Witness Name: Professor Sir Michael McBride
Statement No.M1/MCBRIDE/01
Exhibits:
Dated:

UK COVID-19 INQUIRY

WITNESS STATEMENT OF PROFESSOR SIR MICHAEL McBRIDE

I, Professor Sir Michael McBride, will say as follows: -

1. I, Professor Sir Michael McBride, Chief Medical Officer (CMO) for Northern Ireland, make this statement in response to the request from the UK Covid-19 Public Inquiry ("the Inquiry) dated the 15th February 2023 under rule 9 of the Inquiry Rules 2006 (SI 2006/1838), requiring me to provide the Inquiry with a witness statement in respect of specified matters relating to Module 1.

2. The focus of this statement is my experience and views of pandemic preparedness and planning ahead of the Covid-19 pandemic, including developments and changes during the course of the pandemic, and my professional views on how these could be improved and made more resilient. This additional request from the Inquiry covers a period of some 17 years of my being in post as the CMO, in which there have been many changes in personnel within the Department of Health, and in structural and organisational arrangements, locally and across the UK, in pandemic planning and preparedness. Given the passage of time, this statement reflects my recollection and observation over this period, to the best of my ability, while recognising others' recollections and views may differ.

3. In my experience of numerous incidents, outbreaks, and pandemics there are always areas, with the benefit of hindsight, where it is considered that capabilities and response capacity could have been better. This is undoubtedly the case in the

Covid-19 pandemic which presented an immense and unprecedented global challenge. While ultimately a matter for the Inquiry to determine, in my view, the Department of Health did seek to ensure an appropriate and proportionate level of pre pandemic planning and preparation, with the resources available and in the context of many other competing priorities.

4. The four UK CMOs, along with other colleagues, have written a technical report for our respective successors to share information and learning acquired throughout the pandemic, with the aim of informing the response to any future pandemic. While we recognise each pandemic will be different and depend, in large part, on the pathogen and mode of transmission, there are certain areas of commonality which will be important for future planning and preparations. These are addressed in the four nations CMO's Technical report on the COVID-19 pandemic in the UK [see exhibit INQ000199192]. This report considers a number of aspects and issues of relevance to Module 1 of the Covid-19 Inquiry and may be of assistance.

5. While I will not rehearse here the content of this report, there are a number of areas I would wish to highlight. In chapter 1 we have included a section on "understanding the pathogen" which describes the emerging knowledge of the characteristics and epidemiology of SAR CoV-2. We also provide a number of reflections and advice for future CMOs or CSAs on a range of areas, which I believe are important for future pandemic preparedness. For example, in chapter 5 we consider future modelling capacity to inform decision making and opine that this may benefit from a broader based approach to include economic modelling, in addition to epidemiological modelling.

6. In chapter 6 we consider the significant limitation in testing capacity at the outset of the pandemic, and the unprecedented subsequent expansion of this. For the future it would, in my view, be of benefit if the diagnostic industry was included in contingency planning as key partners in providing surge testing capacity. We also consider the operational challenges faced in contact tracing given the challenges of pre-symptomatic and asymptomatic transmission in the absence of routine mass asymptomatic testing. As a well-established and effective public health tool, it is essential that future pandemic preparedness includes contingency planning for large scale contact tracing, supported by digital platforms, and adaptations for

older people and those with visual or hearing problems. While operational arrangements were developed at considerable pace during the pandemic response, there was not an established operational plan at the outset, and the contact service in Northern Ireland, as initially developed, required subsequent review and significant expansion. I discuss this issue and testing later in my statement.

7. In chapter 8.2 of the UK CMOs technical report we consider the profound impact of the Covid-19 pandemic on residents, staff, carers and families in care homes. In effect, during the pandemic there were three separate ongoing pandemics: (i) in the community; (ii) in care homes (which closely followed the level of community transmissions and prevalence); and (iii) in hospitals. Future pandemic preparedness should particularly focus on those most at risk of harm due to clinical vulnerability and also as a consequence of health inequalities, recognising that the impact may vary, depending on the pathogen and route of transmission. It is however highly likely that given age related factors, the level of close personal care required and other environmental factors, those in care homes will remain particularly vulnerable in future pandemics, especially in any respiratory disease epidemic.

8. I have structured my statement to summarise the high level organisational structural and wider system arrangements which are covered in greater detail in the Corporate and CMO/CSA Module 1 statements [Reference M01/NIDOH/01, M01/HSCNI/01 and M1/CMOCSANI/]. I do not intend to repeat information already provided in those statements unnecessarily, but some context is required to properly address the questions posed in this rule 9 request, particularly in relation to the systems, processes, and structures for pandemic preparedness in Northern Ireland. I have provided some reflections on how well these arrangements worked in achieving pandemic preparedness and how they might be improved. In providing these comments I have drawn on my experience of previous emergency situations, outbreaks, and the 2009 H1N1 pandemic. As a general point, in my experience, no plans or structures are entirely adequate and require flexibility and scalability during response, speed in decision making, and adaptability – all plans, by necessity, evolve during the course of any response. This type of agility and

flexibility is essential, as is post-response review, and regular testing of capabilities and identification of gaps in those capabilities. I have sought to cover my specific role and function as CMO for pandemic preparedness, learning during the pandemic, and to detail my conclusions.

PART 1: STRUCTURE, POLICY AND RESOURCES THAT SHAPED NORTHERN IRELAND'S PANDEMIC READINESS

Overview

9. As outlined in the Module 1 Corporate Statement, The Executive Office (TEO) is responsible for leading civil contingencies preparedness and response, as well as the non-health pandemic planning and the wider consequence management in Northern Ireland. TEO is also responsible for co-ordinating both health and non-health advice to the Northern Ireland Executive, to assist Ministers in making decisions which are cross-cutting in nature. This is an extensive remit and consideration should be given to the level of specialist technical knowledge, expertise and capabilities and capacity to fulfil these responsibilities to lead and support this work. The Department of Health is responsible for managing the health consequences of emergencies; this has been articulated in the Department's Lead Government Department Plan since 2010 and subsequently in the Department's Emergency Response Plan of 2019 [see exhibit INQ INQ000184662].

10. The key strategic emergency preparedness body for the public sector in Northern Ireland is the Civil Contingencies Group (Northern Ireland) (CCG(NI)). This group is chaired by the Head of the Northern Ireland Civil Service and the Secretariat is provided by TEO. The Department is represented at all meetings of the CGG(NI).

11. As previously described, CCG(NI)'s role is to provide strategic leadership to civil contingencies preparedness; to exercise a corporate governance function for civil contingencies preparedness; to oversee delivery of a cross-cutting work programme to enhance resilience across the public sector; to share information on civil contingencies risks and preparedness; to participate in the effective delivery of

the Northern Ireland Central Crisis Management Arrangements (known as NICCMA) during an emergency; and to report to Ministers.

12. Under the Northern Ireland Civil Contingencies Framework – originally published by TEO in 2011 – the Department of Health is required to maintain, review, test and exercise, and update an Emergency Response Plan to ensure its ability to deliver an effective response to emergencies. The Northern Ireland Civil Contingencies Framework 2011 also outlines the external entities with which Health and Social Care organisations are required to work, in terms of preparedness and response to emergencies. All Northern Ireland public service organisations are required to discharge their civil contingency responsibilities under this Framework (this Framework was updated in 2021 – exhibit INQ000188740).

13. As described in the Module 1 Corporate Statement, within the Department, Emergency Planning and Preparedness is recognised as a key corporate function and as such is included in the Departmental Risk Register [exhibit INQ000185379]. My observations in response to pandemics and severe weather events, based on my experience from 2006, is that all government departments in Northern Ireland and their arm's length bodies should now take prompt action to fully engage with emergency preparedness training and exercising in order to gain a shared understanding of respective roles and responsibilities. This is an essential prerequisite for a fully integrated whole of government and cross-sectoral response at times of extreme challenge, such as during a pandemic. Given changes in personnel and associated loss of experience over the years, this capability will need processes to be put in place to ensure it is maintained.

14. A review of the role, purpose, and membership of all strategic and operational civil contingencies groups such as CCG(NI), NI Emergency Planning Group, C3 working group and the associated emergency planning groups and workstreams would, in my view, be beneficial. It is also important that these roles and structures are subject to planned regular review and that these arrangements are kept under regular review by respective Permanent Secretaries, Departmental Boards and the overarching Northern Ireland Civil Service Board. In order to maintain focus and to identify future opportunities for improvement, consideration should be given to

proportionate regular planned review by Departmental Internal Audit and the Northern Ireland Audit Office (NIAO).

Health and social care sector

15. The second phase of the Review of Public Administration in 2009 saw the establishment of the Health and Social Care Board (HSCB), the Public Agency (PHA) and the Business Services Organisation, in the weeks immediately prior to the start of the 2009 H1N1 pandemic. This presented some challenges during the pandemic response with newly established organisations, organisational interfaces, and people new to certain roles within these structures – albeit experienced public health consultants and staff with previous emergency preparedness experience transferred from the old to the new structures. However, the new structures also presented opportunities to revisit and realign previous emergency planning arrangements and provided a renewed focus on health improvement and health protection with the establishment of the PHA. Following the Hussey review [exhibit INQ000187742] and the experience of the pandemic, there is now a further opportunity to consider in the ongoing organisational review of the PHA, the additional capabilities and capacity required within the PHA, subject to the normal resourcing considerations.

16. Department of Health responsibilities and those of its Arm's Length Bodies (ALBs), in respect of emergency preparedness are outlined in DoH Policy Circular HSC (PHD) Communication 1/2010 – Emergency Preparedness for Health and Social Care [exhibit INQ000188755]. This circular was issued in light of the changes in Health and Social Care structures as a consequence of the implementation of the Review of Public Administration in 2009. The terms of reference and membership of the Northern Ireland Health Emergency Planning Forum, which the Department and the PHA co-chaired, were refreshed in order to ensure that the requirements of the 2010 Policy Circular were met. The revised role of the Northern Ireland Health Emergency Planning Forum was to: advise and inform all HSC organisations about aspects of emergency preparedness; share good practice and facilitate the promotion of continual improvement in emergency preparedness; provide feedback on emergency preparedness strategies and policies (including

Controls Assurance Standards/Core Standards); and provide a forum for discussion of training needs and best practice.

17. A further practical outcome of the 2010 Policy Circular was the establishment of a Joint Emergency Planning Board (JEP Board), co-chaired by the HSCB and the PHA, and supported by the Emergency Planning leads in the HSCB, PHA and BSO. The purpose of the JEP Board was to seek assurance on HSC preparedness to manage a response to emergency incidents (in adherence to the 2010 Policy Circular and within the context of the Northern Ireland Civil Contingency Framework), and to ensure an appropriate and proportional level of HSC preparedness to enable an effective HSC response to emergencies which have a significant impact on the local community.

18. Taken together, these changes helped to reaffirm emergency preparedness responsibilities across the Health and Social Care Sector and brought renewed focus on the significance of emergency planning.

19. As detailed in the Department's Emergency Response Plan (ERP) [see exhibit INQ000184662], the Department is responsible for leading and co-ordinating the health response when an emergency has been categorised as serious or catastrophic and requires a cross departmental or cross-governmental response. My experience is that this plan has been kept under review, updated, and tested and was helpful in preparing for pandemic response. The testing element is of critical importance and requires significant planning and preparation, whether across the UK or locally, if it is to be done well. There needs to a firm commitment to prioritising the testing of plans and capabilities. Although it is understandable, on occasion, that the testing of such plans has been postponed due to other more immediate priorities. An example this was Operation *Yellowhammer,* which is covered more fully below [at paras 55-56].

20. I also believe there would be significant benefit in conducting such testing of emergency response plans and joint exercises on a North/South basis involving respective Northern Ireland and RoI health departments, expert advisory arrangements and other relevant government departments. While a matter for respective Ministers, given the cross jurisdictional dimensions, the experience of

the Covid-19 pandemic would suggest that consideration should be given to testing such arrangements at a UK/Ireland level.

21. In respect of health and social care organisations, it should be noted that the Health and Social Care Board (HSCB) remained as an entity until its dissolution under the Health and Social Care Act 2022. The functions of HSCB were transferred in the main to the newly established Strategic Planning and Performance Group (SPPG) located within the Department of Health. The SPPG reports directly to a Deputy Secretary within the Department, rather than functioning as an ALB. The role of the SPPG as the Commissioner of HSC services is to work with service providers in HSC Trusts in agreeing levels of service and making payments, thereby ensuring resources are used in the most effective and efficient way.

22. Following the Covid-19 pandemic it would be best practice for respective organisations in health to review the effectiveness of all of the extant arrangements for emergency planning and preparedness and to identify any potential areas for improvement. As Departmental policy lead I intend to commission a review of the health arrangements to ensure future resilience as part of our lessons learned exercise and will wish to take into account the learning identified by the Inquiry.

Controls Assurance Standards and Core Standards

23. The Controls Assurance Standards (CAS) process was in place within the Department from 1 April 2002 – 31 March 2018. At the direction of the Department, all relevant health and social care public bodies were required to annually self-assess their compliance against the Emergency Planning Controls Assurance Standard (CAS). Each organisation was expected to demonstrate that it had a scalable emergency preparedness plan enabling it to respond to a range of emergency situations, and that it had pandemic influenza preparedness and response plans in place. If there were any gaps in compliance, organisations had to demonstrate actions that they would implement to enable full compliance and provide an associated action plan.

24. In April 2018 the CAS process was replaced by the Core Standards Framework [exhibits INQ000188761 and INQ000188762] for Emergency Preparedness which

is based on NHS England Core Standards. ALBs were required to assess and report annually on their organisation's level of assurance, based on Evidence of Assurance examples provided. There are 2 Core Standards, one for Emergency Planning and a second relating to Hazardous and Toxic Materials. All organisations had to complete the former, whereas only HSC Trusts, NI Ambulance Service (NIAS) and NI Fire and Rescue Service (NIFRS) had to complete the latter.

25. The criteria that were assessed included: Duty to Maintain Plans – Emergency Plans and Business Continuity Plans; Training and Exercising; and Preparedness. The organisations' plans were expected to reference pandemic influenza and infectious disease outbreak and associated generic roles all parts of the organisation have in relation to emergency response.

26. Core Standards returns from the ALBs were assessed for compliance by the Department's Emergency Planning Branch and a summary was provided to me by way of assurance. In a similar vein to the CAS process, for any areas in which "full" assurance could not be determined, ALBs were required to identify any mitigating factors and the action they proposed to undertake to attain full compliance. Revised arrangements in 2022, following dissolution of the HSCB, required HSC Trusts to submit their Core Standards Returns to SPPG for assessment, with SPPG providing a summary report to the Department on compliance across the sector. All other ALBs, including PHA, SPPG, and BSO submitted individual returns in respect of the Core Standards to the Department.

Resources

27. While I am unable to provide specific supporting evidence, it is my view that changes in people and organisational arrangements over the 17-year period I have been in post have had an impact on system preparedness. These impacts were both positive and negative in terms of skills and experience, corporate memory and system capacity and capability. While as outlined below I was able to achieve a relatively modest increase in resources for emergency planning within the Department, I should highlight that the prioritisation of finances for emergency planning generally is the responsibility of accounting officers (Permanent Secretaries and Chief Executives) in the respective government departments and

HSC organisations (and other public bodies). In the normal course of events, emergency planning and preparedness will always be competing against more immediate priorities faced by departments and public bodies.

28. There is a continual balance required between what may be needed in the response phase to any emergency or pandemic and what is proportionate and affordable at other times, given other priorities. During this period there was generally a modest increase in capacity within EPB from when I first took up my role in 2006. In 2008 I successfully bid for additional staffing resource to focus particularly on our pandemic preparedness in the Department to bring us in line with timescales for delivery in the rest of the UK. This increased the number of staff from 6 to 10 in the Emergency Planning Branch in 2008. This additional staffing was of enormous benefit during the 2009 H1N1 pandemic response. These additional posts were not intended to be permanent, due to budgetary constraints within the Department, however we successfully retained two additional posts and permanently increased our staffing complement to 8 staff within the Emergency Planning Branch. Funding for and resourcing requests made in respect of NI's contribution to both local and UK stockpiles of PPE and antiviral drugs were always supported by the Permanent Secretary and were funded accordingly by the Department. The exact amounts vary year-to-year, depending on the expiry dates of items in the stockpile and the costs of replacement products. Sums in the order of £2 – 5 million were spent annually in the 5 years immediately preceding the pandemic.

29. Over the subsequent period, partially in response to major exercises, the H1N1 pandemic, and in particular as a result of the preparations for a "no deal" EU Exit, there was a much welcome and greater focus on interdepartmental planning, and preparation and capacity building. Last year, given the experience of the Covid-19 pandemic, I commissioned a review to inform subsequent restructuring of structural and staffing arrangements within my command (the CMO Group). One of the aims of this review was to increase the dedicated resource in this area with the establishment of a new directorate within CMOG, the Emergency Preparedness, Resilience and Response Directorate with a focus on pandemic preparedness and building further Departmental capacity and skills for emergency response [exhibits INQ000187743 and INQ000187744].

Integration with UK structures and processes

30. Given its relatively small size, Northern Ireland does not have the capacity or capability to replicate the systems, processes, and structures for pandemic preparedness in other jurisdictions. In that context Northern Ireland benefits from close integration into wider UK systems both in terms of planning, preparation and response. Some key areas of integration are outlined below.

31. Northern Ireland does not have its own Scientific Advisory Group for Emergencies (SAGE) but relies on the independent scientific advice provided by the UK SAGE group. NI representation at SAGE meetings, either with observer or with participant status, is dependent on the nature of the emergency being experienced. For most of the Covid-19 pandemic, the Chief Scientific Advisor (CSA) or deputy CSA attended as a SAGE participant and throughout we received the minutes of meetings, and consensus recommendations. We were sighted on all papers reviewed.

32. The Joint Committee on Vaccination and Immunisation (JCVI) provides advice to all 4 UK health Ministers/Departments on vaccination and Immunisation matters. It has a statutory role in England and Wales, while health departments in Scotland and Northern Ireland may choose to accept its advice. JCVI draft recommendations and minutes of meetings are shared with relevant officials in Northern Ireland. The advice of JCVI in my experience has always been accepted by Ministers in Northern Ireland.

33. The New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG) is an expert committee of the Department of Health and Social Care (DHSC), which advises their CMO and, through the CMO, ministers, DHSC and other government departments. It provides scientific risk assessment and mitigation advice on the threat posed by new and emerging respiratory viruses and on options for their management.

34. NERVTAG's scope includes responsibility for identifying new and emerging respiratory virus threats to human health including strains of influenza virus and other respiratory viruses with potential to cause epidemic or pandemic illness, or

severe illness in a smaller number of cases. NERVTAG is scientifically independent and draws on the expertise of scientists and health care professionals together with colleagues in related disciplines.

35. NERVTAG communicates its advice to UK health departments through the published minutes of meetings and through statements. Ministers, CSAs or Medical Advisors may request advice from the Committee directly. The Department attends NERVTAG meetings as an observer, and was represented during the Covid-19 pandemic. Given the highly specialist nature of the expert advice, Northern Ireland would generally follow NERVTAG advice.

Pandemic Influenza Strategy

36. The UK Pandemic Influenza Strategy was revised and published in 2011 [exhibit INQ000188766], following the completion of lessons learned in relation to the 2009 H1N1 pandemic [see exhibit INQ000183435]. Following on from that the Department revised and published NI Health and Social Care Influenza Pandemic Preparedness and Response Guidance [see exhibit INQ000183431] to assist HSC organisations to revise their pandemic preparedness plans in 2013. Revised plans at UK and Northern Ireland level were rehearsed through Exercise Cygnus in 2016, focusing on a more severe pandemic than had been experienced during the 2009 H1N1 response. Lessons learned [see exhibits INQ000183434 and INQ000183435] were identified at local and UK level following the exercise and we again amended our Emergency Response Plan at local level [see exhibit INQ000184662].

37. By 2018, UK pandemic planning was being led by Whitehall via the National Pandemic Flu Readiness Board, with representation from devolved administrations. In light of learning from Exercise Cygnus, a number of UK workstreams had been developed, of which Northern Ireland was a part, namely: Surge and Prioritisation, Excess Deaths, Community Care, and Moral and Ethical.

38. In March 2018, I established a NI Pandemic Flu Oversight Group (with representation from the Department, the then HSCB and the PHA) to oversee development of HSC Influenza Pandemic Surge Guidance during 2019. Furthermore, in November 2018, I requested that the PHA and HSCB establish a

Task and Finish Group to develop updated Northern Ireland pandemic flu guidance. The output of that work was the Northern Ireland Health and Social Care Influenza Pandemic Surge Guidance, which was submitted to the Department's Emergency Planning Branch (EPB) in draft form on 1 July 2019. As covered in the Module 1 Corporate Statement, it was determined by EPB that further work was required on this guidance, however this was paused as capacity was redirected to preparation for a potential "no deal" EU Exit throughout the remainder of 2019. There was no opportunity to promptly resume this work subsequently due to the emergence of the COVID-19 pandemic in January 2020. However, work on pandemic preparedness did resume on a four-nations basis late in 2022, with the establishment of a new Emergency Preparedness, Resilience and Response Directorate, within CMOG. This relatively new directorate leads the strategic and policy work in this area and works with a wide range of stakeholders to ensure that effective response arrangements are in place at a local, UK and international level.

PART 2: WHAT WORKED WELL IN PREPARING NORTHERN IRELAND FOR A PANDEMIC

Communication, messaging, and information sharing

39. Northern Ireland benefitted significantly from close integration with the UK wide response activities, and we had full access to and the benefits from emerging research evidence and information and learning. This information and evidence was shared through the range of UK structures that had been established as part of pandemic response some of which are highlighted above. Access to this information and the Department's membership of these UK wide arrangements ensured that the advice that professional and policy colleagues and I provided to the Health Minister was as fully informed as possible. It also allowed for situational awareness of the impact of new variants as they arose in the various jurisdictions at different times.

40. As an emergency evolves, my role as CMO is to ensure that data is disseminated clearly to inform decision-making. One of the challenges identified during the 2009 H1N1 pandemic was collation of information which was not routinely collected or

collated in real time. As the H1N1 pandemic reached its peak, the demand on senior staff to respond to requests for media interviews and to counteract misinformation became unsustainable. Significant demands were also placed upon the Departmental statistical staff to provide rapid, up-to-date information on a regular basis. In response to this, I introduced and fronted weekly media briefing sessions, accompanied by a panel of experts from across health and social care organisations. These sessions provided a forum for updating and informing the public and the media, and for sharing the facts of the situation to avoid the spread of misinformation. This arrangement proved to be extremely useful and set a rhythm for proactive interaction with the media and reduced the number of ad hoc queries during the H1N1 pandemic.

41. During the Covid-19 pandemic however, public communications were developed in conjunction with the other UK CMOs and in line with the UK Pandemic Flu Communications Strategy. The aim was to ensure consistency and clarity in messaging across the four nations, recognising that this was important in terms of public understanding, and it was designed to support the profound behavioural change that was being sought from the public.

42. During the response phase, building on learning from the H1N1 pandemic, I commissioned a Covid-19 Public Information Dashboard [exhibit INQ000130401] from Departmental statisticians to provide a common data source covering a wide range of data that could be shared widely with decision makers, HSC staff, the media, and the public simultaneously. The Dashboard included NI wide summary information about the volume of testing and the number of deaths reported by HSC Trusts that were associated with Covid-19. Although the Dashboard was based on similar information published by other UK jurisdictions, the NI Dashboard included additional data about ICU bed occupancy and availability.

43. The intention was to provide data in a clear and understandable way to support decision making and share evidence of the impacts of planned health interventions. It was also intended that the Dashboard would help to minimise multiple requests being made to the Department for the same information/ briefings and thereby avoid duplication of effort and unnecessary burden on staff. Reflecting on my experience during the Covid-19 response, while the requests for

information remained significant I consider that the Public Information Data Dashboard [exhibit INQ000187741] was key to data transparency and effective engagement with the public on planned health interventions. During the pandemic, and following an external review of the capacity and capabilities within the PHA by the former CMO of Wales Ruth Hussey [see exhibit INQ000187742], there has been significant work on data acquisition, flow and analysis within the PHA. This dimension and other areas are now being considered as part of a wider organisational review of the PHA.

44. The CSA and I worked closely with communication colleagues in the Department and the Executive Information Service (EIS) within TEO in communicating scientific and public health advice through media interviews and briefings, press releases, written opinion pieces and press conferences in support of Ministers. The CSA and I also worked with an external media company and provided advice on behavioural evidence to inform public messaging. This included regular engagement in support of junior Ministers with a wide range of sectors including, for example, retail, hospitality, and faith groups. I believe that such approaches worked well, ensuring there was an understanding of the evidence underpinning policy decisions. In my experience this was of benefit in maximising support for the implementation of non-pharmaceutical interventions (NPIs) in particular. The public and their considerable efforts and support were a key asset in the pandemic response and central to this was communicating the evidence and basis for the advice and policy decisions taken.

45. As CMO I had not previously been asked to provide ongoing advice to the NI Executive and had only attended the Executive on a limited number of occasions before the Covid-19 pandemic. During the pandemic one of my main roles (along with the CSA) involved providing support to the Minister in briefing the Executive, presenting modelling scenarios, and advising on measures to reduce community transmission. The mechanisms and format for these Executive updates and briefing sessions evolved during the course the pandemic. The interactive nature of the engagement with Ministers allowed for direct explanation of some of the uncertainties of the evolving evidence and science and also the uncertainty around the modelling scenarios. While Ministers will have their own views on how helpful

this was in informing decision making, I believe that it worked well, notwithstanding the challenging circumstances and difficult choices faced.

CMO joint working at a UK and NI/RoI level

46. During the response phase to Covid-19, I worked closely with the three other UK CMOs to agree, when requested, joint advice to the UK government and to my own Health Minister. While there were some differences in interpretation of emergency science, data and emphasis, the advice was generally broadly consistent across the UK. Details of this joint advice and the policy areas addressed are covered in detail within the CMO Technical Report [see exhibit INQ000199192]. The rationale for any different policy decisions in respective jurisdictions was the subject of analysis in the public domain and media commentary. Such differences in policy decisions were a factor of difference and variation in the trajectory of the pandemic, rates of community transmission, and hospital pressures. In addition, it should be noted that the decisions by Ministers considered non-health impacts such as wider societal and economic factors applying in their respective jurisdictions.

47. With my DCMOs, I met regularly with my CMO/DCMO counterparts across the Devolved Administrations and the Republic of Ireland (RoI) to exchange intelligence and discuss and agree, as appropriate, public health advice and communication strategies for communicating with the public. Historically there had been very close cooperation and regular engagement with RoI at official level. During the Covid-19 pandemic, the Departments of Health in Northern Ireland and RoI had weekly meetings, which I chaired jointly with my RoI counterpart. The meetings were attended by the CSAs and DCMOs from both jurisdictions, and respective subject-specific policy lead officials. Data was shared in relation to the pandemic trajectory in both jurisdictions, together with information concerning a range of pandemic specific policies, including inter alia: testing, vaccination, and policies covering international travel in relation to border health measures.

48. Such regular engagement with CMO colleagues and the associated fora were already well established on a wide range of professional and policy issues prior to

the H1N1 pandemic and were very much a part of our "business as usual" arrangements. Their importance became very evident during the 2009 H1N1 pandemic, where we quickly gained an appreciation of their significance in terms of maintaining robust connections between UK and Republic of Ireland partners. These professional and policy networks were invaluable and could be "switched on" and the pace of meetings turned up very quickly when the need arose, such as during the Covid-19 pandemic.

Access to local expert advice and expertise

49. A Strategic Intelligence Group (SIG), was established and chaired by the CSA, and provided advice and expertise to inform the HSC Covid-19 response. The Group considered scientific and technical evidence emerging from SAGE and other expert sources, alongside data in respect of Northern Ireland on the local trajectory of the pandemic. The evidence and analysis considered by SIG informed my advice to the Minister and the Executive. SIG proved invaluable in independently considering SAGE advice and papers together with a range of other emerging international scientific evidence on policy areas such as the use of face coverings, contact tracing and ventilation. SIG (given its membership which included representation from Queen's University Belfast, Ulster University, Cambridge University, the PHA and the Department) allowed all such evidence and recommendations from SAGE to be considered more broadly and, in particular, from a Northern Ireland perspective. Notwithstanding the temporal differences in the spread of the virus in urban and rural areas, local government districts in Northern Ireland and counties in the RoI, it was also the case that at times the spread of the virus on the island of Ireland (being in both Northern Ireland and in RoI) differed to other parts of the UK.

50. Given that Northern Ireland would not be able to replicate the scale and nature of UK advisory structures such as SAGE, it is important that local sources of expert advice can be stood up at short notice to interpret the scientific advice and consider its applicability to this jurisdiction. This rapid response certainly happened during Covid-19, and I believe this was due to the good relationships and networks that existed between the Department and the local Universities and industry. The participation of SIG members was facilitated by their employment

organisations on a voluntary basis. The employing organisations' willingness to do this was essential to maintaining the necessary level of engagement. Whilst there was no difficulty sustaining this engagement during the emergency, there is no doubt that involvement in a voluntary capacity placed significant additional pressure on key individuals.

51. Informal arrangements for voluntary assistance to the Department would need to be kept under review where an emergency response is protracted, as was the case here. Consideration is now being given to options to formalise partnership arrangements between the PHA and academic institutions as part of an ongoing organisational development review of the PHA.

52. Partnership work with academic institutions and other government departments such as DAERA was vital in the establishment of new surveillance systems such as the Waste Water Surveillance (WWS) for Covid-19 and the establishment of SARS -CoV-2 genomic sequencing in NI as part of Covid-19 Genomic UK (COG-UK) arrangements. This enabled ongoing genomic sequencing to detect emerging mutations of the virus and variants of concerns to be monitored and their clinical significance to be observed. Given the size of Northern Ireland I believe that such academic partnerships should be factored into future pandemic planning and preparation.

53. The PHA played a pivotal part in the overall response to the Covid-19 pandemic, and I worked very closely with public health colleagues in the PHA, which provided professional advice and support in coordinating the public health response. In some instances the PHA led elements of the response, at my request and on behalf of the Department. This collaborative "one system" approach was essential given the resourcing implications and the scale of the demands to enable the response.

Modelling

54. A learning point from the 2009 H1NI pandemic was the importance of local Northern Ireland specific population level modelling capability within the then newly formed Public Health Agency (PHA). However, at the onset of the Covid-19 pandemic, while we had access to several UK modelling groups, the absence of

Northern Ireland specific modelling capability remained a deficit. The UK modelling which included modeling of the pandemic in NI by UK groups generally lagged behind, and did not have the most up to date data to inform the advice to the Minister and the Executive. While there were individuals with relevant expertise in Northern Ireland, there was no formal modelling capacity immediately available to me. This was rapidly addressed, and I asked the CSA to develop a NI Modelling Group which was maintained and evolved throughout the pandemic response as knowledge about the virus, immunity, and the effectiveness of NPIs developed. As a result of this learning during the response to Covid-19, at my direction, this deficit has now been addressed, and modelling capacity has been established within the PHA and can be activated as and when required.

Operation Yellowhammer

55. Whilst the preparations across the UK for EU Exit did divert some of our focus away from pandemic preparedness planning during the pre-Exit period, many aspects of preparation for the consequences of a potential "no deal" EU Exit were, nevertheless, advantageous from an emergency preparedness perspective. This included the additional training undertaken on emergency planning and response within the Department; enhanced multi-agency command and control training across all Northern Ireland Government Departments and multi-agency responders; development of a list of Departmental Emergency Operations Centre volunteers, expanding the group of individuals available to mount an emergency response; improvements in the resilience of supply chains; and increased buffer stocks and stockpiles for medicines, medical devices and clinical consumables. These arrangements were also exercised, including in conjunction with UK colleagues as part of the Operation Yellowhammer preparations. This is described more fully in the Module 1 Corporate Statement

56. In addition, as part of EU Exit preparations, the Department created a bespoke EOC facility which was fully kitted out with IT, which facilitated situational awareness and cooperative working. Along with the willingness of colleagues right across the Department to contribute to the collective response, having a modern, bespoke emergency operations facility within the Department was a major

strength, particularly in the initial stages of the pandemic response.

Testing capacity for SARS-CoV-2

57. Testing was a critical part of the Northern Ireland (and UK) Covid-19 pandemic response. Given that Covid-19 was an entirely new virus, testing capacity was initially a significant limiting factor which impacted on policy decisions early in the pandemic. This was compounded by global demand for reagents and other disposables. We increased our testing capacity significantly through the formation of new partnerships to deliver on this, both locally (through the NI Covid-19 Testing Scientific Advisory Consortium), and nationally (under the UK National Testing Programme). The former group was established at my request comprising both NI Universities, the Agri-Food Biosciences Institute and the ALMAC Group to boost local NI based testing capacity - referred to as 'pillar 1' as opposed to the UK National Testing Programme which was referred to 'pillar 2'.

58. Increasing our testing capacity enabled us to commence a number of important testing programmes in general practice, emergency departments and care home settings. These programmes helped us to understand the activity of the virus and to monitor trends in Covid-19 infections. They also helped us design and implement appropriate control measures where they were needed, both in hospital and in community settings.

59. As testing capacity increased significantly, particularly with the establishment of 'pillar 2' testing as part of the UK National Testing Programme, and with the roll out of reliable community testing with lateral flow devices as the pandemic progressed, there was greater flexibly in policy choices available to Ministers. A major strength was the established networks between the health service, academia, other government departments and their ALBs, and industry. This was particularly important, for instance in the development of Covid-19 testing capacity, given the particular challenges in this area at the outset of the pandemic. Partnership working through the NI Pathology Service, the Regional Virus Laboratory with AFBI within DAERA, the ALMAC Group and QUB through the Scientific Consortium, which I initiated, allowed Northern Ireland to maximise existing laboratory testing capabilities using a variety of testing platforms and to standardise testing arrangements.

60. The issues around testing and testing capacity are addressed in greater detail, including recommendations in the CMO's Technical report [see exhibit INQ000199192]. The ability to rapidly scale up laboratory testing capabilities in the event of any new emergent pathogen will be important for future emergency planning, preparation and resilience.

Research

61. The research capability in the UK was a strength in providing the answers to important questions and had a major role in shifting the response to the Covid-19 pandemic from a broader based societal approach, with very significant implications for the public, to one more focused on medical countermeasures such as vaccines, drug treatments and other improvements in clinical management. This important role of research in the pandemic is covered more fully in the four UK CMO Technical Report.

62. In Northern Ireland, researchers and the public played a very significant role in supporting UK wide major research programmes in recruiting to all the UK national studies. Undoubtedly this research made a significant contribution in reducing morbidity and mortality and in reducing the reliance on NPIs as novel treatments and vaccines became available as a consequence.

63. Overall, in respect of research, it will be important to embed the learning from the pandemic about the more rapid approval arrangements, recruitment to studies and implementation of research findings into clinical practice in other areas for the future.

PART 3: POTENTIAL FOR IMPROVING PANDEMIC PREPAREDNESS IN NORTHERN IRELAND

Access to scientific advice and wider expertise

64. SAGE provides the main source of scientific advice to the UK Government and also, where appropriate, to the Northern Ireland Government, in the event of an emergency. SAGE is a forum which Northern Ireland does not have the capacity to fully replicate; nor would it be scientifically or technically feasible, nor

operationally warranted, to duplicate its work. However, there is no automatic representation of Northern Ireland on SAGE, as was apparent in the early stages of the Covid-19 pandemic. To ensure that Northern Ireland has full policy awareness of the extent to which there is scientific uncertainty, and that there is a range of opinion which has been considered in discussions, it would be of benefit if Northern Ireland was entitled to be represented on SAGE as soon as these arrangements are established. This would similarly be the case with respect to other UK Scientific Advisory Groups operating in emergencies and direct NI representation on these groups was certainly of benefit throughout the rest of the pandemic.

65. In terms of expert group meetings and the demand for scientific advice, it was my experience, particularly early in the Covid-19 pandemic, that ensuring representation at all meetings was at times extremely challenging. This was due partly to the sheer number and frequency of expert group meetings, together with the very significant degree of support required by Ministers and the Executive (in addition to the full stand-up of the Department's Emergency Response Plan). I was greatly assisted in this by both my DCMOs and, in particular, the CSA, Professor Ian Young, on his return to work in late March 2020 and in due course by retired former colleagues.

66. While the Department of Health was able to provide scientific and public health advice to inform Executive decisions in relation to NPIs, my observation was that Ministers initially felt less informed of the wider societal and economic consequences of NPIs (the provision of advice on the societal and economic consequences of non-health interventions is the responsibility of government departments other than Health). This was later addressed, and there was extensive work undertaken by the Department for Economy, both in relation to understanding the economic consequences and seeking to mitigate these.

67. During the pandemic response, up until some point in 2021, the Department and the Minister of Health led in preparing the pandemic related Executive papers. This entailed seeking input from other departments, as opposed to central coordination with TEO seeking the Department of Health's input along with input from other departments. This meant that early in the pandemic the emphasis was

on health impacts. However, in the Spring of 2020, the Department developed a mechanism to assess the wider societal and economic impacts of the NPIs and to inform the pathway out of restrictions. This resulted in a more structured approach and input from other departments to inform Executive papers. Subsequently TEO took over the coordination of Executive papers on restrictions and sought health input. However, the responsibility for the making of regulations giving effect to Executive decisions on coronavirus restrictions, (both domestic restrictions within Northern Ireland and those relating to international travel) sat with the Health Minister. Therefore, the Department of Health led on Assembly Committee scrutiny and, following an initial period where Junior Ministers led, Assembly debates.

68. In the early stages, irrespective of whether economic modelling and such wider analysis been available, in my view it is highly unlikely it would have made a material difference to the urgent decisions required by Ministers to save lives and to protect the health service. Ministers may however have felt better and more fully informed in subsequent policy decisions in terms of the non-health consequences.

69. In Northern Ireland, in terms of future preparedness, it may be worthwhile for us to develop a cross departmental forum which focuses on gathering and interpreting data from multiple analytical disciplines during an emergency to aid Executive Ministers in considering and balancing what might be conflicting advice and data from different sources and departments. Alternatively, it may be useful to have a cross-departmental expert group consisting of the different analytical disciplines, which could be tasked with reconciling the various sources of advice and coming up with consolidated advice or a consensus position to aid Ministers' decision making.

70. The inter-departmental approach was eventually adopted during the pandemic with an interdepartmental group considering the NPIs and pathway out of restrictions. In my view this worked relatively well although it was limited in scope of the matters considered. For the future, a cross departmental expert group could possibly be chaired by the TEO CSA (once appointed) and have representation from other departmental CSAs or technical advisors, and this could help ensure that more broadly balanced advice is provided to Executive Ministers. This would

be a matter for TEO to consider further. It should be noted however that it is likely that the perspectives arising from Health advisors and Economic advisors would be quite different, and arriving at resolved advice is likely to prove challenging, particularly in the context of the need for rapid decisions in a fast moving and rapidly evolving.

71. At UK level a broader range of subgroups focused on other disciplines might also feed into SAGE, with consolidated SAGE advice to Ministers reflecting a broader range of perspectives and consequences. As indicated, a similar Northern Ireland specific approach could also be considered, as evidenced from a health perspective by the establishment of SIG by the CSA. In any future pandemic, the establishment of a SIG equivalent should occur immediately.

72. As indicated earlier, throughout the pandemic the spread of the virus in Northern Ireland at times more closely mirrored the spread in the RoI and vice versa, albeit this was to a variable extent. While informal professional networks worked well, in my view, further formal consideration should also be given to how best to ensure the sharing and coordination of emerging scientific evidence, and how that might best inform policy makers and decision making across the respective administrations. Decisions are rightly a matter for respective Ministers and governments, and are informed by the advice provided in respect of the level of community transmission, pressures on health and social care services and consideration of the wider societal and economic considerations. These differ geographically over time, as will the weight attached by policy makers to wider societal and economic considerations. It was at times necessary to try to explain the perceived difference in these policy decisions which were, understandably, the subject of considerable public debate. This had the potential to undermine public health messaging and confidence, although I believe this was avoided to a significant extent due to the work between respective jurisdictions, Ministers and officials.

A more tailored approach to those with vulnerabilities

73. While balancing risk and harm is often complex and particularly so with respect to visiting in care homes, greater consideration and planning needs to be given to

how best to mitigate the adverse impact on residents and families of social isolation, and the adverse impacts on quality of life during a pandemic. It is also important that, in future planning, consideration is given to research and innovation in improving resilience of care homes to a range of infections. Consideration also needs to be given to operational support arrangements for providing augmented care provision, in recognition of the importance of this, as demonstrated during the pandemic.

74. Similarly, those living in more socio-economically deprived areas were disproportionately impacted directly as a consequence of the Covid-19 pandemic. It is also the case that the Non-Pharmaceutical Interventions (NPIs) that were introduced to control community transmission had a disproportionate impact on those who were more socioeconomically deprived. In addition, single parents, women, younger people in part-time employment and those in essential public facing services were also adversely impacted. This needs to be factored into future planning.

75. Furthermore, in my experience, school children from more socio-economically deprived backgrounds, and those who were in receipt of free school meals were disproportionately impacted by requirements to socially isolate, as a consequence of contact tracing, and did not have the same opportunity of access and support in terms of remote learning, despite the significant efforts of teachers and parents. Any future pandemic preparation and planning needs to seek to more fully mitigate the disproportionate effects on parts of society likely to be most impacted. While this example refers to education, it is a cross-cutting consideration for all departments, and would merit greater central coordination.

Emergency response staffing resources

76. This was a very fast moving, rapidly developing, emergency situation in terms of spread of the virus, development of scientific and public health understanding and translation of that into policy. The Department of Health in Northern Ireland is by far the smallest compared to its counterparts in the rest of the UK. As a consequence, there were a very small number of individuals in NI addressing all of the issues covered by a much larger number of people in the other nations. While

this impacted across the Department and undoubtedly other key Northern Ireland departments, this impact was particularly acute within the CMO Group (CMOG) in the Department of Health. There is simply not the agility and responsiveness within the Department to adequately resource or respond to multiple competing/urgent demands in an emergency. Consequently, the demands on small groups of staff, both in the Department and across the HSC, can at times be almost unsustainable. It has to be acknowledged that this is an area of a vulnerability and risk to the Department.

77. During the Covid-19 pandemic response, we relied heavily on the extraordinary efforts of many in the Department and across the wider health and social care system. More specifically in relation to scientific, medical, and technical expertise we relied heavily on support from outside the Department, including: retired colleagues; support of university colleagues and secondees from the PHA, the Regulation and Quality Improvement Authority (RQIA); the Strategic Investment Board; external management consultancy and a veterinary epidemiologists loaned from DAERA, by way of example. Over a number of years, it has proven challenging to recruit to specific senior medical officer posts in the Department, due in part to the opportunities elsewhere, and also differences in remuneration in the Civil Service as opposed the HSC and the additional costs to the Department of secondments. In the future, consideration should be given to hybrid roles and joint appointments between organisations. None of these additional staffing arrangements had been planned for, or considered in advance, in terms of capacity or business continuity to respond to a pandemic of this scale and duration of Covid-19.

78. The pressures on staff were compounded by the initial challenges of working from home and a need to ensure that the necessary IT support, such as laptops and printers was provided. At the outset, working arrangements were significantly disrupted. People were put into teams or cells and had to develop effective working relationships very rapidly, in very testing circumstances. Difficulties in communication with colleagues were compounded by the fact that the use of video-conferencing facilities (such as Webex and Zoom) were still in their infancy.

The first wave was characterized by small number of people working really long hours, with no ability to "switch off." As is my experience, and in the case with all emergency responses in which I have been involved, once a "battle rhythm" was established, teams rapidly adapted to remote working and routines were established, although this was undoubtedly a major change and challenge at the outset. There has been important learning in terms of business continuity management within the Department, and in terms of learning how best to support staff in such circumstances.

79. The duration and intensity of the response limited the opportunity to allow key individuals to rotate out and have adequate time to rest and recover. This was particularly evident at the top levels of the Department and among the professional roles, including my own. I recognise the significant and unrelenting demands on all staff and, in particular, on the professional and technical roles during an emergency response due to the small numbers of staff, who are not interchangeable.

80. Any emergency response is characterised by long hours and seven day working, for months at a time and with essentially no leave for an extended period of time. This significantly impacts on people's family lives, their work-life balance, and their physical and mental wellbeing. I am therefore indebted to these colleagues who continued in these unrelenting roles, despite all of this. Equally though, some of the aforementioned impacts result in staff burn-out, and this is often characterised by staff moves between waves or at the end of the response to an emergency. The exodus of staff as a result of experience of the associated work load and pressures, whilst understandable, creates a gap that is hard to fill. Consequently, situational awareness and corporate memory, as well as specialist knowledge and skills are lost – and this takes time to regain and rebuild.

81. Succession planning is very difficult in small teams as is the case in Department generally, and this is doubly difficult in areas requiring specialist knowledge and skills. This was identified in the lessons learned in the 2009 H1N1 pandemic. In response to Covid-19, following a rapid review [see Exhibits INQ000188799,

INQ000188800 and INQ000188801], I recognised after the first wave that there was a need to "spread the load" outside the CMO Group for managing the processes and for staffing the HEALTH GOLD command and control structures. Our efforts to address this issue culminated in the establishment of a dedicated Covid-19 Directorate and wider subject expert cell structures to manage the breadth of our response. However, such steps did not address the load that was placed on those specific individuals who held the requisite knowledge, skills, and expertise, operating in key roles, and on whose judgement and professional opinion I and the Minister relied. I recognise that there are no easy answers to this issue that ensures proportionate capabilities are maintained.

82. All of my emergency planning staff are administrative civil servants, and these posts are not considered "specialist posts" requiring specialist skills. When vacancies occur the posts are currently not permitted to be trawled to enable recruitment of this specialist knowledge, or a promotion of a deputy within the Unit or Group, thereby retaining knowledge and expertise. Instead, the post is filled by lateral transfer at that substantive grade. It can then take several years for that person to develop the necessary competence, specialist knowledge and skills. This is an area that requires more thought and discussion with the Head of the NI Civil Service and Corporate HR, and consideration should be given to creating specialist posts, requiring specialist skills which would enable better forward planning and succession planning, and which would enable us to recruit and retain suitably skilled individuals.

83. Consideration also needs to be given to what we can build on from the Covid-19 pandemic response to provide broader, more enduring capabilities in surveillance, monitoring and interactive analytic systems across public health. Through the restructuring of CMOG and the organisational review of the PHA now underway there is the opportunity to do so. Elements of this such as modelling capacity, enhanced respiratory surveillance and analytical capacity have already been progressed [see exhibit INQ000187742].

Adequacy of Structures for Data Analysis

84. In response to the Covid-19 pandemic it was necessary to stand up a range of scientific advisory structures and a modelling group, however data flows to inform modelling were initially limited. Refinement of data collection and automation of flows via PHA and the Information Analysis Directorate (IAD) was required and took time to establish and to quality assure before these could be placed in the public domain. This required close collaborative work between the Trusts, PHA, Information and Analysis Directorate (IAD) within the Department and the Northern Ireland Statistics and Research Agency (NISRA). Similarly, as previously mentioned, the Strategic Intelligence Group (SIG) was established to allow consideration of relevant scientific information specifically from a Northern Ireland perspective. While this ad hoc group was stood down in January 2022, it could be rapidly re-established if required and consideration is being given by the PHA as to how through joint appointments with academic institutions in Northern Ireland how this might be more formally arranged.

Contact Tracing

85. In addition to the limitation of testing capacity, in the first wave as case numbers increased rapidly, there were significant challenges in maintaining contact tracing at the intensity and scale required to ensure chains of transmission were interrupted as effectively as possible. More generally, contact tracing is most effective when levels of community transmission and numbers of cases are lower. The CSA provided advice to the PHA as to the number of contact tracers likely to be required, although the initial model developed by the PHA was of a smaller scale. When reestablished on 18 May 2020, contact tracing was maintained throughout the response at times of very high prevalence the efficiency and effectiveness of the service was reduced.

86. I commissioned a Rapid Diagnostic Review of the service which reported on 12th October 2020. The main purpose of this review was to support the ongoing and future delivery of the contact tracing service by looking at the elements that had worked well to date, and to consider what measures were required to effect improvements in terms of efficiency and effectiveness supported by appropriate technology and high quality information systems. Delivery of the recommendation

[see exhibit INQ000183433] was supported through the appointment to the PHA of a Director with responsibility for the Covid-19 Contact Tracing Service in NI and with oversight by the Test, Trace, Isolate, Protect Strategic Programme Board [exhibit INQ000137363] which I established and chaired from May 2020.

Support from Other Government Departments

87. Pandemic response requires a whole of government response with respective departments leading on areas in line with their departmental responsibilities or lead government department roles, as appropriate. In particular at the outset of the response there was an expectation that representatives from the Department of Health would be able to attend all meetings held by other departments to provide support and answer questions. At times this included requesting update information relating to the pandemic that was already publicly available. This is understandable, given the fast-moving pace of the pandemic, the high level of uncertainty and the complexity of the information, and the support non-health partners wanted in having health representatives there to advise them directly. Undoubtedly this was of benefit in securing sectoral specific support for NPIs, it did however place an additional strain on already hard-pressed Departmental staff.

88. As outlined above, it is essential that departments across the Northern Ireland Civil Service and their Arm's Length bodies fully engage with emergency preparedness training and exercising in order to gain a shared understanding of each other's roles and responsibilities and to ensure that partners segue easily from planning to response. It would be useful to consider and clarify the role, purpose and membership of strategic and operational civil contingencies groups such as CCG(NI), NI Emergency Planning Group, C3 working group and the emergency planning groups and workstreams that sit under these. A system of regular review of these roles should also be instigated. This would be good practice after any major response.

89. Although tragically many people died during the Covid-19 pandemic, it could be considered fortunate that the system for the management of significant excess deaths in NI was not tested during the response. However, there remains a considerable piece of preparedness and planning work required to ensure that NI

is prepared for this eventuality in the future – whether excess deaths are caused by another pandemic or a civil contingency related event. Excess deaths management is now the responsibility of the Department of Justice (having previously been the responsibility of TEO) and I would suggest it is timely for progress on this important piece of work to be reviewed.

PART 4: CONCLUSIONS

90. Given the current wider financial situation in NI, resourcing implications and likely reductions in the staffing complement in the Department, emergency planning and preparedness is one of many competing priorities, some of which may be more immediate. The opportunity costs of resourcing one area as a priority over another has consequences, resulting in less resources to progress other important areas. It will be difficult to maintain readiness at a high level across the Department, government, or the wider HSC system in anticipation of future pandemics. For the future, the focus should be on ensuring that both generic and specific technical expertise, skills and capabilities are maintained within the Department, within a core group of individuals, which can then be rapidly flexed and expanded in response to any new emergent threat. Additionally, there should be a staffing resource maintained across government who have generic transferable skills, as required. It is important that these capabilities are viewed across other government departments as an essential element of risk management and effective governance in delivering key policy objectives and as such, this needs to be considered more widely in all relevant government policy areas, and systematically and regularly tested.

91. Recognition of the wider system wide government capabilities to ensure such leverage and flexibility is important so that the deployment of staff and resources can be dialed up and down as necessary. As was evident at the height of the pandemic, the health consequences, and impacts, (while hugely significant), were one aspect. There were also profound impacts across all of society and the economy, on children, young people and older people, although not all were impacted equally, this needs to be factored into future planning, mitigations and contingency arrangements. It is important therefore that there is a whole of government approach to the impact and synergies of potential threats and interventions. As such, energy should be directed less towards a specific plan for particular pathogens, but rather there should be focus on capabilities and how these are developed, integrated, and maintained across all government departments, so that a resilient whole of government approach is achieved. This would also have the benefit in potentially reducing the demands on the Department

of Health for generic support and advice, and allow the focus of the Department to be more directed to the health response and provide only more specialist technical advice to other Departments as required. That said, as previously indicated, I believe the support to other departments and engagement with a range of their stakeholders was important in securing understanding and support for the actions required, and the importance of this should not be underestimated. Alternatively, as described above, and as has been indicated in the CSA statement, the development of a specific cross departmental group, possibly chaired by the TEO CSA (if appointed,) could coordinate and fulfil this role.

92. I have sought to highlight some of the key areas which I believe are particularly important, some of the measures already taken to address these, and some of the work now underway. It is vitally important as we seek to recover the health of the population and rebuild the health service following the pandemic (given significant other competing priorities and resourcing constraints) that all of the learning to date and that arising from this Inquiry is fully embedded. There will always be more immediate priorities and opportunity costs of maintaining preparedness and readiness, however, as this pandemic has demonstrated, even when prepared, the impacts on people, society and the economy are profound. A legacy to those most affected and those still living with all the consequences is to ensure a more resilient better prepared system for the future.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: Personal Data

6 June 2023

Dated: _____