stephen Reicher drew attention to the fact that 'behavioural fatigue' was a dominant strand in SAGE's early deliberations and instrumental in the delayed lockdown, but the idea has no basis in behavioural science (see report section 4.7).
We believe this is a reference to the Government advisers who attended SAGE but were not behavioural scientists:

> *'It was believed in Government that the British people would not be able to stick with restrictions and so restrictions should be delayed. When this idea first came out it was ascribed to behavioural scientists. It did not come from behavioural scientists. It actually came*

*from non-behavioural scientists making assumptions and therefore giving very bad advice.'* (Reicher)

8.2.32 Scientists were required to abide by the notion that policy advice to ministers should be confidential, even though they were not civil servants, needing to be shielded against public awareness of the position they advocated. They continued to be active scientists with no future career in Government in prospect. Sir David King, former Chief Scientific Officer, referred to the Phillips Commission into the Government's handling of BSE, which recommended full transparency for scientific advice (see 8.2.20). Sir David himself insisted on it when he was Chief Scientific Adviser during the foot-and-mouth epidemic. Dame Deidre Hine's report into swine flu recommended the same principle.[8.16]

8.2.33 The smothering of the independent science voice was most graphically seen in the presence of the most senior scientific advisers standing either side of the Prime Minister at the regular Downing Street press conferences, with the Prime Minister conducting the process and sometimes refusing them the opportunity to give a full answer. This was personally demeaning for them, but more importantly reduced respect for their independent opinions, both in government and amongst the public.

8.2.34 However, after the disastrous first few weeks of the epidemic when the scientists acted at least in public with docility, we began to see that they would use publication of their research to force a reconsideration about the strategy of herd immunity. When the public became aware of the disastrous death roll that would follow, even the Prime Minister was forced to take notice.[8.17] So although tens of thousands of lives were lost because of the initial lack of transparency and because there was poor public health leadership, ultimately SAGE came good, at least during the first wave. In subsequent waves, the Prime Minister was even less amenable to rational argument and the death toll soared. It is very clear that full transparency and therefore independence of scientific advice would have changed the dynamics of how the Government was led during the pandemic and we have no hesitation in recommending it.

## Arm's length regulators who failed to regulate

8.2.35 National bodies outside of central government deserve some investigation. They are typically set up at arm's length from government and although ministers will set their overall mission and agree the level of resources, the bodies are at arm's length to give them the independence to serve their mission as they think best. We have testimony from two witnesses on how two such bodies failed to live up to their mission during the pandemic.

8.2.36 Jean Adamson, a member of Covid-19 Bereaved Families for Justice and herself an expert in the field of social care, gave evidence on how the Care Quality Commission fulfilled its role (see report section 4.9). An academic expert, Professor Raymond Agius, gave evidence about the poor response of the Health and Safety Executive in defending workers against unsafe working conditions (see report section 5.4).

## The Care Quality Commission

8.2.37 The core mission of the CQC was to regulate the health and social care sector on behalf of its users, who were by

definition vulnerable people not able to act themselves in their own best interests. The CQC's website makes great play of the fundamental standards of care that it upholds. Among the dozen or so standards listed are: 'person-centred care, safety, safeguarding from abuse, complaints systems and the duty of candour'[8.18] – all of which they claimed to uphold.

8.2.38 Our witness, Jean Adamson, presented a challenge to them. Her beloved father died of Covid in a care home in April 2020, and she was a professional expert in assisting care homes to achieve the standards set out for them by the CQC. She joined Covid-19 Bereaved Families for Justice shortly after her father died and through engaging with others began to realise the enormity of what had happened to thousands of people in care homes. She became a seeker after truth having difficulty getting the most basic information about what had happened to her father:

> *'We need to understand why our loved ones died in a place where we expected them to be safe ... After my father passed, I made a formal complaint to the care home ... They did not give me answers to my questions about hospital discharges, about the number of cases in the home and they did not give me an un-redacted copy of my father's notes.'* (Adamson)

8.2.39 Her experience of her father's care home was evidently that it did not live up to the standards set for it by the CQC. Most of her evidence, however, was reserved for the subject of the CQC:

> *'We feel very let down by the Care Quality Commission, as the health and social care regulator for England ... I felt they would be supportive of bereaved families but what actually happened is that they refused to disclose the number of Covid-related deaths in individual care homes ... an important measure of the quality of a care home.'*

8.2.40 Her interpretation of this behaviour on the part of the CQC is that they have sought to protect the commercial interests of the care sector rather than be open and honest and transparent to families. She said that in her discussions with senior staff of the CQC it was obvious that they were petrified that if information came out and that led to people moving their relatives away from poorly performing homes this would lead to a loss of care home beds as such homes would collapse:

> *'I feel that the CQC's position has become untenable ... It is no longer arm's length but has become political'* (Adamson)

8.2.41 Although it had the governance to be an arm's length body and the formal mission, it actually functioned as though it was part of the DHSC. A few days before Ms Adamson gave her evidence to this inquiry the CQC advised that it would be publishing the care home by care home information on Covid related deaths on 21 July 2021. This was done, although it should be noted that figures were not published for the time before 10 April 2020 on the grounds that figures were too unreliable before that date. The question remains – why did it take so long to publish this material and for the CQC to remember whose interests it exists to promote and protect?[8.19]

## Health and Safety Executive

8.2.42 Chapter 5 of this report, drawing heavily on the evidence of Professor Raymond Agius, sets out in detail how the body set up to protect the safety of

people at work, the HSE, failed to do so during the pandemic (see report section 5.4). The evidence shows that it deferred to PHE in what was clearly on their part an attempt to rationalise the inadequate supply of PPE, endorsing PHE statements. It failed to bring into consideration its own expert knowledge on aerosol transmission of viruses and failed to speak up for the use of higher grade masks for health care workers who were not working in ICU but potentially in contact with infected patients even after these masks belatedly became more widely available. The evidence of its failure on this protective measure is that health care workers in ICU, in close contact with highly infected patients undergoing respiratory treatment were in fact less likely to catch Covid than other health care workers deemed less at risk and therefore less well protected.

8.2.43 Equally significant was the lack of HSE's voice in protecting other parts of the workforce outside the NHS. The origins of HSE as a protective regulator, working especially in non-unionised settings where the workers could not organise to protect themselves, seems well and truly in the past. The high incidence of Covid in workers running essential services, the failure to demand that premises are properly ventilated and that protective equipment was provided, all contributed to a betrayal of the fundamental mission of the HSE. As with the CQC, they allowed themselves to be drawn into the programme being defined by Ministers in the core of Government rather than fulfilling their statutory duty. This tells its own story about the overwhelming power of the core of the executive in our system of governance. Even organisations set up by Parliament to be at arm's length from that power seem to be drawn into it.

## Accountability of ministers and public servants with statutory responsibilities

8.2.44 Is there a remedy in law so that ministers and other public servants can be called to account? Michael Bimmler, a barrister specialising in public and human rights law discussed the legal aspects of the Government's response to the pandemic. Bimmler explained the 'no harm' principle which exists in international law, which says that states have a duty to take all appropriate measures to prevent and reduce what is called significant trans-boundary harm. This applies to natural disasters, during which states have to take appropriate steps to prevent harms. The greater the risk of the harm at hand, the more efforts are required from the state. With regard to the pandemic, all states were subject to this duty, so they had a duty to stop further spread of the pandemic, or at least to take such steps as they could to stop the further spread, and to prevent or reduce further outbreaks.

8.2.45 International Health Regulations (IHR), dating from 2005, and adopted by more than 190 states in the World Health Assembly place a number of mandatory obligations on states. These include, for example, a duty to develop and maintain the capacity to respond promptly and effectively to public health risks including pandemics, and a duty to base that response on scientific principles and evidence. These international laws raised a number of questions as to whether the UK's response actually complied with IHRs, including adequate pandemic planning, and a capacity to respond promptly and efficiently. Bimmler noted the availability of PPE and ventilators, discharge of patients

into care homes without testing, protection of patients in hospitals and care homes, and reaction to the second wave.

8.2.46 He also discussed the European Convention on Human Rights (ECHR), in particular the right to life, the right not to be subjected to inhumane treatment, and the right to respect for private and family life. He explained that the Government has to take proactive steps to promote these rights by putting appropriate safeguards in place, and that they are systemic duties owed to the public at large, in particular to exposed people. This would include frontline workers in the NHS, and the vulnerable such as the elderly and those with pre-existing medical conditions:

> *'It is quite clear from the case law that acts and omissions in areas such as health care policy, health care provision, health care regulation, are covered by this article to the right to life.'*

8.2.47 He pointed out the 'duty to investigate' when a state's breach of those duties under the ECHR had cost someone's life. This could range from a coroner's inquest to a public inquiry if national level policy decisions were involved. He also reinforced the evidence of Professor Raymond Agius in chapter 5 by noting the duty of employers to ensure the health and safety of their employees at work by providing a safe workplace with necessary training and equipment (such as PPE), and that a breach of those regulations could be a criminal offence.

8.2.48 On enforcement, he pointed out that it was difficult to challenge breaches of international law, but that claims against breaches of ECHR could be brought in UK domestic courts

## Central government departments

8.2.49 There has been much criticism of central government for its role in leading the response to the pandemic (see above 8.2.9 to 8.2.43). However, several witnesses have reminded us that in some respects central government performed well. Where strategic agreement about a response had been reached within the centre of the centre, there were cadres of hard-working and well managed staff able to deliver new services at speed. Professor Portes draws our attention to the major successes achieved by HMRC, working closely with the Treasury, to develop and implement the furlough scheme and support for business.

8.2.50 Another example he gave was the DWP's expansion of Universal Credit to much larger numbers of claimants, their removal of the obstacles to receiving benefit which are part of the normal run of things. The £20 top-up could not have been in the gift of the DWP without backing from the Treasury, but perhaps is a tacit acknowledgement from them that the cuts to benefits during austerity had left basic benefit levels too low for survival when times were harder.

8.2.51 Another example quoted in our evidence is the Department of Housing, Communities and Local Government. They get a commendation from Steve Cowan, Leader of Hammersmith and Fulham Council, for their willingness to share information with local government and to work in partnership, and for extending the funding of local government so that it could do the job required in a pandemic.

8.2.52 There were other more fraught examples of the work of central government departments brought to our notice by witnesses. Kevin Courtney

naturally had a lot to say about the role of the DfE in the pandemic (see report section 4.25).

8.2.53 All of this evidence is reinforced in a recently published report written by former journalist Nick Timmins for the Institute for Government,[8.20] which demonstrates a systemic weakness in the education sector that cannot be fully explained by a weak Secretary of State. The DfE found itself having to run the nation's schools in a time of crisis with a wholly inadequate capacity to work effectively at the regional and local level, and – according to Timmins – a pathological hatred of local government which made working in partnership with them a little difficult.[8.20]

8.2.54 Our witness Professor Jonathan Portes was right to draw attention to the difference in pandemic performance between those parts of central government at some distance from the chaotic centre, who did a commendable job in providing extended services which were vital to the survival of very many people. Not all of central government was shambolic

## 8.3 LOCAL AND REGIONAL RESILIENCE

8.3.1 While the overall architecture of public health was unfit for purpose in the pandemic, we are fortunate that very many public health specialists took it upon themselves to make a contribution. We have already noted the contribution many of them gave to indie_SAGE and further to enhancing public understanding of the pandemic through their writings. Many of these people were also witnesses at this Inquiry.

8.3.2 At the local level, there are many examples of voluntary and community action led by public health specialists on a voluntary basis. Our witness Janet Harris said of her work in Sheffield that it grew as a result of noticing the failings in the Test and Trace system and because of her earlier substantial experience in mobilising the community to combat infectious diseases. Janet Harris is a semi-retired public health specialist. When coronavirus hit she and friends began to realise that Test and Trace was not working well and recruited and trained a group of local volunteer support workers to provide assistance for people who had been told to isolate. With the assistance of doctors in one of the city's hospitals, they also did contact tracing for coronavirus patients in hospital, which no official agency was doing (see report section 3.7).

8.3.3 No government at the national level can hope to deal with a pandemic without local and regional actors playing a significant part. It is in the nature of infection that it has to be stopped house by house and street by street, and that this can only be done by people with local knowledge and local credibility. We have already heard that the public health function at the regional level had been 'eviscerated', and during the decade before the pandemic, local authority funding had been stripped away leaving it less capable of responding to an emergency (see report section 1.4). Public health went into local government after the 2012 Health and Social Care Act and also lost funding once its ring-fenced protection was removed. Additionally, over the decade local government lost control of its micro-level service providers, the schools, as the Government herded them into academies, outside local authority control.

8.3.4 Despite this disabling history, we are fortunate that at least some strong local leadership capacity remains.

A case in point is our witness Cllr. Steve Cowan, leader of Hammersmith and Fulham Council. He pointed out what a centralised country this is, and that local government 'tends to wait for instructions from central government and then follow them'.

8.3.5 He went on to say that in February 2020 he had noticed that many other liberal democracies, mentioning South Korea, Germany and California were adopting restrictive policies and that the UK government appeared to be an outlier:

> *'It looked like the Government's focus was not on the Covid pandemic. Their heads seemed to be in a different space from where I thought they ought to be ... a lot of them were off ski-ing.'* (Cowan)

8.3.6 In the February half term holidays, he came to the view that since there had been no word on the pandemic from the Prime Minister, that probably meant he was not thinking about this issue, which also in turn meant others may not be. He instructed the chief executive to put Hammersmith and Fulham onto a civic emergency footing, and to work out with staff what the council would need to do to protect the population. Hammersmith and Fulham was one of the first councils to declare a civic emergency on 13 March, stopping all public meetings and closing the parks in the light of parks being very crowded because of unseasonable fine weather.

8.37 At the regional level, they worked with other London councils and agreed on a letter to the Prime Minister demanding a lockdown. This was signed by all London council leaders, including Conservatives, and was received by No 10 the day before lockdown was announced. After the lockdown announcement on 23 March:

> *'Quite good relationships were established between the Department of Communities and local government, with regular meetings and the Secretary of State Robert Jenrick saying 'spend what you need. We will reimburse you.'* (Cowan)

There was not in fact full reimbursement.

8.3.8 Of particular note is the borough's work with its care homes:

> *'There are four large homes, all private sector. Council officers had realised that untested people were being discharged from hospital into these homes in the first week of April. Already there had been 25 deaths from this group of patients.'* (Cowan)

The lead member for health and social care and the Director of Public Health arranged for the homes to have free PPE (from Charing Cross Hospital), training for staff in infection control, with testing carried out locally by Imperial College. This gave the lie to the claim by Matt Hancock to the Select Committee on Health and Social Care that it was impossible to test patients who were being discharged from hospital to care homes.

8.3.9 The council had the statutory power to close the homes if they were failing to protect residents, but needed the care they provided for local people, so they worked positively with them – ingenuity, collaboration and soft power were the order of the day:

> *'It really was something where the public sector ethos at ground level really worked and we all rose to the challenge – local government, NHS, care homes, teachers.'* (Cowan)

8.3.10 Nine months after the first lockdown, on Sunday 13 December 2020, London council leaders were called to a Microsoft Teams meeting with the Public Health Director for London, Professor Kevin Fenton.

> *'He told us that unless there was a full lockdown during the next eight days, there would be a second wave which would dwarf the first and lead to far more deaths.'* (Cowan)

8.3.11 For the second time in this evidence, Cllr. Cowan told us that at the London-wide (regional level) there was cross-party agreement to send a demand to Government for a London-wide lockdown from people from all parties. Unfortunately, this time they were unsuccessful in forcing a lockdown within that time frame, resulting in far more deaths than there need have been:

> *'I think the Prime Minister was more focused on being the man who gave you Christmas rather than focused on the science of stopping the second wave.'*

8.3.12 The Hammersmith and Fulham story shows what can be done in places with effective leadership to mobilise the resources needed to protect people. And yet apart from local government's sponsor department, The Department of Communities, Housing and Local Government (which has just experienced a name change removing the words 'local government' from its title) the disdain of Whitehall for town hall is very clear, not least in the quotation above revealing attitudes in the Department for Education (8.2.53).

8.3.13 It is clear to us that in any future public health emergency, central government needs to work in partnership with local government and local public services, sharing information and resources. This probably applies to public policy in general, but certainly in the circumstances we examined it is a ludicrous conceit to act as though all wisdom belongs in the No 10 bunker.

## THE PEOPLE'S COVID INQUIRY

**The People's Covid Inquiry took place from 24 February to 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.

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