Written evidence submitted by Professor Paul Rogers

*Early warning of biosecurity incidents – the COVID-19 experience*

Summary

The COVID-19 pandemic has been a chastening experience for the United Kingdom. Prior to the outbreak the 2018 Biological Security Strategy stated that we are “globally renowned for the quality of our preparedness planning, and we have world-leading capabilities to address significant biological risks”, and that “the UK has in place a comprehensive and well-tested system for rapidly detecting and identifying disease outbreaks”.

This self-assessment was broadly accepted worldwide but, in practice, the UK has proved to be one of the very worst performing countries of all. For much of the past year it has had the worst death rate per capita from COVID-19, despite the epidemiological advantage of its geographical separation from Europe. This paper examines the initial failures, specifically the failure to recognise the significance of the COVID-19 outbreak and secondly the failure to follow the examples of states that reacted rapidly to the pandemic. The key question to be answered is whether this was an intelligence failure or stemmed from a particular political approach.

Introduction

The Joint Committee’s inquiry into the national security machinery has broad terms of reference and while this evidence relates to the overall aims of the inquiry it is particularly relevant to the following specific elements:

- How the NSC maintains its centrality in the policy-making process, sets ministerial direction and oversees implementation of national security decisions;
- The appropriate role and remit of the National Security Adviser, including the NSA’s required interaction with the NSC, COBR and ministers;
- The role of key Government departments and agencies in national security policy-making;
- The collection, use and analysis of data across national security relevant departments, and the mechanism for the NSC collecting evidence to aid its decision-making.

This evidence is concerned with early warning capabilities in the key period from November 2019 to February 2020 when the UK proved to be disastrously slow in responding to the developments in East Asia. In particular, the government did not appear to recognise the significance of early indicators of the COVID-19 outbreak or even of the rapid responses implemented by the authorities in some territories such as Taiwan and Hong Kong. It can be argued that this was simply a failed learning experience and that it is unreasonable to apply hindsight to an unprecedented phenomenon. This is not appropriate. The UK government claimed to be a world leader in biological security but in practice it proved to be a world loser. It did not follow the stated policies in the 2018 Biological Security Strategy, nor did it learn from *Exercise Cygnus.* It even closed down the key Threads, Hazards, Resilience and Contingency Subcommittee of the National Security Council less than a year before the COVID-19 outbreak.
Context

At the time of writing (early February 2021) and depending on the definition used, the UK has experienced between 117,000 and 130,000 COVID-related deaths, when it was originally suggested that 20,000 deaths would be a ‘good’ outcome. If the current rapid vaccination programme delivers to its maximum potential then in the best case the eventual death toll may be limited to below 150,000, but with long-term health, social and economic consequences. That probable death toll will be approximately twice the entire civilian death toll within the UK in the six years of the Second World War. Moreover, it is now becoming clear that the COVID-19 virus will be the major component of the world disease environment for some years with the potential to throw up many variants with differing levels of infectivity and lethality.

For the UK, the pandemic is proving to be by far the worst security disaster for 75 years, not least due to serious failings in response, especially in the early months. The Joint Committee will be doing parliament and the country a great service if it can establish the reasons for the failure and ensure that the country comes out of the crisis genuinely better prepared for further biological emergencies. That must include a much-improved capability to recognise and respond to future disease outbreaks at a very early stages and it is in this context that the paper focuses on the experience and responses of the government in the four months to February 2020.

UK Awareness and Response

The Secretary of State for Health and Social Security, Mr Hancock, was made aware of the outbreak on Friday, 3 January 2020, received advice from the UK Health and Security Team on Monday, 6 January and spoke to the Prime Minister, Mr Johnson, on Tuesday, 7 January following his return from a 10-day holiday. Mr Hancock updated parliament on Thursday, 23 January when, according to a government statement the risk level of a pandemic was “Very Low”, remaining at that level until Wednesday, 29 January when it was raised to “Low”, two days before the first reported case in the UK.

The first meeting of the COBRA emergency committee was announced on Friday 24 January but was not held until Monday, 27 January and was chaired by Mr Hancock, not the Prime Minister, who was not present. Neither did he attend the next four COBRA meetings concerning COVID-19.

The developing pandemic was not held to be of particular significance, and this was made clear as part of a major policy speech delivered by Mr Johnson on Monday, 3 February:

“…we are starting to hear some bizarre autarkic rhetoric, when barriers are going up, and when there is a risk that new diseases such as coronavirus will trigger a panic and a desire for market segregation that go beyond what is medically rational to the point of doing real and unnecessary economic damage, then at that moment humanity needs some government somewhere that is willing at least to make the case powerfully for
freedom of exchange, some country ready to take off its Clark Kent spectacles and leap into the phone booth and emerge with its cloak flowing as the supercharged champion, of the right of the populations of the earth to buy and sell freely among each other."

The Prime Minister took a further 12-day break from Downing Street shortly after that speech.

The evolving pandemic only became a core political issue in the UK at the end of February following the first recorded case of local transmission. The UK’s subsequent handling of the COVID-19 pandemic remained in the context of this forcefully expressed belief in focusing primarily on the economy, contrasting with countries that prioritised the pandemic and proved more successful in limiting it. In the UK this has resulted in considerable and ongoing controversy over many issues including the lack of PPE, a weak test and trace system and limited support for well-supervised isolation procedures, inadequate support for care homes, the halting of community testing in March, lack of border controls, delayed imposition and premature ending of lockdowns, failure to bring in a recommended “circuit breaker” and rapid changes in schools closure policies.

**Early Indicators**

Chinese government sources originally gave 8 December 2019 as the date of the first recorded infection with COVID-19 but this was later amended to 17 November. Phylogenetic analysis suggests that the animal/human “jump” could have been earlier and open source commercially available satellite data indicates that there was “a dramatic increase in hospital traffic outside five major Wuhan hospitals beginning late summer and early fall 2019” and that the traffic increase also coincided with elevated activity on a Chinese internet search for “certain symptoms that would later be determined as closely associated with the novel coronavirus.”

On 9 April 2020 one of the main US news channels, ABC, reported that US intelligence sources first got indications of the Wuhan disease outbreak of unknown origin in late 2019:

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

The NCMI is part of the US intelligence system with about 100 epidemiologists, virologists, toxicologists, military medical experts and others based at Fort Detrick in Maryland and charged with tracking potential health and related threats to US military personnel overseas. According to ABC:

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

It had the potential to be a cataclysmic event and was briefed repeatedly to the Defence Intelligence Agency the Joint Staff at the Pentagon and the White House. ABC continued:

“From that warning in November, the sources described repeated briefings through December for policy-makers and decision-makers across the federal government as well as the National Security Council at the White House. All of that culminated with a detailed explanation of the problem that appeared in the President’s Daily Brief of intelligence matters in early January, the sources said. For something to have appeared in the PDB, it would have had to go through weeks of vetting and analysis, according to people who have worked on presidential briefings in both Republican and Democratic administrations.”

In the event, the Trump administration did not see it as a significant issue but staff within the intelligence community saw fit to pass on details to counterparts in allied states including NATO and the Israeli Defence Force (IDF). This was later confirmed in The Times of Israel, quoting a news item on Israel’s Channel 12 news that:

“The US intelligence community became aware of the emerging disease in Wuhan in the second week of that month [November] and drew up a classified document. Information on the disease outbreak was not in the public domain at that time – and was known only apparently to the Chinese government.”

The IDF began planning “for the possibility that the disease could spread to the Middle East”, but the Israeli Ministry of Health did not share this concern at the time, reportedly following the negative response of the Trump administration. At the time of writing there does not appear to be any reliable indication as to whether the UK or any other NATO state took this warning seriously.

Overall, the NCMI work, the Israeli report and the open-source data relating to Wuhan hospital and Chinese web activity all point to knowledge being available to governments in the NATO alliance at a very early stage, leading to a number of questions that should be directed towards the UK government.

Early Responses

UK awareness of the new disease outbreak reached cabinet level on 3 January 2020 and the Prime Minister by 7 January. The first COBRA meeting was not called for three weeks and, even then, the threat level remained “Low”. Meanwhile an assessment of the evolving issue was already in the public domain in the UK in some detail in a report on the digital website of New Scientist on 7 January and in the print edition of 11 January. That report and many others in East Asia were showing that health authorities in several countries neighbouring China were reacting rapidly to the Wuhan outbreak. Actions included checks on the health of travellers arriving in Taiwan from Wuhan even before the end of
December, warnings to health professionals in Hong Kong to be aware of people presenting at hospitals and health centres with respiratory irregularities and even recommendations that such people should be moved to negative pressure isolation facilities.\textsuperscript{xvi} These moves contrast markedly with the UK experience and it is essential to determine why this was the case and why the UK’s response was so lamentably poor.

**Implications**

Prior to COVID-19 the UK government saw itself as world-leading in biological security but failed to demonstrate this in practice even though, as the committee’s earlier report showed, there had been exercises to assess preparedness. There are several reasons that might be given for this failure. They include the inevitable “easy with hindsight” defence but also point to COVID-19 starting half-way round the world, that faster-acting countries had had direct experience of the SARS crisis nearly two decades earlier and that COVID-19 had unusual features, not least its capacity for asymptomatic transmission.

None of these is valid in relation to the UK government’s high level of confidence in its own capabilities. Just over a year after the outbreak in the UK the pandemic has developed into what is, by far, the worst security disaster for generations, with a devastating health impact and a socio-economic and behavioural legacy that may last decades. Furthermore, even this is a best-case scenario and assumes a fully effective transition to generalised vaccination, a test and trace system that is at last fit for purpose and a virus that does not mutate into more dangerous forms. It also assumes that the new border quarantine procedures will be adequate even though they are weaker than those in countries such as Australia, New Zealand and Singapore.

**Questions**

In its report on Biosecurity and National Security (October 2020) the select committee makes many recommendations for improvements to national biosecurity which, if fully implemented, will undoubtedly improve the UK’s ability to respond to further pandemics, more of which should be expected in the coming years and decades. The current inquiry rightly places emphasis on the national security machinery, and this provides an opportunity to explore the role of that machinery in presenting early evidence of the development of the pandemic. In order to do this it would be helpful to have answers to a number of general and specific questions.

**General**

- How does the intelligence machinery, and in particular MI6 and GCHQ, routinely monitor the risks from biosecurity hazards especially pandemics?
- How is this monitoring coordinated with allied capabilities, not least within NATO and especially with the United States?
• Does the intelligence machinery have the equivalent of NCMI and, if so, how is that integrated into the machinery as a whole? If not, is there a broadly equivalent capability elsewhere in the intelligence machinery?

Specific

• How did the National Security Council react to the closure of its Threats, Hazards, Resilience and Contingency Subcommittee in 2019, prior to the COVID-19 pandemic? Did it, for example, change its mode of operations to compensate for that loss?
• How did NATO react to the NCMI report of November 2019, how was this passed on to the relevant elements of the UK’s intelligence machinery and how was that integrated into the UK’s own assessments?
• When and how was the National Security Council first informed of the outbreak and what role did the intelligence agencies play in that process?
• When was the situation in Wuhan recognised in diplomatic missions in the region, especially in Beijing?
• When were reports sent to the FCDO and how were they then shared across government?
• When was the National Security Council first aware of the rapid responses of regional territories and countries to the evolving crisis before 7 January 2020 and to whom was this communicated in the UK?
• Mr Hancock was first informed of the Wuhan outbreak on 3 January. Who informed him and what was the nature and extent of the information?
• What information did the National Security Council receive from Porton Down and when?

These questions are amongst those that may assist in determining the reasons for the UK’s disastrously slow response to the pandemic, a response that has arguably resulted in many tens of thousands of avoidable deaths as well as many survivors who will experience the debilitating and potentially long-term chronic condition of “long-COVID”. They should also assist in responding to the question of whether this was an intelligence failure, stemmed from a particular political approach or was a combination of both.

Conclusion

The pandemic has been a public health disaster that is unprecedented in recent times, has caused huge loss of life and will have long term health, social and economic consequences. It is essential that lessons are learnt from the disaster and while much attention is on the handling of the pandemic once it was embedded in the country it is essential that there is a strong focus on the early months. Indeed, it can be argued that the very slow response at the start of 2020 was at the centre of the disaster that has since unfolded and should be the initial focus of any analysis of the national intelligence machinery and its relationship with government.
Paul Rogers is Emeritus Professor of Peace Studies at Bradford University and an Honorary Fellow of the Joint Service Command and Staff College. He is a biologist by original training, working initially as a lecturer in plant pathology at Imperial College and also as a senior scientific officer in Uganda and Kenya for what was then the UK Ministry for Overseas Development. This paper relies entirely on open source intelligence (OSINT).

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Ibid


It should be noted that the original ABC report did elicit a denial from the NCMI but this was couched in careful words saying of a Coronavirus-related product/assessment in November 2019: “No such NCMI product exists”, but this was issued in April 2020 and did not say what might previously have existed. [https://www.goodmorningamerica.com/news/story/intelligence-report-warned-coronaviruscrisis-early-november-sources-70031273](https://www.goodmorningamerica.com/news/story/intelligence-report-warned-coronaviruscrisis-early-november-sources-70031273)


