

The Nature of the Threat: Culpable Ignorance and the Humiliation of the Johnson Government in the COVID Crisis

A reply to Lawrence Freedman, [‘Strategy for a Pandemic: The UK and COVID-19’](#)

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‘[Boris Johnson’s] hospitalisation on 5 April and close brush with death will have left him with no doubts about the nature of the threat’ - Freedman, page 64.

As the first wave of the Covid-19 pandemic in the UK slowly wanes, controversy wages over the [more than 63,000 excess deaths](#) between mid-March and mid-May 2020, a figure which will increase substantially over the summer and may be the largest in any European country. Deaths in residential care homes make a huge contribution to this toll: [estimated at over 22,000](#), they represent more than 1 in 20 of the 430,000 residents in these homes compared to mortality of less than 1 per 1000 in the rest of the population. The Johnson government’s policy was strongly criticised by independent experts before it introduced a lockdown on 23 March, and it is widely believed that policy contributed to the large death tolls, including its partial [‘seeding’](#) of care home deaths by hospitals discharging untested COVID sufferers into them.

In these inauspicious circumstances, Sir Lawrence Freedman, emeritus professor of war studies at King’s College London, has published a lengthy [‘preliminary account’](#) of scientific advice and political judgement in UK policy-making during the first phase of the pandemic. As one would expect it is a well-informed, often well-judged and nuanced piece. However it has important failings and should not stand unquestioned as the first cut of early UK pandemic history. Above all, it fails to address the culpable ignorance of policy-makers and advisers about the nature of the threat which British society was facing.

Calibrating life-risks with political risk

Freedman’s aim is to establish a first draft of history now, while events are still recent, so that the inevitable future inquiry (he was a member of the Chilcot inquiry into Iraq) does not simply judge with hindsight. It is important, he argues, that this draft accurately reflects what happened at the time; we must not simply judge the decisions of January to March 2020 with the benefit of knowing what they led to in May 2020. The question ‘is not what should have done knowing now the effects of this first stage, but what might have been done given what was known at the time.’ His take is that ‘here was a new and poorly understood virus, with its scope and direction uncertain - coming in either like a strong wind, perhaps barely touching those at its edges, requiring temporary shelter, or else a hurricane, potentially overwhelming those in its path.’ (56) This paper will suggest that these questions were not as open as he suggests. Enough was known in late January, and certainly by mid-February, about the scope and impact of the new

disease for prudent planners to have identified it as probably a mortal threat to the population, and enough about its direction to assume that a hurricane was highly possible.

Freedman acknowledges many failings of the Government's approach, but he allows it considerable leeway. Even over the failure to introduce social distancing between 12 and 23 March - widely seen as the single most consequential mistake and one for which he blames Johnson personally (47-48) - he pulls his punches: 'An earlier, more decisive imposition of the social-distancing measures could well have diminished the extent of the virus's transmission, but that would still have depended on high levels of compliance. It is also possible that the gradual route followed ... meant that people became more accepting and better prepared.' (57) The 'amplifying warnings did not push the country into rash action, and in fact may have come just in time to spare the country an even more desperate experience.' (63) Certainly if 'lockdown' had not begun on 23 March, the situation would have become far worse than it did; but it was the delay, not the many criticisms, which was reckless.

Strikingly, Freedman even suggests that the timing of the lockdown policy can be judged a success: 'most importantly for the government, it met its main target, which was to flatten the curve before the health service was overwhelmed' (57), albeit at the terrible cost of the care home epidemic. Freedman is right about the Government's prime aim. It was, perhaps, no accident that the order of its slogan after 23 March was 'Stay at home. Protect the NHS. Save lives.' Policy was never designed to protect the maximum number of lives, but to save as many lives as was necessary to prevent the collapse of the NHS, which would have constituted a catastrophic failure of government.

Johnson's administration was calibrating the number of lives lost with the threat to the economy and its political credibility, through the crude but simple measure of the capacity of the health service to survive. Yet since it now looks likely that the UK's excess deaths for 2020 as a result of the pandemic will be in the range 75,000 to 100,000, it is difficult to agree with Freedman that 'prevent the NHS from being overwhelmed' (while an essential instrumental goal), should have replaced the simple protection of the population as the main policy aim.

Failing to learn from China

Freedman argues that the Government's choices were shaped not only by capacity constraints - which were to a considerable extent of their own making - 'but also by their incomplete and evolving understanding of the properties of COVID-19'. (26) The disease was indeed new; if our knowledge of it is still incomplete today, it was more so in early 2020. Yet this should not lead to the conclusion that the attributes which were crucial from a policy point of view were *in general* 'poorly understood', as Freedman claims. On the contrary, it appears that it was the UK government and its advisers who poorly understood widely available information, which the World Health Organisation and the governments of some other countries quickly grasped.

Freedman acknowledges that by late January, evidence was emerging ‘of the exceptional infectivity of COVID-19 and the likelihood that it would spread quickly and cause many fatalities.’ (37) Despite the Chinese cover-up in December and January, by this point alarming reports from Wuhan made it clear that the new coronavirus could cause a very dangerous disease. The Chinese regime’s unprecedented policy response was a red flag to policy-makers elsewhere, to which many other governments responded. On 7 February, the widely publicised death of the whistleblower Dr Li Wenliang at the age of only 33 dramatised the shocking effect of the new disease across the age range. Indeed a paper with the same date - ‘Hubei early deaths 2020.07.02’ - was linked in [a paper](#) presented on 10 February to the Scientific Advisory Group for Emergencies (SAGE), the government body whose papers Freedman analyses, by an Imperial College team headed by Neil Ferguson. It included a table analysing 39 cases, 46 per cent of whom died under the age of 70.

Michael Gove, a key minister in Johnson’s government, has followed the US president, Donald Trump, in blaming China, [claiming](#) that some of its reports on the virus were unclear about the ‘scale, nature and infectiousness’ of the disease. Freedman also gives credence to this idea, and certainly later information - about dangers such as recrudescence, lasting damage to survivors, and an extreme syndrome affecting a number of children - has shown it to be even more severe than was understood in early 2020. However the available information still amply showed a very serious threat.

Freedman fails to mention that on 17 February, Chinese doctors released a [comprehensive paper](#) based on an analysis of 72,000 confirmed and suspected cases, which concluded that while the disease ‘may be less severe than SARS and MERS’ (which have very high death rates) it was ‘more contagious’. The paper was widely reported in the global and UK press, and instantly became the major source for WHO and national policies towards as well as scientific discussion of the virus. It described 81 per cent of confirmed cases as ‘mild’, 14 per cent as ‘severe’ and nearly 5 per cent as ‘critical’. However it explained that ‘mild included non-pneumonia and mild pneumonia cases. Severe was characterized by dyspnea, respiratory frequency ≥ 30 /minute, blood oxygen saturation $\leq 93\%$, PaO₂/FiO₂ ratio < 300 , and/or lung infiltrates $> 50\%$ within 24–48 hours. Critical cases were those that exhibited respiratory failure, septic shock, and/or multiple organ dysfunction/failure.’ Half of those in the third category died.

The 81 per cent were distinguished from ‘severe’ by the fact they were not hospitalised, but other reporting suggested that many suffered serious illness in their homes; the WHO soon [renamed this category ‘mild or moderate’](#). The other widely-reported elements of the paper were the age gradient of mortality (from zero for under-10s to 3.6 per cent of cases aged 60–69, 8 per cent 70–79, and 14.8 per cent over 80), the significance of comorbid conditions such as hypertension, cardiovascular disease and diabetes (although 32.8 per cent of victims did not have these), and the fact that 63.8 per cent of the people who died were men.

Some of these elements of the paper clearly informed UK government thinking. Now advisers and ministers repeatedly cited the fact that most cases were ‘mild’, while policy moved towards

dubbing the over-70s and those with comorbidities ‘the vulnerable group’. Yet although the paper was widely influential, Freedman concludes from a meeting of the New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG) on 21 February - several days after it had been widely publicised - that advisers believed ‘there was still considerable uncertainty around what had happened in China.’ (38)

Two main issues suggest that SAGE failed to carefully analyse and absorb key lessons of the Chinese paper. First, the flipside of 80 per cent of cases not requiring hospitalisation was that 20 per cent of cases *could* require this and 5 per cent might require intensive care, if the distribution were reproduced in the UK. This indicated a potentially overwhelming challenge to the NHS (such as Wuhan had demonstrated for the Chinese health system) should this highly contagious disease affect a large proportion of the population in a short period. Although as Freedman points out, John Edmunds’ team argued on 21 February that a UK epidemic could require 220,000 ICU beds against a capacity of 4,562 and proposed that the risk level should be ‘high’, his view (communicated after the meeting as he was unable to attend) was not adopted. Instead, the challenge to systems was not fully recognised by the government at this stage; Freedman suggests that it was only ‘Italy’s terrible experience’ at the end of the month and in early March which would ‘transform attitudes’ even among the advisers; ministers were even slower to respond.

Second, the Chinese paper did not present a sharp disjuncture between vulnerable and non-vulnerable age groups, but a gradient of increased risk in every cohort from age 40. Crucially, the paper showed that the *numbers* of victims were much more evenly distributed across the age range than the *risk* of mortality. In China, half of all deaths were of people aged under 70, a fifth under 60, and there were as many deaths aged 60-69 as 70-79. The disease had not only killed elderly people near the end of their lives, but also many who had decades left to live. Freedman notes that it was acknowledged that ‘older people were by far the most vulnerable but younger people could get infected as well’ (39), but a broad threat to the UK population across the age groups was not recognised. Instead, in the weeks after the appearance of the Chinese paper, the government moved to the view that the over-70s were the core of ‘the vulnerable group’. Chinese experts had indicated on 17 February the nature of the threat with which Johnson would come face to face in April; but neither he nor his advisers had been paying sufficient attention.

Culpable ignorance and its causes

Therefore the UK’s failure was not just that (as the evidence Freedman discusses confirms) its dalliance with ‘herd immunity’ cost lives and it was ‘slow’ (as Labour leader Sir Keir Starmer frequently claims) to test, provide personal protective equipment (PPE), lock down and realise the threat to care homes. Nor was it simply, as Freedman shows, that the government’s advisers continued working from the UK’s internationally praised pandemic influenza plans - despite knowing from a 2016 exercise that they lacked key resources necessary to implement them - and only acknowledged far too late the different character of the challenge posed by COVID-19;

while for the government itself it took second place to Brexit and even flooding in Yorkshire. Rather, the central failure, which informed and amplified all these failings, appears to have been culpable ignorance of the nature of the threat.

Governments' failures to adequately address the available information is a common feature of the international crises which Freedman, like the present writer, studies. In 2003, the UK government followed the US in denying evidence which suggested that the Iraqi regime no longer possessed weapons of mass destruction, and used the residual uncertainty about the issue to hype what proved, as many predicted, to be a non-existent threat. In 2001, 9/11 involved a catastrophic failure of the Bush administration to process and act on intelligence which its agencies possessed about the threat of an al-Qaeda terror attack on the USA. Similarly in 1982, a general 'lack of attention' and 'low priority' by Margaret Thatcher's government to the conflict with Argentina over the Falkland Islands was compounded by 'not recognising the change in political conditions in Buenos Aires' and 'the seriousness of the crisis compared to its predecessors', as Freedman comments in his 1988 book, *Britain and the Falklands War*; the result was an invasion that could have been prevented.

In these crises, crucial information about the threat was variously missed, lost in the system, minimised for political reasons, or misinterpreted. Freedman argues that it 'required a leap of imagination from observing a spreading virus causing distress in China to describing how it might hit the UK.' (62) However there was not only a lack of imagination. If the critical, detailed information available in plain view had been appropriately processed and acted upon, it could clearly have led an approach which would have saved many of the lives which have now been lost. Advisers and ministers were clearly referencing the main source for this information, and yet the severity of the illness, the breadth of the threat to the population and its implications for the NHS seem all to have been poorly understood by both.

Any public inquiry should start by investigating how these groups, between them, came to operate between mid-February and mid-March without anything like as clear a perception of the threat as they could and should have had. The tasks for an inquiry are, therefore, to disentangle the numerous reasons for this situation; to explore the relative responsibilities of advisers and ministers both individually and collectively; to examine the policy failures to which culpable ignorance contributed; and to address the consequences of misrecognising the threat in the implementation of policy. If it is accepted that their ignorance was culpable, the outcomes for those who fell ill from the disease, those who died and their families, and for the wider society which experienced, and will continue to experience, enormously greater disruption to their lives and livelihoods than if the UK government had correctly recognised the threat and developed appropriate policies to address it, will also need to be addressed.

Some possible reasons for this core failure are indicated by Freedman in his discussion of specific failings. They include the 'institutional memory of the overreaction to swine flu' (62), 'groupthink among professional communities' (63), and ministers' failure to ask the experts the right questions or 'interrogate their advice' (63). There was also the core assumption that while

COVID-19 might be somewhat more serious than influenza, it should be treated like it as a disease to be managed - more or less in accordance with the existing flu plans - rather than as one to be suppressed at all costs, as other serious emerging diseases (SARS, MERS, Ebola) had been treated internationally and as COVID-19 was being treated in East Asia. Linked to this, there was an overriding concern with the speed of transmission rather than the clinical effects of COVID-19. This concern of the epidemiologists, who were the most influential scientific group, appears to have prevailed partly because of the absence of strong clinical and public health inputs into SAGE. The bias seems to have been reinforced by a 'behavioural' view, associated with the government's Behavioural Insights Team led by David Halpern, that British people would not comply with the radical lockdowns increasingly seen elsewhere; although as Freedman (61) points out, members of the behavioural advisers group, SPI-B, dissented.

Another factor was the centrality, for UK advisers, of the 'trade-off between protecting as many people as possible from the first wave and being best prepared for the second.' (43) Saving lives in the first wave was treated as a tactical decision, linked to the goal of 'herd immunity' and the idea that only a limited 'flattening of the curve' was required, rather than the moral imperative that - in the light of the government's primary duty to protect the population - an adequate appreciation of the threat would have evoked.

This idea of the trade-off appealed to the government; Johnson called it a 'balance' with protecting the NHS, in his 'take it on the chin' comments of 5 March. It led to his chief of staff, Dominic Cummings, being [credibly reported](#) as talking of a policy of 'herd immunity and let some of the old people die'. For Freedman, this becomes Cummings 'entertaining some sympathy for the idea of herd immunity' (53). The connection of 'let the old people die' - according to journalists, widely used by Conservatives as a shorthand for policy in mid-March - to the escalating mass death in care homes is not explored.

Putting population protection in second place

Therefore culpable ignorance of the nature of the threat reinforced the pursuit of the flawed strategic goals which made the immediate protection of the population a relative rather than an absolute requirement. As has been widely noted, the consequences were dire. One was the abandonment of key measures which might have inhibited the spread and death toll. The UK initially followed classical public health procedures for epidemic management, quarantining citizens repatriated from Wuhan, testing the first cases and tracing and isolating their contacts, but these methods were abandoned. Although the government's Brexit policy had been justified by the increased control of the UK's European borders, no attempt was made to use existing powers to proactively manage the influx of travellers - many of them UK citizens returning from holidays - from northern Italy as its epidemic accelerated in mid- to late-February. Combined testing and tracing continued at a low level but was ended altogether on 12 March. It was almost as though after the 7/7 terrorist attack on London the government had relaxed attempts to identify suspects at the border and stood down teams of specialist police investigators.

Freedman lays a basis for excusing these failures, claiming that governments reading a February WHO report on Chinese tracing efforts - 'more than 1800 teams of epidemiologists, with a minimum of 5 people/team, [were] tracing tens of thousand of contacts a day' - would have been 'daunted' by the challenge of emulating them. (39) Yet governments in Taiwan, Hong Kong, Singapore, South Korea and Germany were not daunted. Mobilising a mass army of tracers was not really a more radical idea than building, as Freedman puts it, 'new hospital capacity around the country with impressive speed' (58), an idea which the UK *did* copy from China. Yet since UK policy-makers were interested in managing rather than suppressing the virus, the idea of a mass tracing system seems to have been so far outside their mindset in February and March as not even to be discussed. Only after criticism grew did the health secretary, Matt Hancock, commit on 18 April to revive testing, tracing and isolating, and to recruit 18,000 tracers; it later transpired that the new system would not be operational until June.

Another profoundly debilitating consequence was a bifurcated communication strategy, which may have encouraged middle-aged and younger people to take a relaxed attitude to the risks of COVID-19 while exposing a segment of the older population to extreme harm. In February and March, ministers and advisers lost few opportunities to reassure people that in most cases the disease was 'mild'. Freedman notes that the behavioural group of advisers (SPI-B) expressed concern that people's sense of responsibility had been undermined by 'messaging around the low level of risk to most people and talk of the desirability of building "herd immunity".' (54)

A question for the inquiry is how the exclusion of middle-aged and younger people from the category of the 'vulnerable' was reflected in NHS operating procedures and affected life-chances in this way. Did the idea that the under-70s were not particularly vulnerable lead to neglect of some cases in younger, and especially much younger, people? There were distressing reports in March of sick younger people who were advised by NHS 111 or ambulance crews to stay at home, as a result dying there or being taken to hospital too late.

The inquiry will need to examine how the 'over-70s' came to be defined as not just 'more vulnerable' but the core of 'the vulnerable group', as it was officially defined from March to early April. Halpern notoriously spoke on 11 March of 'cocooning' the elderly while the rest of the population acquired 'herd immunity'. Freedman criticises only the messaging: 'As an approach to communicating risk, this turned out to be a disaster. The implications were as alarming as the terminology was striking. It appeared that the government was preparing to let the disease rip through the community as part of a cold-blooded experiment in disease management. A more positive argument would have explained that the aim was to "deploy extreme cocooning of the elderly to shield them from severe disease and manage the epidemic such that it did not exceed healthcare capacity", which would have had clear advantages economically.' (50)

Thus Freedman misses the huge questions of substance around the government's age policy. These begin with its formulation. Why was protection proposed for the over-70s, and not for the over-60s, who had been equally represented among the Chinese fatalities - and by early March were filling up the critical-care beds in Lombardy? Freedman notes that in late February SAGE

were discussing 'household isolation of those over 65' (45), and gives no clear explanation for the change to a recommendation for 'over 70' on 10 March. However [a paper](#) for that meeting states that it was 'to be discussed and agreed ... as a change from over 65's', that it had been 'modelled for 65+, 70+, 80+', and that epidemiologically 'models using 65+, and 70+ deliver comparable results'. This raises the question of whether the recommendation for 70 could have been the result of political input. Was this where Cummings and his special-adviser colleague steered the committee?

In one sense the change was modest, but 'over-70s', linked to the idea of 'the elderly', implied that middle-aged people were not at serious risk. Yet when the 55-year-old Johnson was admitted to intensive care, a doctor commented, 'fat, 50s', as if he conformed to a recognised type; but he was well under 70 and so, like the other government figures who became ill, had not thought himself at risk. He ultimately escaped the consequences of believing his own propaganda, but the inquiry will need to investigate whether it had fatal consequences for other middle-aged and younger people: [figures](#) from the Intensive Care National Audit and Research Centre (ICNARC) show that the 60-69 and 50-59 age groups have both been *more* represented in UK critical care deaths than the 70-79 and 80+ groups; 91 per cent had lived without assistance, i.e. were not elderly in a clinical sense.

The larger questions, of course, concern the age policy's effects on the over-70s themselves. Was it possible to sufficiently protect them (and those with comorbidities) to justify the decision to allow the virus to spread through the younger population? Did advisers and ministers seriously prepare measures to ensure that protection worked? Freedman represents 'household isolation' and 'special measures around care homes' as equal parts of the 'additional strategy' for older people which complemented 'herd immunity'. However the former involved little more than social distancing advice, which many older people had worked out for themselves even before the official recommendation. It can certainly be argued that many over-70s, especially those like the present writer who were old rather than 'elderly' and possessed adequate social, financial and living resources, managed successfully to isolate themselves through the first wave of the pandemic. The INARC figures could reflect the success of this approach.

However the protection required for care home residents was of an altogether different order, and almost entirely lacking. Far from being cocooned, they were more or less transformed into mass targets for the virus. The absence of protection for the care sector was understood at the time: I sit (as an Independent county councillor) on the Devon Health and Adult Care Scrutiny Committee, which the Chief Executive of Devon County Council and coordinator of the regional response in the South West, [told on 12 March](#) that there was 'a real absence of support for social care' in the government's preparations for the pandemic. A week later, NHS England ordered a mass discharge of hospital patients, into care homes if necessary, without testing.

Freedman does not go far into the wide-ranging questions which the care home mass death raises for the government's strategy, but they are fundamental. Was it ever realistic to imagine that *this* section of the 'vulnerable group' could have been insulated from a rising epidemic in

the population? Given the way homes operated, was there ever any possibility that, once the virus had entered, they would be able to contain it, even with adequate personal protection equipment which many care workers were denied throughout much of this period? Why was there, apparently, far too little consideration of the risks from discharges, or the need for comprehensive measures (such as those belatedly introduced in mid-April) to inhibit the entry of the virus and its spread inside homes? Why were COVID-positive residents not treated in separate facilities, as in some other countries? Equally serious are questions about the treatment of COVID-positive residents. What were the effects of the attenuation of GP services to care homes during the crisis? Did residents have equitable access to hospitals? The ONS [found in May](#) that 72 per cent of residents' deaths had occurred in the homes rather than in hospital: did this reflect the care they needed, or decisions based on the idea that 'elderly' residents were not a priority for hospital care?

Of course, Freedman is not alone in accepting the government's age-bifurcated policy; it has hardly been questioned. The statistician David Spiegelhalter even [claims](#) that COVID-19 is a 'disease of the over-75s almost completely'. However the over-representation of older groups in the death tolls is largely an artefact of the care home mass deaths, which constitute over one-third of the total. In May, [ONS figures](#) showed that men aged 75-84 outside care homes had been 18 times less likely to die during the epidemic than men of the same age in care homes. This was a measure of the catastrophic effect of government failures in this area.

The politics of humiliation

Freedman concludes his assessment: 'His [Johnson's] hospitalisation on 5 April and close brush with death will have then left him with no doubts about the nature of the threat and that his decision [to impose a lockdown on 23 March] was correct.' These comments, following criticisms of the prime minister and his government, imply that by then Johnson had corrected the dire mistakes to which his cavalier attitude to COVID-19 together with the policy failings of his government and its advisers had contributed.

This is altogether a far too optimistic note on which to end an assessment of this phase. Johnson's U-turn was a recognition that policy in the preceding weeks had been deeply flawed and was on the verge of precipitating the collapse not only of the NHS but also, if that had happened, of the government itself. Freedman strangely treats Johnson's administration as just 'the government' but it was the most extreme, right-wing regime in Britain's history, a brittle personalised construct with inexperienced and ultra-obedient ministers which had come to power by eviscerating the traditional Conservative coalition and wresting the political legacy of Brexit from Nigel Farage's eponymous party.

Therefore Freedman does not mention that Johnson initially saw COVID-19 as a threat to the fantasy of 'Global Britain', as he [warned](#) on 2 February that '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'. The

congruence of the scientific advisers' epidemiologically-based inattention to the nature of the COVID-19 threat with the government's determination to let nothing tarnish Brexit should not prevent us recognising that the former suddenly found themselves in a hugely consequential negotiation with ruthless, ultra-centralised political operators.

As Johnson skipped no fewer than five meetings of COBRA, the government's emergency committee, Cummings (who had recently had the Chancellor of the Exchequer fired) was no ordinary political adviser but the embodiment of the absent Johnson's power. His unprecedented presence *inside* SAGE, which Freedman finds wholly unproblematic, cannot have been anything but intimidating to the scientists, who were understandably 'struggling', as he puts it, to understand the unprecedented crisis and recommend an adequate policy.

The government's [ideology of British exceptionalism](#) also played a much more significant role than Freedman allows. Its epidemiological advisers were at least part of the global scientific effort to address the disease, even if they ignored crucial data. Ministers however were determined to absent themselves from European cooperation, and when in mid-March they belatedly discovered a likely ventilator supply problem, indulged in a [bizarre and predictably unsuccessful appeal](#) to manufacturers of all kinds, if necessary to invent (in the course of days or weeks) a new British ventilator.

Freedman's account also suffers from a methodological variety of nationalism, exempting British policy-makers from serious international comparisons despite the fact that this was a global pandemic in which governments everywhere were grappling with the same problems. Comparisons might reveal that many governments made serious mistakes, some of them similar to the UK's. But they would also highlight the advantages which the country had from observing not only China but also Italy and Spain, and how these were squandered especially in the month before March 23, in a reckless disregard of the nature of the threat which was exceeded only by even more maverick populists like Trump and Jair Bolsonaro.

In this sense, Johnson's policy was a disaster for British society and exposed the prime minister and his government in a way which bears comparison with what Freedman rightly called the 'humiliation' of the Thatcher government when Argentina invaded the Falklands, and the similar humiliations of the George H. Bush administration over the Iraqi invasion of Kuwait and of the George W. Bush administration over 9/11. Yet despite his evident awareness of these precedents, Freedman is strangely silent about the dilemma which Johnson's humiliation creates for his regime. In all those cases, leaders reacted to humiliation with decisive military action and recovered their positions by removing their enemies from the field. Johnson responded with a lockdown, of which public opinion was overwhelmingly supportive; even critics acknowledged that Johnson had made the right decision.

Yet even at this moment, the regime recognised the nature of the political threat which it had allowed to emerge. On 30 March, it [rehired Isaac Levido](#), architect of the December 2019 election success, to manage its coronavirus messaging. By 11 April, it had a new public

information video which finally conceded that the coronavirus was ‘threatening to people of all ages’. But his real task, it seems certain, was to work out how to prime public opinion (which, as Freedman notes, the government has been tracking since February) with the Tories’ defence as the multiple scandals of the crisis, over PPE, testing, ethnic minority deaths, etc., threatened to derail what had seemed the UK’s most dominant government in decades. This threat has now become crystallised in the huge national scandal of the care home mass death.

The threat from the March humiliation remains acute because the lockdown brought only a brief respite, and the pandemic and economic crisis threaten to be lengthy and debilitating. Above all, the situation is hugely politically charged because the government had made only a fairly short-lived tactical adjustment to its policy (albeit a major one) on 23 March. By late April, ministerial discussions on their ‘exit strategy’ (a term of military origins, Freedman [reminds us](#)) centred on the idea of ‘[running hot](#)’, allowing infections to continue at the level which could be contained within the expanded hospital capacity. This choice would inevitably threaten broad public support, and possibly even divide the government’s core Brexit coalition.

It was not clear that advisers, whose fingers had been badly burned in the first phase, were so keen on this new version of the ‘flattened curve’ strategy, but it seems to have struck a chord with Johnson. His much-criticised mixed messaging as he eased the lockdown on 10 May seemed to have been designed to nudge a proportion of mainly manual workers back to work even at the cost of a sustained pattern of moderately higher death. However the rate of the reproduction of the disease (R_0 , popularised as ‘R’) was to be kept under 1 to protect the hospital system.

Therefore although the idea of ‘herd immunity’ has been abandoned (estimates of the proportion of the population infected are still in the range 5-10 per cent, compared to the 60 per cent or more regarded as necessary for immunity), the kind of trade-off envisaged of in February and March is still central to policy. As the government aims to persuade younger people to return to work, [official guidance](#) appears to have abandoned the briefly-embraced idea of a broad threat to the population, returning to the idea that ‘those aged over 70, those with specific chronic pre-existing conditions and pregnant women’ were ‘more clinically vulnerable to COVID-19 than others’.

Rather than Johnson’s having ended conflict over his government’s approach on 23 March, the post-lockdown phase is rapidly reviving the controversies of the early period. Without a widely available vaccine, effective treatments or a very ambitious test, trace, and isolate policy, there appears likely to be considerable resistance to what would effectively be a partially sighted return to normal working and social life. Given the low priority the government has given to clearing the ‘fog’ of the pandemic, society’s appreciation of the nature of the threat seems likely to partially frustrate its attempts to promote a slow return to something normal. This tension threatens a kind of stalemate between government and society, as well as within the electorate, in which the divisive politics of the Brexit period, briefly suppressed during the lockdown, are beginning to return.

As political and media criticism of the government's policies mounts and its approval ratings fall, the question of Johnson's fightback is becoming more acute. Lacking the diversionary military response which humiliated governments had reached for in violent crises, will he opt for its political equivalent, following Trump (as Gove did in April) in ramping up the attack on China? Johnson's rise to power from 2016 to 2019, guided by Cummings, showed exceptional ruthlessness and willingness to take political risks. As the threat to Johnson's government increases, the politics of the pandemic are likely to darken.

In these circumstances, Freedman's assumption that there will be a meaningful inquiry into the period up to 23 March is highly questionable. While it is crucially important to provide a first draft of a reliable account - and to that end this article has tried to supplement and correct his version - balanced judgement is unlikely to be sufficient against a regime which came to power by mobilising racist nationalism, suspending Parliament and attacking judicial and broadcasting independence, and now finds itself increasingly cornered by an unexpected crisis which it simply failed to understand.

25 May 2020

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