Writing on the Wall? The UK and the Early Warning Signs of COVID-19

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Summary

COVID-19 is the greatest challenge to global human security in the past 50 years. Before the outbreak the UK Government claimed to be world-leading in pandemic preparedness but is likely to end up being the worst affected state in Western Europe. This analysis seeks to explain why this is so. It examines the national biosecurity strategy published two years ago and the pre-pandemic claim of the UK Government that it was a world leader in the field and then compares that with evidence that the strategy was not followed, leaving the country poorly prepared for the outbreak. The piece then discusses what information was available to the UK Government during the early days of the outbreak and assesses whether it acted accordingly, based on the evidence available. It then explores the rapid and effective responses made by some countries at the start of the year when the UK Government was inactive on the issue. The analysis concludes by arguing that there were serious political issues that militated against early action, setting the scene for a persistent failure to learn lessons from the experience of others and from the failure to implement its own strategy.

Introduction

As of mid-June and as the COVID-19 pandemic continues to spread across the world, it looks increasingly likely that the UK will be the worst affected state across Western Europe, even though it is a state that had prided itself as being "world-class" on biosecurity. Since mid-March, when it is widely argued that the

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UK has been consistently slow and often inefficient in responding to the pandemic, there has been much criticism of the Johnson Government on many counts. They include delays in bringing in lockdown procedures even when other European countries had done so, and there were calls to act being made by many in the UK scientific community, delays in organising a test-trace programme, persistent shortages of personal protection equipment for health and care workers and far too little attention given to the spread of COVID-19 in care homes.

Much of the criticism has its roots in what is seen as the tardiness of government actions from late January to early March and concerns the period from the first COBRA emergency meeting on 27 January onwards. But there is mounting evidence that the Government should have been aware of the risk of a disastrous pandemic and taken far stronger action at an earlier stage. This note therefore covers that period from the first indications of COVID-19 infections through to the first meeting of the COBRA Government emergency committee.

It first draws attention to the claims of the Government that the UK was exceptionally well- prepared to respond to a pandemic, contrasts that with what was known of physical preparations and then explores the early evidence that a crisis was evolving. It is likely that more evidence will emerge in the coming weeks but it is already clear that there were many failures and that these will have made the pandemic, the loss of life, the hardship and the long-term damage to the economy far worse than should have been the case.

This briefing is concerned primarily with the UK, but the analysis is applicable to many other states, not least in Western Europe as well as the United States. Although some states believed that they had biological security response

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systems, many of them were ill-prepared for the pandemic even if others acted very quickly and effectively, especially a number in East Asia. The UK may have been a particularly bad example, but it was not the only one. Even so, analysing the behaviour of a state with one of the worst records to date may be of particular value in the future as an example from which to learn.

Preparedness

In August 2018 the Government published the UK National Biological Security Strategy, which emphasised the need to respond to the spread of serious diseases. The first of its kind for the UK, the 46-page strategy is a good example of science-based planning and highlighted the importance of strong public communications as part of swift action in the event of a crisis. Just three extracts illustrate this.

First:

> **“The UK is globally renowned for the quality of our preparedness planning, and we have world-leading capabilities to address significant biological risks. Across local and national Government and the Devolved Administrations, and through our work internationally, the UK invests hundreds of millions of pounds a year in protecting against and preparing for disease outbreaks and biological incidents.”**

Second, relating specifically to pandemic risks, the Foreword states:

> **“Significant outbreaks of disease are among the highest impact risks faced by any society – threatening lives and causing disruption to public services and the economy.” and “As a global leader in the biological sciences, we have an opportunity to demonstrate our expertise and be at the forefront of work to meet these challenges.”**

Third, it concludes:

> **“We cannot predict all the ways in which this risk landscape will evolve in the future, but it is by breaking down barriers, working in a co-ordinated way across and beyond Government, and thinking globally that we will be best prepared to meet the threat of significant disease outbreaks (however they occur).”**

Theory and Practice

At the time of the strategy's publication, the Government could therefore claim, at least on paper, that it was doing its duty, and this was an opinion shared by the World Economic Forum's league table, based on the Global Health Security Index, of pandemic preparedness which put the UK second best out of 195 countries assessed.

While this appears with the benefit of hindsight to be seriously wrong, it needs to be recognised that "preparedness" can be assessed primarily on what a government says it is doing and what its overall strategy is. It is therefore, to an extent, theoretical.

In this respect, the Strategy does go further and points out that the 2015 National Security Risk Assessment (NSRA), did identify a major human health crisis such as pandemic influenza as a Tier One risk. It also made it clear that not all biological risks can be prevented, crises will occur, and adequate resources must therefore be available.

In the context of what has happened since, theory and practice turned out to be very different, as illustrated by warnings from public health officials following exercises undertaken to test the actual levels of readiness. One major planning exercise had assumed a new and dangerous flu pandemic, which according to the *Daily Telegraph* "dramatically exposed the gaps in Britain's pandemic response but its 'terrifying' findings have yet to be published". Afterwards, the NHS England Board was told that in October 2016 "NHS England prepared for and participated in *Exercise Cygnus*, a three-day exercise looking at the impact of a pandemic influenza outbreak, and the significant impacts on health delivery a widespread pandemic in the UK would trigger". *Exercise Cygnus*

showed that NHS resources would be critically overstretched in such a pandemic.

Before this, the Government created several other blueprints for how the UK should respond in the event of an influenza-type pandemic. From 2011-2014, there were three strategies written: the "Influenza Pandemic Preparedness Strategy", the "Health and Social Care Influenza Pandemic Preparedness and Response" and the "Pandemic Influenza Response Plan". Yet the evaluation of *Cygnus* suggests that there was little practical implementation of these plans.

To make matters worse, as recently as last year the 2019 annual *National Security Risk Assessment* specifically dealt with the risk of a flu-type pandemic and urged the Government to prepare fully. As *The Guardian* reported:

> **"The detailed document warned that even a mild pandemic could cost tens of thousands of lives, and set out the must-have 'capability requirements' to mitigate the risks to the country, as well as the potential damage of not doing so."**

It emphasised the need to stockpile appropriate equipment establish disease surveillance, and contact tracing and even draw up plans to handle excess deaths.

According to *The Guardian,* the 600-page Cabinet Office report set out reasonable worst-case scenarios (RWCS) that now make for uncomfortable reading:

- "A pandemic would play out in up to "three waves", with each wave expected to last 15 weeks … "with the peak weeks occurring at weeks 6 and 7 in each wave".
- 50% of the population would be infected and experience symptoms of pandemic influenza during one or more waves. The actual number of people infected would be higher than this, as there would be a number of asymptomatic cases.
- A pandemic of moderate virulence could lead to 65,600 deaths.
- The potential cost to the UK could be £2.35tn.
- Even after the end of the pandemic, it is likely that it would take months or even years for health and social care services to recover.
- There would be significant public outrage over any perceived poor handling of the Government's preparations and response to the emergency."

Part of the explanation for why the Government was slow to respond to the COVID-19 outbreak may lie in a report that a key sub-committee of the National Security Council was first mothballed by Prime Minister Theresa May because of the pressure of government work over Brexit and subsequently scrapped by Mr Johnson when he took over in July last year. This was the Threats, Hazards, Resilience and Contingency Committee (THRCC) that included fifteen Cabinet Ministers among its members. According to one report, "a former Cabinet minister who was a member of THRCC until it was axed said it could have ensured the Government reacted more quickly to coronavirus, adding "Once the pandemic took hold in Italy…alarm bells would have been ringing."

Overall, and in view of what is now known, it does appear that government claims of world-leadership in biosecurity were far from accurate, as became clear from an early stage in the pandemic's development.

Warning Signs

Although the initial belief was that COVID-19 did not make it into Western Europe until well into January of this year, there are indications that cases were emerging earlier. In late December, one French patient taken into hospital on 27 December subsequently tested positive for COVID-19. In China itself, the authorities in Wuhan and later in Beijing tried for many weeks to suppress reports of a new disease condition. They did eventually report to the World Health Organisation that the first infection was recorded on 8 December, but Government sources subsequently indicated that an earlier case was recorded on 17 November.

Precisely when the COVID-19 virus made the "jump" from animal to human host is still not known but it is the subject of considerable research. For example, one method, phylogenetic analysis, tentatively indicates that the transfer from animals to humans could have occurred sometime between September and December last year.

Separately, it was reported on 9 April by one of the main US news channels, *ABC*, that US intelligence sources first got indications of a disease outbreak in Wuhan of unknown origin in November as a result of work by a little-known element of the US intelligence system, the *National Center for Medical Intelligence* (NCMI)*.* The Center's work is focused on the health of military personnel working overseas and this extends to people based at a number of sites throughout South East and East Asia, and according to *ABC*:

> **“Concerns about what is now known to be the novel coronavirus pandemic were detailed in a November intelligence report by the military's National Center for Medical Intelligence (NCMI), according to two officials familiar with the document’s contents".**

The report was the result of analysis of wire and computer intercepts, coupled with satellite images. It raised alarms because an out-of-control disease would pose a serious threat to U.S. forces in Asia -- forces that depend on the NCMI’s work. And it paints a picture of an American government that could have ramped up mitigation and containment efforts far earlier to prepare for a crisis poised to come home.

"Analysts concluded it could be a cataclysmic event," one of the sources said of the NCMI’s report. "It was then briefed multiple times to" the Defense Intelligence Agency, the Pentagon’s Joint Staff and the White House. Wednesday night, the Pentagon issued a statement denying the "product/assessment" existed.

The Pentagon denial was couched in carefully chosen words and might have dampened interest in the report but a week later, on 16 April, the *Times of Israel* reported on a Channel 12 News report that the Israel Defence Force (IDF) had been alerted to the Wuhan outbreak by the US intelligence community,

also in November. US intelligence agencies alerted Israel to the coronavirus outbreak in China already in November, Israeli television reported.

According to Channel 12 news, the US intelligence community became aware of the emerging disease in Wuhan in the second week of that month and drew up a classified document. Information on the disease outbreak was not in the public domain at that stage — and was known only apparently to the Chinese Government.

US intelligence informed the Trump administration, "which did not deem it of interest," but the report said the Americans also decided to update allies with the classified document: NATO and Israel, specifically the Israeli Defence Force. The network said Israeli military officials later in November discussed the possibility of the spread of the virus to the region and how it would affect Israel and neighbouring countries. The intelligence also reached Israel's decision makers and the Health Ministry, where "nothing was done," according to the report.

There is some independent open source support for the view that COVID-19 was active in Wuhan in the autumn in an analysis of commercial satellite data conducted by the Computational Epidemiology Laboratory at Boston Children's Hospital that showed marked spikes in activity at the five major hospitals in the city and indications of a possible link with a spike in respiratory infections.

The Critical Week: 30 December to 5 January

At the time of writing, it is not known whether any NATO allies took up the matter and passed on assessments to governments and according to the UK Government the first communication to the health minister, Matt Hancock, was

not until 3 January. He spoke to ministry officials on 6 January, received advice from the UK Health Security Team and spoke to Mr Johnson on 7 January after he had returned from a 10-day Caribbean holiday. Mr Hancock later updated parliament on 23 January when, according to a government statement, the risk level of a pandemic was "Very Low" and remained at that level through to 29 January when it was raised to "Low", two days before the first reported case in the UK.

This contrasts markedly with developments elsewhere, especially over the period 30 December to 5 January, and not least in territories neighbouring China. Taiwan, for example was already treating the issue as a potentially substantial risk. According to its London representative, "Learning harsh lessons from the SARS crisis in 2003, the Government of Taiwan acted swiftly and established a central command centre in order to respond to the outbreak. Taiwan's health minister held press conferences almost every day to provide updates and information. Tests on travellers from Wuhan, the Chinese city where the outbreak started, began in December.

Hong Kong was also fully engaged at an early stage. By the time Mr Hancock in London had spoken to officials on 6 January and spoken to Mr Johnson on 7 January the Hong Kong authorities were already treating the risk of a major new disease outbreak as a threat requiring immediate responses.

On 3 January the Government of Hong Kong issued a notice reporting that a cluster of 44 viral pneumonia cases of unknown cause in the city of Wuhan had been recorded, with 11 in a serious condition. Because of this the Centre for Health Protection had enhanced surveillance from 31 December and stated that:

> **“Doctors are requested to report to the CHP if they encounter patients with fever and acute respiratory symptoms, or pneumonia symptoms; and who had visited Wuhan (regardless of whether they have visited wet markets or seafood markets there) within 14 days prior to the onset of the illness.”**

It also announced that a dedicated web page had been set up and that additional thermal imaging had been set up at Hong Kong International Airport dedicated to checking body temperatures of arrivals from Wuhan and

> **“Additional manpower has also been assigned to Hong Kong West Kowloon Station of the Guangzhou-Shenzhen-Hong Kong Express Rail Link for checking body temperature of inbound travellers. Those with relevant symptoms and travel history will be immediately referred to public hospitals for isolation, treatment and follow-up.”**

The following day the Government issued a further notice, this time from the hospital authority announcing the activation of Serious Response Level in public hospitals with immediate effect and launched its Preparedness and Response Plan for Novel Infectious Diseases of Public Health Significance. Measures were announced to enhance monitoring and infection control in public hospitals and clinics with immediate effect and frontline healthcare staff “have been reminded to pay special attention to patients' clinical information, including the presentation of fever and acute respiratory illness, or pneumonia, and travel history to Wuhan within 14 days before onset of symptoms.” In an indication of the authorities’ concern:

> **“The spokesperson also stressed that any suspected case will be isolated in negative pressure isolation room for treatment with urgent laboratory investigation will be arranged immediately”.**

The press release also laid down procedures for more stringent infection control measures, including severe restrictions on hospital visits, and also set out requirements for the use of personal protection equipment (PPE) including N95 masks, confirming that “the current stockpile is adequate for three months’ consumption.”

The public impact of these measures in Hong Kong itself may have been low but this is not surprising in view of the ongoing public protests and political upheavals but they demonstrated the considerable concern of health professionals at the risk of a major disease crisis.

Implications

Thus, as early as 5 January, it was evident that at least two administrations, Taiwan and Hong Kong, were greatly concerned about the Wuhan outbreak, and had certainly been aware of developments since late December, but the UK Prime Minister was not even informed of it until 7 January. This was in spite of clear government statements about the serious risk of respiratory pandemics and claims that the UK was a world leader in biosecurity strategy.

Perhaps most surprising is that even on 7 January the issue was already in the public domain in the UK. On that day, *New Scientist* published online a report from one of its writers, Jessica Hamzelou who covers biomedical sciences, that reported on the emerging story even to the extent of including a direct link to the Hong Kong Hospital Authority press release cited above.

By 13 January the WHO was warning of human-to-human transmission risk. This was confirmed by China's health ministry the following day and that the virus had spread across the country. On 23 January a complete lockdown of the whole of Wuhan province was enacted and on the following day *The Lancet* published the first detailed report on the clinical features of the infection. Meanwhile the first case was reported in Thailand on 13 January, in Japan on 16 January and in South Korea on 19 January. On 20 January came the first news of health-care workers being infected after caring for COVIS-19 patients and on 24 January 835 cases were reported in China, 549 from Hubei province and 286 from elsewhere. On Friday 24 January the UK Government finally called a meeting of the COBRA emergency committee but this would not meet until 27 January and Mr Johnson did not attend.

The first clear indication of his approach to the issue came in a major policy speech in Greenwich on 3 February following Brexit, his one mention being a clear reminder of the dominant importance of free trade and economic growth over pandemic risks:

> **“…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.”**

Shortly after the speech the Prime Minister took a further 12-day break from Downing Street and did not attend four meetings of the COBRA emergency committee.

This theme of the centrality of economic growth in relation to health issues continues to be a major feature of the debate on government policy as

reflected in the demands that the lockdown be eased at an early stage, a position that is even more strongly advocated in the United States.

Questions

This preliminary analysis of the UK Government's initial response to the COVID-19 pandemic raises a number of questions. How and when was the Government informed by intelligence, diplomatic and other sources of the nature and extent of the outbreak and of the early responses of governments such as Hong Kong and Taiwan? Press reports in government-supporting newspapers such as the *Daily Mail* have suggested that MI6 kept the Government fully informed of developments, although neither source nor specific dates were given. If these are accurate, though, when did the Government receive such information and how did it act on it?

The UK is a key member of NATO, including staff in senior leadership roles, and is also part of the five eyes intelligence consortium along with the United States, Australia, Canada and New Zealand. If NATO was informed of the outbreak in November, as US and Israeli sources have indicated, did NATO act on it and, if so, how? Why was the UK Government so slow to respond to the emerging crisis and why did the Prime Minister, as head of government, take such a back-seat role when a Tier 1 emergency was developing and was recognised as such by the Hong Kong Government and others?

Finally, how do these early failings relate to the political environment at the time which appears to have prioritised economic growth over risk to health? That is an issue of current controversy over the question of accelerating the easing of lockdown to limit further damage to the economy against the risk of stimulating a second COVID-19 wave.

Caveat

This preliminary analysis can be countered by the argument that it is all with the benefit of hindsight and that such criticisms are therefore easy to make. The problem with this response is that the Government had in place the National Biological Security Strategy and claimed to be world-leading in this regard. This has clearly not proved to be the case. Furthermore, by early January there was already abundant evidence as to the challenge posed by the emerging infection that was immediately recognised in Hong Kong and Taiwan yet there does not appear to be evidence that this had any influence on government.

Conclusion

COVID-19 is having a devastating impact on health and well-being across the world and is the greatest challenge to human security for half a century. While there has been much discussion over how Britain, with a well-developed health system, has responded so slowly to the pandemic, most of this has concerned responses from the end of February onwards. This analysis argues that this is inadequate if a full understanding of political motivation and behaviour is to be sought. That is more likely to emerge from consideration of a wider timescale, with the period from November through to the end of January being highly significant and may help explain the contrast between expectations and outcomes.

The UK has now experienced a 20% decrease in GDP in March and April and is entering the deepest recession in three hundred years. There have been over 40,000 deaths of people tested positive for the virus, at least 10,000 more who were not tested, and excess deaths are already over 63,000. Poorer

people are much more likely to die from COVID-19 and there have been disproportionate deaths among the BAME population. Lockdown is now being eased before the pandemic is fully under control and there are serious concerns over the high risk of a second wave through the autumn and winter. There are fears that this potentially would result in even more suffering and an eventual death toll in excess of 100,000.

The UK Government was confident six months ago that it was well prepared for a pandemic, yet it is abundantly clear that this was not the case, with its responses all too often being too little, too late. This has been despite the best efforts of millions of people and especially the courage of health and care workers. In the circumstances it is essential that lessons are learnt now by establishing an urgent public inquiry capable of producing an initial report within weeks. That might help limit an even greater catastrophe.

Author's Note: *Thanks to Alasdair McKay, Malcolm Dando and Lee Chadwick for assistance with this report.*

Image credit: Number 10/Flickr.

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