IN THE HIGH COURT OF JUSTICE **CO/2123/2020**
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

BETWEEN:

THE QUEEN
(on the application of
(1) DR CATHY GARDNER
(2) FAY HARRIS)

Claimants

- and -

(1) SECRETARY OF STATE FOR HEALTH AND SOCIAL CARE
(2) NHS COMMISSIONING BOARD (NHS ENGLAND)
(3) PUBLIC HEALTH ENGLAND

Defendants

CLAIMANTS' SKELETON ARGUMENT
For substantive hearing, 19-22 October 2021

I. INTRODUCTION AND SUMMARY

1. Between March and June 2020, more than 20,000 elderly and/or disabled care home residents in England and Wales, including the fathers of both of the Claimants, died from Covid-19.[1] The care home population was known to be uniquely vulnerable to being killed or seriously harmed by Covid-19. The Government's failure to protect it, and positive steps taken by the Government which introduced Covid-19 infection into care homes, represent one of the most egregious and devastating policy failures in the modern era.

2. This claim is a legal challenge to the Government's failure to protect care home residents and to the key policies and decisions which led to the shocking death toll. The most notorious of these policies is that of mass discharge of around 25,000[2] elderly and/or disabled patients from NHS hospitals into care homes – including the homes of the Claimants' fathers – without Covid-19 testing or ensuring that suitable isolation arrangements were in place. That policy has been described by the House of Commons Public Accounts Committee as "*reckless and negligent*" and "*appalling*".[3]

[1] See the Office of National Statistics data-sets referred to in ASFG §§33-35.

[2] See ASFG §89, quoting from the National Audit Office Report, "*Readying the NHS and adult social care in England for COVID-19"* (12 June 2020), §16.

[3] *Readying the NHS and social care for the COVID-19 peak* (HC405), §10; also Claimants' Reply §§4-5.

3. The Claimants submit that in a number of respects the Defendants unlawfully failed to protect care home residents from the three principal routes of transmission of Covid: infection by other residents, by external visitors to care homes, and by care home staff.

4. Six particular acts, decisions and/or policies have been challenged: (a) '*Guidance: Coronavirus (COVID-19) – Guidance on Residential Care Provision – Public Health England'* ("**the March PHE Policy**") issued on 13 March 2020 and in force until 6 April 2020;[4] (b) *'Next Steps on NHS response to Covid-19'* ("**the March NHSE Instruction**") and '*COVID-19 Hospital Discharge Service Requirements*' ("**the March Discharge Requirements**"), dated 17 and 19 March 2020 and together referred to as "**the March Discharge Policy**", which directed the mass discharge of hospital patients into (*inter alia*) care homes; (c) *'Admission and Care of Patients during COVID-19 Incident in a Care Home'* ("**the April Admissions Guidance**"), dated 2 April 2020; (d) *Adult social care action plan'* ("**the April Action Plan**"), dated 15 April 2020, by which D1 commenced the reversal of previous policies; (e) '*Support for Care Homes*' dated 15 May 2020 ("**the May Support Policy**"); and (f) '*Admission and care of residents in a care homes during Covid-19'* dated 19 June 2020 ("**the Revised June Admissions Guidance**"). Of these, only the March NHSE Instruction was formally adopted by D2; but the evidence shows that D2 was largely responsible also for the March Discharge Requirements and for key elements of the April Admissions Guidance and the April Action Plan.

5. The Claimants submit that these acts, decisions and policies (for convenience, "**policies**"), both individually and taken together, constituted a breach of the Defendants' systemic and operational duties under Article 2 ECHR, incorporated by the Human Rights Act 1998 ("**the HRA**"), *"to take all steps reasonably necessary to avoid the risk"* (***Rabone v Pennine Care NHS Trust*** [2012] 2 AC 72, §42) and/or *"all reasonable measures which could have had a real prospect of avoiding the deaths*" (***R (Long) v Secretary of State for Defence*** [2015] EWCA Civ 770, §32). As the former Secretary of State for Health ("**SoS**") recognised, it had been clear "*from the earliest days of this crisis ... that people in social care were uniquely vulnerable*" (ASFG §15) and that their safeguarding required that a "*protective ring*" around care homes be established.[5] The Claimants submit that the very opposite in fact occurred and that there were reasonably available measures which could and should have been taken, including for example: testing of discharges before admission to a care home (which was only provided for in the April Action Plan); isolation of discharges before or after admission (prior to the April Action Plan, only isolation of those with symptoms of Covid-19 was required); the giving of appropriate instructions to care homes as to wearing of personal protective equipment ("**PPE**") (instructions were manifestly insufficient until at least 12 April); restrictions on visits to care homes (not advised until 2 April); and instructions against the movement of staff between homes (no action taken until the May Support Policy). Moreover, positive steps were taken, including the March Discharge Policy and the issue of inaccurate instructions regarding the care of individuals who could be infected with Covid-19, which increased the risk of death to care home residents. Given the known vulnerability of care home residents, the Claimants submit that a precautionary approach should have been adopted in

[4] Complaint is also made to the maintenance in force, until the March PHE Policy, of its predecessor, *Guidance for social or community care and residential settings on COVID-19* ("**the February PHE Policy**").

[5] https://twitter.com/skynews/status/1261329991708684294?lang=en

respect of care homes from the very beginning. In fact, the Defendants' evidence is that a precautionary approach was only adopted "*over the course of April*" 2020 (see Hopkins 1 §26) which was, tragically, far too late.

6. For similar reasons, the Defendants' policies amounted to breaches of Article 8 ECHR. They also breached Article 14, because they had a disproportionately prejudicial effect on the elderly and the disabled, which was not objectively justified. The Claimants submit that the Defendants' relevant decisions were taken in breach of their public law duties, including as a result of a failure to have regard to relevant considerations, irrationality and lack of transparency. The Claimants finally submit that the Defendants' actions also amounted to indirect discrimination against the predominantly elderly and disabled residents of care homes, contrary to s. 29 Equality Act 2010 (**"EA10"**) and breached the public sector equality duty in s. 149 EA10. They seek declarations as to the unlawful conduct of the Defendants.

7. Permission for judicial review was granted on all grounds by Linden J on 19 November 2020, rejecting arguments by the Defendants (*inter alia*) that the claim represented an illegitimate attempt to pre-empt a public inquiry into their handling of the pandemic and that the Claimants had no standing to complain about anything other than the immediate facts surrounding the deaths of their fathers.

II. THE LEGAL FRAMEWORK

The ECHR challenges

8. The Defendants have a positive obligation "*to take appropriate steps to safeguard the lives of those within [England]*," which duty requires the State to do "*all that could have been required of it*" to prevent life from being avoidably put at risk: ***LCB v UK*** (1999) 27 EHRR 212 at §36. This responsibility ranks "*among the highest priorities of a modern democratic state governed by the rule of law*" (***R (Middleton) v West Somerset Coroner*** [2004] 2 AC 182, §5). The relevant positive obligation has been analysed as comprising two limbs: (i) the 'systems' duty, to put in place a legislative and administrative framework designed to protect against risks to life; and (ii) the 'operational' duty, to take practical steps to safeguard people's right to life from specific dangers in circumstances where there is a link to the State's responsibility: ***Rabone***, §§12, 16. The Claimants submit that both duties applied here, and are overlapping and complementary. The Defendants were also subject to a 'negative' duty not to act or implement policies which would expose those within the jurisdiction to a significant risk of a breach of their Article 2 rights: ***R (Munjaz) v Ashworth Hospital*** [2006] 2 AC 148 at §§29 and 80.

The systems duty

9. The systems duty arises "*in the context of any activity, whether public or not, in which the right to life may be at stake.*" It requires the State to "*put in place a legislative and administrative framework designed to provide effective deterrence against threats to the right to life*", and (materially) to "*make regulations compelling institutions, whether private or public, to adopt appropriate measures for the protection of people's lives*": ***Tănase v. Romania*** App no. 41720/13 (ECtHR, GC,

25 June 2019), §135.[6] The requirement for such measures to be "*effective*" and "*appropriate*" entails a substantive review by the Court of the sufficiency and satisfactoriness of the measures: see ***Öneryildiz v Turkey*** (2005) 41 EHRR 20, §§97-110, ***Budayeva v Russia*** (2014) 59 EHRR 2, §§147-160, ***Brincat v Malta*** App No. 60908/11 and others (24 July 2014) §§103-117, ***Vilnes v Norway*** App No. 52806/09 22703/10, §§219-245; and, in the domestic sphere, ***R (Long) v Secretary of State for Defence*** [2015] 1 WLR 5006, §§19-33.

10. It appears to be common ground in this case that the systems duty applies. The Defendants, however, mischaracterise the content of the duty. The submission they make is that all that is required is for the Defendants to put in place <u>*a*</u> system (i.e. any system, even an unreasonable one), and that any question as to whether that system was "*effective*" and "*appropriate*" falls to be considered only under the operational duty (below).[7] That submission is wrong. Where there is a systemic flaw in the approach taken, such that the system put in place is not "*effective*", the systems duty will be breached. See, for example, ***Long***, in which Article 2 was found to have been breached by a decision within the chain of command not to follow an order that all military patrols in Iraq should be equipped with an iridium satellite phone, leading (at least arguably) to the deaths of a Royal Military Police patrol at the hands of a mob. As the Court of Appeal held, at §29, "*this is a case of **systemic** insufficiency of control and not mere negligent control by an individual*" (emphasis in original, see also §68).[8] This dictum identifies the category of case that will <u>not</u> give rise to a breach of Art. 2 duty, namely where the harm is a result of mere negligence by an individual. See also (e.g.) ***Budayeva***, in which a breach of the systemic duty was found after a detailed analysis of sufficiency of the mechanisms in place for alerting citizens to mudslides; ***Brincat***, concerning the Maltese Government's approach to asbestos exposure, and ***Vilnes***, for a similarly detailed assessment of measures in place in Norway to protect petroleum divers.

The operational duty

11. It is common ground in this case that "*three key factors must be present in order for the Article 2 operational duty to apply: (i) a real and immediate risk to life; (ii) actual or constructive knowledge of the State of the risk; (iii) a sufficient connection or link with the responsibility of the State*" (D1/D3 DGR §47). Those criteria are drawn from ***Rabone and another v Pennine Care NHS Trust*** [2012] 2 AC 72. Giving the leading judgment in that case, Lord Dyson *inter alia* set out those criteria (at §12); and explained that the test for the existence of such a risk is not whether there "*had to be a "likelihood or fairly high degree of risk*"", finding (at §§35, 38) that a 10-20% risk (in that case, of suicide) was a "*substantial or significant risk and not a remote or fanciful one*", sufficing for the duty to arise (at §41). There need only be "*a sufficient risk … for protective measures to be needed*" (***R (TDT) v Secretary of State for the Home Department*** [2018] EWCA 1395, per Underhill LJ at §46).

[6] See further, as to the application of these in the context of healthcare: e.g. ***Calvelli and Ciglio v Italy*** App. No. 32967/96, 17 January 2002, Grand Chamber at §§48-50; ***Lopez de Sousa Fernandes v Portugal*** App. No. 56080/13, Grand Chamber at §§164-67.

[7] D1/D3 DGR §§44-46; D2 DGR §§88-90.

[8] For much the same reasons as in ***Long***, the distinction drawn in D2 DGR §90 between breaches of the systemic duty and negligent healthcare provision by an individual does not avail the Defendants in this case.

12. The link to state responsibility will be particularly obvious where the relevant individuals are detained or otherwise under the control of the state, as is in fact the case with a substantial numbers of care home residents (see ASFG §19). However, the operational duty will, in appropriate circumstances, be engaged in respect of large groups of individuals who are not under such control: see e.g. the judgment of the Grand Chamber in ***Öneryildiz v Turkey*** (2005) 41 EHRR 20, §§98, 101 (risk to "*inhabitants of certain slum areas of Ümraniye*" living in the locality of a rubbish dump); ***Stoicescu v Romania*** (App. no. 9718/03, ECtHR, 26 July 2011) (risk to residents of the City of Bucharest arising from potential attack by packs of stray dogs – which was decided under Article 8 ECHR, and illustrates the protective obligations imposed by other ECHR articles).[9]

13. Once the duty is engaged, the test for breach is whether the state took "*all steps reasonably necessary to avoid the risk*" (***Rabone***, §32) or "*such preventive operational measures as [are] necessary and sufficient to protect*" the threatened individuals: ***Öneryildiz***, §101. This involves a detailed enquiry: see e.g. ***Richards*** at §§45-63 (in particular §63, where the Court concluded from a close analysis of the defendant's evidence that the defendant had not demonstrated that, in taking steps to discharge the operational duty, it had set a clear objective, by reference to an accurately articulated understanding of what outcome needed to be secured and by when, and then working out what steps would achieve that objective). As Fordham J also noted in §63 of ***Richards***, the burden of proof that the steps required by Article 2 have been taken is on the defendant.

14. D1/D3's pleading is unclear, but appears to accept that if analysed "*from first principles*", the operational duty arises at least in respect of "*some*" of the facts of the case (DGRs §§48, 51). That apparent admission is plainly correct (see ASFG §§165-169) but the Defendants make three points to seek to avoid it, none of which have merit. **First**, it is suggested that the courts have placed a 'definitional' "*additional limitation*" on the operational duty, that it should not be owed "*to ... a broad and indeterminate category of people*" (§§48-49). This is incorrect. There is no authority to that effect and none is cited. D1/D3's real argument is that the duty should not *in principle* be owed to "*anyone living in a care home*", on the basis that that is a broad class. However, as they accept, the Strasbourg Court has applied the operational duty to broad classes of people, in ***Öneryildiz*** and (on their case) ***Budayeva.***[10] Residents of care homes are evidently an identified and identifiable group: not least as it was in respect of that group that several of the policies under challenge were made. It has indeed been stated that the operational duty should be interpreted "*in a way which does not impose an impossible or disproportionate burden on the authorities.*" That is the basis and justification for the three criteria set out in ***Rabone*** at §12. It is not a mandate for a first instance Court unilaterally adding to those well-established criteria, which have been approved at the very highest level.

15. **Second**, it is suggested by the Defendants that there is a *lex specialis* applicable to "*healthcare provided to vulnerable people in the care of the state*", such that an operational duty only applies in respect of such individuals in tightly defined circumstances (D1/D3 DGRs §50, D2 DGRs §§90-92), relying upon ***R (Maguire) v HM Senior Coroner for Blackpool*** [2021] QB 409. The case-law

[9] There is a substantial overlap between the positive obligations under Articles 2 and 8: ***R (Richards) v Environment Agency and anr*** [2021] EWHC 2501 (Admin) at §42.

[10] For this reason, D2's reliance on the 'mirror principle' (D2 DGR §87) is, on their own case, misconceived. See in any event ***Rabone*** at §§111-113.

relied upon is not in point – it concerns individual cases of medical treatment whereas the present case is concerned with a range of alleged failures to take appropriate protective measures in response to a public health threat. As with the systemic duty (***Long*** *et al*, above), the operational duty will not apply to isolated acts of medical negligence. However the cases do not state any proposition that if a case arises in a 'healthcare' context, the operational duty is otherwise displaced or limited.[11] Further, on proper analysis the present case is not a 'healthcare case'. **Third**, it is suggested that the Defendants did not have actual or constructive knowledge of relevant risks until particular points in time (D1/D3 DGRs §51). This is a question of fact, which is addressed below (§§31-50).

The margin of review

16. The appropriate approach to the Court's review is set out in ***Stoicescu*** at (§59):

> "*…In assessing compliance with Article 8, the Court must make* ***an overall examination of the various interests in issue, bearing in mind that the Convention is intended to safeguard rights that are "practical and effective".*** *This is also true in cases where a general problem for the society reaches a level of gravity such that it becomes a serious and concrete physical threat to the population.* ***The Court must also look behind appearances and investigate the realities of the situation complained of.*** *That assessment may also involve the conduct of the parties, including the means employed by the State and their implementation. Indeed, where an issue in the general interest is at stake, which reaches a degree of gravity such that it becomes a public health issue, it is incumbent on the public authorities to act in good time, in an appropriate and consistent manner…*" (emphasis added).

17. An allegation of breach of Article 2 "*must be treated with great seriousness*" (***Middleton***, §5) and, as under the common law, the Court will apply "*the most anxious scrutiny*" (***R v Secretary of State for the Home Department, ex parte Bugdaycay*** [1987] AC 514, 531 per Lord Bridge).

18. There is a margin of discretion applicable to a considered judgment of a decision-maker, in particular in the circumstances of the pandemic. As recognised in ***Richards***, the decision-maker has "*latitude involving the exercise of judgment and appreciation in (a) appraising a situation, (b) conducting a suitable enquiry and (c) identifying appropriate steps*". The Claimants do not of course dispute that the relevant margin is widened by the unusual and pressing circumstances of the pandemic. However (i) ultimately, it is for the court to decide whether or not the Convention rights have been breached; (ii) where the decision-maker has exercised conscientious scrutiny concerning the matters at issue in the case, the margin of respect or judgment given to the decision may be broader; conversely, if – as the evidence in the present case appears to show – a decision-maker has *not* addressed his or her mind to a particular matter, or if the account given is an *ex post facto* one, the margin given will lessen or vanish: ***Belfast City Council v Miss Behavin' Ltd*** [2007] 1 WLR 1420 at §§46-47, ***Re Brewster*** [2017] 1 WLR 519 at §§50-52; (iii) the existence of a margin of discretion does not affect the Court's obligation to assess in detail the factual and evidential material put forward by the Defendants and to decide whether the Defendants adopted all reasonably available protective measures in respect of a population which they had, from the start, recognised

[11] And even were the Defendants correct, the State's awareness of shortcomings, and knowing endangerment of care home residents, would satisfy the criteria set out in D1/D3 DGRs §50.

as particularly vulnerable to Covid-19. See, for examples of the rigorous approach which is required notwithstanding the margin of discretion: ***Öneryildiz***, §107; ***Long***, §§28-31; and ***Richards***, §63.

Article 14 ECHR

19. Article 14 is also triggered in the present case because the Defendants' actions had a disproportionately prejudicial effect upon the elderly and disabled, who comprise the great majority of care home residents. Those actions were – subject to justification – indirectly discriminatory contrary to Article 14, on the basis of the well-established test in ***DH v Czech Republic*** (2008) 47 EHRR 3, §175; explained in ***R (Stott) v Secretary of State for Justice*** [2020] AC 51 at §8.

<u>The domestic public law challenges</u>

20. The context for the public law challenges is the "*anxious scrutiny*" which must be applied to allegations of breach of the right to life, and the need for a precautionary approach in the face of risk to life. The law on these grounds may be shortly set out:

    a. The decision-maker is obliged to take into consideration only relevant matters, and to exclude "*matters that were irrelevant from what he had to consider*": ***Secretary of State for Education and Science v Tameside MBC*** [1977] AC 1014, 1064-1065. Irrelevant considerations include those which are not logically material to the decision at issue: e.g., ***R v Secretary of State for the Home Department ex p Venables*** [1998] AC 407; ***R v Tower Hamlets ex p Chetnik Developments Ltd*** [1988] AC 858 at 879.

    b. The decision-maker must further *"take reasonable steps to acquaint himself with the relevant information to enable him to [make the decision] correctly"*: ***Tameside***, *ibid*. That obligation "*includes the need to allow the time reasonably necessary, not only to obtain the relevant information, but also to understand and take it properly into account*": ***CPRE Kent v Dover DC*** [2018] 1 WLR 108, §62. The "*wider the discretion conferred on the Secretary of State, the more important it must be that he has all relevant material to enable him properly to exercise it*": ***R (Plantagenet Alliance) v Secretary of State for Justice and others*** [2014] EWHC 1662 (QB), §100(6).

    c. There are two aspects to public law rationality: (a) whether the decision is outside the range of reasonable decisions open to the decision-maker, and (b) "*[a] decision may be challenged on the basis that there is a demonstrable flaw in the reasoning which led to it – for example, that significant reliance was placed on an irrelevant consideration, or that there was no evidence to support an important step in the reasoning, or that the reasoning involved a serious logical or methodological error*": ***R (Law Society) v Lord Chancellor*** [2019] 1 WLR 1649, §98.

    d. The principle of transparency requires that "*public bodies ought to deal straightforwardly and consistently with the public*": ***Nadarajah v Secretary of State for the Home Department*** [2005] EWCA Civ 363 at §68, and requires *inter alia* that public utterances be clear, certain and transparent: ***R (Limbu) v. Secretary of State for the Home Department*** [2008] EWHC 2261 (Admin), §§65-69; ***R (Oboh) v. Secretary of State for the Home Department*** [2015]

EWCA Civ 514, §§28-32; ***R (Richmond Pharmacology Ltd) v The Health Research Authority*** [2015] EWHC 2238 (Admin), §§48, 77, 86; ***R (Justice for Health Ltd) v Secretary of State for Health*** [2016] EWHC 2338 (Admin), §§128-150; ***R (Hutchinson and others) v Secretary of State for Health and Social Care and anr*** [2018] EWHC 1698 (Admin), §§116-135.

21. As is implicit in the above, each of these grounds is to be considered on the basis of the actual reasoning process of the decision-maker. The views or knowledge of civil servants are irrelevant, unless communicated to the decision-maker: ***R (National Association of Health Stores) v Department of Health*** [2005] EWCA Civ 154 at §73, ***Revenue and Customs Commissioners v Tooth*** [2021] 1 WLR 2811 at §70. As it was put in the latter case, *per* Lord Mance DPSC, "*[t]here is no principle of collective knowledge within a department.*" It is for this important reason that the Claimants have been pressing, thus far unsuccessfully, for (a) disclosure of the materials considered by the relevant decision-maker prior to deciding to adopt each of the policies under challenge, and (b) (in the case of D1/D3) confirmation of which among the documents disclosed by the Defendants are said to have been considered by the relevant decision-maker.[12]

22. The relevant law in relation to the EA10 challenges is explained in §§91-96 below.

III. THE DEFENDANTS' APPROACH TO THEIR EVIDENCE

23. The Defendants' evidence runs to hundreds of pages, but is deeply unsatisfactory. The Defendants' witness statements are admitted not to be primary evidence of fact, but rather "*are, and are designed in nature to be, corporate. They are deliberately designed in that way so that they draw on sources of documentation some, or many, of which may not necessarily be subjects to which the businesses can themselves speak from personal recollection or knowledge.*"[13] They are effectively statements of 'departmental position'. Broad and unspecific statements, often in the passive, abound.[14] Many of these statements emanate from a witness (Mr Surrey) whom, the Defendants have now admitted, was *not even in post* at the time of many of the events he purports to describe.[15] There has been no

[12] This was also, in part, to assist in reducing the documentation before the Court. In the event, D1/D3 declined to answer the question or to provide any other assistance in identifying superfluous documents from amongst those they had disclosed.

[13] Transcript of hearing before Eady J, 25 August 2021, p.31G.

[14] E.g. Surrey 2 §§46 ("*Scientific understanding at the time was that transmission of the virus was greatest via symptomatic individuals in the first few days of symptoms, through close contact and droplets, not by airborne transmission*."), §48 ("*Although the possibility of asymptomatic transmission was noted early on in the pandemic, it was thought to be low due to low levels of asymptomatic transmission with similar respiratory viruses, although it could not be ruled out in its entirety*"), §53 "*It was on this basis that infection prevention and control advice was based on limiting and avoiding contact as well as decontamination of the environment*"), §72 ("*it was believed that the virus was not circulating in the community at this time*"); Dodge §89 ("*it was important for the NHS to ensure these issues were addressed*"), §107 ("*It was viewed as the appropriate, and only, realistic response to the incoming influx of Covid-19 patients at that time*"), §204 ("*On 5 April 2020 it was suggested that the same be done with care homes in other regions*.")

[15] Until 30 March 2020, Mr Surrey worked in the Department of the Environment, Food, and Rural Affairs. Mr Surrey's evidence prior to 30 March 2020 (and, one assumes, for some unspecified period thereafter, given the need to 'get up to speed'), is therefore (at best) hearsay based on information from (unnamed) third parties.

attempt to comply with the requirements of CPR PD32 §18.2, that the sources of the information relied on in these statements should be identified.

24. Notably, the Defendants have failed to identify or explain the material before the decision-makers when the decisions in question were taken, or the reasoning process of the decision-makers. In summary, as set out further below:

    a. D1/D3 have stated in correspondence that, in respect of each of the decisions under challenge, the decision-maker was the SoS personally (see GLD's letter of 15 September 2021).

    b. However, no documents have been disclosed recording the advice to SoS; the SoS's decision; any discussion preceding the decision or the reasons for the decision in respect of the February PHE Policy, or the March PHE Policy, and only very limited documentation, much of which doesn't consider the relevant issues, in respect of the March NHSE Instruction, the March Discharge Requirements, the April Admissions Guidance, and the April Action Plan. D1/D3 appear to have adopted an approach whereby the repositories of the key civil servant in D1's department, Ms Roughton, was not even searched for the relevant time period, on the basis that the application of keywords returned too many relevant documents (see Robertson §28.4).

    c. Thus far, the Defendants have also refused to disclose WhatsApp, text and private email messages which, according to public domain material, were a key conduit for advice to, and discussions with, ministers during March to May 2020 (Conrathe 2 §§77-89).

    d. Nor does the Defendants' witness evidence address candidly what material was before, or in the mind of, the decision-makers when making the decisions under challenge.

25. These comprise glaring lacunae in the Defendants' evidence which would be disturbing in a conventional judicial review claim. They are wholly unacceptable in a claim raising issues, including factual issues, with reference to Article 2 ECHR and challenging decisions which at the very least contributed to the deaths of tens of thousands of vulnerable individuals (for the correct approach to factual issues in a case such as the present, see ***R (Al Sweady) v Secretary of State for Defence (No 2)*** [2010] HRLR 2).

26. The Claimants have sought and been refused (by Eady J) disclosure of the materials which were before the decision-makers at the relevant time and the opportunity to cross-examine the Defendants' witnesses. As the Defendants have been unwilling to disclose primary documentation, the Claimants have instead pressed for further explanation of these matters, referring to the duty of candour (as explained, for example, in ***R (Citizens UK) v Secretary of State for the Home Department*** [2018] 4 WLR 123, §106) and the ***Health Stores*** principle (see §21 above):

    a. In correspondence of 7 September 2021, the Claimants asked each of the Defendants to identify the documents already disclosed which were relied upon as evidencing the consideration by the decision-makers of the various matters referred to in the evidence. The Court is respectfully asked to read that letter in full.

b. In response, D1/D3 have refused (in correspondence of 17 September 2021) to provide that information. They purported to misunderstand the 7 September 2021 letter as a request for further disclosure. They then asserted that they "*have referred to all the documents we rely on in our description of the decision-making process in the witness statements we have filed,*" without even attempting to distinguish what of that material was before the decision-maker (and so relevant) and what was not before the decision-maker (and so irrelevant). They characterised the Claimants' pursuit of clarity in regard to what materials were before the decision-makers as "*an extremely unreasonable diversionary tactic*".

c. In that correspondence, D1/D3 have expressly admitted that "*the decision-making process was not based on formal submissions setting out all the considerations and supporting documents*." This appears to comprise an admission that much of the material said by D1/D3's witnesses to be relevant to the policies under challenge was not before the decision-maker (the SoS), whilst refusing to say what was and what was not. Contrary to the position of D1/D3, the absence of a formal ministerial submission in relation to any particular decision does not exhaust the duty of candour but rather requires an account to be given of relevant, less formal communications with him.

27. D1/D3 have thus failed in their basic obligation to put the key relevant evidence before the Court. It is not sufficient to comply with the duty of candour to assert repeatedly what was not before the SoS, without being open about what advice (if any) he did receive and consider.

28. The Defendants have accepted that they will "*stand or fall on the quality of the explanation [they] have given in [their] statements*."[16] It is submitted that the explanations given are both short of quality, and fail to address the issues that the Court must consider to determine the case. In the circumstances, the Court is entitled to, and should, draw inferences against the Defendants as to the nature and extent of the information that was, in fact, before the decision-makers and as to whether the decision-makers did, as alleged, carefully weigh various competing considerations before deciding to adopt the policies under challenge, with all of the consequences that then ensued. See, for example, the approach approved in ***R (Das) v Secretary of State for the Home Department*** [2014] 1 WLR 3538, §80.

29. More generally, in resolving the various factual disputes which arise on the claim, the Court should adopt the approach recently enumerated by Linden J in ***R (NB and others) v Secretary of State for the Home Department*** [2021] EWHC 1489 (Admin), namely "*a common-sense approach to the evaluation of the evidence as a whole, applying the burden of proof and taking into account the fact that there has been no "live" evidence or cross examination. In my view, as part of this exercise it is permissible to take into account the quality of the evidence on a given point, and whether that evidence is within the knowledge of the deponent and, if not, the source of their information. In the case of exhibits, it is permissible to consider such evidence as the deponent provides to explain its contents and as to the source and reliability of the information which it contains*".

[16] Transcript of hearing before Eady J, 25 August 2020, p.32A.

IV. SOME MATERIAL FACTUAL MATTERS

Care home residents' unique vulnerability

30. Although it would appear to be common ground, it is important for the Court to understand the reasons why care home residents were known to be "*uniquely vulnerable*" to Covid-19 (ASFG §15):

    a. It was clear from an early stage that, due to their age and other health conditions, they were disproportionately likely to suffer serious symptoms from, and to die of, the disease (see ASFG §17, quoting a study dated 16 March 2020). For the UK population as a whole (i.e. including care home residents), the Infection Fatality Rate of Covid-19 ("**IFR**") has been estimated at 1.25% (and so the IFR for the population excluding care home residents will be lower). The IFR for care home residents was 35.9% (Gordon 2 §§124-127).

    b. An estimated two thirds exhibit behaviours associated with dementia (Gordon 2 §315, Chubb §7-9), are prone to "wander" and cannot be relied upon to practise social distancing. They may not be aware of, or be able to communicate, symptoms of illness (Gordon 1 §16c).

    c. UK care homes are physical environments that are particularly conducive to the rapid spread of Covid-19 if it enters the home (Chubb §6). Care homes are residential, not clinical, environments and are unsuited to rigorous infection control (Gordon 1 §25). Many homes do not have any healthcare professionals on-site (Gordon 1 §27-8). Only a minority of staff have any formal training in infection control at all (Gordon 2 §271, Chubb §11). The sector was (and was known to be) under-staffed and under-resourced (Gordon 2 §316, Chubb §10). During the period relevant to the claims, one in six care homes had been assessed as "*requires improvement*" or "*inadequate*" by the CQC (ASFG §20). The care homes least capable of providing safe care were those most likely to have, and be prepared to provide, beds to accept discharges without testing or protective isolation (Gordon 1 §26).

    d. Care homes did not have the PPE necessary to protect residents and staff in March-April 2020 (Gordon 1 §§35-38; Chubb §§28-30; also DB/1064). Shortages of PPE were even more acute in the care sector than in hospitals because, amongst other things, key supplies were "*held back or even 'requisitioned' for the NHS*" (ID1/98). The National Audit Office found that "*across all types of PPE over the period, trusts received 80% of their estimated requirement whereas social care providers received 10%*" (Conrathe 1 §42). The shortage of PPE is also attested to by those working in care facilities in the relevant period (Kendrick §§25-29, Gordon 1 §§35-38).

The Defendants' knowledge of pauci-symptomatic, pre-symptomatic and asymptomatic transmission

31. The Defendants contend that they did not have actual or constructive notice of the real risk of transmission of Covid-19 by the pauci-symptomatic (persons with mild symptoms, such that they would be unlikely to report or be observed as ill), pre-symptomatic (persons before onset of symptoms) or asymptomatic (persons who don't develop symptoms) (together, "**asymptomatic transmission**") prior to the April Action Plan on 15 April 2020. This is advanced as the justification

for, *inter alia*, the decisions (i) not to advise limiting visits to care homes until April 2020,[17] (ii) not to test admissions to a care home until 15 April 2020,[18] (iii) not to require admissions to care homes to be protectively isolated until 15 April,[19] (iv) not to recommend the use of PPE when caring for asymptomatic individuals until some point between April and June 2020,[20] and (v) not to recommend or enact restrictions on staff movement between care homes until 15 May 2020.[21] The heavy reliance that they place on this contention has led D1/D3 to characterise this matter as the "*underlying issue*" in this case (D1/D3 DGR §10).

32. Putting matters at their lowest, the Claimants submit that the evidence before the Court establishes that the Defendants had actual or constructive knowledge of the real risk of asymptomatic transmission by late February 2020, and on any view by the dates of the March PHE Policy, the Hospital Discharge Policy and the April Admissions Guidance. The evidence, which does not now appear to be seriously disputed, is set out at §§10-136 of Professor Gordon's second statement and in Professor Costello's statement, which the Court is invited to read in full. The following paragraphs highlight the principal evidence of asymptomatic transmission as it emerged from January 2020 onwards.

Chronology of evidence

33. As early as 18 January 2020, Sir Jeremy Farrar of SAGE was referring to asymptomatic transmission as a "*probability*" (Gordon 2 §20). On 28 January 2020, PHE produced a paper citing two examples of asymptomatic transmission but stating that the evidence was at that stage insufficient to conclude there was "*major asymptomatic transmission*" or asymptomatic/pre-symptomatic transmission "*on a significant scale*" (DB/725). There was no evidence against asymptomatic transmission, rather only limited evidence for it. SAGE's advice at this time was that there was limited evidence of asymptomatic transmission but "*early indications imply some is occurring*" (Gordon 2 §25).

34. On 4 February 2020 SAGE stated that "*asymptomatic transmission cannot be ruled out and transmission from mildly symptomatic individuals is likely*" (Gordon 2 §35). By mid-February 2020, scientific research supported "*the transmission potential of asymptomatic or minimally symptomatic patients*" (Gordon 2 §41, Costello 1 §10). On 24 February 2020 the Lancet reported a study indicating that two patients had tested positive "*a day before onset*" of symptoms, "*suggesting that infected individuals can be infectious before they become symptomatic*" (Gordon 2 §44**,** Costello 1 §11).

35. On 4 March 2020 a study of Chinese asymptomatic infections indicated that "*asymptomatic carriers can result in person-to-person transmission and should be considered a source of COVID-19*

[17] D1/3 DGR §39.

[18] D1/3 DGR §24(c), Surrey 2 §§177, 210, 237, 266-267; Miller §58.

[19] D1/3 DGR §§26(a), 26(f), D2 DGR §111(iii).

[20] Miller §125.

[21] D1/3 DGR §34(b)-(d), Surrey 2 §320, Miller §148.

infection" (Gordon 2 §53). On 6 March 2020 a further study stated that the evidence suggested that "*pre-symptomatic transmission is occurring*" (Gordon 2 §54, Costello 1 §13), and NERVTAG recorded the views of Professor Neil Ferguson of SAGE that WHO material "*highlighted that infectiousness seems to be just before and just after symptom onset*" (Gordon 2 §55). On 9 March 2020 Lord Bethell, a Minister in D1's department, stated to Parliament (Gordon 2 §62): "*Large numbers of people are infected and infectious but completely asymptomatic and never go near a test kit.*" On 12 March 2020, the European Centre for Disease Prevention and Control ("**the ECDPC**") published a report including extensive evidence of pre-symptomatic and asymptomatic transmission (Gordon 2 §66, Costello 1 §20).

36. On 13 March 2020, the date of publication of the March PHE Policy, the Government Chief Scientific Adviser (Sir Patrick Vallance) ("**the CSA**") publicly stated on the *Today* programme that "*[i]t looks quite likely that there is some degree of asymptomatic transmission. There's definitely quite a lot of transmission very early on in the disease when there are very mild symptoms*" (Gordon 2 §67). Also on 13 March 2020, the Defendants published guidance to the NHS for 'healthcare settings' ("**the March NHS Guidance**") stating that there "*have been case reports that suggest infectivity during the asymptomatic period*", and recommending that PPE should be worn when treating all patients at all times (Gordon 2 §§70, 223).

37. On 15 March 2020, a Columbia/Imperial paper on undocumented infection in China was published, noting that "*pre-symptomatic shedding may be typical among documented infections*" (Gordon 2 §74). Also on 15 March 2020, Professor Costello authored an article in *The Guardian* noting the Government's failure to take account of pre-symptomatic and asymptomatic infection in its policy response to Covid-19: "*asymptomatic contacts may be highly infectious, so they should be tested, isolated and followed up in the community*" (Costello 1 §24).

38. On 16 March 2020, the Defendants announced that those in the same household as a symptomatic case should isolate for 14 days ("**the 14 day household isolation policy**"). Both the CSA (Gordon 2 §85) and the SoS (Gordon 2 §77) explained that the purpose of the policy was to address the real risk of asymptomatic transmission. Also on 16 March 2020, the Imperial College COVID-19 Response Team (headed by Professor Neil Ferguson of SAGE and NERVTAG) published *'Report 9: Impact of non-pharmaceutical interventions (NPIs) to reduce COVID-19 mortality and healthcare demand*', authoritative modelling which was determinative in provoking the first "lockdown". The modelling was predicated on the proposition that there was significant pre-symptomatic and asymptomatic transmission of Covid-19 (see Gordon 2 §§80-83). Similar assumptions were incorporated in the SAGE modelling that formed the basis of the Defendants' decision-making.

39. On 17 March 2020, a study found that "*many asymptomatic persons were actually a source of SARS-CoV-2 infection but were considered healthy before they underwent screening*" (Gordon 2 §87). On 18 March 2020, a further study "*estimated that 44% of transmission could occur before first symptoms of the index*" and recommended that protective measures be adjusted to address *"probable substantial pre-symptomatic transmission"* (Gordon 2 §§88-89, Costello 1 §22). Also on 18 March 2020, a study by the US Centre for Disease Control and Management ("**the CDC**") of Covid-19 deaths in a care home in the United States identified "*difficulty identifying persons with COVID-19 based on signs and symptoms alone"* as a key risk factor in care home deaths (Gordon

2 §92). On the same day, the Prime Minister stated: *"the thing about this disease, it's an invisible enemy and we don't know who's transmitting it"* (Gordon 2 §91). Notwithstanding this acknowledgment, the March Discharge Policy was promulgated on 17 and 19 March 2020.

40. On 24 March 2020, PHE updated its paper on asymptomatic transmission (FSDB/167). It recorded several case studies and modelling papers containing evidence of asymptomatic and pre-symptomatic transmission, noting which was the "*most convincing*", and also noting that the modelling papers concluded there was "*substantial pre-symptomatic transmission*". On 25 March 2020, a note written by Dr Hopkins and Dr Hayward of SAGE stated that "*Current guidance is focused around health and social care workers in contact with known or suspected cases but wearing masks only during these exposures does not take account of the fact that patients may transmit prior to symptom onset"* (Gordon 2 §95). On 26 March 2020, Professor Yvonne Doyle of D3 stated that it was "*correct*" that "*people could be spreading the virus to others for up to five days before they show any symptoms"* (Gordon 2 §99**)**. On 26 March 2020, the Scottish Government issued guidance requiring that care home transfers should be subject to protective isolation for 14 days on transfer wherever they had contact with a Covid-19 positive case (Gordon 2 §97). The first "lockdown" regulations came into force in England on 26 March 2020.

41. On 27 March 2020, an updated version of the CDC study of Covid-19 deaths in a care facility in Washington State concluded that "*symptom screening could initially fail to identify approximately one half of SNF residents with SARS-CoV-2 infection*" (Gordon 2 §100); this study was specifically drawn to D3's attention three days later, prompting a comment that care homes were "*Lots of Little Diamond Princesses*" (DB/1451). On 30 March 2020, the Defendants published a Covid-19 public information and advice campaign that stated: *"anyone can spread it"* (Gordon 2 §101). On 31 March 2020, a further study found that "*between a third and a half of transmissions occur from pre-symptomatic individuals"* (Gordon 2 §102). Also on 31 March 2020, NHSE presented a paper to SAGE on transmission of coronavirus in hospital settings, which (i) noted that "*A key additional risk is transmission of coronavirus from non-diagnosed COVID-19 positive patients or staff, i.e. those who are asymptomatic or pauci-symptomatic",* and (ii) recorded that even acute NHS Trusts had not been able effectively to limit Covid-19 transmission within their facilities (Gordon 2 §§103-104).

42. On 1 April 2020, a further study found that there was a "*likelihood that viral shedding can occur in the absence of symptoms and before symptom onset"* (Gordon 2 §108). On 2 April 2020, the date of adoption of the April Admissions Guidance, the WHO published '*Coronavirus disease 2019 (COVID-19) Situation Report – 73'*, which reported that pre-symptomatic transmission of Covid-19 was established (Gordon 2 §109). On the same day, PHE updated its paper on asymptomatic transmission. The paper stated that evidence supported a "*reasonable assumption virus may be shed during the late incubation period*", and that "*available evidence to date suggests the possibility that some asymptomatic/pre-symptomatic transmission is occurring*" (FSDB/189). On 3 April 2020, PHE presented to NERVTAG on asymptomatic and pre-symptomatic transmission. The minutes confirmed that *"both pre-symptomatic and asymptomatic transmission are assumed in the SPI-M models*"; and stated NERVTAG's view that "*it was agreed that there is data of pre-symptomatic transmission (both direct and indirect, based on the models)*" (Gordon 2 §111-112).

43. The Claimants submit that there was sufficient evidence of asymptomatic transmission by the time of the March PHE Policy (13 March 2020) and that the Defendants knew or should have known that this posed, at the least, a real risk to vulnerable care home residents. The evidence was sufficient for the CSA to confirm this on the *Today* program on that date. By the time of the March Discharge Policy, the March NHS Guidance had addressed that very risk in advice to the NHS, the key modelling relied upon by the Government had been completed, relying heavily on the presence of such transmission and the household isolation policy had been adopted in order to address the risk. By the time of the April Admissions Guidance, D3 was publicly confirming the risk posed by pre-symptomatic transmission and important research on the issue of Covid-19 transmission within care homes had been published, confirming the inadequacy of a symptoms-based approach. The Defendants knew or ought to have known that without an effective "protective ring", care home residents were going to be at real risk of infection from persons entering their home who did not exhibit Covid-19 symptoms.

The Defendants' case on asymptomatic transmission

44. The Defendants' witness evidence, and case regarding actual or constructive knowledge of the risk of asymptomatic transmission is internally inconsistent and has recently been subject to a late, important, attempted change of position. D1/D3's pleaded case is (and remains) that "*until very late March or early April 2020, there was no firm scientific evidence to support asymptomatic transmission*" (D1/D3 §51(b)). D1/D3 assert that prior to mid-April 2020, there was not "*scientific consensus*" (D1/D3 DGR §10, Surrey 2 §210) as to the "*scale*" of asymptomatic transmission (Hopkins 1 §39), or "*major*" (Surrey 2 §46) asymptomatic transmission, or a certain "*amount*" of asymptomatic transmission (Hopkins 1 §24). The Defendants also go so far as to assert that the evidence was inadequate to show even the "*presence*" or "*existence*" of asymptomatic transmission (Surrey 2 §210), or that there was even "*a degree*" of asymptomatic transmission (Hopkins 1 §26), or that such transmission was "*possible*" (Dodge 2 §38), or that asymptomatic individuals "*might infect other individuals*" (Surrey 2 §266).

45. The principal evidence served by the Defendants on their actual or constructive knowledge of the risk of asymptomatic transmission was that of Dr Hopkins. See, in particular, §§25-26 of Hopkins 1:

> "*A substantial evidence base began to build from the beginning of April. This developed as follows…*
> *This new evidence was a gamechanger as it highlighted that staff and residents could be asymptomatic and potentially transmit infection. The advice that scientists gave to Government on risk in care homes was updated in light of the international and national studies. From the publication of the CDC Washington study onwards, PHE applied a precautionary approach, and over the course of April they began to advise that:*
>
> > *a. There is likely to be a degree of asymptomatic transmission of COVID 19 in care homes in both residents and staff.*
> >
> > *b. By the time a single asymptomatic case is identified in a home, the virus will probably already be circulating in the home amongst residents and staff…*"

46. Dr Hopkins' evidence was, therefore that: (i) D1/D3 did not consider that there was a substantial evidence base prior to April 2020, (ii) D1/D3 did not advise or apply a precautionary approach in respect of the risk of asymptomatic transmission until "*over the course of April*", and (iii) it was allegedly *"game-changing"* new evidence that emerged for the first time between 2 April and the decision in the 15 April Action Plan to introduce requirements for testing and protective isolation that caused the Government's *volte face* on these issues.

47. As to the case advanced in the DGRs and Hopkins 1, the Claimants submit:

    a. The DGRs and supporting evidence did not address the position in respect of pauci-symptomatic transmission at all. As Professor Gordon explains (Gordon 2 §13), as early as 4 February 2020, SAGE made clear that "*transmission from mildly symptomatic individuals is likely.*" By 25 February, it was warning of transmission from those with "*extremely mild symptoms*" (Gordon 2 §45). As Professor Gordon explains, it follows from this that the Defendant's policies as implemented until 15 April 2020, which principally or wholly relied on symptom-based screening of elderly and disabled, and which did not utilise testing or protective isolation, were always *"fundamentally flawed"* and inadequate.

    b. The only basis for D3's apparent doubts about asymptomatic transmission was an unevidenced assumption that Covid-19 would behave in the same way as SARS and MERS. Even by the time of the policies under challenge, D3's advice still referred to the SARS/MERS assumption (see FSDB/168). This was also erroneous: D3 knew or ought to have known that the evidence did not support this approach, and there was clear SAGE advice against it (Gordon 2 §32, Costello 1 §§3-7). The Defendants now appear to have disclaimed any reliance on the SARS/MERS assumption, at least from mid-February onwards (Hopkins 2 §12(a)), without addressing the inconsistencies between this and the contemporaneous documents.

    c. The publicly available evidence, as set out in Gordon 2, demonstrates that the Defendants had actual or constructive notice of a real risk of asymptomatic transmission long before mid-April 2020. There is no attempt in Dr Hopkins' evidence to explain the comments of the Chief Scientific Advisor on 13 March 2020, or indeed the NHS guidance published on the same day, both of which are flatly inconsistent with the case she advances. As for the supposedly *"game-changing"* evidence, very little of note emerged after the April Admissions Guidance (see Gordon 2 §§132-136, which analyse the evidence pointed to in Hopkins 1). The documentary evidence in fact indicates that the Defendants changed course in the April Action Plan, requiring testing and isolation of all new care home residents, because of the very high Covid-19 case numbers in care homes, rather than because of any new scientific evidence (ID1/843).

48. Following service of the Claimants' reply evidence, the Defendants filed a further witness statement of Dr Hopkins, seeking significantly to shift their position on actual or constructive knowledge of the risk of asymptomatic transmission. Dr Hopkins now argues that the Defendants were "*always aware of the risk*" of asymptomatic transmission (Hopkins 2 §3(2)), and asserts that the risk was considered and taken into account but was outweighed by other considerations on each occasion

when the Defendant failed to implement protective measures to address asymptomatic transmission. In particular, she now seeks to argue that, though the Defendants were always aware of this risk, the measures that would have protected care home residents (such as testing or protective isolation of all entrants to care homes) were not possible or would have been "*draconian*" and "*potentially harmful*" (Hopkins 2 §13(e)).

49. There are a number of fundamental difficulties with Dr Hopkins' further evidence. It is inconsistent with her own prior evidence,[22] without any explanation being offered for the differences between the two. Insofar as it is now suggested that various protective measures were considered on the basis of an earlier appreciation of the *"real risk"*, but were rejected following a "*nuanced balancing exercise*" (Hopkins 2 §13(f)), Dr Hopkins' evidence is materially deficient. No details of the suggested balancing exercise are provided. There is no explanation of who is said to have conducted it, when it was conducted, or why the relevant conclusion was reached. Perhaps most strikingly, Dr Hopkins does not refer to or exhibit a single document evidencing any such "*nuanced balancing exercise*". The Claimants have sought disclosure of such documents (refused), and invited the Defendants to identify any documents in their disclosure which evidence Dr Hopkins' new case (also refused).

50. With particular reference to the contention that the Defendants considered but rejected the measure of requiring temporary isolation of all entrants to care homes, on the grounds of this potentially causing *"grave harm"* to those isolated: (a) there is not a single disclosed document evidencing such consideration by the decision-makers (in particular, the SoS), and the Claimants do not accept that it took place; (b) no expert advice on this issue been disclosed or even referred to; (c) if it really had been decided that the risks posed to an individual by 10 days of isolation in a single room was of greater weight than the risk of causing a Covid-19 outbreak throughout the care home to which they were to be admitted, that momentous decision would surely have been documented; (d) the proposition is plainly flawed and irrational; and (e) it is inconsistent with the policy adopted by the Defendants on 15 April 2020, which did require isolation, yet no new evidence is said to have arisen on this issue between 2-15 April.

<u>Testing of patients discharged to care homes</u>

51. Significant factual disputes have arisen in relation to the Defendants' failure to provide for Covid-19 testing of hospital patients before discharge into a care home. In March 2020, testing capacity was being scaled up and it was necessary to prioritise eligibility for testing. The SoS adopted his testing prioritisation policy on 11 March 2020 ("**the PHE Testing Priority Policy**" (DB/1063)) (Dodge 2 §71(6)); it remained unchanged even after the adoption of the March Discharge Policy. Those discharged from hospital to care homes were not on the priority list. The Defendants have

[22] As to whether PHE advised that there was "*a degree*" of transmission prior to the purportedly "*gamechanging*" *evidence* in April, compare Hopkins 1 §22 (asymptomatic cases "*a possibility*", but transmission "*unlikely*") and §26 (only in April was there "*likely to be a degree*" of transmission) with §13(b) of Hopkins 2 ("*aware from an early stage that there was likely to be at least some degree*"). See also the inconsistency of Hopkins 2 with the evidence cited in the final sentence of §44 above. As to when the SARS/MERS presumption was abandoned, compare §22 of Hopkins 1 ("*over the course of April*") with §12(a) of Hopkins 2 ("*rapidly*" once evidence "*started*" to build, giving an example from 17 February). As to when the advice on "consensus" changed, compare §25 of Hopkins 1 ("*substantial*" evidence *"began to build from the beginning of April"*) with §3(2) of Hopkins 2 ("*<u>by the end of March</u> and into April 2020, there was a weight of evidence*").

served vague and general evidence that "*careful consideration was given to how to prioritise testing across the population*" (Hopkins 2 §16) and that allocation of tests was "*based on available evidence in respect of need and risk*" (Miller §54). However, none of D1/D3's witnesses have been prepared to state that there was consideration of whether care home admissions should be included in the PHE Priority Policy. The documents that have been disclosed: (i) make clear that care home admissions were not considered when the policy was made, and (ii) do not evidence any later consideration of whether care home admissions should be added. D2, who was not responsible for the policy, baldly asserts that this was "*considered*" (Dodge 2 §88) and "*assessed*" (§130). No documents have been exhibited or disclosed that support D2's surprising assertion, and the witness statement of Mr Dodge does not provide any specific factual evidence supporting it.

52. The Defendants now say that testing before discharge to a care home would not have been a reasonable measure. In the DGRs and supporting witness evidence the Defendants contended that there was no available testing capacity (D1/D3 DGR §24, Surrey 2 §202, Miller §58). This was incorrect. The Defendants' own data show that, throughout the period from 20 March 2020 to 15 April 2020, there was substantial unused testing capacity of several thousands of tests per day (Gordon 2 §§151-165). It follows that if they had properly considered the position, the Defendants could, without any expansion in testing capacity, have provided tests to all or a significant proportion of the c. 25,000 patients who the Defendants state were discharged from hospitals to care homes between 17 March 2020 to 15 April 2020 (Gordon 2 §152).

53. In the further statement of Dr Hopkins the Defendants seek to advance various new arguments to meet this point. **First**, Dr Hopkins asserts that Professor Gordon's evidence is referring to swab capacity, but not laboratory capacity (Hopkins 2 §19(c)). This is simply incorrect: the figures he cites (fn 7) are the Government's own figures for "*lab capacity*". **Second**, Dr Hopkins asserts that "*at some points and in some regions, there were more tests available than there was laboratory space to process them*" (Hopkins 2 §19(c)). No documents are exhibited or referred to and no explanation is provided as to what or how many *"points"* are referred to. Materially, these is no suggestion that any such alleged isolated incidents could or would have prevented the Defendants from using the substantial spare testing capacity that was available during the relevant period to test all or a significant proportion of the discharges. **Third**, Dr Hopkins suggests that this is an issue that could only be known with hindsight (Hopkins 2 §19(a)-(b)). This is also wrong. It is Mr Miller's evidence that capacity was being monitored on an on-going basis (Miller §§46-50), and the Defendants would accordingly have been well aware at the relevant time of significant unused testing capacity. **Fourth**, Dr Hopkins appears to suggest that the Defendants made a decision that they should not add care home residents to the PHE Priority to ensure that they retained enough unused excess capacity to ensure that they always had extra, and did not run out of capacity for the categories that were included (Hopkins 2 §19(b)). No documents are exhibited or disclosed that record any such decision and the Claimants do not accept that any such decision was made. If it had been made, it would have been irrational. Hoarding unused testing capacity to use on (e.g.) "*clusters of disease in […] boarding schools*" (DB/1063), whose pupils faced no appreciable risk of death or serious injury from Covid-19, while not testing patients who were to be introduced into uniquely vulnerable care home populations, is not a course that any rational person would adopt.

54. At the very least, the Defendants could, and should, have adopted a policy that tests should be performed on hospital patients proposed for discharge into a care home wherever there was

available capacity. The Defendants' evidence is that an unspecified number of NHS Trusts unilaterally adopted precisely this approach (Dodge 2 §180), but surprisingly the Defendants did not consider or promulgate any policy requiring that all discharging NHS bodies should do so. No explanation for this has been put forward and none of the Defendants' witnesses give evidence seeking to justify it.

V. THE UNLAWFUL POLICIES

The February PHE Policy

55. The Claimants challenge the Defendants' failure to reverse or materially change the February PHE policy before 13 March 2020, when it was replaced by the March PHE Policy (ASFG §1831(1)-(3)). Until 13 March 2020, D1/D3 continued to advise that it was "*very unlikely that people receiving care in a care home or the community will become infected*", and that there was "*no need to do anything differently in any care setting at present*". Yet the Defendants' position was that community transmission had been a "*realistic probability*" since 10 February 2020 and "*highly likely*" since 2 March 2020 (Gordon 2 §§209-211). The disclosed documents record that D1's own contemporaneous assessment was that the guidance was "*insufficiently detailed*" (DB/1029), "*doesn't help providers prepare*" (DB/1057) and "*isn't meeting the needs of the care sector*" (DB/1034).[23] The Claimants submit that in the circumstances, the February PHE Policy became unlawful, and should have been rectified or replaced by 2 March 2020 at the very latest.

The March PHE Policy (13 March 2020)

56. The March PHE Policy was the Defendants' published care homes policy between 13 March 2020 and 6 April 2020. In this period, infections were seeded in care homes which would ultimately lead to the peak of infections in the first week of April, during which 5,900 homes reported an outbreak (ASFG §32). The decision-maker who adopted this policy is said to have the SoS, but D1/D3 do not appear to have disclosed any documents recording advice to the SoS, any decision by the SoS or any reasons for his decision.

57. The policy failed to address the risk from **visitors** to care homes. Rather than instructing care homes to (i) stop all visits, (ii) limit visits to exceptional circumstances, and/or (iii) require that visits should only be conducted using appropriate distancing and PPE mitigation measures, the guidance merely provided: "*care home providers are advised to review their visiting policy, by asking no one to visit who has suspected COVID-19 or is generally unwell, and by emphasising good hand hygiene for visitors. Contractors on site should be kept to a minimum. The review should also consider the wellbeing of residents, and the positive impact of seeing friends and family.*" Visits from persons who were infected with Covid-19 but did not have symptoms would, on this advice, continue. On 23 March 2020, the UK Senior Clinicians Group unanimously advised that care homes should ban all visitors save for emergencies (DB/1415). The visiting guidance in the March PHE Policy was not rectified or replaced.

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[23] As Professor Gordon states, the relevant sections "*were cursory, flawed and did not contain practical and realistic measures to assist care homes in infection control*" (Gordon 2 §§202-213).

58. In defence of the March PHE Policy, the Defendants rely upon: (a) an assertion that understanding at that time was that "*transmission occurred from symptomatic individuals*", (b) the "*level of transmission within the community*", and (c) concerns about "*potential physical and emotional impacts on residents and their families*" if visits were restricted (Surrey 2 §130). No evidence is before the Court of any, or any lawful, process of consideration of these matters by the SoS and none of the points made constitute justification since: (a) asymptomatic transmission was known to be a real risk by 13 March 2020 as set out at §§31-38 above, (b) by the time the policy was adopted, the Defendants had considered that sustained community transmission had been occurring for around two weeks (Surrey 2 §80), and were aware that the paucity of community testing meant they did not know what the level of transmission within the community was (c) if visits were to occur, a requirement for physical distancing and PPE would not have given rise to any significant *"physical and emotional impact"*, (d) no evidence or explanation has been provided regarding any such impact, and (e) any concern in respect of these matters was not sufficient to justify not acting to address the risk to the life and well-being of care home residents: hence the Defendants' subsequently adoption and maintenance, over a lengthy period, of a policy of prohibiting all but emergency visits to care homes.

59. As regards the risk of transmission from **staff**, the policy both increased, and failed to take lawful measures to address, the risk. On PPE, the guidance instructed care home staff that "*if neither the care worker nor the individual receiving care and support is symptomatic, then no personal protective equipment is required above and beyond normal good hygiene practices*". However, as Dr Hopkins wrote on 25 March, the guidance "*does not take account of the fact that patients may transmit prior to symptom onset*" (DB/1353). The PPE guidance in the March PHE Policy was not rectified or replaced. Further, the March NHS Guidance that was published on the same day as the March PHE Policy had explicitly drawn attention to the risk of transmission without symptoms and advised that various items of PPE be worn at all times by all healthcare workers (Gordon 2 §§222-223). Inexplicably, the Defendants failed to advise the use of PPE in care homes when caring for individuals without symptoms until 12 April 2020 (Surrey 2 §235).

60. On staff movement, the policy failed to address the risks arising from use of agency and bank staff. The January NHS Guidance had provided that *"the use of bank or agency staff should be avoided"* (DB/674). Scottish guidance to care homes on 12 March 2020 provided that *"the use of bank or agency staff should be avoided wherever possible"* (Gordon 2 §349). In contrast, the March PHE Policy stated that "*care home providers are advised to work with local authorities to establish plans for mutual aid, including sharing of the workforce between providers.*" Care home providers were thus invited to take positive steps to increase the numbers of staff working across multiple facilities, thus increasing infection risk. The Defendants seek to justify this failing by praying in aid potential concern regarding pressure on staffing numbers (Surrey §144-145). This stated concern would have been met by advising that agency and bank staff should not be used, at the very least wherever this was feasible without putting residents at risk, and also – as was done in the May Support Policy – by providing funding to address such workforce issues as might arise. This provision was not revoked until 15 May 2020 (see Gordon 2 §326), notwithstanding the significant CDC care home study of 18 March 2020 which highlighted staff movement as a key source of infection (Gordon 2 §92).

61. The policy was inadequate as regards the transmission risk from other **residents**, in particular those being newly admitted, or re-admitted, to a care home. The policy contained none of the essential measures required to address the risks of transmission from new admissions from the community or hospitals (in particular, testing, protective isolation, and instructions to use PPE). This was despite SAGE's conclusion on 10 March 2020 that "*transmission is underway in community and nosocomial (i.e. hospital) settings*" (DB/1059). The Defendants' response is that "*scientific understanding suggested the virus was transmitted by those with symptoms*" (Surrey 2 §135). Again, this is no answer (and note that the relevant advice remained in force until 2 April).

62. The policy did not provide adequate guidance on infection control measures to be adopted in care homes. Unlike NHS staff, most care workers have no medical background or training and many care homes have no medically trained staff at all. Care staff needed detailed guidance and training on infection control. Yet the Defendants' guidance to care home workers amounted to five paragraphs, which were markedly less protective than the guidance the Defendants provided to the NHS on the same date (see Gordon 2 §§219-234). For example, on hygiene and decontamination, NHS workers were given several pages of detailed guidance on management of linen, uniforms, body fluid spills, management of clinical and non-clinical waste, management of equipment and the care environment. Care home staff, who might be caring for a patient just discharged from hospital, were issued with two paragraphs telling them to clean surfaces, double-bag waste, and throw anything away that was soiled with vomit or diarrhoea. These are fundamental failings which will have had real impact "on the ground", not "technical criticisms" as the Defendants allege. Providing adequate guidance would have cost nothing and would not have detracted from any legitimate aim or objective of the Defendants.

<u>The March Discharge Policy (17-19 March 2020)</u>

63. The Defendants decided, by measures issued on 17 and 19 March 2020 respectively, to direct the urgent discharge of all "*medically fit*" patients from hospital (whether or not infected with Covid-19), including into care homes: (i) without requiring Covid-19 testing, (ii) without requiring protective isolation either before or after entering a care home, (iii) without requiring the use of PPE by the receiving care home, and (iv) without any assessment or confirmation of the care home's capability to provide safe care. The inevitable effect of the March Discharge Policy decision was to transfer, without rudimentary precautions, large numbers of infected patients into closed environments containing the segment of the population most vulnerable to being killed or seriously harmed by Covid-19 infection. The policy was maintained, in substance, for a month, until – following a mushrooming death toll and increasing public and political pressure – the Defendants changed course on 15 April 2020.

(a) Failure to consider the safety of care home residents

64. The Defendants' aim was to free up hospital beds in order to ensure that hospitals had greater capacity to treat patients infected with Covid-19, or otherwise in need of care. The Claimants: (a) accept that in principle this was a legitimate aim, but (b) submit that pursuing that legitimate aim neither required nor justified the Defendants failing to consider, and to take, all reasonably available steps to protect the uniquely vulnerable care home residents who would be put at risk by this policy. The evidence shows that there were a number of significant protective measures that could, and

should, have been introduced to protect care home residents without undermining the Defendants' objective.

65. According to D1/D3, the SoS was the decision-maker for the March Discharge Requirements; for D2's March NHSE Instruction, it was the Chief Executive, Simon Stevens. There is no evidence that either decision-maker considered (a) the risk that the policy would create for care home residents, or (b) what protective measures could or should be taken to address that risk. The disclosed material provided to the SoS comprised two documents. First, a note that was discussed at a meeting on 12 March 2020 entitled "*How can we free up hospital bed capacity by rapidly discharging people into social care?*" (DB/1078). This merely addresses the means by which the discharge policy would be implemented. Second, a note to the SoS of 17 March 2020 annexing "*enhanced discharge guidance*" (DB/1213). The only material point made is that there would be free out of hospital care and support to anyone discharged from hospital which "*will remove barriers to discharge and transfer between health and social care, and get people out of hospital quicker and back into their homes, community settings or care settings*". An email dated 13 March refers to a "*formal, fully-developed proposal of how this would look to go in a submission to SoS*" (SB/50). No such submission has been disclosed. No documents have been disclosed recording the decision of the SoS or any of his reasoning in adopting the March Discharge Requirements. There is no evidence of the careful balancing exercise alleged in §55 of the D1/D3 DGRs.

66. For its part, D2's position is that the impact of the discharge policy within care homes does not fall within its responsibility (D2 DGR §§102, 104-105). The only evidence of concern for the position of care homes was that of the National Incident Review Board (NIRB), which had been set up to provide oversight of D2's response to Covid-19. The NIRB approved the proposed discharge requirements subject to a request "*that further consideration should be given to the application of this approach for care homes, including Covid-19 testing practices at discharge to support safe care home admissions*" (§7.3 ID1/229). It appears, however, that D2 (specifically Mr Dodge) disregarded this request: Mr Dodge's evidence asserts that "*further consideration continued*" (Dodge 2 fn 49), but no details are given and no documents whatsoever have been disclosed evidencing any such further consideration by D2.

(b) Transfer was not conditional on care homes' ability to provide safe care

67. Discharge of a patient into a care home was in no way dependent upon the receiving care home's ability to care for Covid-19 positive patients safely. On the contrary, D2's requirements were deliberately framed as a mandatory directive to discharge anyone who was medically fit to leave. As Mr Dodge stated, D2 was issuing "*not a framework but instructions*"; "*tone-wise this is total command and control. You must do X. Zero scope for ambiguity*" (ID1/169). This is how the Requirements were understood and actioned by NHS bodies (Gordon 2 §241) and the result was that care homes came under immense pressure to accept discharges (see Kendrick §§13-16, Gardner 1 §8, Gordon 1 §13, Chubb §§18-20).

(c) Failure to provide for testing before admission to care home

68. See above: this was not justified either by a belief that Covid-19 was only transmitted by the symptomatic (§§31-50 above) or by a shortage of testing capacity (§§51-54 above).

(d) Failure to provide for protective isolation

69. The Defendants failed to require, or even recommend, protective isolation of all patients being transferred into a care home (either before or after transfer). D1/D3 plead that they "*had to weigh very carefully the benefits and harms of imposing this degree of isolation on a cohort this vulnerable*" (D1/D3 DGR §26(e)). There is no evidence that they did in fact weigh these benefits and harms, still less that the decision-makers, the SoS or the CEO of D2, did so (see above, §§64-66). Nor has any clinical advice or any other evidence has been disclosed to support the recent allegation that the Defendants regarding the effect of protective isolation to be "*draconian*" (Hopkin2 §13(e)) and a "*grave harm*" (Hopkins 2 §46(b)). Providing for isolation of all transfers to care homes, including those who did not have Covid-19 symptoms, would not have undermined the Defendants' goal of increasing NHS capacity, but would have protected care home residents from immediately coming into contact with an infected former hospital patient. Notably, by this time a person who had come into contact with a positive Covid-19 case was required to isolate for 14 days under the household isolation policy; but a patient discharged to a care home who might have been in contact with several positive cases in hospital was not precluded from mingling immediately with other care home residents.

The April Admissions Guidance (2 April 2020)

(a) The development of the guidance

70. The Defendants' principal objective in formulating the April Admissions Guidance was not to protect the lives and well-being of vulnerable care home residents but rather to induce care homes to accept discharges of patients transferring from hospital, whether or not it was safe for them to do so.

71. Hence, on 22 March 2020, D1's lead official, Ms Roughton, wrote to the Deputy CMO, Ms Harries, noting that "*We are experiencing problems on the ground with care homes refusing to accept patients discharged from hospital unless they have been tested negative for Covid-19, as they are fearful of accepting someone who then infects everyone. As you can imagine building care home confidence in accepting patients is going to be critical for us to free up the 30000 beds"* (DB/1298). Ms Roughton suggested that Ms Harries/D3 should *"make some very clear statements about how care homes should feel it is safe to accept patients from hospital".* The initial draft guidance produced by D3 was significantly more protective of care home residents than the policy subsequently adopted. As well as containing more detailed provisions on infection prevention and control and use of PPE (DB/1326), it provided, e.g.:

    a. "*Decisions on transfers need to be carefully considered depending on local risk assessment on a case by case basis. [...] The protection of susceptible unexposed vulnerable population groups is of utmost importance and all efforts should be made locally to manage this in the best possible way minimising risk to the vulnerable residents.*" (DB/1328).

b. "*PHE advises against **any** transfers of asymptomatic patients into a care home affected by a COVID-19 outbreak (suspected or confirmed outbreak)*" (DB/1328).

c. "*PHE advises against **any** transfers of confirmed COVID-19 cases into a care home which does not have any cases of COVID-19*" (DB/1329).

72. On 24 March 2020, D2 began to press for the protective measures in D3's draft guidance to be removed or watered down, arguing that they "*could be seen to frighten care homes and reduce much needed capacity*" (ID1/535). Paul Johnstone of D3 initially appears to have sought to resist D2's pressure, noting his (well-founded) concerns that D2's changes would "*put residents at risk when not needed*" (ID1/534). A conference call was held at 5pm between D2 and D3 to discuss these issues, the record of which confirms that D2 was pressing for the removal of passages which "*will lead to the sector being too risk adverse, creating blocks in the system*", whilst D3 was expressing concern as to the impact on care homes and their residents if the guidance did not contain appropriate warnings and safeguards ("*I explained the rationale behind our approach and support the aims to free up beds in the NHS but we needed to be really careful because in managing the short term we could have a far worse situation on our hands"; "freeing up NHS beds is an important priority however the primary aim is keep care workers and those receiving care safe from COVID-19 and infection"* (DB/1362)). At the end of the call, D2 stated that if necessary they would escalate matters via their CEO to the Minister (DB/1362). It is not clear whether this happened, but D3 accepted D2's changes after a further call on 25 March 2020 (DB/1361).

73. The new draft removed many of the protective measures that had been included in the draft PHE guidance, including the measures at §71(a), (b) and (c) above (ID1/548). Neither the Defendants' witness statements nor any disclosed documents explain or record: (a) which ministerial decision, if any, led to the removal of D3's protective measures and, in particular, whether the SoS was asked to consider retaining such protective measures, (b) what advice (if any) the SoS had before him in respect of these protective measures, or the policy more generally, or (c) what the reasons were for his decision to adopt the policy without the protective measures. The effect of the decision was that the advice of the responsible, expert body (D3) was abandoned and the interests of D2, which disclaims legal responsibility for protecting the lives and well-being of care home residents, were adopted as governing the Defendants' policy. This was despite the fact that, on 27 March 2020, D3 was informed that the data was "*showing a rapid increase in reported cases in the care home sector*" (DB/1416).

74. Consideration was also given to whether care homes should be instructed to protectively isolate all newly admitted discharges. Mr Surrey states that on 27 March 2020, a proposal for precautionary isolation "*for all patients discharged to care settings*" was presented to the Senior Clinicians Group (Surrey 2 §284). A short note of the meeting (which appears to have been redacted and has been disclosed without its attachments) reveals that the SCG agreed that there should be a 14 day isolation period for all patients discharged to care settings (DB/1415). However, a 14-day isolation period was ultimately only mandated for patients with Covid-19 symptoms (in the April Admissions

Guidance) and, in other guidance issued by D3 on 9 April 2020, for the small minority of patients who had tested positive in hospital before discharge (Surrey 2 §285).[24]

75. The Minister for Social Care (Helen Whately MP) was asked to approve the guidance. Her initial comments included a question: "*WHY ARE WE NOT PLANNING TO TEST PATIENTS FOR DISCHARGE TO THE CARE SECTOR. THIS WOULD MAKE SUCH A DIFFERENCE"* and "*THIS IS WRITTEN LIKE THE NHS IS DIVINE AND CARE HOMES ARE SLAVES*" (SB/228). Her final set of comments includes the following: *"PHE DOES NOT ADVISE TESTING FOR THOSE WITHOUT SYMPTOMS. WE HAVE BEEN TOLD OUR CURRENT TEST METHODOLOGY ONLY WORKS IF YOU HAVE SYMPTOMS. (IF YOU DON'T HAVE SYMPTOMS THE IMPLICATION IS THAT YOU WOULD TEST NEGATIVE AND IT COULD BE A FALSE NEGATIVE – so better to follow the quaranteening [sic] process)*" (SB/259). The Defendants have not disclosed any advice of PHE that: (a) those without symptoms should not be tested, or (b) the Defendants' tests did not work on those without symptoms.[25] Moreover, it appears (a) that the Minister was of the view that patients entering care homes who did not have symptoms should be isolated (quarantined), but (b) that she believed or had been told, quite wrongly, that isolation ('*quaranteening*') would be required for such patients entering care homes when the draft made clear on the following page that this was only the case for patients with symptoms.

76. D1/D3 assert, however, that it was the SoS, not the Minister for Care, who decided to adopt the April Admissions Guidance. D1/D3 have refused to identify the advice or information the SoS was provided with. The only potentially (tangentially) relevant material the Claimants can identify concerns visiting policies (DB/1300), financial measures to encourage care homes to accept new residents (DB/1356) and the PPE shortage (DB/1410). D1/D3 do not appear to have disclosed any documents recording any decision by the SoS in respect of the April Admissions Guidance or any reasons for any such decision. There is no evidence of the careful balancing exercise alleged in §55 of the D1/D3 DGRs.

(b) The content of the guidance

77. The April Admissions Guidance contained a number of provisions which failed to protect care home residents, and indeed increased the risk to them of Covid-19 infection, but which served to further the Defendants' objective of inducing care homes to accept patient discharges from hospitals:

    a. The guidance provided that Covid-19 positive patients could, and should, be discharged to care homes, both those who had been tested and those who had not. It stated that "*Negative tests are not required prior to transfers/admissions into the care home*".

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[24] It appears that Dr Hopkins also made an ill-fated attempt to insert 14-day isolation for some dischargees without positive tests to be inserted into the guidance; at D2's instigation, her comment was removed (DB/1361). This is not addressed in Dr Hopkins' evidence.

[25] The highest that Dr Hopkins is willing to put the point in her second statement is that "*the reliability of testing within asymptomatic individuals was yet to be determined*" (Hopkins 2 §18), though she refers to no contemporaneous advice on the matter. Instead she refers to a study several months later (June 2020), after the Defendants had in any event decided to test dischargees, which in any event concluded only that the false negative rate is higher if samples are taken early in infection.

b. The guidance provided: "*if an individual has no COVID-19 symptoms or has tested positive for COVID-19 but is no longer showing symptoms and has completed their isolation period, then care should be provided* ***as normal***". It also contained a summary table of residents' care needs after discharge. The row headed "*no symptoms of COVID-19"* stated: *"provide care as normal*".

c. The guidance advised that care home staff should only wear PPE when caring for residents with symptoms (ie. "*possible or confirmed Covid-19 patients*", as defined in Annex B).[26]

d. The infection control advice provided in the guidance was defective and inadequate (Gordon 2 §§265-320). For example, the guidance advised that staff who come into contact with a Covid-19 positive resident while not wearing PPE "*can remain at work*", on the basis that the contact was likely to be "*short-lived*". To the extent that care home workers were advised to wear PPE, they were not adequately trained or advised on how to do so (Gordon 2 §§270-280). Advice on hygiene and contamination remained "*cursory*", and markedly less detailed than guidance to NHS workers (Gordon 2 §§303-305).

e. All care homes were being told that they could and should accept discharges, without any provision for assessment or confirmation of a care home's capability to provide safe care. As Mr Dodge of D2 wrote in a contemporaneous briefing note: "*we now have new joint guidance ready to go which makes clear that they* ***must accept these patients****, and that it is safe to do so providing they follow clear procedures*" (ID1/723; emphasis in original). The Court will form its own conclusion on Mr Dodge's explanation, in a footnote, that this statement was a "*typo*" (Dodge 2, fn 62).

f. The guidance did not instruct care homes that visits should be stopped or limited to exceptional circumstances, stating merely that family and friends "*should be advised not to visit*". This was notwithstanding that the UKSCG had concluded on 23 March 2020 that "*only absolutely necessary visitors (end of life moments, food delivery, doctors coming) should be allowed*" (DB/1415). There is no documentary to explain why the UKSCG advice was not followed.

g. The guidance did not revoke the provision in the March PHE Policy which encouraged sharing of staff, or set out any other measures to address the risk of transmission from staff.

h. The guidance stated in respect of discharges: "*Some of these patients may have COVID-19, whether symptomatic or asymptomatic.* ***All of these patients can be safely cared for in a care home if this guidance is followed***" (emphasis in original). The statement in

[26] Professor Gordon explains that the guidance linked to a different document which contemplated the use of PPE for asymptomatic residents in periods of sustained community transmission (DB/1552), but that the Defendants only clarified on 12 April 2020 that the latter passage had come into force (one official suspected that this was deliberate, due to limited supply: Gordon 2 §295).

bold was incorrect, and should have been known by the Defendants to be incorrect, for multiple reasons (see Gordon 2 §§243-264).

<u>The April Action Plan (15 April 2020)</u>

78. The April Action Plan partially reversed significant elements of the Defendants' policies. The Defendants would move to institute a policy testing all patients discharged to care homes from hospital. Where a test resulted was "*still awaited*", the patient would be discharged and, pending the result, isolated. Discharges who tested positive should be isolated for 14 days. "*If appropriate isolation/cohorted care is not available with a local care provider, the individual's local authority will be asked to secure alternative appropriate accommodation and care for the remainder of the required isolation period*". In respect of discharges who tested negative, "*we still recommend isolation for 14 days. This will normally be in a care home that is able to meet that requirement, or it could be under alternative local authority made arrangements assisted by appropriate NHS primary and community-based care*." For individuals coming from the community, "*the care home may wish to isolate the new resident for a 14-day period following admission*". For the first time, therefore, there was provision for: (a) testing new entrants to care homes, and (b) isolating all new entrants. There was also, belated, admission that not all care homes could safely isolate residents.

79. The April Action Plan followed a decision by the SoS on 9 April 2020 that he wanted a new social care strategy (Surrey 2 §296). There is no disclosure to explain his reasoning, and the Claimants infer that the escalating death toll in care homes will have been significant to it (see ASFG §34). On 10 April 2020, officials sent the SoS advice (DB/1685) that all patients be either quarantined in NHS Community or Nightingale hospitals, or tested by the NHS before discharge, with all entrants to care homes to be isolated upon admission for 14 days in dedicated isolation wings. This was accepted by the SoS, and Mr Dodge was sent an official level draft of a new social care strategy that evening (ID1/826).

80. D1/D3 case in these proceedings is that the reason for the SoS's decision to change policy was "*new scientific advice*" (D1/D3 DGR §26(f)), in particular as regards asymptomatic transmission. No such advice has been disclosed and the evidence shows that this is not correct. Not a single scientific study mentioned by Dr Hopkins as part of the supposedly "*gamechanging*" evidence in §25 of her first witness statement was first published between 2 April 2020, when the April Admissions Guidance was published, and 10 April, when the SoS decided to change policy. In her second statement, Dr Hopkins says that PHE was "*particularly persuaded*" by the "*Easter Six*" study (Hopkins 2 §8), a surveillance study on UK care homes, and suggests that this was the real spur for the changes. That cannot explain the SoS's decision to change policy. Even on the Defendants' carefully worded witness evidence, it is stated that the Easter Six study shared preliminary findings with the UK Senior Clinicians Group in the "*week commencing 13 April*", at least four days <u>after</u> the meeting on 10 April at which the SoS asked for a strategy involving testing and quarantining all discharges. D3's advice is then premised almost entirely on "*growing international evidence of asymptomatic transmission in care homes*", citing studies published on 27 March 2020, 30 March 2020 and 2 April 2020 (DB/1884).

81. The disclosed documents reveal an unedifying, but successful, campaign by Mr Dodge on behalf of D2 to remove from the new document provision that discharges to care homes be isolated in NHS

community and Nightingale hospitals, and that a negative test was required in all cases before transfer to a care home. D2's concern was that any changes must not affect the new rapid discharge model provided for in the March Discharge Policy, so that D2 did not "*lose one of the most important strategic long term benefits of the incident*" (ID1/383). Mr Dodge sent a re-draft of the new policy to DHSC on 14 April 2020 (ID1/840), which stated that "*the NHS Discharge requirements will continue to apply*" and made clear that either care homes or local authorities would be responsible for arranging isolation rather than NHS hospitals being used for this purpose. Mr Dodge insists in his witness evidence that D2 considered that community and Nightingale hospitals were unsuitable to be used for isolation "*on clinical grounds*" (Dodge 2 §92), citing concerns about staffing, "*significant work and resources*" (§191), and preserving capacity. But no clinical evidence to that effect (contemporaneous or subsequent) has been provided. The only documents to which Mr Dodge refers to, in support of this view, are several emails *written by him* (ID1/826, ID1/838, ID1/840). The *only* evidence on this point from a clinician is Professor Gordon's evidence that the hospitals were "*entirely appropriate*" for the purpose of quarantine (Gordon 2 §410). D2 also succeeded in inserting provision for patients to be discharged into care homes before their test results had come back (ID1/868).

82. Though the April Action Plan was an improvement on what had gone before, its suite of measures was not sufficient to protect care home residents. Despite the promise to "*move to institute*" a system of tests for those discharged to care homes, this was not implemented immediately. The Plan did not address the risks arising from care home staff, including use of agency and bank staff, and staff movement between homes. It did not fully address the risk of transmission from patients transferring from the community, providing only that care homes "*may wish*" to isolate these residents on entry. And there was still no effective mechanism for verifying whether a care home could safely implement isolation, so that isolation could take place elsewhere if it could not.

The May Support Policy (15 May 2020)

83. The May Support Policy set out steps which care homes "*should consider taking*" in order to reduce staff movement between care homes. This was too little and too late to address that important issue.

84. There is no explanation in the Defendants' evidence for the delay in introducing measures to limit staff movement. As set out above, action was taken both in the NHS and in the Scottish care system to address this issue from the start of the pandemic. The CDC study published on 18 March 2020 said explicitly that "*staff members working in multiple facilities contributed to intra- and interfacility spread*" (Gordon 2 §92). A month later, on 17 April 2020, a D3 official emailed colleagues to say that a "*clear area of concern is visiting healthcare or social care staff moving between facilities*" (Miller §156, DB/1990). The Minister for Care is said to have decided, then, to "*move forward*" with policies to restrict staff movement at a meeting on 22 April 2020 (Surrey 2 §347). Still, the policy did not change.

85. In mid-April, No.10 and the Cabinet Office began to become exercised about the Defendants' failures to protect life in care homes. According to the subsequent writings of Dominic Cummings, the Prime Minister's then Chief Adviser, he became aware at this time that "*everything to do with care homes was extremely bad and the CSA and CMO were ringing alarm bells daily with No10, and warning us that neither DHSC nor PHE could cope in general or viz care homes in particular*"

(CE/2738). The Cabinet Office and No. 10 intervened. On 28 April 2020, following a "*deep dive*" into social care policy, the Cabinet Office told the Secretary of State: "*DHSC, working with MHCLG, to provide a plan and timeline for operationalising all of the recommended proposals in Annex 3 on restricting workforce movement"* (SB/79). On 30 April 2020, the Prime Minister's Implementation Unit examined this issue further (Miller §159), and recommended on 4 May 2020: "*Staff should not, where possible, work in more than one care setting - this includes agency staff who should be block booked/isolate before moving to a different facility*" (DB/2302). The findings of the review clearly made for sobering reading in No. 10. Mr Cummings texted the Prime Minister on 3 May 2020: "*I think we are negligently killing the most vulnerable who we are supposed to be shielding and I am extremely worried about it*" (CE/2378, 2757).

86. Rather than issuing advice to limit staff movement immediately in accordance with the Cabinet Office and PMIU findings, the Defendants deliberated over whether to make restrictions mandatory. On 7 May, DHSC requested yet a further report on the evidence (Miller §161, DB/2342). On 14 May 2020, this report cited "*low-level evidence from three Covid-19 outbreaks in North America*" to suggest that restricting staff movement could help to reduce transmission (DB/2501). This was evidence from mid-March. The policy finally changed on 15 May. Despite delaying the change in policy specifically in order to consider legal restrictions upon workforce movement, the May Support Policy did not introduce them. It did not even give care homes clear recommendations as to what they should do, but only a menu of measures which they "*should consider taking*" (including to "*ensure that members of staff work in only one care home wherever possible*").

<u>The Revised June Admissions Guidance (19 June 2020)</u>

87. The Revised June Admissions Guidance provided, for the first time, that "*no care home will be forced to admit an existing or new resident to the care home if they are unable to cope with the impact of the person's COVID-19 illness for the duration of the isolation period*". But the guidance still provided for transfer of Covid-19 positive patients to care homes, without any system for verifying whether care homes were, in fact, able to care for them safely. That system was only introduced in September 2020 in a scheme led by DHSC (Surrey 2, Annex §19), although D1/D3 also assert that "*it was not DHSC or PHE's role*" to assure that care homes could safely isolate residents with Covid-19 (Surrey 2 §398). Nor was there provision for compulsory isolation in a facility outside the care home (such as an NHS hospital), where a discharge could not safely be isolated in a care home. In respect of transmission by staff, the guidance still only told care homes what measures they should "*consider*" taking.

VI. SUBMISSIONS

<u>Article 2</u>

88. The Claimants' claims under Article 2 ECHR are set out in detail in ASFG §§178-183 (for the period to 15 April 2020), and §§184-193 (after 15 April 2020). Their submissions may be shortly summarised.

    a. Care home residents were known from the outset of the pandemic to be particularly vulnerable to infection with, and death from, Covid-19. Covid-19 posed a real risk to

their lives. As D1 has accepted, what was required was that measures should be taken as quickly as possible to establish a *"protective ring"* around care homes.

b. There was no protective ring and care home residents were not protected. Obvious and readily available protective measures were ignored or discounted. There was a catastrophic death toll in care homes during the first wave of the pandemic.

c. There is no evidence that anyone in authority (a) identified the risk to care home residents at an early stage, (b) considered what needed to be done to protect them and in what timescale, still less (c) ensured that those steps were taken. The only concrete evidence of any serious consideration being given to the protection of care home residents is D3's initial stance during the drafting of the April Admissions Policy, which quickly evaporated in the face of lobbying by D2. No such consideration was given prior to the adoption of the March Discharge Policy. There was no careful balancing of risks as alleged in §55 of the D1/D3 DGRs. In the absence of evidence of the necessary judgments being made at the time, the Defendants cannot maintain their claim to a broad margin of discretion.

d. Instead, and inexplicably, the Defendants claim to have adopted the necessary "*precautionary approach*" only during the course of April 2020 (Hopkins 1, §26) when huge damage had already been done.

e. The Defendants' key line of defence, that there was that there was no sufficient evidence until mid-April 2020 of transmission of Covid-19 from persons without symptoms, is untenable. That risk was clear, and should have been acted upon, far earlier. What they describe as "*the underlying issue*" falls to be resolved against them.

f. The system of law and other regulation applicable to care homes was wholly inadequate to prevent the widespread introduction of Covid-19 into care homes through staff, visitors and, in particular, through residents discharged from NHS hospitals. In particular, the system could not prevent the safety of care home residents being entirely subjugated to, and compromised by, the interests of the NHS in freeing-up hospital capacity that might be needed in the future.

g. Even assuming the most significant margin of discretion, the Defendants cannot discharge the burden of showing that they took all reasonably available steps to protect the lives of care home residents. The failures to consider or require testing of hospital discharges using available testing capacity, to require mandatory isolation of all patients before or after entry to a care home and to give advice on wearing of PPE equivalent to that given to NHS staff are particularly clear examples. There are many others. That submission, evidently, does not entail the imposition of an impossible or disproportionate burden upon the State. It required only that care home residents were given some semblance of the priority which their uniquely vulnerable position called for. The Defendants also took positive steps, through their policies, which endangered life, including the discharge of known or suspected Covid-19 positive patients into care homes, and the instruction to care

homes up to at least 12 April 2020 to care for asymptomatic residents without additional measures.

h. The strategy pursued in the April Admissions Guidance of down-playing the risks of infection within care homes in order to ensure that care home operators did not object to accepting hospital discharges is a particularly stark instance of failure to give weight to, and to protect, the lives of care home residents.

i. The Claimants submit there were breaches of the systems duty, the operational duty and the ***Munjaz*** duty.

<u>Other ECHR claims</u>

89. The Claimants do not pursue their claim of breach of Article 3 ECHR which, on reflection, does not add substantively to the Article 2 claim. They maintain reliance upon Article 8 ECHR – the right to respect for private life and the home – in the alternative to Article 2, and in the event that the Court decides that one or more of the duties under Article 2 was not triggered. Policies which introduced, or failed to prevent the introduction of, Covid-19 into care homes interfered with Article 8(1) rights, and were not justified. Their Article 14 claim focuses on the discriminatory impact of the March Discharge Policy, and its reinforcement in the April Admissions Guidance, which disproportionately disadvantaged the elderly and disabled population of care home residents, who had Covid-19 infection compulsorily introduced into their homes, which they were not free to leave. It is that disproportionate impact which has to be, and cannot be, justified.

<u>Domestic public law claims</u>

90. The Claimants' domestic public law claims are set out at ASFG, §§194-222. The ability to pursue these claims has been hampered by the refusal of D1/D3 to identify the advice and other materials which were considered by the relevant decision-maker, the SoS, in the case of each policy. However, by way of summary:

a. Given the pressing context, the standard of review is a high one, namely *"anxious scrutiny"*.

b. On the evidence, there are clear instances of obviously relevant considerations not being taken into account prior to critical decisions being made. Most seriously, there was a failure to assess the risk to the lives of care home residents which would be caused by the March Discharge Policy and the April Admissions Policy, and to weigh that risk against the benefits which were perceived for these policies. There was, on the evidence, no consideration given to amending the PHE Testing Priority Policy in order to include hospital discharges, or to providing that tests on discharges should be conducted wherever capacity allowed. There was a failure to consider the likelihood of transmission from persons without symptoms until – according to Hopkins 1, §§22, 26 – some point in April 2020. There is no evidence of any consideration being given to the unsuitability of the care home environment for isolation and infection control.

c. There is a significant overlap between the Defendants' failure to take into account those relevant considerations and their failure to conduct a sufficient enquiry before adopting the policies under challenge. The Claimants also rely upon the apparent failure of D1/D3 to consult the experts who had been convened to provide advice on these matters, in particular NERVTAG, which recorded on 24 April 2020 that it had not been asked to comment on care home measures.

d. So far as irrelevant considerations are concerned, two points can be highlighted (in the absence of confirmation as to what was considered by the SoS). It was legally irrelevant for the Defendants to take into account and pursue, by the April Admissions Policy, the objective of overriding the legitimate concerns of care home operators for the protection of their residents. It was legally irrelevant for D2 to pursue, in negotiations on the April Action Plan, the objective of seeking to preserve for the long term what it regarded as the benefits of the March Discharge Policy, and thereby block the use of NHS facilities for isolation of patients who could not safely be isolated in the care home to which they were to be discharged.

e. There are also obvious instances of irrationality. It was irrational to adopt the March Discharge Policy without taking any steps to safeguard the vulnerable care home residents who would be exposed to Covid-19 infection as a result. If, notwithstanding the absence of supporting evidence, the Court accepts that the Defendants decided that it was preferable to introduce Covid-19 infection into the resident population of a care home rather than temporarily to isolate a hospital discharge in a single room with care support, that was an irrational conclusion. It was illogical and irrational to proceed on the basis that there was no real risk of transmission from asymptomatic persons whilst adopting other measures – shielding, household isolation, school closures, national lockdown – which were premised on precisely the opposite view, that people should "stay at home" because it was not known who was infectious. It was irrational to prioritise available testing capacity for school children, whilst not prioritising hospital discharges into the uniquely vulnerable care home population.

f. As regards the duty of transparency, D1/D3 have not dealt straightforwardly and consistently with the public, but have misled the public. The Secretary of State's statement on 15 May 2020 that "*from the start we've tried to throw a protective ring around our care homes*" was, as the evidence shows, false. So was the Prime Minister's statement on 13 May 2020 that "*We brought in the lockdown in care homes ahead of the general lockdown*". If there was any lockdown in care homes at all during the period covered by this claim, it was not brought in until mid-April 2020 at the very earliest. These statements seriously misrepresented the Defendants' decisions and actions and were, in the circumstances, unlawful.

<u>The EA10 claims</u>

91. The Claimants submit that the March Discharge Policy constituted unlawful indirect discrimination, contrary to ss. 19 and 29 EA10 for the following reasons (see ASFG, §§223-229). <u>First</u>, *vis-à-vis* s.19(1)(a), the Policy of discharge into care homes without testing or isolation, is a provision,

criterion or practice which was applied to the Claimants' fathers and other care home residents (including discharges) because they were directly affected by it, through being exposed to the greater risk of Covid-19 infection.

92. Second, *vis-à-vis* s.19(2)(b), the PCP put elderly and disabled persons at a particular disadvantage, because (a) those discharged from hospitals were disproportionately elderly and/or disabled (25,000 individuals were discharged into care homes by a policy which was designed to free up 30,000 beds), (b) the residents of the homes to which these persons were admitted were disproportionately likely elderly and/or disabled, and (c) both cohorts were at much greater risk of dying from Covid-19 than younger, able-bodied persons whom the NHS might wish to treat in their place. It is no answer to the greater risk to which the elderly and/or disabled were exposed to assert, as the Defendants do (D1/D3 DGR §64(a)), that, by protecting the NHS, the policy also protected some older and disabled people. The Defendants also argue, with respect to the disadvantage suffered by persons discharged, that the Claimants assume that hospital would have been a safer environment for them (§64(c)). That is a fair assumption, given the unsuitability of the care home environment for effective isolation and infection control; and the point does not address the point that the existing residents of care homes would undoubtedly have been safer if Covid-19 positive patients had not been discharged from hospitals into their homes.

93. Third, *vis-a-vis* s.19(2)(c), the policy put the Claimants' fathers and other care home residents at the relevant disadvantage because they were exposed to a real risk of Covid-19 infection, in homes which had been pressured to accept discharges from hospitals. The Defendants argue that the Claimants have not proved a "*causative link*" between the policy and their fathers' deaths (D1/D3 DGR §65, D2 DGR §128) but the risk of infection is clear (albeit that in Dr Gardner's case, it is possible, although not proven, that her father had contracted Covid-19 already before the new resident was admitted). Fourth, *vis-à-vis* s.19(2)(d), the policy was not objectively justified as a proportionate means of pursing a legitimate aim, asserted to be "*the need to free up hospital capacity*" (D1/D3 DGR §66, D2 DGR §116(a)) or by any other aim (see ASFG, §§227-229). The Defendants have not demonstrated that NHS capacity would or would likely have been breached if they had adopted a different policy, such as discharge with additional safeguards for care home residents like testing and/or mandatory isolation of discharges.

94. As to the public sector equality duty in s. 149 EA10 (set out in ASFG, §230), the relevant principles are stated in *Bracking v Secretary of State for Work and Pensions* [2014] EqLR 60, §§25-26 and include the following: (a) equality duties are an integral and important part of the mechanisms for ensuring the fulfilment of the aims of anti-discrimination legislation; (b) an important evidential element in the demonstration of the discharge of the duty is the recording of the steps taken by the decision maker in seeking to meet the statutory requirements; (c) the relevant duty is upon the decision-maker personally and what matters is what he or she took into account and what he or she knew; thus, the decision-maker cannot be taken to know what his or her officials know or what may have been in the minds of officials in proffering their advice; (d) a decision-maker must assess the risk and extent of any adverse impact and the ways in which such risk may be eliminated before the adoption of a proposed policy and not merely as a 'rearguard action', following a concluded decision.

95. The documents disclosed by the Defendants do not, in respect of any of the policies under challenge, evidence that any consideration was given to the PSED by the alleged decision-makers, namely: (i) for D1/D3, the SoS, and (ii) for D2, its Chief Executive. In respect of the March PHE Policy, the April Admissions Guidance and the April Action Plan, the Defendants refer to <u>no</u> documentary evidence of consideration of the PSED at all. In respect of the March Discharge policy, the only relevant advice that the SoS received was: "*We have considered the Public Sector Equalities Duties and do not believe there are any issues here*" (DB/1213). This did not constitute the SoS having due regard to the position of the relevant protected group (the uniquely vulnerable care home population) that was required by law. In respect of the May Support Policy, the Defendants have disclosed an email to the Minister of State's private office (i.e. not to the SoS), which simply says: "*We have considered the statutory duties, including the Public Sector Equalities Duty and Family Test. As currently drafted, we do not think the letter has any issues of concern in this regard*" (SB/118). The previous submission is repeated.

96. The Defendants advance two main contentions in response to this ground of claim. First, they submit that "*the very nature of the exercise*" (D1/D3 DGR §68), that is, that "*the policies were being developed for the protection of the elderly and vulnerable in care home settings*", meant that it was "*inevitable*" that the decision-makers would give due consideration to matters listed in s.149 (Surrey 2, §408). That submission is fundamentally flawed on two grounds: (a) it seeks to subvert the requirement that it is the decision-maker personally who must have regard to the statutory objectives, and (b) it is based on the false premise that if a policy has implication for a protected group it inherently (and indeed inevitably) follows that merely by considering the policy a public body discharges the s. 149 duty. The submission is also untenable on the facts: as the evidence shows, the relevant policies were not principally or mainly formulated to protect the life and safety of vulnerable care home residents, but to free up hospital beds at all costs, and to persuade care homes not to decline to admit hospital discharges. Second, the Defendants make bare assertions, without any specific witness or documentary evidence of the knowledge or consideration undertaken by the alleged decision-makers – the SoS and CEO – that the PSED was 'considered' in making each decision or policy subject to challenge (Surrey 2 §408, Dodge 2, §§142(6) and 184(3)). There is in fact no evidence that the SoS or CEO personally considered the PSED.

<u>Causation/relief</u>

97. The Defendants plead that the Claimants have failed to prove that any breach of duty was "*causative of the Claimants' fathers deaths*" (D1/D3 DGR §56, see also D2 DGR §110). This assertion is made, in both pleadings, under the head of the ECHR claim, though it is not clear what defence it is supposed to support. There are also wider denials of causation in the Defendants' pleadings: that discharge "*did not play a significant role in seeding infection in care homes*" at all (D1 DGR §19), and, on D2's part, that care home deaths are not "*properly attributable to the March Discharge Policy*" (D2 DGR §§78-81).

98. The Claimants make three points on causation. <u>First</u>, the Defendants' points concerning Ms Gardner's and Ms Harris's fathers are not understood to be advanced as part of any objection to their standing, which would not properly be made at this stage in any event. Though the Defendants did advance an argument on standing in their Summary Grounds (D1/D3 SGR §§46-47, D2 SGR §§42-45), they refrained from any such objection in their Detailed Grounds. Linden J expressly

acknowledged at §§6-7 of his Permission Decision that he had considered the argument on standing and held that the Claimants should have permission to proceed on all grounds, including grounds of challenge to policies which were adopted after the Claimants' fathers died. The Defendants' decision not to revive points on standing in their DGRs was the proper one (see *R (Chandler) v Secretary of State for Children, Schools and Families* [2010] PTSR 749, §77).

99. Second, the Defendants' points on causation – whether in relation to the Claimants' fathers in particular or care home residents in general – are irrelevant to liability and, by the same token, to whether declaratory relief should be granted. Though the Claimants do not say that these are the facts of the instant case, it is obvious as a matter of logic that a state can breach its ECHR duties by endangering lives, whether or not deaths in fact resulted.

100. Third, and in any event, the Defendants' wider arguments as to causation are unsustainable in fact. Professor Gordon explains in detail (Gordon 2, §§166-181) that the main evidence relied upon by the Defendants to support their claim that discharges caused only a small proportion of care home deaths, is a seriously methodologically flawed report by D3. It excludes those who were not tested (when testing was largely unavailable to care home residents), excludes 10% of cases due to unmatched address data, excludes patients transferred to a care home for the first time, excludes chains of infection that fall outside its specific definition of "*outbreak*", and excludes cases falling outside its specific definition of a potential "*seeding*" case. Professor Gordon concludes that "*the report underestimates, and almost certainly very substantially, the true number of relevant deaths*".

101. Dr Hopkins, in her second statement, makes barely any attempt to defend the research, saying only that the methodology was subsequently reviewed (§42) and that, such are the limitations of the data, "*there is a possibility of both over- and under-counting*" (§43). Strikingly, to the extent that she stands by the conclusions of the study, her evidence is only intended to support the point that it is "*likely that the infection rate has always been driven by asymptomatically infected staff*" (Hopkins 2, §45). The Defendants' failure to address this route of transmission is just as much under challenge as is their discharge policy: as set out above, the Claimants allege that it was unlawful to advise until mid-April that staff care for asymptomatic residents without using PPE, to fail to train care workers in infection control until May, and to fail to limit staff movement until the May Support Policy. Accordingly, even if causation were relevant to liability, the Defendants' evidence on the issue would take them nowhere.

VII. CONCLUSION

102. By reason of the matters set out above and in the Claimants' Amended Statement of Facts and Grounds and evidence, the Court is respectfully invited to grant the declaratory relief sought.

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22 September 2021