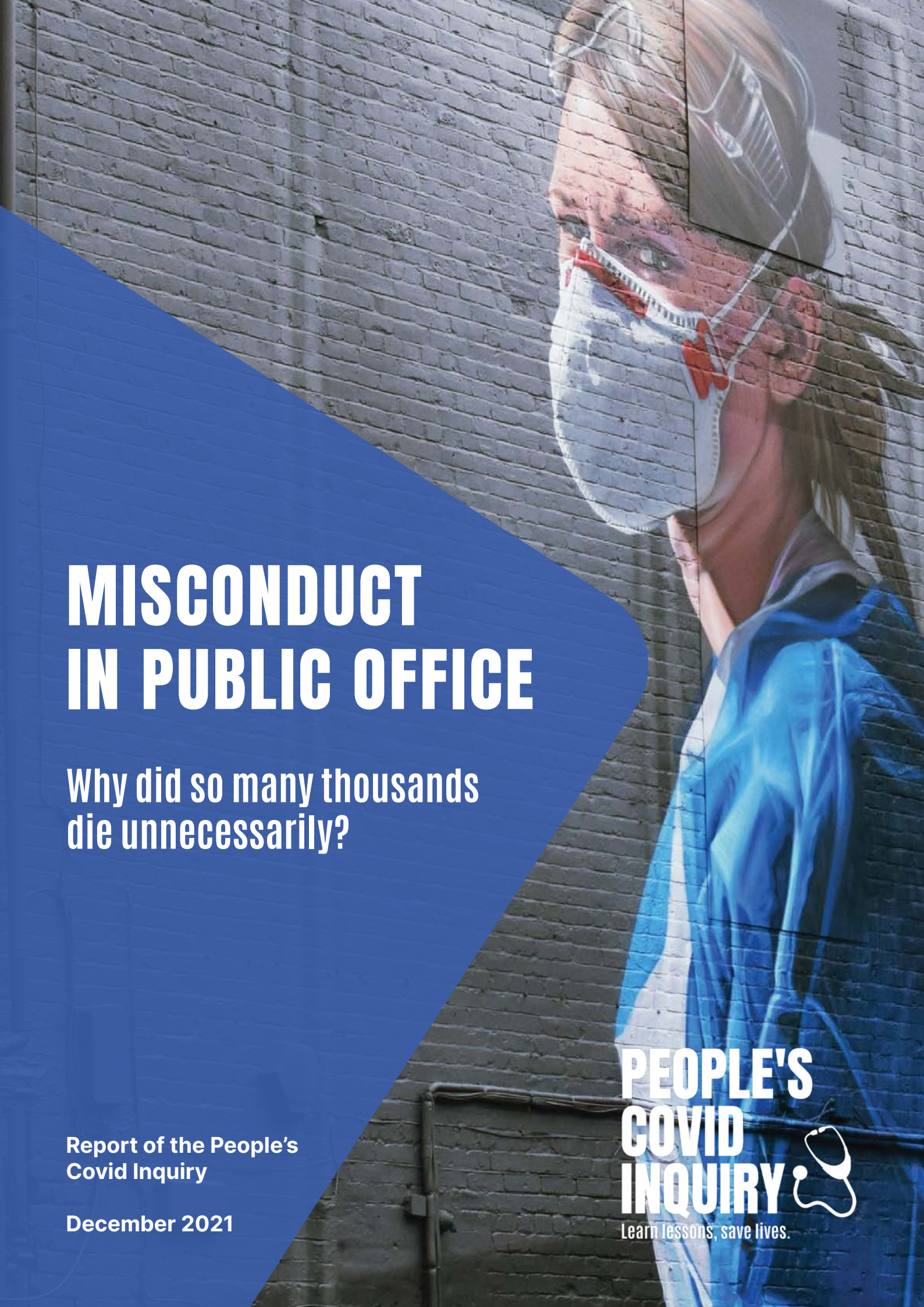

# MISCONDUCT IN PUBLIC OFFICE

## Why did so many thousands die unnecessarily?

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

**December 2021**

PEOPLE'S COVID INQUIRY

Learn lessons, save lives.

# FINDINGS AND RECOMMEDATIONS

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 not 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 despite having a renowned national health service and a world reputation in public health.

**F2.2** 167,000 deaths have Covid 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 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 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 populations.

**R4.2** The social determinants of health must be a 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 populations.

## 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 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 death toll.

**F6.2** NHS 111 should not have replaced primary care for Covid patients. The outsourced NHS 111 Covid 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 sidelined 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 WHO, and 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), WHO bedrock of pandemic response. In England there is still no effective coordinated system; a privatised Test and Trace remains 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 safely, each was lifted without an effective FTTIS being in place.

**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. 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 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 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.

**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, and working with the trades unions to develop these. Covid 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 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 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 helplines 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 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 2020, 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 schools 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** The Cabinet of the UK Government failed to impose limitations on prime ministerial power.

**F15.6** The UK 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.

## 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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