1 **Tuesday, 7 May 2024**
2 **(10.00 am)**
3 **LADY HALLETT:** Good morning.
4 **MS DOBBIN:** Good morning. My Lady, please may I call the
5 first witness for today, please, Mr Pengelly.
6 **MR RICHARD PENGELLY (sworn)**
7 **Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 2C**
8 **LADY HALLETT:** Ms Dobbin.
9 **MS DOBBIN:** Thank you.
10 Can I ask you to give your full name to the Inquiry,
11 please.
12 **A.** It's Richard Pengelly.
13 **Q.** Mr Pengelly, I think you have a witness statement in
14 front of you, I think it comes to about 113 pages, and
15 that you've signed that statement at the very end. Is
16 that correct?
17 **A.** That's correct, yes.
18 **Q.** Are you content that that witness statement is true to
19 the best of your knowledge and belief?
20 **A.** I am, yes.
21 **Q.** Thank you.
22 Mr Pengelly, I think it's right that you became the
23 permanent secretary to the Department of Health in
24 Northern Ireland in 2014?
25 **A.** Yes, July 2014.

1 **Q.** I think that you then moved posts to become the
2 permanent secretary to the Department of Justice in
3 2022; is that right?
4 **A.** April 2022. And then subsequently, three weeks ago,
5 I've moved again to become chief executive of the
6 Education Authority in Northern Ireland.
7 **Q.** I didn't know that, so thank you very much.
8 I think it's right, then, that your tenure at the
9 Department of Health lasted some eight years and spanned
10 periods of time when power-sharing arrangements were
11 both extant or suspended; is that right?
12 **A.** That's correct, yes.
13 **Q.** Just in terms of the role of the permanent secretary to
14 the Department of Health in Northern Ireland and what
15 that encompasses, is it right to characterise it as
16 essentially tripartite, in that, first of all, you
17 obviously have the statutory responsibilities of leading
18 that department and ensuring that it fulfils its
19 statutory obligations? Is that right?
20 **A.** Yes, but just with the caveat that I would be leading
21 the department subject to the direction and control of
22 a minister when in place.
23 **Q.** Yes, of course. And I think that --
24 **LADY HALLETT:** Mr Pengelly, I'm sorry to interrupt -- I'm
25 sorry, Ms Dobbin -- you slightly drop your voice in the

1 middle --
2 **A.** I'm sorry.
3 **LADY HALLETT:** It's just you're softly spoken, not a bad
4 thing, but we need to, all, hear everything you say.
5 Thank you.
6 **MS DOBBIN:** Then the other very distinct part of your role
7 was that you were the chief executive of the health and
8 social care services as well. Is that also correct, or
9 the right way to characterise it?
10 **A.** That's correct, but just by way of explanation, unlike
11 the position in England where the National Health
12 Service has a legal entity, what we call HSC in
13 Northern Ireland, the health and social care system,
14 it's a number of individual organisations, there isn't
15 the individual legal entity. So I'm chief executive --
16 it's a sort of virtual chief executive post, if that
17 makes sense.
18 **Q.** All right. Just so we're clear about this, and I will
19 ask you about it in a bit more detail as we go through
20 your evidence, but, first of all, I think it's right
21 that within the Department of Health in
22 Northern Ireland, it's essentially an umbrella for
23 a number of social care services as well; is that right?
24 **A.** Yes, our five regional, what we call health and social
25 care trusts will provide both healthcare and commission

1 social care on behalf of the population.
2 **Q.** Can you just help me with whether or not the department
3 also then had responsibility for other social care
4 services, for example like social work, so adult social
5 services and children's social services as well?
6 **A.** Yes, the department would hold the policy remit for all
7 social services, and that would be delivered through
8 what we call arm's length bodies, like the health and
9 social care trusts, but the -- so one of my senior
10 colleagues would have been the chief social services
11 officer, he's a professional social worker by background
12 and would act as the head of profession for the social
13 work profession across the public sector.
14 **Q.** Nonetheless, in terms of the nexus between you and those
15 organisations, you are -- nonetheless you remained the
16 permanent secretary with oversight --
17 **A.** Yes.
18 **Q.** -- of all of that full gamut, as it were, of social
19 services as well?
20 **A.** Yes, that's right.
21 **Q.** Then the other part of your role was that much more akin
22 to what might be expected of a permanent secretary in
23 that you were the principal policy adviser as well to
24 the minister; is that also correct?
25 **A.** That is, yes.

1 **Q.** And obviously during the pandemic that was
2 Minister Swann; yes?
3 **A.** Yes.
4 **Q.** What you've said in your statement -- and, sorry, I'm
5 just going back, if I may, to the period before
6 January 2020 -- that in that period of time between 2017
7 and 2020, that you exercised your functions in
8 accordance with section 3 of the Northern Ireland
9 (Executive Formation and Exercise of Functions) Act
10 2018; is that --
11 **A.** That's correct, yes.
12 **Q.** We haven't touched upon that Act yet in the Inquiry, but
13 I think it's right that that was enacted so as to give
14 senior officials like you further powers in the event
15 that power-sharing was suspended; is that right?
16 **A.** Yes, essentially it gave permanent secretaries the power
17 to take decisions that would normally have been taken by
18 ministers, but we wouldn't have created the new policy
19 or departed from a policy set by previous ministers. So
20 it was the sort of operational decisions that would
21 normally go to a minister but within a fixed policy
22 environment.
23 **Q.** I think that broadly the Act gave you a power to
24 discharge functions in the public interest; is that
25 correct?

1 **A.** Yes, any time we exercised the power or
2 a decision-making power that would have previously gone
3 to ministers, it was a public interest test had to be
4 applied.
5 **Q.** What was the limit, then, on that power, that said you
6 couldn't, for example, enact new policy or take
7 decisions that, for example, might be controversial?
8 **A.** The key element was the public interest test. It was
9 a rule of thumb that we couldn't get into new policy
10 because policy really is the preserve of elected
11 representatives, but it was taking decisions. So maybe
12 it best to illustrate by way of some examples. New and
13 emerging drugs, even very high cost drugs that come on
14 the market that normally would be for a minister to
15 decide: does the cost justify the benefit? So I would
16 have taken decisions about commissioning new drugs.
17 I suspect we'll come on to the transformation agenda,
18 but some decisions within the transformation agenda too.
19 **Q.** All right. It's really just trying to understand what
20 the limits of your powers were, because as the Act puts
21 it in terms of the public interest, so would you have
22 received advice, then, on an ongoing basis as to the
23 extent to which you could enact new -- well, let me --
24 I'm jumping ahead. Could you in fact enact new
25 legislation during the period of suspension, or was that

1 something that --
2 **A.** We didn't do legislation. Typically if colleagues were
3 putting forward advice that would normally have gone to
4 a minister, that would come to me for a decision, but it
5 would include the addition of a public interest test
6 that weighed up the pros and cons from the public
7 perspective of either taking or not taking the decision.
8 There was, again, a general rule of thumb that if the
9 decision could await the return of ministers, it should
10 wait, so there had really to be a pressing nature
11 associated with the decision, but fundamentally was it
12 in the public interest to take this decision, or
13 sometimes is it in the public interest to not, because
14 not taking a decision is in itself a decision.
15 **Q.** Yes, I understand.
16 Just in terms of that idea as to whether or not
17 a decision could await a minister coming back, how --
18 that must be quite difficult to judge if you have no
19 idea whether or not power-sharing will be resumed within
20 a given period of time?
21 **A.** It is, and so certain decisions would have been subject
22 to regular review, because at various times the mood
23 music was political talks were reaching the point where,
24 you know, there was the prospect of a return. In those
25 cases a decision was becoming urgent, we might think we

1 can pause for a couple of weeks but if it hasn't -- if
2 the ministers haven't returned within a couple of weeks,
3 at that stage we might have to take the decision.
4 **Q.** All right. We'll come back, because obviously I'm
5 asking you this because it relates very much to health
6 services and the need for reform in Northern Ireland
7 before 2020. I'll come back to that, if I may.
8 I just wanted to touch on another very distinct
9 aspect, as you've said, about Northern Ireland services
10 which is the integration of health and social care
11 services. Again, if I can just make sure I've
12 understood it properly, that arises in the conventional
13 sense of having integrated services in that the
14 Department of Health oversaw primary care, hospital
15 care, other specialist health services; correct?
16 **A.** Yes.
17 **Q.** But then also had responsibility and oversight of things
18 like care homes and nursing homes as well?
19 **A.** That's correct, yes.
20 **Q.** And then, as we've said, all of the full range of other
21 Social Services --
22 **A.** Yes.
23 **Q.** -- as well.
24 The benefit of that, as it might be understood, is
25 that when you have oversight of the whole system, you're

1 able, for example, to foresee where there are
2 weaknesses, for example, in social care --
3 A. Yeah.
4 Q. -- and how that impacts then on health services; is that
5 right?
6 A. Yes. It also -- I'm at the risk of jumping ahead. When
7 we get into the issue of care homes during the pandemic,
8 the integrated nature would have been very helpful, but
9 we may come on to that in a bit more detail later.
10 Q. Yes.
11 A. It also allows health and social care trusts to take
12 a broader population assessment. One of the big issues
13 in the provision of healthcare through emergency
14 departments is what's called the back door of the
15 hospital. We tend to get queues at the front door where
16 people come to emergency departments and we have the
17 four-hour and 12-hour waits. The back door of the
18 emergency department is where people can be admitted
19 into the hospital.
20 Q. Yes.
21 A. But creating space in a hospital sometimes requires the
22 discharge of patients from hospital into the community,
23 so the oversight of care and residential homes by
24 an integrated health and social care trust can smooth
25 that path too and try to assist. We haven't been

1 spectacularly successful given the wider pressures on
2 our system, which again we may touch on later.
3 Q. I am going to back to that, because I think it's
4 important to make clear, so, for example, the concept of
5 bed blocking ought in theory, in an integrated system,
6 to be something that's much easier to overcome, because
7 you understand where there's capacity in the social care
8 system; correct?
9 A. Yes, and I think the practical outworking is we
10 certainly have better transparency about the issue but
11 sometimes having the levers to actually reach into
12 a care home and create the space and there is an issue
13 too about personal choice. Space sometimes arises in
14 a care home that would make visiting by the family,
15 for example, very difficult, so issues still remain that
16 are common to both an integrated and a non-integrated
17 system.
18 Q. I think in fact when we look at the Bengoa report in
19 2016, effectively -- and I'm summarising -- he said that
20 any -- that any integration was more illusory than real.
21 Is that a fair way to summarise it?
22 A. I think that's very fair, and certainly if I cast my
23 mind back to the latter part of 2014 and 2015, at times
24 I made the comment to senior colleagues that I noticed
25 quite often in Northern Ireland we wore it as a badge of

1 pride that uniquely we had an integrated system. At
2 times I struggled to see the real manifestation of that
3 in terms of tangible benefits for patients. So I think
4 that's a very fair assessment by Bengoa.
5 Q. All right. So certainly this Inquiry shouldn't proceed
6 on the basis that when it came to responding to the
7 pandemic, that Northern Ireland by virtue of its
8 integrated system was in a better position than other
9 parts of the United Kingdom?
10 A. I think if we take the holistic view of the provision of
11 health and social care, given other pressures, I don't
12 think we were in a markedly better position, but if
13 I look at the specific issue of the relationship with
14 care homes, particularly for issues like the provision
15 of PPE and the -- some considerable hours of nursing
16 time were made available into residential and care homes
17 by trusts because of the long-standing relationship that
18 existed. So there were very, very practical benefits
19 that flowed from the integrated nature of our system.
20 Q. All right, we'll come back and look at care homes in
21 slightly more detail, but just understanding the
22 pressures then that existed in terms of health services
23 in Northern Ireland -- I will come to the Bengoa report
24 in a little more detail -- but I think it's right that
25 one of the principal issues that were affecting

1 Northern Ireland was the sheer length of its waiting
2 lists --
3 A. Yes.
4 Q. -- and the lengths of time that people were waiting for
5 elective care as well; is that right?
6 A. That's right, and maybe just a little bit of background,
7 the timeline and that. If we go back to about 2013, the
8 position in Northern Ireland was pretty much
9 in equilibrium. There weren't outrageously long waiting
10 lists either in terms of numbers waiting or the length
11 of time that individuals had been waiting. But it's
12 important to understand that that position had been
13 reached by what we call waiting list initiatives. That
14 was -- so there was a misalignment between the capacity
15 of the system and the demands that were being placed on
16 the system, but that mismatch was being met through
17 one-off money that was provided through what's called
18 the in-year monitoring process, where the Executive in
19 the course of a financial year finds itself a certain --
20 say another sector doesn't spend a bit of money that
21 they'd planned to spend, that would come back to the
22 Executive for reallocation. Back in 2013, and the year
23 or two before it, a lot of that money would have been
24 routinely reallocated in health service, who would have
25 purchased waiting list initiatives from the independent

1 sector, and that's what kept the waiting list position
2 in equilibrium.
3 Q. Okay.
4 A. As we moved into 2014, the financial position changed.
5 That additional in-year money was no longer available
6 and you can track the escalation of waiting lists from
7 2013 onwards through to about 2020.
8 Q. Yes, because I think in your witness statement you say,
9 I think, the waiting lists in Northern Ireland pre-2005
10 were in fact the longest in the UK, the situation
11 improved until 2013 --
12 A. Yes.
13 Q. -- but then steadily deteriorated after 2013, and
14 I think what you've said in paragraph 37 of your
15 statement and what you have cited, but I want to make
16 sure that you agree with it, that in terms of evidence
17 that was put before Northern Ireland Affairs Committee
18 it was said that Northern Ireland currently -- and,
19 sorry, I should say this was in 2018 to 2019 --
20 Northern Ireland currently has the worst performing
21 health service in the UK, with none of the waiting list
22 targets currently being met.
23 A. I think from memory that the statement about "worst
24 performing in the UK" was, I think, made by the BMA at
25 that stage. Certainly numerically none of our targets

1 were being met, but the qualitative assessment in terms
2 of how that stood in comparison to other parts of the UK
3 I think was a more subjective judgement, because some of
4 the waiting lists are articulated slightly differently,
5 but, I mean, the BMA is a respected organisation and
6 there they are, it's a professional perspective.
7 Q. Well, I wanted to check, because you cited it in your
8 witness statement, and I wanted to understand the extent
9 to which you were citing it, because it was evidence
10 that -- or information that you accepted. But if I can
11 just take the objective evidence in terms of whether or
12 not Northern Ireland had the worst waiting lists as
13 compared to the United Kingdom, was that correct in 2018
14 to 2019?
15 A. Yes, our numbers were higher, but, as I say, some of the
16 waiting list targets are articulated slightly
17 differently, so it's more of a subjective comparison as
18 opposed to everyone using exactly identical metrics.
19 But I wouldn't argue that we were in a markedly better
20 position than anyone else. I certainly wouldn't push
21 back the assessment that, you know, we were the poorest
22 performing region of the UK.
23 Q. I think that the statistics, and again you've set this
24 out in your statement, was that, at that time, the
25 waiting lists were 400,550 people. That's out of

1 a population of 1.9 million people. So before the
2 pandemic that looks very high?
3 A. It is. But just the one caveat to that is some
4 individuals will be on more than one waiting list, you
5 know, if they have a couple of different conditions. So
6 it's not that if you've lined up the full population,
7 400,000 of them would be on a waiting list. There was
8 400,000 waits.
9 Q. I understand.
10 A. And that will be similar for other jurisdictions. So
11 it's not saying that it alters the comparison.
12 Q. And I think that the statistics then, and again perhaps
13 this isn't surprising, but those statistics have gotten
14 worse since the pandemic as well?
15 A. That's correct, yes.
16 Q. So that there's now over -- it's over half a million
17 waits, as you have characterised it.
18 Just in -- so we understand, then, the position from
19 2013 got progressively worse in terms of waiting times,
20 but in terms, then, of your ability to address those
21 issues during the period of suspension, I think what
22 you've set out in your statement was there was a limited
23 ability to undertake the radical transformation that
24 would have been required; is that correct?
25 A. Yes, there's -- the position, there's a nuance to the

1 position in terms of the period 2017 to 2020. There is
2 a narrative that exists in the community that, for those
3 three years -- the Executive agreed -- the Bengoa report
4 was published I think in about October 2016 --
5 Q. Yes.
6 A. -- and then that became an input into the health
7 minister developing the Delivering Together
8 transformation strategy, which was a ten-year
9 transformation strategy, which was then taken to the
10 Executive and it received Executive agreement.
11 There is a narrative that that then sat on the shelf
12 gathering dust for three years while there were no
13 ministers. The reality is that document at the point of
14 agreement set out 18 actions -- the first wave of
15 actions, there were 18 actions. Prior to the return of
16 ministers, all 18 actions had been delivered, so we were
17 able to progress.
18 What didn't happen was the development and evolution
19 of the next set of actions. The advantage we had -- and
20 we touched earlier that in the absence of ministers we
21 couldn't create new policy -- through a quirk of timing,
22 prior to the collapse of the Executive we had
23 cross-party agreement to a new Delivering Together
24 transformation strategy, so that allowed me the
25 framework to take decisions that, in the absence of that

1 strategy, I wouldn't have been able to take.
2 So some work was taken forward, but -- for example,
3 some of that work would have been consultation on a new
4 model of stroke care, we undertook that work -- we
5 couldn't take it to the next stage, which would be
6 decisions as regards what a new model of stroke
7 provision would look like.
8 So it's just that nuance that some work progressed
9 but not all the work we would have like to progress had
10 ministers been in place.
11 **Q.** So I think there's two points that you make in your
12 statement. I think the first one is the budgetary
13 constraints that you operated under during that period
14 because of the absence of power-sharing. So there
15 wasn't -- I think is this right, you had to operate
16 under one-year budgets; is that correct?
17 **A.** One-year budgets, but also in the position that we
18 weren't actually getting confirmation of our budget
19 until quite late in each financial year, which makes
20 financial planning even more difficult than just
21 a one-year budget on its own. So that was a very, very
22 challenging financial position.
23 **Q.** Then I think the second point, which is related to the
24 evidence you've given, that you were able to take
25 reforms so far --

1 **A.** Yes.
2 **Q.** -- that the radical reform did require the --
3 **A.** Yes.
4 **Q.** -- authority of ministers --
5 **A.** It did.
6 **Q.** -- in order to take it one step further.
7 The reason I'm asking you all of this, Mr Pengelly,
8 is obviously the question of the extent to which the
9 fragility of the health service impacted on the response
10 the pandemic thereafter, so after January 2020, is
11 important.
12 Can I ask for your view on that and the extent to
13 which it may have conditioned the response --
14 **A.** Yes.
15 **Q.** -- of what ministers were able to do?
16 **A.** I think there are two very clear dimensions: there's the
17 system and there's the people in the system.
18 The system was, whatever language I choose,
19 certainly suboptimal. The structure of our system
20 wasn't, and isn't yet, right for the services we're
21 trying to provide to the population of Northern Ireland.
22 And reform at that stage, the reform programme, was
23 focusing on reconfiguration of services in many cases.
24 So that didn't happen.
25 So we certainly entered -- we entered the pandemic

1 with a configuration of services that wasn't as good as
2 it could have been. I think had an Executive been in
3 place for three years it wouldn't have been perfect but
4 it would have been better than it was at the point we
5 entered the pandemic.
6 The other big point to make in terms of people, the
7 first number of years that I was in health, if we look
8 at emergency department activity as a real measure of
9 the temperature of the health system, and four-hour
10 breaches and 12-hour breaches, people waiting longer
11 than 12 hours for admission or discharge, in the early
12 years of my tenure, there was a real seasonality to
13 that, that we had extreme winter pressures, and then
14 from about the spring through to the autumn the system
15 fell back into a good state. The important bit of that
16 was it meant that staff across the system, particularly
17 in emergency departments but throughout the system, they
18 actually got some meaningful downtime and some respite.
19 By the time we entered the pandemic, as
20 a combination culmination of the growing pressures in
21 the system flowing from an ageing population, the lack
22 of transformation, there is virtually no discernible
23 seasonality, particularly in emergency departments, now.
24 12-hour breaches are a manifestation every month.
25 So we entered the pandemic with a very, very tired

1 workforce. Up to the point of the pandemic the
2 continual provision of high quality health and social
3 care was reliant on the goodwill of staff. That is
4 still the case.
5 But that is not a finite well of goodwill, and
6 people are tired. They have been going above and
7 beyond. And I certainly would not tolerate any
8 criticism of staff in our health and social care system
9 for the way they performed, but it's important to make
10 the point that they entered the pandemic with a degree
11 of fatigue flowing from the state of health and social
12 care.
13 **Q.** Is it correct that you actually had real workforce
14 pressures in any event, for example because of shortages
15 in staff across both hospitals and social care as well?
16 **A.** Yes, we were carrying large numbers of vacancies. And
17 at the tail end, towards the end of 2019, there was
18 industrial action from our nursing colleagues in terms
19 of the pay position. That -- that was part of a vicious
20 circle, leading to more vacancies with our nursing
21 colleagues, because other jurisdictions were more
22 attractive to them as a proposition to work in. So --
23 and that was true too of medical colleagues. So there
24 were vacancies flowing from both the pay system and from
25 workload pressures, which just compounded the problem.

1 **Q.** All right. So just in terms of coming into the pandemic
2 then and that issue of how the response might have been
3 conditioned, would it be right to characterise health
4 services in Northern Ireland in January 2020 as being
5 extremely fragile or is that putting it too high?
6 **A.** I don't think it's putting it too high. I think we were
7 in a very difficult space, because -- you've mentioned
8 that the figure in and around that time of waits was in
9 excess of 400,000, we were routinely missing the 12-hour
10 targets for emergency department, red flag targets were
11 being missed. So it was a service that was under
12 intense pressure, and the pressure was growing on
13 a daily basis, notwithstanding what was coming through
14 Covid. So I think to describe it as fragile is entirely
15 legitimate.
16 **Q.** Did it also mean, then, and I know this might be taken
17 as read but it might nonetheless be important to say it,
18 that there were a large number of people with
19 unaddressed health needs as well in Northern Ireland?
20 **A.** I think that's fair, given the numbers waiting, yes.
21 **Q.** So did that mean, at the start of the pandemic,
22 obviously, when there was -- and we'll come to look at
23 the specifics of this -- obviously when there were
24 concerns about health services being overwhelmed, was
25 that concern particularly acute in Northern Ireland,

1 given the fragility of the health service; in other
2 words that there was very little capacity in
3 Northern Ireland to shoulder the burden of the oncoming
4 pandemic?
5 **A.** Yeah, I think that's fair. And again, the two
6 components to it -- the typical metric for hospital
7 capacity is that ideally a hospital should run at no
8 more than about 85% capacity, to create a bit of churn
9 in the system. I think all our hospitals were routinely
10 running well in excess of 85%. But that's, again, with
11 the workforce condition and the number of vacancies and
12 the tired workforce. So I think all those issues
13 contributed to the service not being as resilient as it
14 otherwise would have been had other changes been in
15 place.
16 **Q.** All right. So just, if I may, then move on to the
17 beginning of the pandemic and the burgeoning awareness
18 of it in Northern Ireland. I think we know, and I won't
19 take you to your statement about this, that within the
20 Department of Health a silver command was set up on
21 22 January 2020.
22 **A.** That was silver command for -- it wasn't within the
23 department, that was the wider health and social care
24 system. I think that was led by colleagues in Health
25 and Social Care Board and the Public Health Agency.

1 **Q.** Yes, sorry, it's probably important that I establish
2 this first. I understand that that was -- that's
3 an operational response --
4 **A.** Yes --
5 **Q.** -- is that correct?
6 **A.** -- that's right.
7 **Q.** Did you have a role in instituting that or saying "This
8 is the right time to stand up" --
9 **A.** The decision would have been taken at the Health and
10 Social Care Board and PHA, but departmental colleagues,
11 particularly in the Chief Medical Officers' group, would
12 have been in constant dialogue with colleagues in those
13 organisations about that decision.
14 **Q.** Before we move on to that group, it's probably important
15 just to establish that in terms of the management of the
16 Department of Health, the CMO in Northern Ireland is
17 actually part of the top management team; is that
18 correct?
19 **A.** That's correct, yes.
20 **Q.** So he is part and parcel of the management structure of
21 the department in terms of its day-to-day work; is that
22 correct?
23 **A.** That's right, yes.
24 **Q.** So he isn't an independent adviser like
25 Professor Sir Chris Whitty is, he doesn't have an

1 independent role within government, for example?
2 **A.** It's not independent, but his professional advice is
3 independent, it's not subject to any form of oversight
4 by the likes of myself or the ministers, but he provides
5 independent medical advice. He also -- he holds
6 a policy remit as well, but the CMO advice has
7 an independent aspect to it, if I'm making that clear.
8 **Q.** So, again, to be clear, from your perspective as
9 permanent secretary, he is there to provide advice, so
10 in the conventional sense --
11 **A.** Yes.
12 **Q.** -- of a medical adviser or --
13 **A.** Yes.
14 **Q.** -- a CMO, but separate to that is also part of the
15 management structure?
16 **A.** Yes, that's correct.
17 **Q.** And within the management structure, then, what is the
18 remit of the CMO?
19 **A.** It's broader healthcare. There's areas of healthcare
20 policy. The CMO would have been the senior sponsor for
21 the Public Health Agency, and the public health
22 dimension in there. He would have input into other
23 policy areas that other senior colleagues were working
24 on. So quite -- he'd also senior oversight of RQIA,
25 which is the regulator for Health and Social Care.

1 **Q.** All right. We'll come back probably and touch on all
2 those different points.
3 But just coming back, then, to the standing of the
4 silver command, so did that take place independently of
5 you, you weren't involved in that decision?
6 **A.** I wasn't involved in that decision.
7 **Q.** Do you know what prompted that decision to be made?
8 **A.** It was -- I think it was prompted by the request for the
9 development and evolution of surge plans because of the
10 awareness of the growing threat of the Covid as maturing
11 into a pandemic, the dialogue from the Chief Medical
12 Officers' group with colleagues, and both the board and
13 the PHA.
14 **Q.** At that point in time, is that an understanding that you
15 would have shared then?
16 **A.** Yes, yes.
17 **Q.** All right, and I think we can see, and perhaps if we
18 bring this up on screen, please, this is INQ000308458,
19 please, and if we could go to page 12.
20 In terms of the risk presented to Northern Ireland
21 by travel, and specifically from Wuhan itself, I think
22 this demonstrates that on 25 January in fact
23 Northern Ireland had a number of visitors from there,
24 I think there was a coach of people; yes?
25 **A.** Yes, that's right.

1 **Q.** So I think we can see that the PHA were despatched to go
2 and provide advice?
3 **A.** Yes, I think -- and I think I remember the conversation
4 that, you know, in the absence of any other legislative
5 mechanism, there was no further intervention that could
6 happen at that stage as distinct from any -- there
7 wasn't a professional view(?) about what was needed, but
8 colleagues from the public health side of PHA went and
9 provided advice to the group. I think they were -- they
10 arrived off the boat late in the evening, checked into
11 a hotel, and were up very early the next morning and on
12 the bus on the road to Dublin, so it wasn't a long stay.
13 **Q.** I think we can see from your messages that it's right in
14 fact that no-one had any power --
15 **A.** No.
16 **Q.** -- to do anything about the visitors because in fact
17 they were -- they reported that they were
18 asymptomatic --
19 **A.** Yes.
20 **Q.** -- so there was nothing more to be done, and I think the
21 visitors then made their way to the Republic of Ireland.
22 **A.** I believe I'm right in saying that one of the
23 conversations I had was when PHA colleagues were calling
24 to give them some advice, the question: what would
25 happen if our colleague noticed that one or more of them

1 was symptomatic? That turned out not to be the case, so
2 they had reported themselves as being asymptomatic, and
3 I think that was confirmed, to the best of my
4 recollection, by the colleague who called with them.
5 **Q.** But nonetheless any idea that this pandemic was
6 something happening on the other side of the world --
7 **A.** Yes.
8 **Q.** -- and presented no threat to Northern Ireland was very
9 clearly dispelled --
10 **A.** Yes.
11 **Q.** -- at this point in time.
12 We know, and the Inquiry has seen, that on
13 25 January there was an email from Professor Woolhouse,
14 and that the Northern Ireland CMO was a recipient of it,
15 setting out concerns about modelling done in Scotland
16 and about the potential overwhelming of the Scottish
17 medical system.
18 Was that information about which you were aware at
19 the time, or did you understand that to be a concern at
20 that point?
21 **A.** I understood it to be a concern, even at that stage, at
22 the end of January.
23 **Q.** Yes.
24 **A.** But it -- and colleagues were always very careful to
25 point out this wasn't a prediction, it was scenario

1 planning at that stage, but that was certainly one of
2 the causes for concern, that that was a possible
3 trajectory that we were embarking on.
4 **Q.** We'll come to that issue of prediction versus scenario,
5 I think, as we go through your evidence. But just
6 coming back again to the information that was known
7 about that time, we also know that on 28 January
8 Professor Whitty sent an email to Downing Street about
9 the two scenarios that he foresaw might play out, either
10 that China would control -- there would be a large
11 outbreak, but China would control the outbreak, or the
12 reasonable worst-case scenario which was that there
13 would be a large outbreak and China wouldn't be able to
14 control it.
15 Again, was that something that you were familiar
16 with, or did you have that understanding at the end of
17 January?
18 **A.** I can't recall specifically seeing the text of the
19 email, but I do recall, and dialogue with the Chief
20 Medical Officer at the time, that that was the sort of
21 message he was conveying to us, that -- of those two
22 available scenarios, and the latter more concerning
23 scenario about overwhelming of the service.
24 **Q.** All right, and I think in fact we can see that from
25 WhatsApp messages that we've looked at already in

1 the Inquiry.
2 And perhaps if we could go to this, please,
3 INQ000308436, and it's the last entry on page 2.
4 I think this is the message to you from
5 Sir David Sterling effectively, I think, the main part
6 of it being that the message that was being conveyed to
7 Northern Ireland officials was that China had lost
8 control.
9 **A.** Yep.
10 **Q.** And I think if we go over the page, that was a message
11 that you had received as well.
12 **A.** Yep.
13 **Q.** We see your response at the top. I won't read all of it
14 out, but:
15 "At one level, very worrying, although at peak time
16 here will present 'only' ..."
17 You have put that in parenthesis:
18 "... as bad flu as opposed to anything more
19 sinister."
20 And then you said that most people don't appreciate
21 how bad a flu it is.
22 **LADY HALLETT:** Can I just go back for a second, Mr Pengelly:
23 when people in your position, and many others around you
24 and in the rest of the UK, were told that the two
25 scenarios were China contains or global pandemic, didn't

1 anybody stop and say: well, wait a minute, we know that
2 visitors from Wuhan, the centre of where the disease has
3 started, have been visiting, as you've just described,
4 Northern Ireland, so doesn't that indicate that back in
5 January people should have been questioning whether
6 China had -- could ever contain it, because their people
7 were travelling the world?
8 **A.** I think that's a very fair point. I mean, my
9 understanding was that that was why the assessment was
10 that the second of the two scenarios was seen as the
11 most likely situation, that it wouldn't be contained
12 within China.
13 **LADY HALLETT:** My point is that that should have come
14 earlier than February, it should have come in January,
15 because you all knew that people were travelling the
16 world --
17 **A.** I think in January we were starting to plan on that
18 basis, certainly within -- I think it was 27 January
19 that in the Department of Health we activated our own
20 gold arrangements, so that certainly pre-dated this
21 exchange.
22 **LADY HALLETT:** Sorry to interrupt.
23 **MS DOBBIN:** I don't think we get any sense, Mr Pengelly,
24 from this message of the sort of alarm that might be
25 expected, it being understood that the second of the

1 scenarios was, first of all, in fact playing out, and
2 that individuals from that part of China had in fact
3 been in Northern Ireland, so no protection in
4 Northern Ireland on the basis of travel?
5 **A.** Well, the travel bit is obviously outwith the devolved
6 space.
7 **Q.** Of course.
8 **A.** So that wasn't an issue for us. But as I say, by
9 6 February, you know, we had been in activation mode of
10 our own gold arrangements for over a week by that stage,
11 so the preparatory and planning work was kicking into
12 overdrive in the department at that stage.
13 **Q.** I just want, before this disappears from the screen --
14 that obviously Sir Richard was -- and he's been taken to
15 this -- recognised at that point in time that the
16 problem would be when it hit care homes and hospitals.
17 Again, was that something that you had a keen
18 appreciation of at that time as well?
19 **A.** Certainly in terms of our planning work and surge work,
20 we were commissioning work from colleagues across the
21 sector in terms of surge plans for both hospitals and
22 care homes.
23 **Q.** In terms of your understanding that this would only be
24 a bad flu, where were you getting that understanding
25 from?

1 **A.** That was just a reflection. And there's always a risk
2 when a non-expert like myself tries to interpret what
3 medics are saying, but at that early stage there was no
4 sense of what the symptomatic position for Covid would
5 be. I think there was a sense that it could present as
6 flu-like symptoms. And, you know, my language in this
7 was trying to make the point that people often refer to
8 themselves as having flu when they have a cold, and
9 a flu is a much more difficult illness to endure and
10 experience than a cold, so hence the "only as a bad
11 flu", but at this stage, you know, we were very much in
12 the foothills of understanding how the virus would
13 present itself.
14 **Q.** Is that an understanding you would have had from the
15 Northern Ireland CMO?
16 **A.** I -- I assume it's from conversations that -- CMOs
17 about -- but, again, there's always the risk that --
18 you know, it certainly wasn't a definitive briefing that
19 the CMO gave me about how exactly this would present
20 itself, it was more my, probably clumsy, interpretation
21 of words that the CMO was using.
22 **Q.** I want to move on, if I may, just to, I think it's
23 right, Mr Pengelly, that the two scenarios presented by
24 Professor Sir Chris Whitty did become integrated into
25 Northern Ireland policy.

1 So if we can just have a look, please, at
2 INQ000425583.
3 Can you help me, first of all, we've already seen
4 who Ms Redmond is. She's -- she sits within the CMO --
5 A. Yeah.
6 Q. -- group in the Department of Health, and I think she
7 was the director of Population Health.
8 A. That's right.
9 Q. We just so some other officials to whom this was being
10 circulated. Can you help as to whether or not they're
11 also part of the CMO group or --
12 A. They all would have been. You see Cathy Harrison is
13 now, currently, the Chief Pharmaceutical Officer. I'm
14 not sure just at that stage whether she had taken a post
15 or was -- she was Deputy Chief Pharmaceutical Officer,
16 but she's a professional pharmacist.
17 Q. Okay.
18 A. And the other three colleagues are Civil Service policy
19 colleagues.
20 Q. All right. And I think we can see at paragraph 8 the
21 integration into the policy position as the Department
22 of Health; is that right?
23 A. Yes.
24 Q. Again, so there can be no doubt, then, in
25 Northern Ireland, as to the understanding of the

1 position; yes? It was well understood --
2 A. Yes.
3 Q. -- that those were the two scenarios.
4 So that is on 5 February, and we now know -- and
5 again perhaps if I could bring this up -- this is
6 6 February, we've seen this already.
7 It's INQ000218470.
8 And this is the letter from Ms Redmond again.
9 A. Mm-hm.
10 Q. And I think we can see, if we go to page 2, it being
11 advised -- and it's the third paragraph up from the
12 bottom -- that the Department of Health was providing
13 advice to other parts of government in Northern Ireland
14 that it wasn't necessary to activate the contingency
15 arrangements, the central contingency arrangements, at
16 that time; yes?
17 A. Yes, but I think just to be clear, and at the risk of
18 speaking for Liz in this, the activation of the NICCMA
19 arrangements can be called for by the lead government
20 department. I -- I'm interpreting this form of words as
21 being, at this stage: we in the Department of Health are
22 not calling for the activation, the decision about
23 whether or not to activate it is an issue for TEO.
24 So I don't think I would interpret this as us saying
25 "Don't activate NICCMA", as opposed to "We are not

1 placing a request". And the reason for that being that
2 within health we had activated our own gold structure,
3 so we were doing what we needed to do to prepare from
4 a health perspective, and at this point in the cycle we
5 weren't seeking assistance from anyone else at this
6 stage, but the issue about activation of NICCMA
7 fundamentally was an issue for TEO as lead in civil
8 contingencies.
9 Q. The advice goes further than that, though, doesn't it,
10 because it's saying -- sorry, if we could just bring
11 that back up again -- if we look at the second line, so
12 what she says is:
13 "I do not consider it necessary to activate NICCMA
14 at this time, unless or until the infection appears in
15 [Northern Ireland] and impacts are experienced here."
16 So it's going further. It's not -- this isn't
17 advice that -- you may wish to think about it. This is
18 advice coming from the Department of Health that there
19 isn't any need to stand these up unless and until the
20 virus was felt in Northern Ireland?
21 A. And I absolutely -- I take that point in terms of the
22 words that are in front of us. The point I would make
23 is that, from the Department of Health's perspective,
24 I would be reluctant to offer a view as to what other
25 departments were doing, because we now -- now, I didn't

1 know this at the time, but in terms of preparations for
2 Module 1 and for this, we now know that the assessment
3 in and around this time was that other departments, in
4 terms of plans for sector resilience were around
5 18 months behind where they could have been. So there
6 was an issue about what other departments needed to do
7 and the extent to which they needed to engage.
8 I don't believe it's for the Department of Health to
9 say: you should or should not stand up the contingency
10 arrangements to deal with those aspects.
11 I can see that, from the form of words in front of
12 us, you can interpret that. I would attribute that more
13 to loose drafting, that we're saying what we should be
14 saying is: from the health perspective, we don't request
15 the stand-up at this point in time.
16 Q. I'm going to explore that with you, because there are
17 a series of communications in the same vein as this.
18 Perhaps if we could go on, please, to look at
19 INQ000185378, and if we just look at page 1.
20 I think that this is your briefing or
21 an aide memoire for you and for a briefing of other
22 permanent secretaries; is that right?
23 A. That's right, yes.
24 Q. Just -- you might be able to help us with this, was this
25 part of a regular meeting at which all permanent

1 secretaries would meet in Northern Ireland aside from
2 the pandemic, or was this a special --
3 **A.** No, there's a -- for as long as I've been a permanent
4 secretary, Friday morning the permanent secretaries meet
5 for just a regular stocktake. So that's -- that
6 happened pre and post-pandemic.
7 **Q.** I think we can see on this page, on page 1, there's
8 reference to planning for the reasonable worst-case
9 scenario. So you explained or you were certainly
10 briefed to explain that to colleagues.
11 **A.** Yep.
12 **Q.** If we go to page 3, please, we can see, if we look,
13 first of all, at "Sector Resilience", that you were
14 giving advice that consideration was needed across
15 departments on sector resilience, and on the basis of
16 the spread; correct?
17 **A.** Yep.
18 **Q.** So in other words, because of the global spread.
19 And I think if we go to bullet 2, you foresaw that
20 there would be a need for further guidance and
21 co-ordination but again, at 3, that you didn't consider
22 that it was necessary to set up the central contingency
23 arrangements in Northern Ireland, although you do point
24 out to your colleagues that it's an evolving situation;
25 yes?

1 **A.** But I would just point out this is the briefing note
2 that I was given as an aide memoire for the meeting, and
3 I suspect there may have been a sense of cut and paste,
4 and the same source material used is Liz's letter and
5 mine. My interpretation of the position remains, and
6 I -- regrettably I can't recall the exact form of words
7 I used in speaking to this with my permanent secretary
8 colleagues, but my position would be: we're not calling
9 for the stand-up at the moment, but the issue as to
10 whether or not it stood up remains one for TEO.
11 **Q.** Can I just ask, just to explore that, and I'm going to
12 come on to more communications about this, but why the
13 Department of Health wouldn't have wanted other
14 departments to stand up arrangements, or wouldn't have
15 wanted that co-ordinated approach, given that the
16 worst-case scenario was, in fact, eventuating?
17 **A.** But I think, and forgive me if I'm dancing on a pinhead,
18 the point I'm making is I wasn't calling for it.
19 **Q.** Yes.
20 **A.** It wasn't that I was saying it shouldn't happen. I, at
21 that stage, didn't know the state of preparation.
22 Establishing the arrangements comes at a cost, because
23 it pulls colleagues away from other work. And I've
24 talked earlier, particularly in the context of health
25 and social care, the stresses and strains and the

1 pressures that colleagues were under; that was also true
2 across the wider Civil Service in terms of -- you know,
3 going back to, I think, the 2014 voluntary redundancy
4 programme that -- so there was a sense of shortage
5 across the system.
6 So the point was: I wasn't calling for it; that's
7 not to say that if it was needed it shouldn't happen,
8 but the assessment needed to take account of what is the
9 value in creating it, at that point in time, as against
10 the cost of bringing the staff together to do that,
11 because it meant that something else wasn't happening,
12 and I wasn't in a position to have that transparency
13 across other departments.
14 **Q.** Okay, I think there's a number of things that are
15 contained within an answer, if I may try to unpick them.
16 First of all, the Department of Health was the lead
17 department at this stage?
18 **A.** For the health response.
19 **Q.** Yes, well, it was the lead department in terms of the
20 contingency arrangements, wasn't it --
21 **A.** No, it was the lead government department for the health
22 response to the pandemic.
23 **Q.** Well, perhaps this is just a semantic difference, but in
24 terms of across Northern Ireland, do you accept that it
25 was the lead department in terms of the response to the

1 pandemic?
2 **A.** I would accept it was the lead government department for
3 the health response to the pandemic. If there was other
4 sectoral responses to the outworking of the pandemic, it
5 wasn't for the Department of Health to lead on those
6 aspects.
7 **Q.** Are you --
8 **A.** We may have had a role in advising and providing expert
9 advice, particularly through the Chief Medical Officer.
10 **Q.** The 2016 protocol that sets out the emergency -- or that
11 sets out the contingency arrangements for an emergency
12 in Northern Ireland sets out the concept of a lead
13 department, doesn't it?
14 **A.** Mm-hm.
15 **Q.** Do you accept that the Department of Health was the lead
16 department for the purposes of those contingency
17 arrangements?
18 **A.** But I would characterise the lead government department
19 role was in the context of the health response to the
20 pandemic. I don't think it was for the Department of
21 Health to be the lead department for the response from
22 other sectors.
23 **Q.** But --
24 **LADY HALLETT:** Mr Pengelly, I'm sorry to interrupt, but
25 I heard a lot about this during the course of

1 Module 1 -- forgive me, Ms Dobbin -- and there is this
2 concept of a lead government department model.
3 So, for example, in the UK Government, the Health
4 Department, the Health Secretary of State chaired the
5 original COBRs because they were the lead government
6 department. And it wasn't qualified by "for health",
7 they led the response in the early days until the
8 Prime Minister became involved and chaired COBR himself.
9 I'd understood that Northern Ireland was the only
10 other part of the UK where the lead government
11 department model applied and, similarly, is the lead
12 government department model for the response, as
13 Ms Dobbin is putting to you. That was the evidence
14 I thought I'd heard in Module 1.
15 **A.** Forgive me, my Lady, if I'm getting -- creating a sense
16 of confusion. We can be the lead government department
17 in terms of articulating the response and the Department
18 of Health cannot dictate or mandate other departments,
19 the sectoral response from another sector --
20 **LADY HALLETT:** Cannot dictate, but you can lead.
21 **A.** But forgive me, I don't understand what "lead" means if
22 it doesn't ...
23 **LADY HALLETT:** Well, as in encouraging others to check that
24 their resilience is better, getting them prepared.
25 **A.** Is that not the role for the central -- the civil

1 contingencies role as discharged through the Executive
2 Office? That would be my understanding.
3 **MS DOBBIN:** Right. We might come back to the civil
4 contingencies protocol because it's obviously important
5 that we do understand this.
6 Just focusing for a moment on your suggestion that
7 in terms of the Department of Health -- what really
8 ought to be conveyed here is you're saying "We were only
9 asking other people to stand up civil contingencies --
10 other departments to stand up civil contingency
11 arrangements", is that what you are saying?
12 **A.** Yeah, yeah.
13 **Q.** The Department of Health was the department that was --
14 Minister Swann was attending COBR at this point, wasn't
15 he?
16 **A.** That's right, yes.
17 **Q.** So he was the person who was integrated into the
18 UK Government response --
19 **A.** Mm-hm.
20 **Q.** -- yes? And would have understood, and your department
21 would have understood, then, all of the other parts of
22 the response that were ongoing at central government;
23 yes?
24 **A.** Mm-hm.
25 **Q.** And would have understood the potential consequences of

1 what was coming down the road in terms of the pandemic;
2 yes?
3 **A.** Yes.
4 **Q.** So the Department of Health would have been in
5 a position to send out the message to other departments
6 about what might be required from them in order to be
7 a part of a cross-departmental response; do you accept
8 that?
9 **A.** Yes, very much so, but that message coming from COBR
10 about the UK analysis, at COBR, for example, they
11 wouldn't have discussed the state of preparedness of
12 Northern Ireland departments, so it would have been at
13 the more macro level. That message, and I know
14 Minister Swann attended, I think I'm right in saying,
15 although I can't say for certain, I think officials from
16 TEO may have been dialling in to some of the COBR
17 meetings. Notwithstanding that, Minister Swann would
18 have briefed, and I think there were some exchanges
19 about the minister briefing FM and dFM on the emerging
20 position, but even ultimately whether or not -- if the
21 correspondence there showed that we were calling, all we
22 would be doing would be putting the request. The TEO is
23 fundamentally a TEO decision in the context of their
24 assessment of the state of readiness of other sectoral
25 partners across Northern Ireland at that stage.

1 **Q.** But you were the department that understood the full
2 potential consequences, yes, of what might be required
3 in order to have an all-society response to the
4 pandemic?
5 **A.** In these very early stages our focus was on evolving the
6 health response and the health consequences of it, so we
7 wouldn't have been sighted on either the state of --
8 I mean, and fundamentally activation of NICCMA is more
9 into the response phase than the prepare stage. At this
10 early stage in February, we were still a number of weeks
11 away, for example, from the first case in
12 Northern Ireland, which I think was 27 February, so
13 that's why the health assessment -- and we were very
14 much looking at it from the health perspective -- we
15 weren't asking for the activation of the arrangements
16 from the health perspective at that stage, but we
17 weren't fully sighted on the needs of other departments
18 in Northern Ireland.
19 **Q.** I'll come back to that, but just in terms of your view
20 that the contingency arrangements are part of
21 a response, is it your position, then, that Ms Redmond
22 was right when she was saying, then, there isn't a need
23 for contingency arrangements unless and until the virus
24 arrives in Northern Ireland?
25 **A.** I think Ms Redmond's assessment at that point in time,

1 based on what she knew at that point in time, that we
2 didn't need to ask for the activation. Liz wasn't
3 making an assessment about the state of preparedness or
4 the need for a response in other sectors. My assessment
5 is she was speaking from the health perspective. So
6 I can't offer a view as to whether or not she was right
7 about the state of readiness in other sectors at that
8 point in time. I would argue TEO were the lead for
9 civil contingencies and that was their assessment to
10 make.
11 **Q.** I'm going to come on, because there's more material to
12 look at on this issue. Perhaps if I could just go,
13 though, to -- and I'm just going to check that I have
14 the right INQ number for this. It's the next document,
15 which is a presentation by Dr Naresh Chada. I have that
16 at INQ000 -- I've got the right one, thank you.
17 So this was a presentation given by Dr Chada, who
18 I think is the Deputy Chief CMO?
19 **A.** Yes.
20 **Q.** And I think -- is this a document that you're familiar
21 with, Mr Pengelly?
22 **A.** Yeah, I have seen it in the past -- I mean, I wouldn't
23 be able to recite sections of it, but I certainly have
24 seen it before.
25 **Q.** I don't think we expect that. Is this a document that

1 you would have seen at the time?
2 **A.** Yes, yes.
3 **Q.** All right.
4 So if we go, please, if we may, to page 5, really
5 just setting some of this so that I can put it in
6 context, Mr Pengelly, but I think this is a presentation
7 that he gave, I think, to permanent secretaries or
8 people in other departments. Is that your
9 understanding?
10 **A.** That's my understanding, yes.
11 **Q.** I think if we go to page 6, please, so he's setting out,
12 isn't he, what's happened to date; yes?
13 **A.** Mm-hm.
14 **Q.** Sorry, if I didn't, forgive me, but I think that the
15 date of this presentation is 13 February, and it was
16 given on 20 February.
17 **A.** Sorry, I'm confused, because the date on it is the
18 19th -- it's 13 February, three weeks later, sorry.
19 **Q.** I think we can check that, but we understand that it was
20 given --
21 **A.** On the 20th.
22 **Q.** -- that it was a presentation that was given on
23 20 February, but we can orientate ourselves from the --
24 **A.** Sorry, I --
25 **Q.** So we can see him setting out what the position was on

1 19 February; yes?
2 **A.** Yes.
3 **Q.** So making the point to departments that obviously there
4 had been spread to a number of countries, and by this
5 stage it's right, isn't it, Mr Pengelly, that there were
6 a number of cases in the United Kingdom --
7 **A.** Yes.
8 **Q.** -- although not yet in Northern Ireland; correct?
9 **A.** That's right.
10 **Q.** If we just look at page 14, please, so I think this sets
11 out some of the work that was going on in the Department
12 of Health; correct?
13 **A.** Yes, that's right.
14 **Q.** And I think we can see surge preparations referred to
15 there -- I'm going to come back to the surge
16 preparations -- and if we go, please, to page 15, so we
17 assume he explained what the reasonable worst-case
18 scenario is; yes?
19 **A.** Yes.
20 **Q.** And if we go to page 16, please, so we can see that he
21 was recommending that they consider their pandemic
22 influenza planning as a starting point; correct?
23 **A.** Yep.
24 **Q.** And that he knows, and he's communicating, that the
25 elderly and those with existing health conditions would

1 be disproportionately affected; yes?
2 **A.** Yes.
3 **Q.** And were setting out that the planning assumptions
4 predicted excess deaths, massive impacts across
5 government, school closures, rail and road transport
6 issues, and huge costs; correct?
7 **A.** Yes.
8 **Q.** And I think he also set out at page 17 the case fatality
9 rate as well, and the numbers of people who would be
10 potentially affected; correct?
11 **A.** Yes.
12 **Q.** Then at 19 sets out the wider sectorial impacts as well;
13 correct?
14 **A.** Yes.
15 **Q.** So, again, that would tend to suggest that the
16 Department of Health was providing an advisory role to
17 other departments about the potential reach and impact
18 of the pandemic --
19 **A.** Yes, correct.
20 **Q.** -- across Northern Ireland, do you agree?
21 **A.** Yes.
22 **Q.** But notwithstanding that, Mr Pengelly, if we go to
23 INQ000425535, please, and again this is another
24 permanent secretaries stakeholder group, and again
25 I think this is an aide memoire prepared for you; yes?

1 A. Yes.
2 Q. And I think if we go to page 2, please, I think we can
3 see again under "Sector Resilience" the second bullet
4 point deals with -- I think that's largely concerned
5 with the levels of people who would become ill and the
6 people who would be off work; correct?
7 A. Yep.
8 Q. Doesn't actually mention -- I don't think this document
9 mentions the fatality rate, for example.
10 A. I don't think so.
11 Q. Again, I think if we look at the fifth bullet point
12 down -- on page 2, yes -- we can see again:
13 "It is not necessary to activate the contingency
14 arrangements at this time; however ...
15 Again the reference to it being an evolving
16 situation.
17 In light of everything that Dr Chada had said, why
18 was that still the position, if not the advice, that was
19 being given by you to other permanent secretaries as
20 late as 21 February?
21 A. I think, and apologies at the risk of repeating myself,
22 but I again read this, and bearing in mind this was the
23 brief that was given to me as opposed to a record of
24 what I actually said, that our position was we weren't
25 yet calling for the establishment of the crisis

1 management arrangements, we were focused in terms of
2 health. So we didn't feel, in terms of the evolving
3 work that we were doing in and around 20 February when
4 this document was produced, that our work needed the
5 support of the NICCMA arrangements. We weren't in
6 a position -- and I recognise that the wording here
7 doesn't necessarily suggest this, but I don't believe we
8 were saying the TEO do not establish NICCMA as opposed
9 to we are not calling for its establishment at this
10 stage, because we were focused at this stage on our own
11 evolving preparatory work to the emerging situation. As
12 we said, we will reach that stage, and that's in the
13 context, as I've said, that establishing these
14 arrangements comes at a cost in terms of other work
15 being stood down, and that's -- my view remains that
16 that's a call that can only be made when you have the
17 transparency about both the work that needs to be done
18 in other sectors and the cost of doing that work in
19 terms of other preparation work, because NICCMA is
20 fundamentally about co-ordinating a response. The
21 building blocks of that are there's an individual
22 sectoral response and then you start to join the dots
23 across sectors. I still think that the judgement on
24 that at this point in time was one for someone with more
25 line of sight about what was happening in other sectors.

1 Q. What might be thought very surprising is the Department
2 of Health is not saying at this time "We are facing the
3 most enormous crisis we've ever faced and we really need
4 every government department to co-ordinate because this
5 cannot just be a Department of Health response".
6 A. But I don't -- I'm not suggesting we were saying it in
7 those terms. I think we were saying: we are facing into
8 a crisis and there's a huge amount of work to be done,
9 let's be very careful that we don't initiate
10 arrangements that undermine the sectoral response and
11 the evolution and development of the sectoral response
12 to allow it to be joined across sectors, because
13 establishing the NICCMA arrangements comes at a cost,
14 people need to be relocated from other areas of work,
15 a judgement has to be made that at the point in time on
16 20 February was that other work of a higher priority
17 than a NICCMA arrangement which will inevitably be
18 required but is it required this week or next week, and
19 that's the judgement call.
20 Q. But all that the civil contingency arrangements foresee
21 is that there will be a cross-departmental approach to
22 an oncoming emergency. Do you agree that that's what
23 the protocol provides for?
24 A. There absolutely has to be a cross-departmental
25 approach, but a cross-departmental approach has to be

1 built upon the foundations of a departmental analysis
2 and response about what is needed, and then we join
3 sectors.
4 I think I'm -- I'm maybe perhaps being very clumsy
5 in the way I'm making it, but I just think when we
6 establish structures and architecture that remove people
7 from other work, we need to be very, very careful and
8 consider where is the immediate priority and value. Is
9 it the work they're doing today or is it the work that
10 the new structure will be doing tomorrow? Because if
11 that's not absolutely needed for another week, we should
12 let colleagues stay and do the work they're doing for
13 this week. We didn't have a line of sight on that and
14 that was a judgement call that I think TEO had
15 visibility in terms of what was needed at that stage.
16 So we certainly weren't saying NICCMA wouldn't ever be
17 needed; it's always a judgement call about what point
18 you trigger that, because it comes with a cost.
19 Q. So, from your perspective as a permanent secretary at
20 this point in time, what did you see as the
21 cross-departmental part of the machinery that was
22 considering planning across the departments and which it
23 understood what planning was taking place and --
24 A. Well, I think -- I mean, there was planning work
25 happening in each department, certainly, and I can only

1 speak in detail in terms of the Department of Health.
2 **Q.** Yes.
3 **A.** There was the regular dialogue that was happening at the
4 permanent secretary meetings, and we can see both
5 the 7th and 21st -- this was clearly an agenda item --
6 I think I'm right in saying that 20 February CCG met for
7 the first time.
8 **Q.** That's correct, there was an officials' meeting of CCG,
9 that was the only meeting that took place --
10 **A.** But that in itself would have brought departments
11 together on a cross-departmental basis, so that was
12 happening at this point in time -- on this very day.
13 **Q.** Were you at that meeting?
14 **A.** The CCG meeting --
15 **Q.** The CCG meeting.
16 **A.** -- on the 20th? I don't think I was at that meeting.
17 **Q.** We've seen the minutes of what was discussed at that
18 meeting and it wasn't -- it was a few topics, it
19 wasn't -- there's no sense of it having been any sort of
20 very detailed consideration of cross-government plans in
21 Northern Ireland.
22 **A.** Which, if I may, I would pray in aid of the point I'm
23 making, that sometimes creating the architecture doesn't
24 actually achieve the objective, why very careful thought
25 needs to be given that we don't precipitously trigger

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1 architecture that may not be needed for another week or
2 two. As I say, I don't think I was at that 20 February
3 CCG meeting.
4 **Q.** There's an alternative interpretation of events which is
5 that it just wasn't understood or appreciated at that
6 point in time the gravity of the situation that
7 Northern Ireland faced.
8 **A.** I can see that that's an alternative interpretation, but
9 I think in terms of the briefings that had been given to
10 permanent secretary groups and the work we were doing in
11 the department, that certainly wasn't our position on
12 it.
13 **Q.** What I was going to say was that interpretation may have
14 been coloured or informed by the position that was being
15 taken by the Department of Health, which was that there
16 wasn't any need for contingency arrangements to be stood
17 up at this point in time.
18 **A.** I don't believe it would have, no.
19 **MS DOBBIN:** My Lady, I don't know if that's a good time for
20 a break.
21 **LADY HALLETT:** Yes, of course.
22 11.30.
23 **(11.11 am)**
24 **(A short break)**
25 **(11.30 am)**

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1 **LADY HALLETT:** Ms Dobbin.
2 **MS DOBBIN:** Thank you, my Lady.
3 Mr Pengelly, I just want to stick, if I may, with
4 the civil contingency arrangements and the point that
5 you made that the Department of Health didn't, in the
6 correspondence we've just seen, or at those points in
7 time, think that it would be assisted by civil
8 contingency arrangements being stood up by the
9 government in Northern Ireland.
10 It didn't think it would be assisted by those being
11 stood up, did it, when, on 24 February, WHO published
12 its report on its mission to Wuhan. I don't know if you
13 remember that? It was at that point that WHO said that
14 there needed to be an all-society response to the
15 pandemic, and that at this point in time, for example,
16 focus needed to be placed on contact tracing and
17 rigorous quarantine. Do you remember that
18 communication?
19 **A.** Very vaguely. I can't remember the specifics of it.
20 **Q.** All right. But we can be clear that that didn't prompt
21 any change in approach on the Department of Health in
22 terms of a wider governmental response, did it?
23 **A.** No, I mean, it clearly didn't because, you know, there
24 wasn't an immediate call by us to establish the NICCMA
25 arrangements, but it was an evolving piece, and, as

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1 I said, it was always a judgement call. And actually
2 clarifying -- you know, I'm not sort of clinging
3 desperately to the notion that we got it exactly right
4 about when, I'm just trying to help -- explain our
5 thinking about the position at the time.
6 But we were on a trajectory to clearly needing
7 NICCMA. I think it was early March so, you know, we are
8 talking about the separation of a few days at most here.
9 But in and around 20 February, when Dr Chada made the
10 presentation, 24 February I think --
11 **Q.** WHO, yes.
12 **A.** -- you've touched on that -- we were evolving towards
13 it, but clearly in our minds, at that stage, we hadn't
14 reached the stage where we'd come out formally and
15 called for the establishment of NICCMA.
16 **Q.** It didn't change whenever the first case of Covid was
17 detected in Northern Ireland either, did it?
18 **A.** No.
19 **Q.** And --
20 **A.** But I think it did in the very early days of March,
21 I think it -- there was -- I think there was
22 correspondence from the Chief Medical Officer. He used
23 the phrase, I think, "We need an increasing lean-in to
24 the position", which led to, I think, the establishment
25 on, I think, 18 March.

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1 Q. That's right. But again, that was even after WHO
2 declared that Covid-19 was a global pandemic as well,
3 and that was on 11 March, wasn't it?
4 A. That's right.
5 Q. So even that didn't promote a whole-government response,
6 did it, in Northern Ireland?
7 A. But, again, I think I'm trying to differentiate
8 between -- a whole-of-government response is absolutely
9 essential in terms of the fight against the pandemic.
10 When the architecture is formally triggered -- because
11 there was dialogue happening at a whole-of-government
12 level, the value proposition of established -- formally
13 establishing and trigger these mechanisms on a specific
14 date, I think these are fine judgements and, you know,
15 I think it's very difficult to say that today is wrong
16 and tomorrow is right. But these were judgements in and
17 around that period.
18 Q. Yes, I think what your evidence seems to be suggesting,
19 but you must tell me if I'm wrong, Mr Pengelly, is that
20 you saw these contingency arrangements as primarily
21 responsive to a crisis as opposed to a vitally important
22 part of planning the response to a crisis?
23 A. I think there's an element of that, and if you look at
24 the definition of NICCMA it's about ensuring that the
25 response phase is working on a cross-sectoral basis.

1 I think that the sharper point I'm trying to make is
2 that I think in the middle of a crisis, when resources
3 and people are stretched to breaking point, we must make
4 sure that anything and everything we do has a value
5 proposition. I don't fully grasp at this stage that the
6 value proposition of establishing the NICCMA
7 arrangements in early February would have been greater
8 than the cost to other activities that was happening on
9 a sectoral basis, to losing that capacity. At some
10 point we reached a crossover point, and I think it's
11 a fine judgement about when that crossover point was.
12 Some time between early February and mid-March when it
13 happened, I don't know specifically.
14 But I think the focus needs to be on the value
15 proposition rather than -- having the architecture in
16 and of itself wouldn't have delivered value. It was how
17 we used the architecture. And I think there's other
18 examples of that later in the pandemic.
19 Q. All right. I want to pause there just to check that
20 I understand. There's obviously a distinction between
21 what value you understood at the time there might be in
22 having a formal government contingency response at
23 an early stage.
24 Does it remain your position that you can't see that
25 there would have been any value in having that sort of

1 response at a much earlier stage?
2 A. No, I think all I'm trying to do is explain our thinking
3 at the time, and our thinking at the time was the work
4 that we were focused on in the Department of Health
5 would not have been facilitated on, for example,
6 6 February, when Liz wrote her letter, or on 7 February,
7 when I spoke to my permanent secretary colleagues. We
8 didn't feel there was a major enhancement to the work we
9 were doing on that day by calling for the establishment
10 of the NICCMA arrangements.
11 Whether there would have been a value proposition in
12 other sectors, I think I would have to leave that to
13 colleagues who would have a line of sight into the
14 issues in those other sectors.
15 So, looking back from this remove, I would say,
16 I think, as a rule of thumb, earlier establishment would
17 be better, but I still -- but earlier establishment with
18 a clearly defined value proposition. Because I think
19 that the point, and we may have slightly different
20 perspectives on it, but if we reference the 20 February
21 CCG, which I don't think I was at, that was part of the
22 architecture of bringing folk together, but your reading
23 of the record of that -- your interpretation was there
24 wasn't a lot of value that maybe came out of that
25 meeting. Possibly those colleagues were drawn away from

1 other work in doing that. And I'm just making that --
2 and I think in a very clumsy way, that when resources
3 are stretched we need to ensure that we make the best
4 use of them at all times, because there is more work
5 than there is time available.
6 Q. Just going back to some fundamentals about all of this,
7 and just being clear, did the Department of Health
8 understand in February 2020 that there was going to need
9 to be a whole-government response to the pandemic?
10 A. Absolutely, yes.
11 Q. Did it understand that there would be many areas of
12 overlapping policy responsibility within departments?
13 A. Yes, we knew that there would be. I'm sorry, my
14 hesitation is just I'm not sure we could have
15 specifically and clearly defined them all at that stage,
16 but there was an inevitability about those overlaps
17 existing. I think that's the point of your question.
18 Q. Did you also understand that this wasn't about --
19 I think the way you've put it in answers is: we wouldn't
20 have been assisted by what we were doing, that civil
21 contingency arrangements aren't about what we are doing
22 but it's about what all of us are doing within
23 government in order to meet an oncoming emergency?
24 A. But I think they're two very, very different questions,
25 because the question about do I, as the permanent

1 secretary of health, ask TEO to convene a set of
2 cross-departmental structures, for me to ask them to do
3 it, in the context that they could initiate that without
4 recourse to myself, the value -- the question I need to
5 put to myself is: do I need these?
6 My point is I'm not sighted on the value that there
7 would be for other colleagues in other departments on
8 that specific day about establishing that. And, more
9 importantly, would the value outweigh the cost in terms
10 of the repositioning of resources? I wasn't sighted on
11 that, so I am not -- and I think this is the point about
12 the form of words in both the aide memoire and the
13 6 February letter. My interpretation now is my position
14 was not that I am saying "Don't do it", I am saying
15 "I don't need it on this given day". But there's
16 an inevitable trajectory towards that.
17 **Q.** To take something like children's social services, for
18 which you had responsibility, there's a huge overlap,
19 isn't there, with schools, for example, and with --
20 schools play an integral part, don't they, in child
21 protection?
22 **A.** Yes.
23 **Q.** And in the wider provision of social services to
24 children; do you agree?
25 **A.** Mm-hm.

1 **Q.** I'm going to take --
2 **A.** Yes.
3 **Q.** -- this outside health for a moment because it's
4 a straightforward example. Both departments would have
5 to work together, wouldn't they, in order to be able to
6 plan for an oncoming pandemic and, for example, the
7 closure of schools; yes?
8 **A.** Yes.
9 **Q.** So both of those departments would need to meet and have
10 overlapping plans in order to ensure that there weren't
11 obvious gaps --
12 **A.** Yes.
13 **Q.** -- child protection?
14 **A.** But that can happen outwith NICCMA arrangements.
15 **Q.** Was this happening, then, at the time?
16 **A.** I can't give you a factual answer yes or no in terms --
17 because that's an operational conversation. I assume it
18 was happening but I can't speak to the complete accuracy
19 of that.
20 **Q.** Because, I mean, the Inquiry has seen some of the
21 cross-departmental plans that existed in March 2020, and
22 it might be thought that they're extremely rudimentary.
23 We've seen a document that summarises the main points of
24 the plans, and, for example, didn't foresee that schools
25 might be shut?

1 **A.** Were they the plans produced by individual departments?
2 **Q.** They're the central summary of the plans that were being
3 produced.
4 **A.** But could I argue then that maybe the departments
5 spending more time on sharpening those plans was,
6 arguably, a better use of their time? If we take
7 children's social services as an example -- I'm sorry,
8 I'm not trying to be argumentative on this point, I'm
9 just trying to ensure that my position is clear.
10 If we take children's social services, that is a big
11 area. The NICCMA arrangements, if you pull together all
12 departments, you would have two departments that would
13 be very, very interested and very much part of that
14 bilateral discussion. There's arguably a number of
15 other departments that are then drawn into
16 a conversation that possibly isn't the best use of their
17 time. So my point is just one about maximising the time
18 and energy that's available at a point in time. It's
19 not a black and white issue about should we or shouldn't
20 we establish structures.
21 **Q.** Again, if I can just ask you about this, you've made the
22 point a number of times that this is all about
23 resources. I'm not quite clear as to why it would have
24 been such a drain on resources to have a formal
25 cross-government approach at an earlier point in time.

1 **A.** At this stage the most valuable commodity we had was
2 people and their time. And certainly -- you know, I can
3 only speak with complete accuracy about colleagues in
4 the department, but I had teams of people that were
5 working ridiculously long days, 16, 18-hour days, with
6 no respite at weekends. So anything additional that
7 happened would have been layered on top of that, and it
8 could have pushed them -- you know, it could have been
9 the difference between breaking point or not.
10 My sense was that there was a similar position in
11 some, possibly not all, other departments, so it's --
12 the resource point is about the impact on people, not
13 about physically spending large sums of money.
14 **Q.** I'm going to move on, Mr Pengelly, if I may, just to
15 understand a bit more then about the planning that had
16 gone on in the Department of Health and to try to
17 understand what structures were on foot in order to be
18 able to respond to the pandemic.
19 The Inquiry understands from the evidence of the
20 Chief Scientific Adviser, Professor Young, that there
21 was no modelling capacity in Northern Ireland until he
22 came back into office after a period of leave, and that
23 it wasn't instituted until the end of March 2020; is
24 that correct?
25 **A.** That's correct, yes.

1 Q. Why wasn't there any modelling capacity or provision in
2 Northern Ireland until that individual came back from
3 leave?
4 A. Well, modelling capacity along the lines you're talking
5 about wasn't a routine activity that we would have had
6 a resource doing that, so the need for it emerged in the
7 course of the pandemic. And I'm making that as -- that
8 central modelling capacity, in terms of having line of
9 sight on the pandemic as distinct from various ad hoc
10 modelling work that would have taken place in the Public
11 Health Agency from time to time, that didn't exist at
12 that point in time because it hadn't been needed prior
13 to the pandemic.
14 I think, looking back, had Ian been about, we would
15 have triggered that capacity before the end of March.
16 But the modelling work -- and Ian can speak to this in
17 much more detail than I can -- the quality of any
18 modelling work is directly proportional to the number of
19 data points you put into that modelling. So any
20 modelling work that was done in late February and early
21 March would have had such a low confidence level
22 attached to it, because of the scarcity of data points;
23 we had one case on 27 February. So it wouldn't have
24 been possible to do comprehensive modelling work in the
25 early and mid-part of March, until case numbers started

1 to escalate.
2 So in the absence of our own modelling capacity in
3 the early part of March we were tending to use modelling
4 work that had been done across the water and look at
5 that and its population application to Northern Ireland.
6 That was arguably at least as, possibly more, accurate
7 than any modelling work that could have been done
8 locally, given the low number of data points at that
9 point in time.
10 Q. I'll come separately to look at why there was a lack of
11 data points in Northern Ireland at that time. But
12 obviously all of this was contingent upon an individual
13 not being in office for a period of time, as we
14 understand it, that modelling didn't happen until he
15 came back, because there wasn't anyone else to institute
16 it; is that correct?
17 A. Well, I'm ... I mean, the -- I wasn't involved in the
18 granular discussion about modelling capacity, but
19 I think that the sense I'm trying to make is we didn't
20 have modelling capacity before then and we knew we would
21 need modelling capacity as we stepped into the pandemic.
22 The -- you want to come back to the number of data
23 points. I think this was an issue that was assigned and
24 Ian was asked to lead on it when he came back. My sense
25 isn't that the Chief Medical Officer, at the early stage

1 of March, was beating the desk in frustration that he
2 needed modelling done and he didn't have Ian available
3 to do the modelling. There was a recognition that the
4 population-based approach, leaning into the work that
5 was being done in other jurisdictions, was fit for
6 purpose at that point in time. That's more my
7 understanding of the position than being part of those
8 conversations.
9 Q. All right. We can take that up with the CMO.
10 But the fact that Northern Ireland didn't have
11 a Chief Scientific Adviser until the end of March might
12 be thought extremely surprising, to say the least, that
13 Northern Ireland completely lacked that input until such
14 a late stage.
15 A. I think that's a fair comment, and Ian had been off on
16 a period of absence, and when he returned -- I think he
17 was off from early February through to March. He'd been
18 in post before that but had been off for a period of
19 absence for a few weeks.
20 Q. We understand from his witness statement that he went
21 off in mid-February, but it doesn't appear that he had
22 any role in the Northern Ireland response before that.
23 Now, obviously we can ask him about that, but that
24 does go to a formal question about the structures
25 available in Northern Ireland. I mean, can you, as

1 permanent secretary, explain why the Chief Scientific
2 Adviser --
3 A. I can't offer a great deal of insight into the work that
4 Ian was doing prior to his departure in February,
5 I think it was -- I mean, there was a lot of work --
6 I think it was a part-time post and it had historically
7 been a part-time post. I think when Ian came back,
8 because of the pressures, it morphed into a full-time
9 post, and I think prior to that it had been leaning more
10 into the R&D space than the scientific officer space.
11 Q. Yes. It's also right that Northern Ireland -- or within
12 the Department of Health there was no advisory group in
13 respect of Covid either, or a special pandemic advisory
14 group; is that also correct? And that Professor Young
15 set that up as well when he came back --
16 A. Yes, that's right.
17 Q. Again, can you help as to why there was no advisory
18 group within the Department of Health for such a long
19 period of time at the outset of the pandemic?
20 A. I don't know the thinking behind that. I think it was
21 just because there were so many moving parts, and issues
22 were morphing in the latter part of January through
23 February into March, it was just one of those issues
24 that we were moving to.
25 Q. I mean, in terms of your role as permanent secretary,

1 did you not think that these were the sorts of
2 structures that ought to be in place from that early
3 point when you understood just how serious the position
4 was?
5 **A.** The specific question, that structure, clearly hadn't --
6 it hadn't occurred to me, that -- and I can't recall at
7 the time was I travelling in the assumption that we had
8 that capacity within the department, or certainly in
9 terms of the relationships and networks that -- through
10 the likes of the Chief Medical Officer network or(?) the
11 full four-nation basis, that we were getting the input
12 through that, and I think at that early stage much of
13 our intelligence was coming through that network rather
14 than trying to recreate it. I think -- you know, there
15 was a paucity of information at that stage. So
16 something that we grew into, for want of a better term,
17 in March. You know, it doesn't jar with me as being too
18 uncomfortable.
19 **Q.** All right.
20 Again I'm just staying within planning and
21 structures for the moment. I just want to ask you,
22 please, if I may, about surge planning, which is
23 something that you've already touched on upon.
24 If we could go to the letter which I think the CMO
25 sent about this. So we can see it. And again, this

1 might be something that you're familiar with.
2 This is a letter from the CMO, I understand it's to
3 Ms Watts, who is one of the people who sits, is that
4 right, within health and social care services?
5 **A.** Valerie, at that stage, would have been chief executive
6 of the Health and Social Care Board and the Public
7 Health Agency on this date.
8 **Q.** These were the two organisations, were they, that were
9 going to be most involved in surge planning?
10 **A.** They, those two organisations comprised health silver
11 and surge -- there was a subgroup of health silver
12 working specifically, I think, at surge planning for the
13 trusts.
14 **Q.** All right, and I think if we go to page 2 we can see
15 it's the paragraph that's in bold that the CMO wanted to
16 see the details of the planning that had taken place,
17 and that he was looking for that to be provided to him
18 by 13 March.
19 **A.** Mm-hm.
20 **Q.** So I think this letter was on -- yes, it's 17 February.
21 So it certainly doesn't appear from this letter,
22 Mr Pengelly, but you may understand more about the
23 detail of this, that certainly in terms of surge
24 planning that there was an urgency about it or any
25 concerns at this point in time about Northern Ireland's

1 capacity?
2 **A.** My sense was that there was an urgency about it, but
3 there was also realisation that it was an extensive and
4 complex piece of work. So I think, forgive me, if your
5 urgency point is related to the gap between the date of
6 the letter and 13 March --
7 **Q.** Yes.
8 **A.** -- I think that's more a consequence of how much work
9 was required to develop, and because, you know, Michael
10 would obviously want to speak to this, I suspect
11 Michael's view was, you know, he would rather have good
12 comprehensive surge plans by 13 March than something
13 that's of poor quality a week or two sooner than that.
14 **Q.** Right.
15 Just -- I'm going to go to the letter, if I may,
16 that was sent -- sorry, if we could stay on that letter,
17 I think we also see, I think it may be the page over, so
18 we'd got the CMO also setting out management of the
19 first case of Covid-19 and subsequent cases --
20 **A.** Mm-hm.
21 **Q.** -- and he sets out -- yes, so it's the first paragraph:
22 "It is still our intention that the first
23 [Northern Ireland] case would be transferred to ...
24 England."
25 **A.** Yes.

1 **Q.** So, again, perhaps you can help with that, and he does
2 go on in the second paragraph to say that that might not
3 necessarily be possible, but nonetheless seems to
4 foresee, as I've said, in the first paragraph, that the
5 plan at that stage was that --
6 **A.** Yep.
7 **Q.** So is that right, that --
8 **A.** That that was the plan?
9 **Q.** -- the planning was that patients would go to England?
10 **A.** No, not -- my understanding of it was there was a plan
11 that patients would go to England, it was the plan that
12 the first patient which reflected just the lack of
13 detailed knowledge about the virus at that stage, as
14 a high-consequence infectious disease, we don't have the
15 facilities in Northern Ireland to deal with that, so the
16 thinking at that stage, the date of this letter, was
17 that the first patient would be taken to a facility in
18 England so that they could be properly monitored and
19 treated whilst our knowledge of the system and our
20 ability to deal with subsequent cases in
21 Northern Ireland evolved. My understanding is in the
22 event we made what's called a MACA, it's the military
23 assistance --
24 **Q.** I'm going to come on to that, if I may, I just want to
25 take it in stages --

1 A. Sure.
2 Q. -- so that we can understand this.
3 I think, sorry, if we could go to the response to
4 that, then; thank you.
5 So this is the letter that was sent in reply very
6 shortly afterwards. Again, we see it's obviously the
7 reply to that letter. And if we go to page 4, and again
8 it sets out in some detail management of the first Covid
9 case, and sets out again in the paragraphs that follow,
10 I think it's right that there was possibly a ward that
11 might be able to care for someone in the event that they
12 couldn't be transferred to England; is that right?
13 A. Yes, there's an infectious disease ward in the Royal
14 Victoria Hospital.
15 Q. I think at the penultimate paragraph from the bottom,
16 that that provision was potentially not available at
17 that point in time, because there was someone who was
18 very poorly already on that ward?
19 A. I think that's right, yes.
20 Q. So, I mean, certainly that was the position, wasn't it,
21 by 20 February --
22 A. Correct.
23 Q. -- that that was still the planning?
24 A. Yes.
25 Q. And obviously this seems to presume that there would be

1 one person as opposed to a number of people who might
2 all get ill at the same time as each other?
3 A. Yeah, I'm not sure, because I think this was more into
4 the medical space in terms of, you know, the medical
5 care for the individual patient or patients, and the
6 learning that needed to flow from that to clinicians
7 locally. I'm not sure, you know -- if the question is
8 if it had been, for example, a family of four
9 individuals that tested positive at the same time, would
10 all four be transferred or would just one of them be
11 transferred for the purposes of learning, as I say, that
12 was more the medical assessment of the care which
13 obviously wouldn't sit on my desk as
14 an administrative --
15 Q. I don't think these letters read as though it's just
16 about learning, it appears to be about whether or not
17 specialist facilities were available in order to care
18 for people.
19 A. But I think it was learning -- as I say, I wasn't
20 involved with it because these are more medical matters
21 so I wasn't involved in the conversation about this
22 point. My subsequent understanding was it was more
23 about the first case and given that we were very much in
24 the early learning curve about the proper treatment of
25 the individual and how the symptoms would present and

1 the risk of cross-infection to colleagues, that the plan
2 was -- but I think the point you're making is if that's
3 one patient, if that was very swiftly followed by
4 a cascade of other patients, it's a very different
5 scenario than one patient, with a pause for --
6 Q. Yes.
7 A. -- a number of days or weeks.
8 Q. Forgive me, Mr Pengelly, this is not about clinical
9 cases because there weren't any in Northern Ireland at
10 this point, this issue was about planning and trying to
11 understand the plans that had been made within the
12 Department of Health, and trying to understand what
13 surge plans existed.
14 A. I accept that, but just -- this is planning, but this is
15 planning for the clinical care of a patient and the
16 transfer of a patient.
17 Q. Yes, but it's not -- it seems to foresee that the first
18 patient would have to be transferred to England; do you
19 agree?
20 A. My understanding -- and, as I said, it's my subsequent
21 understanding, was that a decision was taken that we
22 would transfer --
23 Q. Yes.
24 A. -- it wasn't so much borne out of necessity as opposed
25 to given the lack of knowledge about the way the virus

1 would present itself in a patient in the first episode.
2 Q. Can I just look, then, because you're right that
3 a request was made, if we could please go to
4 INQ000278481.
5 This was when the first case was detected. And as
6 you can see, if we look at the second paragraph, and
7 this was on 27 February, it wasn't on the basis that
8 there was a requirement for learning, it was rather that
9 there weren't any beds with the agreed specification
10 available, or that there weren't any commercial
11 providers who had appropriate equipment.
12 A. The point I would make about that is that the issue of
13 whether or not they had beds available on a given day on
14 27 February, this was a planned transfer because I think
15 the earlier correspondence, was it the 20th February the
16 last one we looked --
17 Q. Yes, you're right.
18 A. So there was a plan in place a week before, at least
19 a week before, that the first patient would be
20 transferred. So I don't know whether again this is the
21 drafting of the letter, I'm not so sure that we could
22 say that the request for military assistance was
23 prompted purely by the fact that there were no beds
24 available on 27 February.
25 Q. It certainly reads that way, doesn't it?

1 A. It does.
2 Q. Again, just to be clear, and again I emphasise it's just
3 about understanding --
4 A. Of course.
5 Q. -- it's not about clinical care, it's just about
6 understanding the state of preparedness, that it
7 certainly does seem to suggest, doesn't it, that
8 Northern Ireland wasn't ready or didn't have
9 an immediately available level of care that would be
10 required in order to look after someone?
11 A. I think the -- the answer to your question is I can
12 absolutely see that reading this suggests the point that
13 you have just made. The point I am making is in
14 subsequent discussions with colleagues my understanding
15 is that this was a planned approach for an early patient
16 given the lack of knowledge; it wasn't that we had grave
17 concerns about our ability to treat patients, and the
18 evolution of surge plans was on the basis that --
19 I mean, we weren't planning to be transferring all our
20 Covid-positive patients, we were going to be treating
21 them. This was, as I say, my subsequent learning,
22 understanding is it's about the learning from that.
23 Q. Right. Well, we can see that this letter is from
24 Minister Swann. When you say you've subsequently
25 learned, is that from the CMO? Does he have --

1 A. It's just in the discussions in the preparations for
2 the Inquiry.
3 Q. For the Inquiry.
4 I'm going to move away, if I may, from that, again
5 just to understand the position that existed around that
6 time in terms of the data that was available in
7 Northern Ireland. You've made the point that there
8 wasn't -- that there didn't appear to be a whole lot of
9 prevalence in Northern Ireland until later in
10 March 2020; correct?
11 A. Yes.
12 Q. But I think it's also right that you had very limited
13 testing capacity in Northern Ireland until that point as
14 well?
15 A. Yes, I think from memory in the sort of February stage
16 our testing capacity had started off as low as maybe 40
17 tests per day. I think by mid-March it had grown to
18 about 200 tests per day. So by any measure, you know,
19 and population numbers, it was a low testing capacity.
20 Q. I think it's also right that, in terms of just picking
21 up or in terms of surveillance in the community, asides
22 limited testing, there wasn't any sort of reach into
23 primary care services in order to understand people who
24 might be going to GPs, for example, with symptoms of
25 coronavirus; is that also correct?

1 A. In terms of getting the -- because in the absence of
2 a test --
3 Q. Yes.
4 A. -- you know, there was -- there would have been ongoing
5 surveillance issues for flu-like -- you know, it's part
6 and parcel of winter planning and flu surveillance, and
7 the initial presentation of Covid could be flu-like
8 symptoms, so I think in the absence of a significant
9 testing capacity, you know, the answer has to be we
10 didn't know at that early stage.
11 Q. Yes. We've heard evidence from Dr McClean of the PHA
12 about the use of the Apollo system, but that that was
13 fairly limited --
14 A. Yep.
15 Q. -- in terms of throwing light on Covid-19; do you agree
16 with that assessment?
17 A. Yes, yes, absolutely.
18 Q. Is it also right that you didn't have an ability to
19 monitor hospitalisation rates for Covid-19 until
20 May 2020?
21 A. Yes, I think that's right, yes.
22 Q. All right. So all in all, in terms of those early
23 stages in Northern Ireland, in fact just a very limited
24 capacity on the part of the Department of Health to
25 understand the prevalence of the virus, save for,

1 I assume, people who were presenting for testing?
2 A. Yes.
3 Q. Just in terms of understanding some more of the
4 difficulties about the data at that time, perhaps if
5 I could bring up, please, INQ000389819, and page 1,
6 please.
7 The Inquiry has seen this email, Mr Pengelly,
8 I think four points down. And this is from the Director
9 of Public Health in Northern Ireland, correct --
10 A. Yes.
11 Q. -- Professor van Woerden? I think we understand, but
12 you may understand a bit more about this, that he was
13 effectively pushing back against the Department of
14 Health's requests for data about deaths in
15 Northern Ireland; is that right?
16 A. Yeah, he was, but, I mean, I read this email more as his
17 point -- the third bullet point about the misleading
18 data, which --
19 Q. Yes.
20 A. -- I became aware of this email, I think last week it
21 was exhibited, was the first I was aware, certainly it
22 wasn't a point that the Director of Public Health had
23 ever made specifically to me in the past. My
24 understanding of the position is it was a common case
25 definition that was used across the UK and for

1 comparative purposes the professional view of others,
2 including Chief Medical Officer, Chief Scientific
3 Adviser and colleagues in -- other colleagues in Public
4 Health Agency was there was more to be gained from the
5 standardised use of a definition that was common to all
6 jurisdictions than a Northern Ireland unique definition.
7 **Q.** So would you read this now, Mr Pengelly -- understanding
8 the point that you only saw it last week -- did you
9 understand, then, that Professor van Woerden was
10 essentially pushing back against a position that was
11 commonly understood and not controversial in other parts
12 of the UK?
13 **A.** Well, the couple of points I would make on this were:
14 I would suggest that if the Director of Public Health
15 had felt so strongly about this, he might have made more
16 of it and escalated it either to myself or the minister
17 at that time. I have no knowledge or recollection of
18 that happening. This was a standard definition. It was
19 a common external narrative about the difference in
20 terms of people dying "from" Covid versus people dying
21 "with" Covid.
22 So what the data that we were producing represented
23 we were very clear about explaining precisely what that
24 was. So I -- when I saw this last week, my sense was
25 more it was Hugo pushing back as regards the pressure he

1 was under to try and produce figures that, you know,
2 he -- my frustration, and I think there was another
3 email exhibited last week, it was an email I'd sent too,
4 which showed some frustration on my part with him --
5 **Q.** Yes.
6 **A.** -- that I felt he just wasn't responding in the way that
7 I had wanted him to respond to that.
8 **Q.** And, Mr Pengelly, it is right that was a fairly--
9 I don't want to overstate it, but it was a theme that
10 endured for some time with the Public Health Agency,
11 wasn't it?
12 **A.** It was a theme that endured for a point in time longer
13 than we would have liked it to endure for. We did move
14 past it, but it was clearly prevalent for longer than it
15 should have been the case.
16 **Q.** If we can just look at some of the issues that arose,
17 because these are obviously important points in terms of
18 understanding some of the difficulties that there were
19 early on in the pandemic.
20 But if we look, please, at INQ000389810. Thank you.
21 We've also seen this.
22 And I think if we go to page 4, please.
23 First, this is Minister Swann's special adviser, who
24 was I think on behalf of the minister setting out the
25 serious concerns that there were -- or, sorry, the

1 concerns there were about serious discrepancies in what
2 the minister was being told. Again, Mr Pengelly, as the
3 Inquiry understands it, it was because Minister Swann
4 was, for example, I think, making public statements --
5 **A.** Yeah.
6 **Q.** -- about figures or about testing --
7 **A.** That's right.
8 **Q.** -- and was concerned that he wasn't being provided with
9 accurate information; is that right?
10 I think if we look -- just looking at that, I think
11 his concern was, wasn't it, that there were concerns
12 that the PHA surveillance figures in general were not
13 accurate; is that correct?
14 **A.** That's correct, yes.
15 **Q.** Then I think this is probably the email that you were
16 talking about, but at page 2, where you say that you're
17 concerned that the PHA just isn't taking these concerns
18 seriously enough.
19 **A.** That's correct.
20 **Q.** So again, how serious an issue was this for the minister
21 at this point in time, that he wasn't being provided and
22 wasn't conveying accurate information?
23 **A.** It was -- I mean, the minister was very sensitive to
24 this issue because his view was that accurate data and
25 reliable data was central, both to taking decisions

1 about our response to the emerging pandemic but also was
2 an issue of public confidence that if we were constantly
3 re-stating figures, the public would have no confidence.
4 I think part of his frustration -- so there was a big
5 part of his frustration was on data accuracy. I also
6 think a part of his frustration was that the response
7 when we raised this with the PHA just wasn't as robust
8 as he would have expected from them in terms of,
9 you know, "We understand the problem and we commit to
10 fixing it rapidly".
11 **Q.** Yes, and I think if we can, just to complete this, if we
12 could look, please, at INQ000440253. I think if we
13 could go to page 2, please.
14 So I think that this was the -- the name has been
15 redacted, but I think that we can see -- and it is from
16 the PHA, I think it's part of the same theme, isn't it?
17 **A.** It is, yeah, very much so.
18 **Q.** And I think we caught a glimpse of your response on the
19 first page, that you were "stunned" by the way the PHA
20 had responded; is that correct?
21 **A.** Yes.
22 **Q.** All right.
23 So in terms of when those issues actually resolved
24 themselves, can you recall when it was that the PHA was
25 actually able to provide accurate data?

1 A. I think the issue resolved itself as we moved into
2 April, and our information analysis directorate
3 colleagues within the department assumed responsibility
4 for the collation and publication, and that's our
5 professional statistical colleagues, and the figures
6 then became published under national statistics
7 conventions with the governance and oversight that
8 associates itself with that.
9 Q. Forgive me, Mr Pengelly, I think it's right that, in
10 fact, the Department of Health effectively took over
11 a number of functions from the PHA at around that time;
12 is that right?
13 A. I think we certainly moved the data issue, and I think
14 other functions we worked very, very closely with them
15 as opposed to took them away from PHA, but we maybe
16 stepped into much more command and control-type approach
17 as opposed to the normal relationship between sponsor
18 department and arm's length body where there's quite
19 a remove between the two organisations.
20 Q. And I think that that also then -- did that also become
21 the position about test and trace as well?
22 A. Yeah, in terms of oversight, the operational delivery
23 stayed with PHA --
24 Q. Yes.
25 A. -- but the governance and oversight of it, the

1 department stepped in.
2 Q. The Inquiry has already seen, and it will hear evidence
3 from Professor Young about this this afternoon, but it
4 is correct, isn't it, that the PHA in an email exchange
5 said -- or, well, I think it is just stated on
6 20 April 2020 that 500 people were being trained in
7 order to be able to undertake tracing. Is that
8 something that you're familiar with?
9 A. I'm familiar with it, again only over the course of the
10 last week when I saw the email last week; I hadn't been
11 aware of that before. But just to be clear, my
12 understanding is the email states the 500 figure.
13 Q. Yes.
14 A. I think there is a disconnect between what the figure
15 states and what actually happened.
16 Q. Yes, that's really what I think the Inquiry is
17 interested in --
18 A. Yep.
19 Q. -- it's the understanding that in fact it was
20 represented to the Chief Scientific Adviser that 500
21 people --
22 A. Yes.
23 Q. -- were being trained.
24 A. And I don't think there can be any other interpretation
25 of that email than that was the case.

1 Q. And that just wasn't correct, was it?
2 A. As I understand it, it was not the case at all, and
3 I think the number of tracers I think peaked later in
4 the year at about 300.
5 Q. Yes.
6 A. So I don't think there was ever a case of 500 being in
7 training.
8 Q. Again we'll pick this point up with Professor Young, but
9 in fact the issue arose again, didn't it, in the autumn
10 of 2020, when again there was an issue with the PHA in
11 terms of them not understanding why there needed to be
12 greater numbers of people trained?
13 A. Yes, I think there was -- but I -- and, sorry, I'm sure
14 you'll cover this this afternoon, but my understanding
15 is that Professor Young was very clear in April 2020
16 about the numbers that would be required as we moved
17 forward. That number, I think, was -- I think his
18 number was in the sort of excess of 300, and a number of
19 50 was quoted in the first draft of the business case
20 later in the year by PHA, which was subsequently amended
21 but the fact that it was 50 is a cause for concern.
22 Q. We can pick up the detail with him, but in terms of your
23 role as permanent secretary, what insight or
24 understanding did you have that tracing capacity was not
25 what it was being represented to be?

1 A. Well, the specifics of the email and the 500, and that
2 misrepresentation -- if that's the appropriate word for
3 it, and I don't know the detail -- it's clearly not
4 a reflection of what happened. I wasn't aware of that.
5 I was aware throughout that period in 2020 that there
6 was frustration in terms of trying to grow testing
7 capacity and that there was a programme work to work
8 with PHA colleagues to both recruit staff and redeploy
9 staff. And then I think at the end of July the
10 proximity app came online which facilitated that, and
11 then in October, I think, the digital self-trace
12 mechanism cam on, so they were components of the overall
13 solution. But there was an intense programme of work.
14 I wasn't intimately engaged in terms of the operational
15 outworking of that, but I'm aware it was the cause of
16 much focus in terms of the dialogue between colleagues
17 and PHA.
18 Q. I think the point is really just the short one of
19 whether or not the Department of Health was fully
20 sighted on the lack of capacity in PHA to undertake
21 tracing or whether or not it was proceeding on a false
22 basis that there was a cadre of tracers trained and
23 ready to go who didn't in fact exist.
24 A. My understanding is that whilst it was never elevated to
25 my desk, senior colleagues in the department were very

1 much aware of the issue about capacity and working with
2 colleagues in PHA to try and address any deficit.
3 Q. All right. So if it is a misrepresentation after
4 a fashion it came to light --
5 A. Yes.
6 Q. -- is that correct? All right. Again, in terms of the
7 individuals who have the detailed understanding of that,
8 would that be Professor Young or the Chief Medical
9 Officer?
10 A. Yes, they were both involved in this.
11 Q. Just in terms of before we leave test and tracing,
12 the Inquiry has seen that on 8 March Northern Ireland
13 was still regarded as being in the contain phase; is
14 that right?
15 A. Yes.
16 Q. In terms of the decision on 12 March to cease test and
17 tracing, was that a decision that you, as the permanent
18 secretary, made within the Department of Health?
19 A. No, that was an issue that flowed from the COBR decision
20 to move nationally from the contain to the delay phase,
21 because there was -- the UK-wide plan had been agreed,
22 I think at COBR, a week before, and it included that --
23 it included the point that when we move into the delay
24 phase, the benefits of contact tracing were redundant,
25 it would be stood down. There were other measures in

1 terms of isolation being put in place as part of that.
2 I understand there is some confusion about the nuances
3 of that decision. My explanation is -- my understanding
4 of it is that it flowed from the COBR discussion on
5 12 March.
6 Q. Maybe be clear about that: is it that that decision
7 **de facto** just applied in Northern Ireland, or in terms
8 of did the decision that was made in COBR apply without
9 any individual consideration of --
10 A. No, there's an understanding that -- as has been
11 explained to me, there was an understanding at the COBR
12 discussion, at which both central government and the
13 devolved administrations were present, that this was
14 a UK-wide decision that was being taken, and all the
15 devolved administrations were part of that decision.
16 Q. But was that -- I mean, in Northern Ireland, was there
17 substantive consideration of the question of whether or
18 not there was still merit in test and trace?
19 A. I -- as far as I'm aware, that decision wasn't taken --
20 to answer your question, it wasn't the subject of an
21 Executive paper and presentation to the Executive and
22 specific consideration in the context of
23 Northern Ireland, I'm not aware that that was the case.
24 The UK-wide decision at which all the devolved
25 administrations were present was the one -- once-for-all

1 decision.
2 Q. I'm putting aside the formal mechanism by which such
3 a decision might be made, it's really just the question
4 of whether or not the substantive or qualitative
5 analysis had taken place in Northern Ireland as to
6 whether there was any merit in continuing to test and
7 trace.
8 A. I think there was a -- sorry, the short answer is that
9 there wasn't the detail and substantive analysis, as you
10 have described it there, because it was swept up in that
11 broader decision.
12 Q. Because the Inquiry understands that test and trace was
13 still being done in quite low numbers in
14 Northern Ireland, it may have been -- it may have put
15 the PHA under pressure, but the numbers were relatively
16 small; is that correct?
17 A. They were small, yes, linked to testing capacity too,
18 but there was also a sense, as we moved into March and
19 case numbers grew, that our limited testing capacity
20 needed to pivot more towards clinical testing for people
21 on admission to hospital to see whether they were Covid
22 positive or not, rather than for a test and trace
23 capacity, until such times as we grew testing capacity.
24 Q. All right, but no qualitative analysis --
25 A. No.

1 Q. -- as to whether that was the position reached?
2 I just want to deal, if I may, with some discrete
3 topics that are important, just to understand the --
4 your perspective as permanent secretary. So I'm just
5 going to deal, if I may, with the question of joint
6 modelling with the Republic of Ireland.
7 Northern Ireland and the Republic of Ireland entered
8 into a memorandum of understanding, didn't they, in
9 March 2020, and they undertook by that informal
10 mechanism, I think, to -- if I can put it in these
11 terms -- both governments will adopt similar approaches
12 guided by scientific evidence, I think that's what was
13 said, and that in relation to modelling the participants
14 are committed to working in partnership to predict the
15 likely impact of Covid-19 and enable evidence-based
16 decisions on how best to respond across the island of
17 Ireland.
18 That was the undertaking in the memorandum, but that
19 didn't, as we -- as the Inquiry understands it, that
20 didn't in fact result in any capacity to undertake joint
21 modelling, did it?
22 A. That's my understanding too. I mean, the modelling
23 group would have been more in this space, but I think at
24 the time the MoU was signed there was an aspiration, but
25 it wasn't underpinned by sort of joint modelling as we

1 would understand it.
2 Q. Can you help with why, given that that was the expressed
3 intent in March 2020, why that didn't eventuate or why
4 it didn't prove possible?
5 A. I think Professor Young might give you a much more
6 fulsome answer, but my understanding was that it was
7 down to differences in methodology and approach, and the
8 modelling, there was very different approaches to
9 testing North and South, and I think trying to bring the
10 two different approaches into a joint model would have
11 been very difficult but, as I say, Professor Young
12 I think understands the nuances of that in a way that
13 I don't.
14 Q. But you weren't involved with your counterpart in the
15 Republic of Ireland to try and discuss what you might be
16 able to do to overcome those kind of barriers?
17 A. No, those were more technical discussions insofar as
18 they took place at a sort of modelling group level as
19 opposed to between myself and my counterpart.
20 Q. It's understood from the evidence that's been provided
21 from the CMO and from others within the Department of
22 Health that it was accepted, or certainly agreed, that
23 Ireland was effectively acting as a single
24 epidemiological unit for the purposes of the virus, so
25 epidemiologically that was the position; is that right?

1 A. Yes, but the way they have explained it to me is that it
2 was a single epidemiological unit, it wasn't the only
3 single epidemiological unit, and certainly the point had
4 been made to me that New Zealand was a single
5 epidemiological unit, that the North and South Islands
6 are much more geographically remote than Ireland is from
7 Great Britain, so there's an argument that the whole of
8 the U -- that the islands, that Great Britain and
9 Ireland were acting also as a single epidemiological
10 unit, so I think there's many nuances to that point.
11 Q. All right, but Ireland, the land mass of Ireland is
12 a small territory and it's got a small population,
13 hasn't it, when you take North and South together?
14 A. It does, but the big complication is the Common Travel
15 Area.
16 Q. Of course.
17 A. It is small and discrete but it doesn't have that ring
18 round it.
19 Q. It's really just trying to understand how important it
20 was or wasn't to the Department of Health that there
21 wasn't that capacity to model on an all-island basis and
22 to have that understanding of how --
23 A. As I say, I don't want to speak for Professor Young, but
24 the explanation and any discussions I have had with him
25 was that the modelling that was happening in our

1 jurisdiction, combined with his understanding of what
2 was happening inside as distinct from doing joint
3 modelling, provided information and analysis --
4 Q. And those --
5 A. -- that was helpful to us.
6 Q. I'm sorry, I didn't mean to speak over to you. And was
7 that regarded as sufficient then from the Department of
8 Health's perspective --
9 A. As I understand it, it was. We didn't feel there was
10 a major deficiency amount.
11 Q. All right.
12 I think you've said "as I understand" on a number of
13 occasions; is that because you're dependent on the views
14 of other people in order to make that point?
15 A. Yes, because I'm dependent on the modelling the Chief
16 Scientific Adviser was doing, his analysis of the
17 modelling work that was done was being done, and was it
18 sufficient and fit for purpose to underpin the decisions
19 that we were putting in front of the Executive, and I'm
20 assured it was.
21 Q. All right.
22 I'm going to move on then, we can take those issues
23 up with Professor Young, to the issue that arose last
24 week about the question of the extent to which
25 government in Northern Ireland operates in

1 a compartmentalised way. And the Inquiry saw evidence
2 last week of the frustrations on the part of the
3 First Minister and the deputy First Minister about the
4 Department of Health effectively being not under their
5 control and operating in a way possibly that was causing
6 them difficulty. Was that a tension or an issue that
7 you were aware of at the time?
8 A. I was aware of a -- what I would describe as a very
9 understandable tension across the Executive, that there
10 was a thirst for analysis and information and data that
11 we all struggled to meet, and part of that was -- we've
12 talked about some issues, particularly in the early
13 stages, about the adequacy and accuracy of data but even
14 when we addressed those points in mid and late April and
15 the department took over the dashboard and we had the
16 data, the reality was that, on any given day, the
17 decision that we were putting in front of the Executive
18 was underpinned by data that was only emerging
19 overnight. So it was a very understandable frustration
20 about the speed and timeliness of getting data. But I'd
21 struggle to think of what -- you know, the alternative
22 would have been to go with an earlier paper that
23 contained data that was maybe 48 hours old, which
24 I don't -- and given the speed at which we were moving.
25 I've heard the frustrations mentioned. I've only

1 ever heard the frustrations mentioned in very general
2 terms. I don't think I can point to any very specific
3 examples of where issues weren't being brought to the
4 Executive or the department. There was a sense the
5 department that -- had access to information analysis
6 that wasn't being shared, so ...
7 I think the pace we were moving at, I understand the
8 frustration, and I think it's always going to be
9 present, but I -- in terms of -- if your question to me
10 was what's the answer to that problem, I do struggle
11 with it.
12 **Q.** No, I think the question is much more about whether or
13 not you recognise or accept that there was
14 compartmentalised behaviour or action on the part of the
15 Department of Health at the outset of the pandemic such
16 that -- we've seen already in emails consideration even
17 being given to -- or certainly discussion about whether
18 one solution was to remove Minister Swann. Those were
19 the kind of --
20 **A.** Yeah.
21 **Q.** -- issues being raised?
22 **A.** I don't accept -- I didn't see, I didn't hear and
23 I didn't experience any compartmentalised behaviour by
24 colleagues in the Department of Health. The issue about
25 the possible removal of Minister Swann, that wasn't

1 something I was ever aware of. Again, I saw it aired
2 last week.
3 I think one of the core issues here that -- is the
4 sheer pressure that was on individuals, and I've touched
5 earlier -- if I may, one of the issues that I think came
6 up last week was the request from the Cabinet Office for
7 information from the CMO, and that there was the
8 exchange about -- I think there was the email about --
9 **Q.** Yes.
10 **A.** I think just in terms of context for that -- I mean,
11 I -- having seen the issue aired last week, I looked
12 into some of the paperwork a bit more. The request came
13 across from the Cabinet Office, I'm not sure when but
14 I think just in the course of the day, on the Friday.
15 It made its way onto the Chief Medical Officer's desk,
16 I think, at about 11 o'clock on the Friday night, while
17 he was still in the office, with the request for
18 a response by lunchtime on the Saturday. And that was
19 after a week of probably being in the office. So
20 I certainly would forgive him for what may have been
21 a rather abrupt response.
22 In terms of then responding, we ultimately responded
23 I think on Monday the 9th, there's a large flurry of
24 activity in the duration of Sunday with colleagues. So
25 it wasn't that this information was readily available

1 and there was a desire that we have it but we're not
2 sharing it. Many colleagues were involved in a lot of
3 exchanges of information on the Sunday and evolving and
4 preparing the information to facilitate a response that
5 happened on the Monday. So I offer that as one
6 illustration and --
7 **Q.** Can I just stop you there, Mr Pengelly.
8 **A.** Sorry.
9 **Q.** We've seen the correspondence. We know that what
10 Cabinet Office was seeking was a response, I think from
11 across Northern Ireland, about some of the measures that
12 were possibly being contemplated at that point in time.
13 I'm not sure that it was clear that it was necessarily
14 just something from the Department of Health to respond
15 to, but that nonetheless the CMO said that
16 Northern Ireland -- well, his advice was: don't respond
17 to this. And as we understand it, it's because
18 government, the Cabinet Office, pressed for a response
19 that it was ultimately replied to.
20 Is that your understanding?
21 **A.** My understanding, the -- my understanding was that the
22 initial response, given the lateness of the hour and the
23 volume of (inaudible), was maybe a little higher
24 temperature than may otherwise have been the case in
25 more benign times. I think my counterpart at the time

1 in the Department of Education also indicated that he
2 would find it very difficult to respond at all or to
3 respond in a meaningful way.
4 I think the point I'm making is work was then
5 initiated within the department and it took two days to
6 develop a response that went on the Monday, as distinct
7 from the department wrapping its arms round it and
8 saying: no, we're absolutely not doing this. And I'm
9 just differentiating that it wasn't we said that Monday
10 because we wanted to make a point; it took us until
11 Monday to generate the answer.
12 **Q.** This is something we'll take up with the CMO and look
13 a bit more closely at the communications, but on that
14 point you didn't see anything wrong or didn't think it
15 was wrong in principle that the CMO should be replying
16 and telling government in Northern Ireland generally not
17 to respond to the requests from the Cabinet Office?
18 **A.** I think that's maybe a question of interpretation.
19 I think his view was that we didn't need to respond.
20 I mean, I don't think Michael was presenting his
21 response as the definitive answer in that question, and
22 the fact that we did ultimately put a response in.
23 **LADY HALLETT:** Can I just step in for a second?
24 A few minutes ago you mentioned the suggestion that
25 a minister, the minister of health should be removed,

1 I think if you read the document fairly, the writer of
2 the document wasn't suggesting the minister should be
3 removed but it was just one of a number of options
4 which --
5 **A.** Sorry.
6 **LADY HALLETT:** No, no, I'm not even sure you did use the
7 word "suggest", but just in case anybody thought you
8 did.
9 **A.** Apologies.
10 **LADY HALLETT:** No, no, I don't think you did, I think I'm
11 just being ultra-cautious.
12 **MS DOBBIN:** I'm sure it's more my fault, so I apologise, it
13 was me trying to summarise an email, but quite right, it
14 was just a number of options for discussion.
15 Can we just, in terms of some of the cultural
16 issues, though, Mr Pengelly, could we, please, look at
17 INQ000305020.
18 Mr Pengelly, we're going to come with other
19 witnesses to look at what happened in autumn of 2020 in
20 a good deal more detail, but this is a letter from
21 Minister Swann that was sent, I think, at a point in
22 time when things were obviously of some sensitivity in
23 Northern Ireland in terms of the direction of travel
24 with infection rates and, I think we'll come with
25 Professor Young, looking at death rates as well.

1 But in terms of what he was saying there, and it's
2 in the second paragraph, where he sets out obviously
3 that they had come to a joint decision as an Executive
4 Committee about what would happen, and then the
5 suggestion that a colleague had gone on to the radio to
6 confuse the position.
7 I think if we look three paragraphs down as well, he
8 refers in that regard to the requirements of the
9 Ministerial Code as well.
10 I picked this letter out because it encompasses
11 a number of things that obviously the Inquiry has seen
12 a bit of thus far, but can you help us, regards the
13 undermining of Executive decision-making by ministers
14 taking public positions that were different to that
15 decided by the Executive Committee, was that a problem
16 during this period, as far as the Department of Health
17 was concerned?
18 **A.** I think -- I think it was a frustration, from memory,
19 with many ministers, that these were very, very
20 difficult decisions, and I think it was rehearsed last
21 week just about the difficulty sometimes of the
22 Executive discussion that leads to the decision.
23 The frustration that certainly the minister of
24 health was reflecting in this letter, and I think some
25 other ministers shared it, was that if the Executive

1 wrestled with a very difficult decision and reached
2 a conclusion, to then attempt to sell that position to
3 the public in a fragmented way would undermine public
4 confidence in the measure that's being adopted and
5 subsequently in -- particularly if it was a restriction
6 that was being put in place, with adherence to that
7 restriction.
8 So that -- that was an issue that bubbled to the
9 surface a number of times, particularly throughout the
10 autumn of 2020.
11 **Q.** But was it regarded as undermining public confidence at
12 points in time when the position was particularly finely
13 balanced or sensitive as regards the transmission of the
14 virus?
15 **A.** Sorry, I know this wasn't your exact question, I don't
16 think there was any quantitative analysis of what it did
17 to public confidence. There was certainly a perception
18 that I heard some ministers make that they felt public
19 confidence and, importantly, adherence with measures put
20 in place would be undermined by colleagues not standing
21 shoulder to shoulder with the decisions taken.
22 **Q.** All right. Well, we can take that point up with
23 ministers.
24 I just want to finish, I have a topic that I hope
25 I might be able to take you to without needing to go to

1 the documents, and it's in relation to care homes,
2 Mr Pengelly.
3 I think it's right that at the outset of the
4 pandemic, I'm sure you're familiar with this, but that
5 certainly throughout March 2020, you, in a series of
6 communications, communicated to those who had management
7 or control over the care sector about surge plans and
8 repeated the point that:
9 "Trusts should ... work to maximise and utilise all
10 spare capacity in residential, nursing and domiciliary
11 care."
12 And that also trusts were to work to fill up vacant
13 places, I think, in the care sector as quickly as was
14 possible, having regard to the need to, I suppose, free
15 up hospital spaces; is that correct?
16 **A.** Yes.
17 **Q.** And I think it's also right that you -- that it was the
18 position that trusts were expediting discharges where
19 patients had been deemed medically fit in hospital so as
20 to move them into the care sector as well, and that that
21 was the -- that was certainly the plan from mid-March to
22 mid-April?
23 **A.** Yes, I think -- just a -- the delay at that point, just
24 to emphasise the discharge was to be expedited in the
25 case where patients were medically fit to be discharged.

1 It had been an enduring problem in Northern Ireland --
2 we touched earlier on some of the challenges about
3 running emergency departments --
4 **Q.** Yes.
5 **A.** -- and admitting patients because beds were filled and
6 "bed blocking". It's been an enduring challenge about
7 timely discharge. The reality is my medical colleagues
8 over the years have emphasised on many, many occasions
9 that, particularly for a frail elderly person, being
10 medically fit to be discharged from hospital means that
11 it is quite a dangerous position to put them in by
12 retaining them in hospital past the point -- for issues
13 like hospital-acquired infection, notwithstanding Covid,
14 but also there -- I think there's -- muscle mass
15 deteriorates at the rate of about 10% a week.
16 **Q.** Yes.
17 **A.** So there are many clinical issues why it's extremely
18 important for timely discharge.
19 **Q.** But in terms of the testing of individuals who had been
20 in hospital and their move into care homes, I just want
21 to make sure that the Inquiry has this correct.
22 I'm not going to bring you to this document, but
23 just -- I can if you need to.
24 **A.** No, no.
25 **Q.** But certainly what appears to have been the position as

1 at 17 March, so this is both in relation to testing
2 leaving hospital and in care homes, that on 17 March the
3 position was that there was testing of residents in care
4 settings where there had been a potential or a possible
5 cluster of outbreak; is that right?
6 **A.** That's right, but the caveat is I think the testing at
7 that stage, due to capacity constraints, was restricted
8 to a maximum of five residents where there had been
9 a cluster, as opposed to all residents --
10 **Q.** Yes.
11 **A.** -- of the care home.
12 **Q.** And that on 12 April there was an agreement to the
13 extension of testing arrangements so that there was
14 testing of symptomatic residents and staff in care homes
15 if there were two or more breakouts; correct? So it
16 wasn't until 12 April --
17 **A.** That's right.
18 **Q.** -- that that position was reached.
19 We can pick this up from an email of 18 April 2020.
20 I won't take you to it, but again, just in terms of
21 orientating ourselves in the chronology, there was
22 a reference in that email to the position in England,
23 that there was a strategy to discharge from hospitals
24 into care homes, and that it stated that all discharges
25 to care homes should be tested for Covid-19, and the

1 email says:
2 "... grateful for confirmation you're ok with that,
3 (think I flagged this was coming - but very happy to
4 chat)."
5 So that's an email internal to the Department of
6 Health. And again, is that correct that in and around
7 18 April it was recognised that individuals going from
8 hospital into care homes should be tested?
9 **A.** The date I have for that is 19 April that that --
10 **Q.** 19 April.
11 **A.** Which also -- in terms of testing capacity I think on
12 19 April our testing capacity moved from 1,000 per day
13 to 1,800 per day, so it wasn't a capacity issue.
14 **Q.** But is that right that it wasn't until 18 April that
15 individuals were being tested upon leaving hospital to
16 come into care homes --
17 **A.** That's right.
18 **Q.** I think it's also right -- and this is a letter from
19 you, I won't take you to it -- but I think from
20 24 April, all new outbreaks in care homes resulted in
21 individuals being tested; is that right?
22 **A.** Yes, that was -- and that was both all residents and
23 staff from 24 April, where there's a new outbreak.
24 **Q.** And I think, again, it's also right, Mr Pengelly, that
25 if an individual was tested in hospital from that date,

1 from 19 April onwards, there didn't have to be a result
2 in order for them to move to a care home --
3 **A.** That's right.
4 **Q.** -- is that right?
5 **A.** That's right.
6 **Q.** And I think it's also right that --
7 **A.** Sorry --
8 **Q.** -- an individual could also move to a care home if they
9 had tested positive, if there were arrangements for them
10 to be --
11 **A.** For isolation, right.
12 Can I just add: in terms of the discharge from
13 hospital to care homes, and you may come on to this with
14 other witnesses, there was a point-in-time review we did
15 later in 2020 with Niall Herity, who is a consultant
16 cardiologist, now, he sampled two weeks, but he
17 discovered that 1.1% of patients discharged from
18 hospital to care homes tested positive within the
19 two weeks, 98.9 didn't test positive, and his analysis
20 of the data was that outbreaks in care homes were much
21 more closely aligned with levels of community
22 transmission than hospital transmission, just by way of
23 context.
24 **Q.** I think that there was also a response, wasn't there,
25 from the sector to that report that said it didn't take

1 into account that there was very limited testing in the
2 time period that he was looking at?
3 A. That's reflected in the report, but the point in the
4 report was of those test -- it was still only 1.1% and
5 that the data flows, as the pandemic endured, showed
6 that -- attract community transmission and I think that
7 was a point-in-time review with a limited dataset.
8 There's subsequent statistical analysis that shows
9 across the UK care home cases much more closely aligned
10 with community transmission than hospital transmission.
11 **MS DOBBIN:** Right, Mr Pengelly, I'm going to stop there
12 because I think there are some questions from other
13 core participants.
14 **LADY HALLETT:** There are.
15 Mr Wilcock.
16 **Questions from MR WILCOCK KC**
17 **MR WILCOCK:** Good afternoon, Mr Pengelly. I represent the
18 Northern Ireland Covid Bereaved Families for Justice and
19 I want to ask you questions on three topics.
20 Topic 1 is the relationship between the
21 Northern Ireland Commissioner for Older People and your
22 department, and we have heard evidence from Mr Lynch
23 about some of the frustrations he experienced in his
24 dealings with the Department of Health, particularly in
25 relation to care homes. As a starting point, presumably

1 you accept that the Commissioner would have been
2 a valuable source of information on any topic, such as
3 care homes, which was inevitably likely to become
4 a critical issue for older people.
5 A. Yes, absolutely.
6 Q. In his statement to the Inquiry, Mr Lynch stated that:
7 "In the early days of the pandemic I found that
8 there was no single point of contact for me, or anyone
9 from my office, to enable us to provide specialist
10 information or guidance on what I feared would become
11 a critical position for older people."
12 And that because of this there seemed to him to be
13 no proper forum for raising his concerns -- and he
14 quotes, for example, testing in care homes that you've
15 just discussed -- and because of this, he felt he had to
16 tell the media that there was a lack of urgency on the
17 part of the Department of Health. Do you have any
18 sympathy with the position the Commissioner found
19 himself in?
20 A. The position is -- I understand his point about not
21 having a single point of contact, there wasn't a defined
22 single point of contact, but there were a number of key
23 contacts that the Commissioner utilised and the evidence
24 I have seen is that they were utilised extensively in
25 terms of two of my senior colleagues. There was a large

1 amount of dialogue. This was happening at a point in
2 time. It's certainly the case that the legitimate
3 issues that the Commissioner was raising from time to
4 time we weren't able to respond to effectively.
5 So the two points, sorry, I want to finish with,
6 there was a lot of engagement and dialogue. More
7 engagement and dialogue with a valuable representative
8 of what is a critical group would always have been
9 preferable had it been possible.
10 Q. Dialogue of course works both ways. Why, if you say
11 that you were looking for dialogue, did the department
12 not actively seek the expertise of the Commissioner for
13 Older People rather than just rely on him to approach
14 you, given that he had a direct line of communication
15 with the people in the care homes and their families?
16 A. Well, my understanding is we did actively seek him out.
17 The difficulty that the Commissioner faced, and it's
18 entirely understandable, is that at the pace issues were
19 moving at the times when we shared copies of draft
20 guidance that he didn't feel he had sufficient time to
21 engage and consider and respond to that, and
22 I understand and sympathise with that point, but that's
23 different from not engaging at all. The problem that we
24 faced, and colleagues in particular faced, the bulk of
25 this guidance was in the early stages, certainly at the

1 late February and early March, was dealing with issues
2 like infection prevention and control, which were really
3 moving from national standards. The -- because as well
4 as speaking to the Commissioner, my colleagues were also
5 speaking directly to other representatives in care homes
6 and to care homes directly. The message they were
7 hearing loud and clear was colleagues in care homes were
8 urgently requesting clear guidance on the emerging
9 latest position, so it was trying to marry those two
10 issues. We didn't always get it right, and with more
11 time there would have been longer and more fulsome
12 engagement, but just the pace of it overtook us at
13 times.
14 Q. Well, just taking up that topic, whether you always got
15 it right, can I ask you, please -- can I ask for
16 INQ000023185, page 2, to be put on screen.
17 While that's happening, Mr Pengelly, I'm hoping
18 that's going to be the index to the Department of Health
19 Covid-19 Emergency Response Strategy which was published
20 on 30 March. Sorry, I think you may have a different
21 reference, which is INQ000130409.
22 We've had the pleasure of having multiple copies of
23 the same documents, as you know, my Lady.
24 So anyway, that is the index to the emergency
25 response strategy that your department published on

1 30 March, and I've put it on screen to give some idea of
2 what the strategy at the end of March purported to
3 contain.
4 Now, I imagine you've had an opportunity of making
5 yourself familiar with this document before today?
6 **A.** Mm-hm.
7 **Q.** Do you accept that this document makes no specific
8 mention of the acutely vulnerable status of older
9 people?
10 **A.** Well, I accept that. I haven't seen the rest of the
11 document before me today, I've read the document
12 recently, but I'm happy to accept that point.
13 **Q.** You've told us this morning about text exchanges that
14 you had with the head of the Civil Service nearly
15 two months earlier, on 6 February, in which
16 Sir David Sterling specifically remarked that the
17 problem will be when the pandemic hits care homes and
18 hospitals. And I know he was talking about a different
19 type of pandemic, but the principle remains the same.
20 Do you accept, therefore, that by 30 March 2020 you
21 and your department were well aware that any response to
22 the Covid pandemic you now knew you were dealing with
23 would have to take account of the acutely vulnerable
24 status of older people?
25 **A.** Yes, and it did.

1 **Q.** So why is there no mention of it?
2 **A.** Well, this is a very high-level strategic document
3 covering the work of the totality of the sector. As
4 I get -- it doesn't run to much more than about
5 17 pages. There were separate very complex workstreams
6 looking specifically at the issue of care homes, so
7 I can understand the frustration that it's not mentioned
8 in the document specifically, but that's not to say that
9 there wasn't a focus and energy on work taking place in
10 terms of the care sector.
11 **Q.** Well, high-level can mean two things -- one, it can mean
12 general policy; or, two, it can just mean vague -- but
13 either way is it not surprising that this document does
14 not refer within those 17 pages to the importance of
15 infection prevention and control measures in the
16 micro-environments of care homes in particular?
17 **A.** As I said, it's a high-level strategic document. It
18 doesn't get into granular detail across every sector.
19 There would be other areas that aren't mentioned, but
20 that -- I must emphasise that's not to say that there
21 wasn't comprehensive workstreams happening in parallel
22 with the development of this document within the sector
23 about care homes.
24 **Q.** Just so I understand your evidence, are you saying that
25 it wasn't a matter of high-level strategy to prevent and

1 control measures in care homes?
2 **A.** No, I'm not. I'm saying this was a high-level strategy
3 document that painted a high-level picture of elements
4 like understanding the path of the curve and measures to
5 flatten the curve. It didn't seek to get into every
6 important aspect of work.
7 The fact that something is not specifically
8 mentioned in there does not mean that it's not
9 strategically important, and I can't emphasise that
10 point enough. Care homes were hugely important to us
11 and particularly the care of all residents within care
12 homes, and indeed the staff.
13 **Q.** Well, I think the public would expect that's the minimum
14 we could expect from the Department of Health, that care
15 homes would be hugely important, but can you not see why
16 it might be thought that the absence, even if this is
17 a high-level strategic document, of any mention of the
18 importance of controlling Covid within care homes in
19 itself indicates that there was a failure in your
20 department to adequately recognise and plan for the
21 acutely vulnerable position of care homes?
22 **A.** I can certainly acknowledge the frustration of the
23 stakeholders you represent that it's not specifically
24 mentioned in this, but I just -- I emphasise, that is
25 not to suggest that this wasn't a strategically

1 important issue of great concern for us in the
2 department.
3 **Q.** Thank you, Mr Pengelly.
4 Next topic: can we have INQ000145670, page 1, on
5 screen, please.
6 This is a letter that you wrote, I think, to the
7 chief executives of the Health and Social Care Trusts,
8 which you've described as the arm's length delivery body
9 for the Department of Health earlier on in your
10 evidence, and in this letter on 25 April 2024 entitled
11 "Key Changes To Testing For Covid-19" you wrote in the
12 last paragraph that:
13 "In advance of discharge from hospital to a care
14 home each patient must be tested for COVID-19, ideally
15 this test will be undertaken 48 hours prior to the
16 patient's discharge to their identified care home."
17 Then rather incongruously you end by saying:
18 "This testing requirement must not hold up a timely
19 discharge."
20 Now, in his evidence to the Inquiry last week, the
21 Commissioner for Older People stated that he thought:
22 "... it was very clear cut that the policy of
23 discharging people without testing into [care homes] was
24 a potentially disastrous one."
25 Now, I used the word "potentially" in view of the

1 answer you gave to Ms Dobbin less than ten minutes ago
2 that, rightly or wrongly, you say not as much damage was
3 done as might have been expected. Do you accept that it
4 was at least a potentially disastrous policy to
5 discharge people into care homes from hospitals bearing
6 in mind the danger of passing on?
7 **A.** Absolutely, it's potentially dangerous.
8 **Q.** Right.
9 **A.** -- if unmitigated, but I think the point that paragraph
10 is making is it must not hold up a timely discharge
11 because other mitigating measures may be in place; for
12 example, isolation within the care home.
13 **Q.** Right. Now, Mr Lynch goes on to say that not only was
14 it potentially disastrous but any policy of discharging
15 people without testing into care homes was quite
16 a reckless decision to allow this to happen. Now,
17 you've already said that in fact the policy could have
18 allowed it to happen because people were getting
19 discharged at times without tests, and even if they were
20 having tests, the results weren't in by the time of
21 transfer. You agree with that?
22 **A.** Uh-huh.
23 **Q.** Even accepting the evidence you've told us about this
24 morning about the historical difficulties in
25 Northern Ireland's fragile health system meaning there

1 has to be a careful balancing act between hospital
2 admissions and discharge, do you agree that nevertheless
3 this striking caveat, that testing must not hold up
4 a timely discharge, is an example of the recklessness
5 Mr Lynch was describing?
6 **A.** I don't agree with the use of the word "reckless".
7 I think we -- I mean, it's hugely important to have
8 regard to the care homes and possibly routes of
9 infection into care homes, but it's also of huge
10 importance to have regard to individuals, and we are
11 talking about people in all circumstances, but for
12 an individual who is clinically fit to be discharged
13 from hospital, particularly, as I said, if they're
14 a frail elderly individual, for them to be retained in
15 hospital beyond that is potentially highly dangerous to
16 that individual. So the approach here is about trying
17 to balance a series of risks, and the solution, whilst
18 imperfect, is hopefully achieving the best alignment of
19 all those competing factors.
20 **Q.** Well, it's not imperfect, it's completely contradictory,
21 isn't it?
22 **A.** Well, I've used the word "imperfect", but I believe it's
23 imperfect rather than contradictory.
24 **Q.** In his statement Mr Lynch goes on to state that he had
25 been receiving calls during March and April 2020 from

1 care home managers and providers expressing concern and
2 frustration about what they saw as a requirement by
3 their respective HSCTs to admit new residents from
4 hospital without adequate testing for Covid-19.
5 Other than through Mr Lynch, what mechanisms were in
6 place for care home managers to convey these concerns?
7 **A.** Well, there's Pauline Shepherd's organisation, I think
8 it's IHCP, I think the colleagues in the department were
9 also in very regular dialogue with Pauline about some of
10 the issues that she was raising, and also particularly
11 for some of the larger care homes there was regular
12 dialogue between colleagues in the department and the
13 owners and managers, both of large and small care homes,
14 so there was many points of dialogue.
15 **Q.** Do you accept that, in spite of the available points of
16 dialogue, the concerns of care home managers and
17 providers were not adequately taken into account when
18 you gave this guidance in this letter?
19 **A.** I mean, I can't argue with the assertion that this
20 letter didn't completely deal with the concerns that
21 were clearly prevalent in some care homes, but through
22 issues like pressures on hospital capacity, pressures on
23 testing capacity, there wasn't a perfect solution to any
24 of these issues. I believe that this letter and the
25 policy we adopted was the best compromise position we

1 could reach in terms of managing all those competing
2 tensions.
3 **MR WILCOCK:** Thank you very much. I've no further
4 questions.
5 **LADY HALLETT:** Thank you very much indeed, Mr Wilcock.
6 Thank you for your help, Mr Pengelly.
7 **THE WITNESS:** Thank you.
8 **LADY HALLETT:** I know you've already helped and I do
9 understand the burden that we place upon witnesses like
10 you, but I'm afraid I can't say we won't call upon you
11 again because, as you may know, I have a health module
12 coming up in the autumn. So thank you for your help
13 today.
14 **THE WITNESS:** Thank you.
15 **(The witness withdrew)**
16 **LADY HALLETT:** I shall return at 2 o'clock.
17 **(1.00 pm)**
18 **(The short adjournment)**
19 **(2.00 pm)**
20 **LADY HALLETT:** Professor Young, I hope you weren't brought
21 here this morning "just in case", and if you were, may
22 I apologise for keeping you waiting.
23 **THE WITNESS:** Not at all.
24 **PROFESSOR IAN STUART YOUNG (affirmed)**
25 **Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 2C**

1 **MS DOBBIN:** May I ask you to give your full name to
2 the Inquiry, please.
3 **A.** Ian Stuart Young.
4 **Q.** I think, Professor Young, you ought to have a witness
5 statement in front of you which you signed on 31 January
6 of this year.
7 **A.** Yes.
8 **Q.** Are you content that that witness statement is true to
9 the best of your knowledge and belief?
10 **A.** Yes.
11 **Q.** Thank you.
12 Professor Young, I wanted to start, if I may, by
13 asking you some questions about your background. You're
14 obviously here to give evidence because you were the
15 Chief Scientific Adviser to the Department of Health,
16 but prior to 2020 I think that it's right that you held
17 that role in conjunction with a number of other
18 positions, or you had a number of other professional
19 roles; is that correct?
20 **A.** That is correct, and I do continue to hold other roles
21 as the CSA role is a part-time role --
22 **Q.** Yes.
23 **A.** -- within Northern Ireland.
24 **Q.** So I think it's right that prior to the pandemic it
25 was -- the commitment was for three days a week; is that

1 right?
2 **A.** Yes, the commitment was for the equivalent of three days
3 per week worked in a flexible way.
4 **Q.** And I think it's also right that you were a professor of
5 medicine at Queen's University as well; is that correct?
6 **A.** That is correct, yes.
7 **Q.** And did you have a particular specialisation as
8 a professor?
9 **A.** Yes, my interests are in laboratory medicine and
10 nutrition, both in relation to my academic work and also
11 clinically, because I had a clinical job as a medical
12 professional within Belfast Health and Social Care
13 Trust.
14 **Q.** Is it right that that role was one of a clinical
15 pathologist then?
16 **A.** Technically a chemical pathologist, which is one of the
17 branches of pathology.
18 **Q.** What you explain in your witness statement was that
19 prior to 2020 a principal focus of the Chief Scientific
20 Adviser's work was that of research and development; is
21 that correct?
22 **A.** Yes, there are three aspects to the role of the CSA: one
23 is as director of research and development for health
24 and social care in Northern Ireland, and that was the
25 component of the job which occupied the greater part of

1 my CSA commitment; the other two aspects of the job are
2 as head of profession for the healthcare science
3 workforce, which constitutes over 2,500 healthcare
4 scientists in Northern Ireland working in over
5 50 separate disciplines; and the third aspect of the job
6 was to provide scientific advice.
7 **Q.** Would it be correct in terms of the specialisation that
8 you brought to the role of CSA, is that better seen as
9 being clinical expertise or is it better categorised as
10 scientific expertise, or is there no real difference
11 between the two?
12 **A.** No, it was very much scientific expertise. As well as
13 being medically qualified, I have a basic science degree
14 and whenever the CSA role was advertised it was open
15 either to medically qualified or scientifically
16 qualified candidates. I was appointed, I think, based
17 on my scientific credentials rather than my medical
18 credentials, so medical advice within the context of the
19 department came very much from the CMO and Deputy CMOs;
20 my role was to provide scientific advice.
21 **Q.** And I think it's right to say as well that your role was
22 specific to the Department of Health rather than being
23 a cross-departmental role; is that also right?
24 **A.** That's correct, yes. My role was specifically and
25 exclusively within the Department of Health.

1 **Q.** You explain in your witness statement, and I'm sure this
2 will be clear as we consider your evidence as well, that
3 you worked very closely with the CMO; is that correct?
4 **A.** I worked very closely with the CMO, and particularly
5 during the pandemic. Prior to the pandemic I was
6 largely independent but reported to the CMO and met with
7 him on a reasonably regular basis, but during the
8 pandemic we worked together very closely.
9 **Q.** All right, and I should have made that distinction clear
10 because when the pandemic started and when you came back
11 to your post in March of 2020, I think it's right that
12 at that point in time it then became a full-time post;
13 is that correct?
14 **A.** Yes, it became the equivalent of a full-time post,
15 I think is what I've said, meaning significantly over
16 40 hours per week, often much, much more than that, but
17 in fact I continued to do my clinical work in the
18 hospital throughout the pandemic and also some academic
19 work at times.
20 **Q.** All right.
21 Just in terms of your working relationship with the
22 CMO, I think it's right you took up your CSA position in
23 2015?
24 **A.** Yes.
25 **Q.** That's right, and did you overlap with the CMO in other

1 professional roles or was it only in your capacity of
2 CSA that you had overlapped with him or did overlap?
3 **A.** The CMO is ultimately responsible for all medical
4 professionals within Northern Ireland, so in that
5 sense --
6 **Q.** Yes.
7 **A.** -- I overlap with him, but in relation to the
8 department, it was purely around scientific advice, the
9 CSA role, and research and development, as I have
10 described.
11 **Q.** All right. So, Professor Young, just returning then to
12 the first few months of 2020, I know that you've set out
13 in your statement that you went on leave in or around
14 12 February; is that right?
15 **A.** That's correct, yes.
16 **Q.** But what you say is that you didn't play any part in the
17 response to the pandemic up and until that point; is
18 that right?
19 **A.** That's correct, yes.
20 **Q.** So I think there had been a number of developments in
21 the Department of Health in January. I think,
22 for example, it had an emergency operating centre that
23 was operational from January, and we know that COBR was
24 on foot from 24 January, and we know, for example, that
25 Sir Patrick Vallance, who is the UK Chief Scientific

1 Adviser, attended COBR from the outset.
2 Was there a reason why you hadn't been integrated
3 into that part of the Department of Health response at
4 that early stage?
5 **A.** I guess that's a question that would need to be directed
6 to others, rather than to me. I mean, I can observe
7 that I wasn't integrated into the response at that
8 stage. I was aware of the emerging pandemic from other
9 areas of my professional life in particular, and my
10 understanding was that the lead in terms of response was
11 coming from CMO and other colleagues within the
12 Department of Health, and my expectation was that
13 I would be called on to provide scientific input
14 whenever they felt that was necessary, and with that in
15 mind I was doing my best to keep up with scientific
16 developments in the wider literature.
17 **Q.** And why didn't you put yourself forward at that time and
18 say that the CSA ought to be part of the response in
19 January until mid-February?
20 **A.** Well, my experience of working in the department was
21 that I was available for advice in a large number of
22 areas. There were a number of areas where I had been
23 called on to give advice, for example around obesity,
24 alcohol, rare diseases, genomics, so -- and policy
25 colleagues would call me in when they felt it was

1 necessary to have additional scientific input beyond
2 what they were obtaining already from other sources.
3 I recall having some general discussions, at least
4 with some of my DA equivalents, and I think their
5 involvement at that early stage was also very patchy, so
6 the expectation was that we might be called on at
7 a later stage.
8 **Q.** I just want to focus on you, if I may, rather than other
9 colleagues in other administrations. Would it be
10 correct to say, then, that at that early stage in the
11 pandemic you didn't see a role for yourself within the
12 response; rather, you were waiting, I think, as you've
13 explained, to be called upon?
14 **A.** I think that's correct, yes.
15 **LADY HALLETT:** I appreciate Ms Dobbin said don't talk about
16 other jurisdictions, could I just ask this question:
17 other jurisdictions you have a Chief Scientific Officer
18 as well as scientific officers for individual
19 departments. When you're talking about colleagues, are
20 you talking about colleagues who were Chief Scientific
21 Officers for their jurisdiction or who were scientific
22 officers for a particular department?
23 **A.** So I'm talking about the Chief Scientific Advisers for
24 the --
25 **LADY HALLETT:** Did I say "officers"? Sorry, advisers.

1 **A.** That's okay. The Chief Scientific Advisers for the
2 departments of health, specifically in Wales and
3 Scotland, which is where -- which I viewed as my
4 equivalents.
5 **LADY HALLETT:** Thank you.
6 **MS DOBBIN:** Thank you, my Lady.
7 So, Professor Young, just coming back then to you,
8 you've set out in your witness statement that you
9 returned to your post on 23 March, having been on leave,
10 and obviously a number of things had taken place in your
11 absence, and I think by that stage Covid was well
12 established in Northern Ireland, wasn't it, and test and
13 trace had been stopped in Northern Ireland on 12 March?
14 **A.** Yes.
15 **Q.** That's right. There had been the announcement of work
16 from home on 16 March in Northern Ireland.
17 **A.** Yes.
18 **Q.** School closures had been announced on 18 March to become
19 effective on 23 March, I think, is that also --
20 **A.** Well, I haven't got that document in front of me, but
21 yes, that seems to be --
22 **Q.** You can take it from me that's not controversial.
23 On 22 March there had been an announcement of the
24 2-metre rule; do you recollect that?
25 **A.** I couldn't give you the exact dates but --

1 **Q.** Don't worry, I don't think any of that's controversial.
2 But in any event, obviously a number of very significant
3 decisions had taken place in your absence. But there
4 obviously wasn't a CSA in post during that period of
5 time; do you understand why no-one had stepped in to
6 take that position during those very important stages of
7 the response?
8 **A.** So within the department there wasn't any deputy to my
9 position, so there I think wasn't anyone obvious within
10 the department to step up, but my understanding would be
11 that other colleagues, mainly medically qualified
12 colleagues, would have been stepping in to fill the
13 gaps, and that in addition scientific input or
14 information to the Department of Health would have been
15 coming via UK-wide sources.
16 **Q.** All right.
17 **A.** But, yes, I recognise that there was a gap.
18 **Q.** I mean, I think the important point, Professor Young, is
19 that we know that it wasn't until you came back that
20 a number of important parts of the response were
21 instituted; for example, it was only when you came
22 back -- and I think you drove this -- that there was any
23 modelling capacity in Northern Ireland; is that correct?
24 **A.** So the week before I returned to work, I contacted the
25 CMO and had a conversation with him about what he felt

1 would be the most important things that I could do on my
2 return to work, and establishing modelling capacity was,
3 I think, the thing that was top of the list at that
4 stage, although obviously there were a number of other
5 things which were also important and which I looked to
6 take ahead.
7 **Q.** And again, why was that contingent upon you being in
8 position? Was that because there weren't other obvious
9 candidates to be able to take that work forward?
10 **A.** So I think -- I can't answer that, obviously, and again
11 it's a question that would need to be better addressed
12 by someone else. Certainly I thought that the amount of
13 data which was available close to my return even was
14 extremely limited in Northern Ireland, and in terms of
15 effective modelling, the key to it is having effective
16 data inputs to allow the modellers to work. I think it
17 would have been possible to do some modelling before my
18 return to work, but that there would have been
19 considerable uncertainties around that, even greater
20 uncertainties than the initial modelling which we did
21 due to the greatly limited data inputs.
22 **Q.** I'm going to come back to the limited data, if I may,
23 shortly. I think it's also right that in your absence
24 there wasn't anyone who had membership of SAGE in
25 Northern Ireland; is that correct?

1 **A.** So that is correct, and again I think that there were
2 observers from Northern Ireland, is my understanding, at
3 the majority of the SAGE meetings, if not all, and that
4 the outputs and minutes from SAGE meetings were being
5 received by the CMO. But following my return to work,
6 I wrote to SAGE secretariat and asked that I join as
7 a full member of SAGE.
8 **Q.** Just in terms of the suggestion that someone from
9 Northern Ireland was attending as an observer -- I mean,
10 it may be that these exist, I don't think we've seen,
11 for example, any notes being provided as to what had
12 been discussed or the nuance of any of the debate at
13 SAGE meetings -- was anyone actually formally reporting
14 back on what was being said at SAGE?
15 **A.** So I know that there are some notes or read-outs from
16 SAGE meetings which were provided by observers, because
17 in terms of preparing for this Inquiry I've certainly
18 seen some examples of those. I can't speak to how
19 comprehensive they were. The SAGE minutes, as you'll
20 realise, unfortunately do not record for early meetings
21 all of those who were present; in particular they don't
22 record the observers who were present. So in terms of
23 Northern Ireland attendance, I understand an effort has
24 been made to reconstruct who was present as an observer
25 for those meetings, and that that information is

1 available.
2 **Q.** Right.
3 **A.** But I don't think observer status is as useful as full
4 member and participant status at SAGE meetings.
5 **Q.** Yes. So I think what you say in your statement was it
6 was only by being a member obviously that you could
7 actually take part in the debates, or put forward,
8 for example, a Northern Irish perspective on what was
9 being discussed; is that right?
10 **A.** That's correct, yes.
11 **Q.** I think what's also right is that there wasn't a body or
12 an advisory body who were synthesising information
13 coming out of SAGE for the purposes of a Northern Irish
14 audience either, that was something that you instituted
15 when you came back as well?
16 **A.** Yes, that's also correct.
17 **Q.** I think it is right that the CMO says that he received
18 papers back from SAGE, but one imagines, given the
19 pressures that he was under as well, the ability of
20 a group of advisers to synthesise that and provide best
21 information, and from other sources as well, must be
22 quite important?
23 **A.** Certainly that became increasingly important as the
24 pandemic progressed, and the volume of papers and length
25 of papers being considered by SAGE increased. So yes,

1 I think being able to synthesise that and provide
2 summary condensed information or advice and then any
3 detail that was necessary to help inform CMO's advice
4 was important.
5 **Q.** Again, can you explain why that wasn't set up until you
6 were back in your post, and I think it was 27 March
7 perhaps when the first meeting of that group took place?
8 **A.** In terms of the strategic intelligence group, it was
9 actually 27 April, I think, the first meeting --
10 **Q.** I'm sorry, that's what I meant.
11 **A.** -- rather than 27 March, before that took place. And
12 I think -- certainly whenever I returned to work, I was
13 meant to be returning on a phased return to work, that
14 didn't happen. I was working very extended hours,
15 seven days a week, and there was a lot to get up to
16 speed with and a lot of information to synthesise. So
17 it was towards the middle/end of April before I got
18 round to establishing a broader group of experts to help
19 with the work of analysing SAGE and other scientific
20 inputs in the context of Northern Ireland.
21 **Q.** But again that sounds as though that was being very much
22 driven by you, as opposed to being part of
23 an institutional response to the structures that existed
24 in the United Kingdom?
25 **A.** In terms of establishing our own scientific advisory

1 group, yes, that was an internal Northern Ireland
2 decision rather than part of a UK structure, and it was
3 driven by the CMO and myself.
4 **Q.** Yes, and again just trying to understand why that hadn't
5 taken place at an earlier point or why it wasn't
6 instigated until you came back, what was the reason for
7 that?
8 **A.** Well, again it's a question probably better directed to
9 others, but I suspect it was to do with the very small
10 number of individuals in the Department of Health
11 covering a much larger number of areas than is the case
12 for the other administrations in the UK. People were
13 just under so much pressure with so much to do that it
14 was impossible to address absolutely everything.
15 **Q.** So even though it's something that would have assisted
16 in the -- assisted them, those very few people with all
17 of those responsibilities, it was just a question of not
18 having the capacity to set that sort of structure up?
19 **A.** I think, as I said, it's a question best directed to
20 others, but, you know, I suspect that that was
21 absolutely one of the reasons.
22 **Q.** All right.
23 The other point that you address in your witness
24 statement was that in terms of the Chief Scientific
25 Advisers' network that existed within the

1 United Kingdom, that that was restricted to membership
2 of one scientific adviser to Northern Ireland; is that
3 right?
4 **A.** Yes, that's correct. After I took up post in 2015,
5 I requested to join that scientific network, that was
6 declined by the UK Government, CSA, and it was explained
7 that they would allow one Northern Ireland CSA to
8 attend. Northern Ireland does not have
9 a cross-government CSA, as is present in Wales,
10 Scotland, or Patrick Vallance in the case of London.
11 There is just myself, and CSA in DAERA, to cover
12 agriculture and -- here. And it was agreed that the
13 DAERA CSA, whose appointment was full time and who had
14 been in post longer than me, would be a Northern Ireland
15 link to the CSA network.
16 However, again I think that that was not any
17 substitute for being able to participate --
18 **Q.** Yes.
19 **A.** -- in the network as all of the London departmental
20 CSAs, for example, are able to.
21 **Q.** In terms of during the pandemic itself, did that remain
22 the position, that you weren't able to attend that
23 group?
24 **A.** It did. During the pandemic it was probably less
25 important, because SAGE was driving the scientific

1 response to the pandemic rather than it being driven
2 through the CSA network, but certainly that remains the
3 case to today, that it's not possible for me to be
4 a member of the CSA network.
5 **Q.** All right.
6 Professor Young, I want to move on, if I may, then,
7 just to ask you about some of the statistics in
8 Northern Ireland. I was going to take you to one of the
9 slides that was shown at the outset of Module 2C
10 starting.
11 So this is INQ000472397.
12 This slide, and I think it's a slide that you might
13 be familiar with, provides a broad picture as to how the
14 pandemic progressed in Northern Ireland, and I just
15 wanted to establish if we had common ground with you,
16 Professor Young.
17 So the first part of the graph, that shows the --
18 effectively the first wave, doesn't it, or the first
19 spike, and that we see from March -- sorry, from January
20 onwards, but peaking in the April time; is that right?
21 **A.** Yes, and just before we go through this, just to make
22 a preliminary comment. So I think the shape of the
23 pandemic is essentially the same with three waves, but
24 the relative size of the peaks in the pandemic varies
25 greatly, depending on whether you look at deaths --

1 Q. Yes.
2 A. -- or ICU occupancy or hospital occupancy or cases, and
3 I'm happy to explore the reasons for that. But this
4 graph shows the shape of the pandemic in terms of
5 deaths --
6 Q. Yes.
7 A. -- and it would be different if we looked at some other
8 parameters, although still having those same three
9 waves.
10 Q. I mean, obviously deaths is one of the most important
11 means by which to measure a response to a pandemic; do
12 you agree?
13 A. Absolutely, yes.
14 Q. If we look, then, at what this shows, it suggests
15 obviously the first peak was -- although the peak was
16 high, it was for a much shorter period of time, wasn't
17 it?
18 A. Yes, it was a relatively short and sharp initial wave,
19 yes.
20 Q. Then it levelled off after July 2020, and then we see it
21 start to pick up again, and I think I'd be assisted if
22 you can help: do we see that the growth, the initial
23 growth, when it starts to ascend quite sharply, is that
24 in and around the September time of 2020 or is it
25 earlier than that?

1 A. So in terms of deaths, it would be towards the end of
2 September, but in terms of following the progress of the
3 pandemic, deaths are the end stage --
4 Q. Yes.
5 A. -- of a process which starts with a case. So they're
6 a lagging marker of the progression, and if we were to
7 look at cases we would see them rising certainly from
8 the beginning of August --
9 Q. Yes.
10 A. -- 2020.
11 Q. That's obviously really important, Professor Young, and
12 I'm going to come back to that just to understand what
13 happened.
14 Can you just help us, then, generally with what the
15 lag is in Northern Ireland between case numbers rising
16 and deaths rising?
17 A. So the lag is something which was observed everywhere
18 and was largely the same. It did change a little bit
19 during different phases of the pandemic, but essentially
20 case numbers -- cases occurring through to risk of
21 hospital admission was about ten days.
22 Q. Yes.
23 A. And then obviously hospital admissions would be rising
24 around ten days afterwards, and then deaths tended to
25 have a much longer window, unfortunately, you know, so

1 would be anything from five days to quite a long time
2 after admission to hospital.
3 Q. All right. We're going to come back and look at that in
4 much more detail in terms of what happened in December,
5 but I think it's right then, when we look at the -- I'm
6 calling it the second wave, but looking at that much
7 longer period leading up to January 2021 and thereafter,
8 is it right to effectively characterise this as a single
9 wave but a much longer wave in time than the first wave?
10 A. Yes, and we would have described that at the time as
11 wave 2 --
12 Q. Yes.
13 A. -- and peaking in January 2021.
14 Q. But I think it's also probably important -- obviously
15 the point about January 2021 is important, but
16 nonetheless the rate of deaths was going up at quite
17 a sharp ascent right up until that period of time,
18 wasn't it?
19 A. There was a difficult plateau in the autumn months of
20 2020, really from October onwards with a relatively high
21 rate of deaths, unfortunately, rising and falling
22 a little bit, and then rising to a significantly higher
23 peak in January 2021.
24 Q. Yes. We'll come back to that, but I just wanted to make
25 sure that we were in broad agreement in terms of how it

1 looks, because I think it will be important when we look
2 at what happened in the autumn. Thank you, that can
3 come down.
4 I also wanted to check whether or not you agree,
5 Professor Young, with the evidence that Professor Hale
6 has given to the Inquiry that effectively, when we look
7 at the first wave of the pandemic in Northern Ireland,
8 the decision to go into a national lockdown was at
9 an earlier stage in the development of the pandemic in
10 Northern Ireland as compared, for example, to England?
11 A. Yes, I do agree with that.
12 Q. And I think that brings us neatly back to you coming
13 back into post on 23 March, which was the day that that
14 was announced. When you came back, did you understand
15 that that was essentially a fait accompli, that that was
16 what was going to happen, or was that a matter of
17 discussion within the Department of Health?
18 A. So whenever I came back, I felt that it was inevitable
19 that there needed to be severe, strong
20 non-pharmaceutical interventions, effectively lockdown,
21 as we came to refer to it, and that there was no
22 alternative at that stage. Now, I can't remember
23 whether it was still a matter of discussion or not
24 immediately when I came back to work, because I was not
25 initially part of those discussions, I was focused on

1 establishing the modelling group and integrating with UK
2 scientific networks, et cetera. But certainly when
3 I came back, I was of the view that that was the only
4 possible intervention or outcome which could take place.
5 Q. All right, and was that because you were confident that
6 the spread in Northern Ireland had reached such a level
7 that it was the only step that could be taken so as not
8 to overwhelm the health services?
9 A. Yes, that was my view at the time, and I'm sure we may
10 return to this, but there was extremely limited testing
11 capacity available at that point, so really very little
12 evidence on which to estimate the actual prevalence of
13 the virus in the community, as we got very good at doing
14 later in the pandemic, but certainly my view at that
15 time is that there was relatively wide community
16 transmission already taking place, we just weren't able
17 to detect it due to lack of testing capacity, and
18 therefore the only intervention, in the absence of
19 testing to prevent it, was effectively a lockdown.
20 Q. Just in terms of why you were confident that that was
21 the position despite the lack of testing, was that
22 because of the numbers of people who were arriving at
23 hospital or was it a sort of scientific assessment on
24 your part that if it looks like that in England and it
25 looks like that in the Republic of Ireland -- I don't

1 know if that was the case -- but if it looks like that
2 in those jurisdictions, that's probably what it's like
3 in Northern Ireland?
4 A. So it was looking like that everywhere in Europe, and,
5 you know, obviously there was somewhat larger number of
6 cases that had been reported in England and some cases
7 in the Republic of Ireland, but given the trajectory of
8 the pandemic in Europe, particularly north Italy, it was
9 inconceivable to me that it would do anything else other
10 than proceed in a similar way in Northern Ireland,
11 unless there was some very strong intervention. So it
12 was a scientific assessment rather than a data-driven
13 assessment.
14 Q. That's a much neater way of putting it, thank you.
15 Just in terms about -- I just want to stay on the
16 issue of the physical island of Ireland, we know that
17 an MoU was entered into between, I think it was in fact
18 the Department of Health in Northern Ireland and the
19 Republic of Ireland, and that it foresaw, and I'm going
20 to summarise it, there would be a high degree of
21 co-operation, effectively, between the
22 Republic of Ireland and Northern Ireland, specifically
23 it foresaw that there would be co-operation on
24 modelling. There was just a few things about that that
25 I wanted to ask you.

1 First of all, is it your position that, as a matter
2 of epidemiology, that the whole island was effectively
3 one unit and that the virus was behaving in that way
4 within the island?
5 A. Yes, I agree that Ireland was a single epidemiological
6 unit, and in my opinion the epidemic proceeded in
7 a broadly similar way across the island of Ireland, but
8 I think that's only a partial truth, because as well as
9 that, the islands of Great Britain and Ireland were
10 a single epidemiological unit due to the existence of
11 the Common Travel Area --
12 Q. Yes.
13 A. -- and therefore the epidemic was also proceeding as one
14 entity across the islands of Great Britain and Ireland.
15 So there was something separate about Ireland as
16 a single epidemiological unit, but it couldn't be
17 considered in isolation from Great Britain due to the
18 existence of the Common Travel Area.
19 Q. If we may stick on Ireland just for a moment, the MoU
20 obviously foresaw that there would be a value in having
21 co-operation about modelling, but we know that that
22 wasn't ultimately possible in terms of having joint
23 modelling; is that correct?
24 A. I think that's correct, and the reason it wasn't
25 possible is that it wouldn't have been meaningful due to

1 the existence of considerable differences in terms of
2 data collection and recording, and if we take the
3 example of deaths, as that is what we were looking at --
4 Q. Yes.
5 A. -- in terms of the preceding graph, within
6 Northern Ireland deaths are recorded within seven days
7 and reported. Within the Republic of Ireland, it's not
8 necessary to report deaths for up to three months. So
9 given those sorts of differences in terms of how deaths
10 are reported and recorded, it becomes impossible to do
11 any meaningful modelling with such different data flows.
12 So I did have quite extensive conversations and
13 discussions with modelling colleagues in the
14 Republic of Ireland to explore options. We certainly
15 shared data and outputs. I think there were occasions
16 when we used our models on the Republic of Ireland, and
17 occasions when they looked at our data with their
18 models, but to combine the data, given the differences
19 in it, would not have been meaningful or helpful.
20 Indeed, it might have been misleading to one or both of
21 us.
22 Q. But would it have been useful if it had have been
23 possible?
24 A. I think it would have been useful if the intention was
25 to make similar policy decisions. Where there were

1 different policy decisions across the two jurisdictions,
2 it would have been less useful, you know, so -- and
3 that's obviously a matter of politics. I mean, I've
4 said that I viewed Ireland as a single epidemiological
5 unit, which I did. I note that SPI-M and its modelling
6 groups very quickly began not to do UK modelling but to
7 report modelling for England, Scotland, Wales and
8 Northern Ireland, for much the -- in other words they
9 didn't think that combined UK modelling would be
10 particularly useful, something I agreed with for other
11 reasons. And also, you know, in fact the gap between
12 Northern Ireland and Scotland is less than the gap
13 between the North and South Islands of New Zealand, and
14 New Zealand worked very well as a single epidemiological
15 unit, in many ways set an interesting example, because
16 there were similar policy decisions governing the entire
17 country of New Zealand and both the North and South
18 Islands. So in terms of the modelling, we could have
19 done it, but there were so many limitations that
20 certainly my view was -- and I think the view of many
21 others -- that it wouldn't have been useful.
22 Q. Just in terms of understanding why it wouldn't be useful
23 to know what was happening in Ireland in order to inform
24 future policy choices, there's obviously a distinction
25 between the two things. Why is it not useful to know

1 epidemiologically what's happening in one part of
2 an island in order to inform what might happen in
3 another part in a week's time, for example?
4 A. Well, I think we did know that and shared that
5 information in the regular meetings which took place
6 following the signing of the memorandum of understanding
7 with the CMOs and Deputy CMOs, and which I attended.
8 And the Republic of Ireland didn't have a scientific
9 adviser in the same sense, but were -- sometimes
10 modellers and scientists from the Republic of Ireland
11 attended. We each shared in detail what our modelling
12 was showing for our part of the island and what was
13 happening in terms of progress of the epidemic.
14 So we tried to get the benefit of knowing what was
15 happening from the modelling without the confounding of
16 combining datastreams that were not equivalent in
17 unhelpful ways.
18 It's a bit like a basket of fruit and you say, "Oh,
19 there's six pieces of fruit in that basket", but
20 actually there are three apples and three pears, and
21 what you need to know is the number of apples and pears,
22 it's not the number of pieces of fruit in the overall
23 basket.
24 Q. All right. In terms of the co-operation that existed
25 between officials -- I was going to say at official

1 level, but between counterparts within departments,
2 within Northern Ireland and the Republic of Ireland, was
3 that predicated upon pre-existing relationships and
4 co-operation or was that something that became
5 established during the pandemic?
6 A. Prior to the pandemic, and I'm sure the CMO would speak
7 to this, my understanding is that there were regular
8 contacts and meetings between the CMOs. I can't speak
9 to the content of those, because I wasn't involved in
10 them.
11 My closest equivalent would have been, I think,
12 chief scientist to the Irish Government, who was also
13 heavily involved in research and development, and
14 I would have met regularly with him in the context of
15 research and development.
16 But, as I say, there wasn't a Chief Scientific
17 Adviser in the same sense, so I had very limited
18 contacts with other parts of the Irish Government or
19 Department of Health.
20 Q. The other sequel, I suppose, to this point, is that
21 certainly the Inquiry is aware that it's still very
22 difficult to compare outcomes in the Republic of Ireland
23 to those in Northern Ireland. So obviously the problem
24 about the three-month lag ought not to be a problem when
25 it comes to being able to compare this far down the

1 line. First of all, is that right?
2 A. I think that -- I think that the three months is
3 a guideline. I think my understanding is that
4 sometimes, in terms of recording deaths, the delay in
5 the Republic of Ireland can be even rather greater than
6 that, and indeed I know they had a cyber attack which
7 impacted, in 2021, on their deaths reporting system as
8 well and attention to which has been drawn by other
9 international bodies seeking to make comparisons.
10 I think ultimately it will and should be possible to
11 make comparisons, and I think it will be important to do
12 that. But at the moment I'm not sure that the data is
13 sufficiently reconciled to allow it to be done in
14 a meaningful way.
15 Q. It's 2024, we're a considerable point past the pandemic
16 ending; are those kind of efforts to be able to make the
17 data comparable ongoing in Northern Ireland?
18 A. So in terms of data available in Northern Ireland, there
19 are a lot of efforts ongoing to make sure that our data
20 is comparable and feeds are comparable to those in
21 England, Scotland and Wales, and the way, ideally, that
22 it would be aligned is that data from the
23 Republic of Ireland would also be comparable to data
24 through the UK. It would be difficult, from our point
25 of view, to have complete alignment with everybody

1 unless the other countries are committed to being
2 aligned with each other, and that's above my head in
3 terms of --
4 Q. Yes, I'm just -- it's obviously very striking that this
5 far down the line it's being suggested that it isn't
6 possible to compare outcomes in the Republic of Ireland
7 with those in the North of Ireland, and you've suggested
8 that there are obstacles to that, because some deaths
9 might be registered longer than three months in the
10 Republic of Ireland, and they've had -- I think you
11 suggested they had some sort of data breach three years
12 ago. So just coming back to trying to understand why
13 it's still not possible now to compare outcomes in the
14 Republic of Ireland to the North of Ireland, are efforts
15 being made to overcome those, the difficulties to which
16 you've referred?
17 A. I think it is possible to compare outcomes. The
18 question isn't about whether it's possible to do it.
19 I think the question is how valid those comparisons are,
20 and that's a matter of considerable debate,
21 scientifically and in terms of epidemiology.
22 Now, I think it's important that it should be done
23 and that researchers should continue to look at it,
24 because I think it's important that we maximise the
25 learning that comes out of the pandemic in order to

1 improve our responses to a future pandemic, and part of
2 that has to be trying to understand what happened on the
3 island of Ireland, with all of its complexities in terms
4 of policy decisions, demographics, population density,
5 all of the other things that might influence outcomes in
6 the North of Ireland versus the South of Ireland.
7 Q. So those seem to be a different set of reasons why it
8 might be complicated to compare the position in the
9 Republic of Ireland to that in Northern Ireland; is that
10 right?
11 A. So I think there's a set of reasons which relate to the
12 data that's available, how the data was collected and
13 the data flows. So that's one set of reasons.
14 The second set of reasons is how you would interpret
15 any differences which might be found when you do
16 an analysis. There are reasons, for example, why you
17 might expect there to be a higher number of deaths from
18 Covid in Northern Ireland than in the
19 Republic of Ireland. For example, population density in
20 Northern Ireland is significantly higher than in the
21 Republic of Ireland, and we know that Covid outcomes
22 tend to be worse in areas of higher population density.
23 Secondly, although people argue about it, there's
24 likely to be a higher degree of socioeconomic
25 deprivation in the North of Ireland than in the

1 Republic of Ireland, and we know that Covid outcomes are
2 worse in areas with larger amounts of socioeconomic
3 deprivation.
4 Now, all of that would need to be factored into the
5 comparison in terms of understanding it. I don't think
6 it could be -- differences could necessarily be
7 attributed easily to policy differences. It would have
8 to take into account that much wider range of factors.
9 Q. But there's obviously a distinction between the bare
10 statistics in terms of comparing numbers of deaths
11 between the two jurisdictions and the reasons why deaths
12 might be higher in Northern Ireland; correct?
13 A. Yes.
14 Q. But in terms of the reliability of the statistics in
15 terms of comparing -- and again I accept, of course,
16 it's just a bare statistic -- but is there
17 a sufficiently reliable basis upon which to say that
18 deaths were higher in one jurisdiction as compared to
19 the other?
20 A. I'm not sure I have seen data which has achieved
21 widespread agreement and on which people have been able
22 to make such a comparison.
23 I'll go back to what I said at the beginning, which
24 is my view that the pandemic proceeded in a broadly
25 similar way across the island of Ireland, and I believe

1 that that will have been the case in terms of deaths
2 ultimately, as in terms of other aspects of the
3 pandemic.
4 But I think more work needs to be done there to
5 understand that and to provide unequivocal evidence.
6 Q. I'm sure you're aware, but I think you addressed it in
7 your witness statement, the academic criticism that's
8 been made, I think, by a Professor Heenan, that although
9 there are -- that there is co-operation at
10 an operational level, that nonetheless there isn't --
11 that -- and she has, I think, described it as almost
12 deliberate that there isn't data available to be able to
13 compare and that that's almost a strategic decision in
14 order to, I suppose, stop enquiry into why there might
15 be differences. I think that is something that you
16 disagree with in your witness statement; is that right?
17 A. I think what I've said is that I've absolutely never
18 seen any evidence of that in my interaction, certainly
19 in the Department of Health. Rather, I've seen a degree
20 of enthusiasm for working as much as possible on
21 an all-island basis and for looking to be able to
22 conduct comparisons.
23 Q. I'm going to move on, if I may, Professor.
24 In terms of the limitations in data in
25 Northern Ireland at the outset of the pandemic, we've

1 touched on this, but I just -- again to make sure the
2 understanding is clear on the part of the Inquiry, there
3 was obviously very limited testing, I think that that's
4 a given, isn't it, until about mid-March?
5 **A.** Well, you know, testing, there was very limited testing
6 to mid-March. In retrospect, mid-March right until the
7 second year of the pandemic there was really quite
8 limited testing.
9 **Q.** All right.
10 **A.** You know, so test numbers continued to ramp up and were
11 low throughout the first wave.
12 **Q.** All right. I'm going to come back and ask you, because
13 I know you obviously played an important part in trying
14 to plan testing in terms of the numbers of people that
15 would be required, for example, for tracing. But I'll
16 come back to that.
17 Just staying with the limited data streams
18 available, there wasn't data available, I think, in
19 terms of hospital admissions, until quite a late point
20 as well; is that right?
21 **A.** So there wasn't reliable data available on hospital
22 admissions until towards the end of April 2020.
23 **Q.** And I think it's right as well there wasn't -- we've
24 heard about the Apollo system that reported flu symptoms
25 being reported to primary care, but again, is it right

1 that that didn't provide any particular insight into
2 Covid-19 in Northern Ireland either?
3 **A.** So, certainly I began to get information from Apollo
4 later in 2020, as one of many data feeds which was
5 supporting our understanding of the progression of the
6 pandemic, but I did not receive that feed early on,
7 certainly not long after my return to work.
8 **Q.** So just coming back, then, to test and tracing, we know,
9 I don't think I need to bring it up because I'm sure
10 you're familiar with the email, it appears you made
11 enquiries in April 2020 of the PHA, and specifically of
12 the Director of Public Health in Northern Ireland, about
13 the number of people who would be required in order to
14 undertake tracing. I think your statement sets out that
15 that was based on, I think it's a European standard for
16 tracing; is that right?
17 **A.** Well, it was based on my understanding of best
18 international practice in terms of contact tracing, yes.
19 **Q.** And we've seen the email to you from the Director of
20 Public Health that appeared to suggest in terms that 500
21 people were being trained in order to be able to
22 undertake tracing in Northern Ireland; is that right?
23 **A.** Yes.
24 **Q.** And is that what you understood the position to be at
25 that time?

1 **A.** Yes.
2 **Q.** Did your understanding about that persist for some time,
3 or did you come to understand that that just wasn't the
4 position?
5 **A.** I did not understand that that was not the position
6 until August/September 2020.
7 **Q.** And was that the position amongst other senior leaders
8 within the Department of Health as well, that they
9 thought that there was a much greater tracing capacity
10 than in fact existed?
11 **A.** Well, again that would need to be addressed, I think, to
12 them, but that was certainly my -- my understanding.
13 **Q.** I mean, I think we might be able to pick this up -- if
14 we could, please, look at INQ000353671. I think if we
15 could please go, I think we probably need to go to the
16 last page of this. No, the penultimate page. If we
17 could just scroll up, please. Yes, this is the right
18 one.
19 Professor, this was an email from the Director of
20 Public Health, I think it was to Ms Redmond, who we've
21 seen in the Department of Health, and I think we see the
22 suggestion -- I think, again, the suggestion had been
23 made that some 500 people would be required -- sorry,
24 300 to 600 people would be required in order to
25 undertake tracing. We see that in the first paragraph.

1 I apologise. And then "Reflections".
2 **A.** So if I just go up to the top, first of all, I think
3 that that email is to Liz Mitchell rather than
4 Liz Redmond.
5 **Q.** Forgive me, yes, I can see that.
6 **A.** So -- yes, so, obviously that is an account of a meeting
7 I had in the middle of September or attended in the
8 middle of September where again I reiterated the need
9 for 300 to 600 staff.
10 So I think at that point I had become aware that
11 they had proceeded with a different model for contact
12 tracing rather than the one that I had given advice on
13 earlier in the year.
14 **Q.** I think we can see that, at the very bottom of that
15 page, under "Reflections", the authors are effectively
16 saying that: if we were to try to do that, we would have
17 to effectively double the entire size of the
18 organisation?
19 **A.** And that's correct, but that was the magnitude of the
20 task which I had felt was necessary to have an optimally
21 effective contact tracing service, based on best
22 international practice.
23 **Q.** I think if we go up this chain, Professor Young, you may
24 be familiar with this. We will see that it's being
25 referred to as "ground hog day", that's the email from

1 the CMO, and then the reference to modelling, the
2 modelling update that had taken place between March and
3 May, when those sorts of figures had been provided, and
4 referring there to the significant incredulity and
5 push-back from PHA that that's what would be required?
6 A. So I hadn't been aware of the incredulity and push-back.
7 I had given advice and -- certainly that may have been
8 experienced elsewhere in the department but I hadn't
9 been aware of that.
10 Q. But anyway, this position, it does appear, had persisted
11 between that much earlier indication in April --
12 A. Yes.
13 Q. -- that there were not, in fact, 500 staff and this
14 position here.
15 I think it's right, I don't think I need to take you
16 to this, but there was an article published in the
17 British Medical Journal where representatives of the PHA
18 had said that they had in fact pushed against the idea
19 that you would ever need this number of people to do
20 tracing, and that they -- I think the suggestion was
21 they had never come close to having that number of
22 people trained.
23 Is that right?
24 A. So I am -- I'm now familiar with that article, yes.
25 I can't remember when I became familiar with it.

1 I wasn't familiar with it at the time that it was
2 published. I'm not sure that they pushed back, more
3 that they rejected the advice.
4 Q. Yes.
5 A. Rather -- I mean, it's how I interpreted it. And
6 indeed, PHA colleagues were the experts in terms of
7 contact tracing. I would not have claimed to be
8 an expert in that -- in that area.
9 Q. Well, I think that after you gave your advice in April,
10 this article suggests -- and it says in terms:
11 "As of 25 May, 78 tracers had been fully trained,
12 says Hugo Van Woerden, the PHA's director of public
13 health."
14 So a very, very considerable reduction in the number
15 of people who you had suggested needed to be trained?
16 A. Yes.
17 Q. In terms of -- you've said that there was limited
18 testing for quite some time in Northern Ireland. Did
19 that tracing capacity then -- presumably it remained
20 quite low for a considerable period of time then during
21 that first year of the pandemic; is that right?
22 A. So the testing capacity was low right through the first
23 wave, much, much lower, and if you were to look at the
24 actual number of positive cases, et cetera, you would
25 see that it was much, much greater later in the

1 pandemic, largely because there was much more testing
2 available and we were identifying a much higher
3 proportion of cases.
4 In the summer of 2020, the number of cases became
5 extremely low. I think that was a seasonal effect, and
6 in fact there were no deaths whatsoever at one stage for
7 10, 12 days in a row --
8 Q. That's in June 2020, wasn't it?
9 A. Yes. Suggesting that actually the transmission, the
10 prevalence of the virus was very low, and there was
11 probably enough testing capacity at that stage.
12 But as the transmission began to increase from the
13 beginning of August or so onwards, and gradually picked
14 up, then -- and became very substantial as we went into
15 autumn, then testing capacity was much more than it had
16 been during wave 1, but not as high as it was during
17 wave 3. So we were picking up a proportion of cases.
18 I mean, one of the key learning things for me from
19 the pandemic is the absolute need for much faster
20 roll-out of testing, because so many things, so many
21 aspects of our understanding and our response were
22 inhibited by lack of access to testing.
23 Q. Right.
24 I just want to -- that, in a way, takes us perhaps
25 to one of the most important phases, then, in the

1 pandemic, which was what happened then after the summer
2 of 2020, and I think I can do this without -- if I can
3 try and jog your memory a bit --
4 A. Yes.
5 Q. -- about some of the chronology, but if I alight on
6 anything that you need to see, please do say,
7 Professor Young.
8 I think, as you've said, there was a period in
9 June 2020 when there had been no deaths and the picture
10 was quite an optimistic one in terms of what had
11 happened. I think it's right, though, that you and the
12 CMO had both said at quite an early stage that it was
13 almost inevitable that there would be a second wave in
14 Northern Ireland; is that right?
15 A. The very first modelling paper I prepared, which was at
16 the beginning of April 2020 --
17 Q. Yes.
18 A. -- after I returned to work, said that there would be
19 a second wave.
20 Q. And it was a question of when rather than if that
21 happened?
22 A. It said that there would be a second wave when the
23 restrictions were relaxed.
24 Q. Yes, and we -- I won't take you through the
25 decision-making process about how to relax restrictions,

1 but I think it's correct that there was a document
2 called the *"Executive Approach to Decision-Making",*
3 which was produced in May 2020, that set out the
4 framework by which the Executive Committee would lift
5 restrictions; is that right?
6 **A.** Yes.
7 **Q.** I think that you and the CMO advocated an approach of
8 lifting restrictions, waiting to see what the effect
9 was, and then considering whether to lift another
10 restriction; is that a fair way of putting it?
11 **A.** Yes, because in general every time a policy decision was
12 made, either to relax or to introduce a new set of
13 restrictions, it took two to three weeks before we could
14 be confident what effect that was going to have. That
15 was the case throughout the pandemic, and obviously was
16 a source of frustration at times in terms of
17 policy-making, which I understood, in that ministers
18 would have liked to know more quickly what the impact of
19 a past decision has made, but it was always between two
20 and three weeks because of the course of the pandemic.
21 **Q.** And I think in terms of the principled approach that was
22 going to be taken, that one of the touchstones --
23 I think there was five -- but one of the touchstones was
24 trying to keep R below 1; is that right?
25 **A.** That's correct. There was a lot of discussion and

1 explanation of R, and what R meant, and ministers
2 committed to -- and understood that when R was less
3 than 1, that would mean that the pandemic was declining.
4 **Q.** Yes.
5 **A.** And when R was above 1, it would mean the pandemic was
6 increasing. Keeping R below 1 was indeed a stated
7 policy position, but not something that was possible,
8 obviously, as the pandemic progressed.
9 **Q.** Yes. So I think we will see that, that in fact very
10 quickly I think it's right that R went above 1 in
11 Northern Ireland, and that I think in fact that must
12 have started in August 2020; is that right?
13 **A.** It probably started even before August 2020. For
14 a while in July we stopped reporting R, the reason being
15 that there were so few cases of the pandemic. And
16 obviously I was anxious that ministers and the wider
17 public understood uncertainty around R, and placing
18 a numerical value on it could sometimes be misleading.
19 I mean, there was a point when all I could say was that
20 R was somewhere between 0 and 3 because the number of
21 cases were so low, and that was obviously not helpful
22 information. So we stopped producing R for a while.
23 But I think it was above 1 from some point in July.
24 **Q.** I think it's right that in July, just generally in terms
25 of the pattern of transmission, that it was mostly young

1 people who were driving increasing rates, but that it
2 was understood that that would inevitably lead to a more
3 general rise in rates across the population.
4 **A.** Yes, I think that's correct. School holidays here are
5 the entire months of July and August, and evidence of
6 transmission of the pandemic was low, young people
7 tended to be less symptomatic, they were mixing probably
8 quite a bit in social settings, understandably, and most
9 of the cases we were seeing were in younger people, but
10 always it was inevitable that that would spread into
11 other segments of the population.
12 **Q.** I'm going to, as it were, ask you about two things in
13 one go, but the Inquiry knows, obviously, that the Eat
14 Out to Help Out scheme was introduced in August 2020,
15 and I think it's right, Professor Young, that that was
16 a -- it was a UK policy, it was introduced in
17 Northern Ireland without anyone making a decision about
18 it or providing advice about it; is that correct?
19 **A.** Certainly no scientific or medical advice about it, yes.
20 **Q.** And I think that at the same time that it was being
21 introduced, that you and the CMO were advising that
22 there shouldn't be the re-opening of pubs that didn't
23 sell food in Northern Ireland; is that right?
24 **A.** That's correct. The CMO and myself were concerned in
25 early August about the increase in transmission, and

1 I think what we felt was an inevitable autumn wave that
2 was coming, and we expressed concern about additional
3 relaxations that were proposed, in particular the
4 opening of pubs which did not serve food.
5 **Q.** If we could just have a look maybe at the advice that
6 you provided at that time, it's INQ000353624.
7 I think we can probably pick up at the fourth
8 paragraph that by that stage, Professor Young, you
9 thought the R rate was close to 2; is that right?
10 **A.** Yes.
11 **Q.** If we go down just a couple of paragraphs, you pointed
12 out that a delay in re-opening pubs -- so I think it's
13 right -- I jumped ahead slightly -- pubs were due to
14 re-open in and around this time?
15 **A.** Yes.
16 **Q.** And you point to the fact that there would be dismay in
17 the sector that that wasn't going to be the position,
18 but that was a matter for the Executive; correct?
19 **A.** Yes, and this comes back, I think, to the broader point
20 that certainly what I was seeking to do all the time was
21 to give advice on the potential implications of
22 decision-making and to highlight the -- and to discuss
23 the range of decisions that might be made, but was very
24 clear that while I could easily give advice on the short
25 to medium-term impacts of decisions on transmission of

1 the virus, and that I could highlight a range of other
2 issues and concerns, both medical and non-medical,
3 educational, economic, societal, that those could not be
4 quantified in the same way, and that Executive had the
5 very difficult task of considering that advice and
6 taking account of that full range of factors in terms of
7 making policy decisions.
8 **Q.** Yes, I'll come back to some of the decisions that were
9 made, but just sticking on this document for a moment,
10 I think you were making the point as well in the last
11 paragraph that schools were about to re-open and that
12 keeping schools re-open or making sure that they
13 re-opened after the holiday was one of the components of
14 the decision-making that had to be fed in at this
15 stage --
16 **A.** Yes.
17 **Q.** -- is that right? In other words, you can't have
18 every -- you may not be able to have everything, and
19 that if you want schools to open, that's important.
20 **A.** Certainly one of our lessons was that it was very, very
21 difficult, if not impossible, to have R below 1,
22 hospitality open and schools functioning normally. That
23 seemed to be just a combination which was not compatible
24 with R less than 1, in our experience.
25 **Q.** I think it's right pubs didn't re-open at this point,

1 they opened a bit later, I think it's in September --
2 **A.** Yes, yes, I think so --
3 **Q.** -- I need to check my notes --
4 **A.** -- yes.
5 **Q.** -- but just coming back to the Eat Out to Help Out
6 scheme, presumably it wasn't helpful to have a scheme
7 that encouraged people to go and socialise or to eat at
8 this point when, for example, you're trying to
9 discourage people from going to pubs, for example?
10 **A.** So it certainly wasn't helpful in terms of the
11 transmission of the epidemic. I think it probably was
12 very helpful for the restaurant sector in economic
13 terms. So, like so many other decisions, there were
14 pros and cons of it, but from the point of view of its
15 impact on transmission of the epidemic, it was
16 definitely not helpful, although I can't put a number on
17 the extent to which it caused increased transmission.
18 **LADY HALLETT:** It should also be pointed out that when
19 I heard evidence in Module 2, the suggestion was that
20 the Eat Out to Help Out scheme was meant to be in
21 a Covid-secure -- as far as you can be "Covid-secure" --
22 environment.
23 **A.** That's correct, and I was generally unhappy with the
24 idea of Covid-secure environments.
25 **LADY HALLETT:** Exactly. I put it in inverted commas.

1 **A.** I made that point repeatedly. With the best will in the
2 world, you know, people eating indoors without face
3 coverings, in properties where, often, ventilation was
4 quite limited, they can't be Covid-secure. The idea
5 that they could be was naive.
6 **MS DOBBIN:** Thank you, Professor.
7 My Lady, I don't know if that's a good point to have
8 the break, or if that -- I was going to move on, but if
9 you want me to keep going ...
10 **LADY HALLETT:** No, that's fine. It's slightly early. How
11 are we doing for timing?
12 **MS DOBBIN:** I think we're fine for timing.
13 **LADY HALLETT:** So if I said 3.30, are you okay for timing?
14 **MS DOBBIN:** If we could come back slightly before that --
15 **LADY HALLETT:** 25 past.
16 **MS DOBBIN:** Thank you.
17 **(3.12 pm)**
18 **(A short break)**
19 **(3.25 pm)**
20 **LADY HALLETT:** Ms Dobbin.
21 **MS DOBBIN:** Thank you.
22 Professor Young, just before that short adjournment
23 I think we had just left the position as it was at in
24 August 2020, and again I just wanted to pick up the
25 chronology with you, if I may, and again if you need to

1 go to any documents in order that I can demonstrate any
2 of these dates, then please do say.
3 I think it's right that in terms of the general
4 picture of the transmission of the virus, the picture
5 just continued to get worse between August and
6 September; is that right?
7 **A.** Yes.
8 **Q.** And that ultimately what was advised was that the
9 Executive Committee consider bringing in some localised
10 restrictions and that was -- I think those were brought
11 into place or that that was decided upon on
12 10 December 2020?
13 **A.** I think 10 September.
14 **Q.** Yes.
15 **A.** Yes, sorry.
16 **Q.** Sorry, did I --
17 **A.** I thought you said December there.
18 **Q.** Sorry, I think it was the way I said it -- 10 September
19 in 2020. So that was, as I understand it,
20 Professor Young, in recognition of the fact that there
21 were certain localities where transmission rates were
22 particularly high; is that right?
23 **A.** That's correct, yes. So at that stage there were marked
24 differences in terms of transmission of the pandemic in
25 different regions of Northern Ireland, and in line with

1 other parts of the UK and Ireland it was felt that it
2 was worth trying the effect of localised restrictions to
3 reduce transmission, although I think we all recognised
4 that the impacts of that were uncertain and at best
5 would be transient in all likelihood.
6 **Q.** Yes. I mean, I think in Northern Ireland it was
7 almost -- and I don't mean this in a pejorative way --
8 experimental because it hadn't been done before in terms
9 of the effect that it would produce.
10 **A.** I mean, it had been tried in some other parts of the UK
11 and Ireland. It was a trial, yes, to see if it would be
12 effective. And the evidence that we had suggested that
13 there was some benefit, but, against the context of
14 a pandemic which was increasing in most other parts of
15 Northern Ireland, at best that was going to be -- that
16 was a transient effect.
17 **Q.** I think it's right just to record that at that point in
18 time, I think it's right, that you and the CMO were very
19 concerned about the picture of transmission as it was at
20 that point?
21 **A.** Yes, we were flagging up concerns about the trajectory
22 of the pandemic and recognising that, you know, we were
23 in an exponential growth phase, as people sometimes talk
24 about, so during such a phase particularly, once you get
25 to higher levels of transmission, you get a very rapid

1 increase in absolute pressures in the system due to
2 short doubling times.
3 **Q.** And I think that was the advice that you were
4 effectively providing at that time, wasn't it, that the
5 picture --
6 **A.** Yes.
7 **Q.** -- was a serious one for Northern Ireland?
8 **A.** Yes, certainly I think we were providing that advice,
9 yes.
10 **Q.** And in terms of the broader advice that's being
11 provided, I think it's right that on 21 September SAGE
12 then also advised that there may need to be a number of
13 measures at least contemplated at that point in time,
14 and one of those measures was a circuit-breaker; is that
15 right?
16 **A.** Yes, there was an important SAGE meeting on 21 September
17 and that advice was very rapidly escalated by us through
18 to the Northern Ireland Executive, I think later that
19 week.
20 **Q.** In terms of when that became pressing or when that was
21 then discussed by the Executive Committee, I think it's
22 right, but please correct me if I'm wrong, that that was
23 then put to ministers or considered on 8 October; does
24 that correspond with your memory?
25 **A.** So I would have to see that. I think that that advice

1 was discussed at earlier Executive meetings than that,
2 but there may have been specific recommendations put on
3 8 October. But from memory I think the advice was
4 conveyed to the Executive without specific
5 recommendations coming out of it at earlier meetings.
6 **Q.** All right. I think we have it at paragraph 422 of your
7 statement, I don't think we need to go to it, but
8 I think --
9 **A.** I'm not sure my statement goes to 422 paragraphs.
10 **Q.** No, as soon as I said it I was thinking that that's not
11 right, I think it's the CMO's statement deals with it at
12 paragraph 422. But let me just check that you agree
13 with him, in that what he says was:
14 "At that time, it was our view that realistically
15 a circuit breaker or lockdown was needed."
16 Does that correspond with your recollection at that
17 time?
18 **A.** Yes, we -- yes, it does, that we definitely felt that
19 a circuit-breaker or lockdown was needed by 8 October,
20 yes, definitely.
21 **Q.** I think maybe if we can bring this up on the screen so
22 that I can remind you of it.
23 It's INQ000065756, please, and I think it's page 7.
24 Perhaps if we just look at page 1, just so that
25 I can demonstrate the date to you, Professor Young.

1 So that is the meeting that took place on
2 8 October 2020 of the Executive Committee, and I think
3 it's right that you attended this meeting in order to
4 address the Executive Committee?
5 **A.** Yes.
6 **Q.** And again, was that to convey to them how serious the
7 position was and the point that had been reached?
8 **A.** Yes, it was. At that stage I was attending most, if not
9 all, Executive meetings, and providing regular updates
10 in terms of the situation. So at earlier Executive
11 meetings than that, I was telling them it was a serious
12 situation, but by 8 October I think we'd reached the
13 point where there was a realistic danger of the
14 healthcare system becoming overwhelmed if there was not
15 a rapid intervention.
16 **Q.** Yes, I'm not putting this to you on the basis that this
17 was late in the day, it's really just to try and
18 understand --
19 **A.** Yes.
20 **Q.** -- what the position that had been reached by 8 October.
21 **LADY HALLETT:** Can I just interrupt for a second.
22 Professor, there are those who question the need
23 ever to have a lockdown. Would you like to explain why
24 earlier in the year, and now again in the autumn, you
25 felt that a lockdown was inevitable?

1 **A.** So ultimately -- ultimately our pathway out of the
2 pandemic -- and we said this from a very early stage in
3 other documents which you will have access to --
4 required us to achieve a high level of population
5 immunity, preferably through vaccination, but also as
6 a result of natural exposure to the virus. At that
7 stage, vaccination was still a number of months away,
8 and there were not really any very effective treatments
9 in terms of antivirals or other interventions to reduce
10 the risk of death. So our concern was that the hospital
11 system in particular would become overwhelmed by very
12 ill patients who would mainly be older patients with
13 Covid, and that that would lead to a very large number
14 of deaths over a short period of time.
15 The only way to avoid that was to greatly lower the
16 level of transmission of the virus in the community. At
17 that stage, it was clear to us that that required R to
18 be below 1, and furthermore to attain a fairly rapid
19 fall-off in transmission it needed to be as far below 1
20 as possible.
21 Now, the best we ever achieved in terms of R was
22 around 0.7, perhaps slightly below, and that was with
23 what came to be known as full lockdown. So it required
24 people essentially to stay at home, to minimise their
25 contacts, for everything other than essential retail to

1 be closed, and for schools to be off. And we'd reached
2 this point in October, when we felt we really needed to
3 get R down to 0.7. I think I was shown that on a --
4 I think I'm shown as saying that in a later stage of
5 this statement. And the only way to achieve that was
6 full lockdown for a period.
7 **LADY HALLETT:** Full lockdown of course has enormous other
8 consequences.
9 **A.** Yes, it does, and we absolutely highlighted those
10 consequences and highlighted the alternatives that
11 schools could be kept open, for example, in which case R
12 would be about 0.9.
13 And what would the implications of that be? Well,
14 a rather slower fall-off in transmission of the
15 epidemic, so fairly high persistent levels of
16 transmission, high hospital pressures through the autumn
17 period.
18 And alternatively you could have closed schools and
19 you could have opened hospitality, I think, and you
20 would have had something around the same result based on
21 our modelling and understanding, so R might have been
22 a little bit below 1. And again, we described that as
23 a possible course of action to try to address economic
24 consequences or educational consequences.
25 There were all the broader ones in terms of societal

1 consequences, which we continued to highlight, you know,
2 loneliness, challenged mental health disturbances,
3 people gaining weight, people drinking too much, all of
4 those other consequences of severe restrictions, which
5 we couldn't easily quantify but which needed to be
6 considered in qualitative terms by ministers who were
7 trying to reach enormously difficult decisions.
8 You know, the easiest thing in the world would have
9 been to -- almost to stop transmission of the virus by
10 having an indefinite complete lockdown until such time
11 as we could roll out vaccination, but that was clearly
12 not something that was ever feasible in terms of the
13 indirect costs of the restrictions, because in many ways
14 the restrictions were as damaging as the pandemic
15 itself, and always ministers were trying to balance the
16 harms of allowing transmission with the harms of the
17 restrictions.
18 **MS DOBBIN:** I think we'll come back to -- and the Chair has
19 perhaps foreseen what I was going to ask.
20 **LADY HALLETT:** I'm sorry.
21 **MS DOBBIN:** Not at all, because I think in fact it's right,
22 that the lockdown that was -- we will see the lockdown
23 that was brought in in fact didn't involve the closure
24 of schools, children -- I think there was a two-week
25 extended --

1 **A.** Yes, two weeks of half-term for children, and then
2 two weeks back, yes.
3 **Q.** So I think it's -- at this point it's just trying to
4 understand the dynamic, as it were --
5 **A.** Yes.
6 **Q.** -- because I think it's right, if we go, please, to
7 page 7 of this, I think we understand -- it helps to
8 understand perhaps the counterviews that were being
9 pressed at this point in time. Now, these are
10 handwritten notes, this isn't an agreed minute or
11 anything like that, but perhaps it gives us some idea.
12 But the idea that you were looking for a damaging
13 approach, I think we see as well on this page as well,
14 that this particular minister was saying that there
15 was -- that I think you and the CMO perhaps were afraid
16 to say where the problem is. I'll ask you about that in
17 a separate question, but I think we start to see here
18 perhaps the suggestion that rather than you advising
19 that your -- I think we can see here the words are
20 "looking for a damaging approach" as opposed to just
21 advising that this is what we think, as the experts,
22 might be required.
23 **A.** And I think if you go on to look further in those
24 handwritten notes, which you're right are not an agreed
25 minute --

1 Q. Yes.
2 A. -- I think the Minister of Health is quoted as saying
3 the CSA's not looking for anything --
4 Q. Yes.
5 A. -- he's giving advice on the impacts of a range of
6 possible interventions and outcomes, which is exactly
7 what I was doing, and I understood that some ministers
8 were unhappy with the information they were receiving,
9 and there was certainly plenty of robust discussion,
10 which I thought was entirely appropriate in terms of the
11 science being questioned, to which I did my best to
12 respond and provide additional explanations, but always
13 I think that I sought to provide -- and I think the
14 minutes will support this -- advice on a wide range of
15 options, including the benefits in terms of reducing
16 transmission, but also highlighting the areas where
17 there would be harms in terms of the interventions, and
18 those were always in, I think, both the mind of myself
19 and the CMO when we gave advice. So, no, I would say
20 I was not looking for any approach --
21 Q. Yes --
22 A. -- I was advising ministers on implications --
23 Q. Yes, decisions -- sorry, I didn't mean to cut across
24 you. It was certainly by no means an allegation that
25 you were overstepping the mark, I think the question was

1 about how your advice was perceived. And I think, as
2 you rightly say, the health minister had to step in to
3 say that you weren't there to tell ministers what to do,
4 you were there in an advisory capacity and that they
5 mustn't, as it were, take your advice in that way.
6 A. Yes, and that was entirely appropriate and certainly
7 something I agreed with, yeah.
8 Q. Just in terms of what position had been reached here,
9 there had been those local lockdowns. I think in fact
10 pubs had re-opened as well on 23 September. I have
11 a note of that if you need to see it. If you're happy
12 to take it from me ...
13 A. I'm happy to take it from you, but can't confirm it.
14 But, I mean, it sounds very reasonable to me, yes.
15 Q. I'm looking at a TEO document that tells me that, so
16 I think it's probably reliable.
17 And schools were back as well, so there were
18 a number of things going on in the epidemiological mix
19 at this stage, I think; is that right?
20 A. Yes, absolutely.
21 Q. I don't think there was a decision on 8 October to do
22 anything in particular, but I think it's right that --
23 and we've certainly seen within a few days of this
24 a note of a meeting at which the CMO was expressing the
25 concern that Northern Ireland was probably about

1 ten days away from having its health services
2 overwhelmed.
3 Is that something that you recollect at that
4 point --
5 A. Yes, so from memory -- and again, I don't have it in
6 front of me -- I think that following that meeting on
7 the 8th there were exchanges over the weekend where we
8 emphasised the fact that we were very close to reaching
9 the point where the hospital system could be
10 overwhelmed, and discussion about the possibility of
11 another Executive meeting earlier -- early the following
12 week, around 10 or 11 October. And I think that's
13 right, we -- the modelling was suggesting around
14 ten days. And of course I indicated earlier that any
15 intervention took around ten days --
16 Q. Yes.
17 A. -- to have an impact, so it was becoming acute in terms
18 of the need, if the priority was to prevent the hospital
19 system from going beyond strain.
20 Q. Just to pick up, sorry, on the point that was made in
21 the meeting, the idea that you and the CMO were afraid
22 to say where the problem was, I think there was some
23 suggestion by the same minister, and it was made in
24 public, that transmission rates were higher in areas
25 that were of a particular political background; is that

1 correct?
2 A. Yes, from recollection, the minister suggested that
3 transmission rates were higher in areas which would have
4 been perceived as predominantly Nationalist in terms of
5 their background and make-up.
6 Q. And I think it's right that the Chief Medical Officer
7 had to make a public statement addressing that and
8 saying that there wasn't a basis, there wasn't
9 an epidemiological basis, for saying that that was the
10 position?
11 A. And I recall being asked about it in more than one media
12 interview, and saying that it had never been an analysis
13 or comparison that we had done, nor would I think it
14 appropriate to do in terms of our response to the
15 pandemic.
16 Q. I think it is right, and this is based on reading across
17 a number of papers, that it was recognised in
18 Northern Ireland that transmission rates could be higher
19 in some areas of greater deprivation than others; is
20 that correct?
21 A. Yes. So the epidemiology within Northern Ireland, as
22 you would expect, was relatively complex, but
23 definitely, as elsewhere, we saw higher levels of
24 transmission in areas with greater socioeconomic
25 deprivation.

1 We also, at certain points in the pandemic, observed
2 a much higher incidence of transmission in the counties
3 of Northern Ireland bordering the Republic of Ireland,
4 and a lot of work was done in those regimes on
5 a cross-border basis by the public health authorities to
6 try to use co-ordinated messaging and risk management
7 approaches to address that problem.
8 Q. So just coming back to the chronology in terms of what
9 happened next, after that meeting where there was
10 concern about services being overwhelmed, it is right,
11 isn't it, there was another Executive Committee meeting
12 at which it was recommended or advised that there be
13 a six-week period of lockdown across the whole of
14 Northern Ireland; is that right?
15 A. So that's -- that's correct, and that was based on the
16 current position in terms of transmission of the
17 epidemic and modelling, in order to give the maximum
18 chance of avoiding the need for further intervention in
19 the pre-Christmas period. And again, a range of
20 different modelling was presented showing the effects of
21 having a period of strong NPIs for anywhere between
22 three weeks and six weeks, so that the Executive could
23 consider the range of options.
24 But, yes, we felt that, from the point of view of
25 short to medium-term consequences of the pandemic,

1 a six-week intervention would be indicated.
2 Q. I'm not going to take you to the notes of that minute,
3 but I think we can see that -- well, certainly it
4 appears on the face of it that there was robust
5 push-back on the part of some ministers at least in
6 terms of the advice that you were providing; is that
7 correct?
8 A. I think that there was, as I've said, at times extremely
9 robust push-back to myself and the CMO by ministers, as
10 they, you know, looked to probe the advice that we were
11 providing. And because the advice was science and
12 evidence-based, then we continued to give the advice and
13 provide explanations for it, whilst stressing the fact
14 that how the advice fed into a policy decision was
15 a matter for ministers.
16 Q. Yes, so I think we see in the notes of that meeting,
17 for example, one minister saying there's "no science
18 just assumptions" and "[I'm] sick of assumptions". So
19 it was obviously being put in a -- more critical,
20 perhaps, even than just robust. Is that right?
21 A. It was very robust, at times, the criticism and the
22 conversation. But, as I say, it did not alter in any
23 way the advice which I was giving or my analysis of the
24 situation.
25 Q. I think that your advice at that point in time wasn't

1 taken, because the decision was to have a four-week
2 lockdown rather than the advised six weeks; is that
3 right?
4 A. I think the decision was taken to have a four-week
5 lockdown. I think that was with two weeks schools open
6 and two weeks schools closed, so it was rather less than
7 the lockdown which had been used in wave 1.
8 I didn't feel at the time that my advice wasn't
9 being taken, I felt that by the majority of ministers
10 the advice had been understood, received and accepted,
11 and that ministers had appropriately factored in a range
12 of other considerations around education, economy,
13 society and family life, and, taking account of the
14 broad range of factors, had decided to go with the
15 four-week intervention that we have described.
16 So I didn't feel my advice was rejected, I thought
17 it was -- it was understood.
18 Q. All right. But the fact that it was four weeks
19 obviously meant that the decision had to come back,
20 didn't it, to the Executive Committee then on -- well,
21 we know it came back on 9 November for the first time,
22 but that four-week period was going to end on
23 12 November?
24 A. Yes.
25 Q. I think by that stage schools were back and the question

1 was whether or not to continue this almost lockdown but
2 with schools -- with children still going to school for
3 another two-week period?
4 A. Yes.
5 Q. Were you at that meeting that took place on -- well --
6 A. Between 9 and 12 November?
7 Q. Yes.
8 A. Yes, I was at all parts of it, I think, yes.
9 Q. All right. But I think it's right -- I'm not going to
10 go back to the papers that had been produced in advance
11 of that meeting, but I think it's right that, broadly
12 speaking, the advice that you were given was that if
13 this almost lockdown wasn't extended that case numbers
14 were going to -- they might arrest for a short period
15 but they were going to go up again thereafter, and that
16 hospital numbers were at quite a high base rate and
17 weren't going to decline either?
18 A. I think that's correct, that was the advice. And we
19 were very concerned about hospital numbers at that time,
20 and in particular for the possible -- possibility of
21 much higher numbers in hospitals in the post-Christmas
22 period.
23 Q. So I think what initially happened, then, just picking
24 up the decision-making process, that the recommendation
25 made by you and the CMO, and I think it was the

1 recommendation for a two-week extension, I think it's
2 right that -- was that initially defeated, as it were,
3 on a vote by the Committee?
4 **A.** So it was a long and complex meeting in multiple parts,
5 and there were, from recollection, a couple of votes on
6 different proposals. But, yes, the initial proposal
7 from the health minister, rather than based on advice
8 from CMO and myself, my recollection is that that was
9 defeated fairly early on in that 9th to 12th week
10 process.
11 **Q.** It's right, isn't it, that that was a vote that was
12 taken on a cross-community basis as well?
13 **A.** Yes, I recall that that was a vote taken on
14 a cross-community basis, yes.
15 **Q.** In terms of, and it may be that it's best that I ask you
16 about this from a principled point of view, the idea
17 that a public health measure should be voted on
18 a cross-community basis, was that of concern to you as
19 a public health -- well, sorry, as a scientific adviser
20 to the Executive Committee?
21 **A.** I mean, as you will be very well aware, the politics of
22 Northern Ireland are complicated and there are firm
23 rules in place around cross-community votes and how they
24 work. I'm not an expert on that. I recall discussion
25 and seeming agreement that it was appropriate, at least

1 in technical terms, for such a vote to be taken, and due
2 process was followed.
3 You know, from a -- I thought it was unfortunate in
4 terms of public perception, particularly given the
5 ongoing discussion of events at Executive meetings,
6 I didn't think it was helpful in terms of public
7 confidence.
8 **Q.** I wonder if it's a little bit more than just
9 a perception of public confidence, though, that as
10 a matter of principle the idea that a health measure
11 should be voted on on that sort of basis, whether
12 that -- and again I ask it as a matter of principle --
13 whether or not that was a matter of concern.
14 **A.** So you'll appreciate maybe that I would prefer,
15 you know, not to comment on that.
16 I think it was unfortunate, I think it was not
17 helpful in terms of public perception and confidence in
18 terms of decision-making. The evidence would suggest
19 that consistent public messaging is important to
20 maintaining confidence and helping with adherence to
21 regulations, and I felt in that context it was not
22 helpful. Beyond that, I can't really say anything.
23 **Q.** Thank you, Professor Young.
24 I mean, obviously this meeting carried on over the
25 course of a number of days and I think -- again, I won't

1 take you to the papers on it, but there were a series of
2 ministerial papers, weren't there, suggesting other
3 courses that might be taken in opposition to having --
4 or to taking your advice; is that right?
5 **A.** Well, I think all of the papers took account of our
6 advice, and I wouldn't want to say otherwise, and we
7 provided advice, I think, in relation to almost all of
8 the proposals that were brought forward when asked to do
9 so. I do recall, yes, that there were a series of votes
10 and proposals during the course of that week before
11 eventually a decision was made, yes.
12 **Q.** I think one of the papers that Minister Long brought
13 forward was effectively to try and broker a compromise,
14 is that right, between different ministers, and I think
15 she suggested that there be a week extension rather than
16 two weeks?
17 **A.** So there were a number of papers which brought forward
18 different proposals from different ministers. I can't
19 really comment on whether individual ministers were
20 seeking to find a compromise or not. Certainly I recall
21 Minister Long brought a paper forward and we commented
22 on that in terms of advice around the likely
23 implications of following those recommendations.
24 **Q.** And I think it's right that during this there was the
25 generation of further papers, and we can ask

1 Minister Swann about this, but effectively addressing
2 why some of the suggestions would nonetheless not --
3 wouldn't protect, for example, the health services in
4 Northern Ireland or wouldn't provide a wholesale answer
5 to the concerns that you had.
6 **A.** Yeah, I mean, I can remember that the various papers
7 differed, sometimes in quite small ways, sometimes in
8 slightly more substantial ways, in terms of what was
9 being suggested. I think we reached a point where we
10 said: well, look, in terms of advice, we can just say
11 this would be a little worse, this would be a little
12 better, we can't possibly model in any meaningful sense
13 what the difference between this paper and the last
14 paper would be, but overall the potential outcome in
15 terms of short to medium-term transmission of the
16 epidemic would look like this. And certainly there were
17 a number of different versions and a lot of intense
18 discussion about them.
19 **Q.** Yes, and I think there was then another cross-community
20 vote as well, wasn't there -- there were two across this
21 period?
22 **A.** Yeah, I recall a second cross-community vote, yes.
23 **Q.** I won't ask you about that, but presumably your position
24 is precisely the same about that one, that it wasn't
25 helpful to public perception and confidence?

1 **A.** I think that's what the evidence would suggest, that
2 clear and consistent messaging and decision-making is
3 important to public confidence and adherence to
4 behaviours.
5 **Q.** I think the net result of all of this, Professor Young,
6 was that there was a one-week extension of the
7 restrictions that were in place, and again with children
8 attending school; is that right?
9 **A.** Yes, that's my recollection, yes.
10 **Q.** And that meant that this issue came back before the
11 Executive Committee once again, a week later, for
12 further decision-making about what to do?
13 **A.** As we had advised that it would probably need to come
14 back, yes.
15 **Q.** I think, and perhaps we can just have a look at the
16 advice, because what was plainly an issue then was what
17 impact that period of restrictions had had; is that
18 right?
19 **A.** Yes.
20 **Q.** I think is it right, and I think we can trace this
21 through a number of your papers, that those restrictions
22 hadn't had the impact that you hoped they would have?
23 **A.** So I'm aware of a comment, I think in handwritten notes,
24 to that, to that effect.
25 I think, looking back, we had observed R falling to

1 around 0.7 during the first lockdown when there was
2 a very high level of adherence and compliance to the
3 restrictions in place. I think while schools were
4 closed we observed R falling to a little bit less than
5 0.8, so -- and indeed evidence suggested that adherence
6 to the restrictions was not as good as it had been in
7 the first lockdown. So in some -- that was probably
8 unsurprising. And then with schools open again, R rose
9 further and was probably not very far below 1.
10 So certainly if the intention had been to try to
11 reduce R to 0.7 to 0.8, it was unsuccessful; R had been
12 a bit higher than that.
13 **Q.** Just in terms of picking up where this left things,
14 then, I think we come back to 19 November and I think
15 the concern remained at this point that health services
16 were still at risk of being overwhelmed; is that right?
17 **A.** So throughout that period, and I think we saw it from
18 deaths earlier, but you'd have seen something very
19 similar in terms of hospital pressures, we were really
20 sitting at a very high plateau, going up and down
21 a little bit. In order for those pressures to be
22 reduced, it needed a sustained reduction in R,
23 preferably close to 0.7, for four to six weeks, which is
24 what we had originally suggested. We'd failed to
25 achieve that and therefore the hospital pressures

1 remained really very high.
2 **Q.** I think it's right, although I can take you to a paper
3 to demonstrate this, the effect of the way the decisions
4 were made meant that when it got to the -- after that
5 19 November, the restrictions that had been in place
6 lapsed and there was then a week's period where
7 non-essential retail re-opened.
8 **A.** So I think -- I think that is correct, but I would need
9 to go back to --
10 **Q.** I will take you to a document, yes, because I think it's
11 important we get this right.
12 **A.** Yeah.
13 **Q.** I think if we are able to, please, it's INQ000422247.
14 I think if we look at page 3, please, so I think if
15 we ...
16 **A.** So the third line down, comments to cafés and
17 non-essential retail being open this week, if that's the
18 point?
19 **Q.** Yes, that was what I was looking for.
20 **A.** Right.
21 **Q.** And we will see this traced -- the impact of that,
22 I think, traced into the other data that you then went
23 on to consider.
24 So that, I think, was on 23 November,
25 Professor Young.

1 I think if we could then, just -- it may help us, it
2 may not be possible to go to this, but if we can, it may
3 help -- INQ000304288.
4 **(Pause)**
5 We may not have that, Professor; I'm just looking.
6 One second, apparently.
7 **(Pause)**
8 So I think this is a meeting note, and I think on
9 page 2, in the fourth point -- yes, sorry, it's your
10 advice, or what you said, which is said under "[Deputy
11 First Minister]".
12 **A.** Yes.
13 **Q.** So I think we do see recorded here that there was
14 nowhere near what had been achieved with the
15 stay-at-home message in wave 1:
16 "Still scope to open up ... after [11th] ..."
17 I think still making the point about not able to
18 have everything open at once.
19 I think if -- thank you.
20 I'll just pick up the thread, then, if I may, with
21 INQ000286272.
22 **A.** So just a brief comment on that: you'll also note that
23 I had not seen any of these prior to the Inquiry, and
24 again, you know, can't comment on the accuracy of the
25 note that has been made.

1 **Q.** Of course. Sorry, Professor Young, and just to be
2 clear, I think when you said there was a handwritten
3 note about the stay-at-home message not being --
4 **A.** Yes.
5 **Q.** -- not having gotten through --
6 **A.** Yes.
7 **Q.** -- I think there may be, and I think we also see it in
8 this note as well.
9 **A.** Yes.
10 **Q.** I think if we can go to the other document, so this is
11 8 December, and I think if we can -- I'm just looking to
12 see where it says this; it may be over the page.
13 Yes, so this was the point that I wanted to pick up.
14 So in terms of the impact of that one week, what appears
15 to have been a relaxation in measures, it does appear
16 that that was then translating into an increase in cases
17 at this particular time, and it was that that I wanted
18 to ask you about. I don't know if that has jogged your
19 memory about that, that it --
20 **A.** No, I think that's -- I think that's correct. I mean,
21 that's what we observed at the time in terms of -- in
22 terms of the data.
23 And I think testing was relatively constant at that
24 stage, from memory, so case numbers always have to be
25 interpreted in the light of any changes in testing which

1 might have taken place. For example, when it came to
2 Christmas we saw for two or three days a big drop in the
3 number of cases. That was just because people weren't
4 getting tested.
5 **Q.** Yes.
6 **A.** So, you know, you've always got to take account of
7 testing, but I think it was fairly constant at this
8 stage so that that one week of relaxation did have that
9 effect.
10 **Q.** I think -- I won't go through all of the documents that
11 I think show us this, but I can, Professor Young, if you
12 do want to see it, but we saw it in the graph that we
13 looked at at the very outset, that notwithstanding the
14 steps that had been taken, the four-week lockdown
15 extended by a week, that nonetheless the rates continued
16 on an upward trajectory at that point in time.
17 **A.** So I think that -- I think that rates came down a little
18 bit during the four weeks plus one week.
19 **Q.** Yes.
20 **A.** But because R didn't get down anywhere close to 0.7,
21 then the drop-off in transmission was less than it could
22 have been in ideal circumstances, and we then saw
23 an upward trajectory, yes, in the run-up to Christmas as
24 behaviours began to alter and there were further
25 relaxations, as indeed is reflected in what we expected

1 to happen in the notes of various meetings leading up to
2 that.
3 **Q.** Yes. And obviously at this point in time we know that
4 there were also the discussions about Christmastime as
5 well --
6 **A.** Yes.
7 **Q.** And I think the way that it was put in Northern Ireland
8 was "protecting Christmas", that may have been used in
9 other places as well, but I think we see that in some of
10 the papers.
11 **A.** There was certainly a desire, at the end of what had
12 been an extraordinarily difficult year, to allow people
13 some degree of mixing and, if not normality, at least
14 interaction around the Christmas period. Our advice
15 emphasised the difficulty that we would have in terms of
16 predicting the impact of that, but that it was
17 overwhelmingly likely to lead to a significant increase
18 in virus transmission. We were particularly concerned
19 about the likelihood of mixing between younger people
20 and older individuals over the Christmas period, who
21 would be at more risk.
22 In addition, traditionally very large numbers of
23 young people in particular return to Northern Ireland
24 from universities in the run-up to Christmas, and we
25 were also concerned about additional introduction or

1 seeding events as a consequence of people coming back
2 into Northern Ireland. So it was a complex situation,
3 difficult to predict, but we knew that it would lead to
4 problems after Christmas.
5 **Q.** Just in terms of trying to understand why,
6 notwithstanding the steps that had been taken in terms
7 of having that four-week lockdown, then an extra week,
8 I know there was that period in between and then I think
9 there's another two-week --
10 **A.** So --
11 **Q.** -- set of restrictions. Sorry, to finish the question,
12 it's really to try and understand why, notwithstanding
13 the fact that there were certainly for points during
14 that period some quite severe restrictions, that
15 nonetheless we see the second wave take the shape that
16 it does.
17 **A.** So there's a document which went to SAGE, of which I was
18 one of the co-authors, and its number is INQ000396813,
19 which compares the autumn interventions in the four
20 countries of the UK, it's a scientific analysis, and it
21 runs with the interventions up to about the middle or
22 end of November, so a significant amount of the period
23 that we're covering. What it shows is that the
24 decisions and interventions made in Northern Ireland
25 were the most effective of the interventions in any of

1 the four nations of the UK, very clearly the most
2 effective.
3 So I think that the decisions which were made were
4 effective, but not as effective as perhaps we would have
5 needed them to be, and some of that relates probably to
6 the timing of the interventions as well as the nature of
7 the interventions. I think the interventions were
8 effective, but always, as we said at that time, earlier
9 intervention is better than later intervention. And
10 earlier interventions of that kind at a lower point on
11 the epidemiological curve probably would have had
12 greater benefit.
13 But I think the evidence and analysis suggests that
14 the interventions in Northern Ireland were good
15 interventions, and to say more effective than those in
16 England, Scotland or Wales.
17 **Q.** Just I want to unpick, if I may, some of that, and first
18 of all without comparing to the rest of the UK, just
19 understanding what happened in Northern Ireland,
20 because, as we've seen, the picture of the second wave
21 obviously demonstrates a larger number of deaths over
22 a greater period of time; correct?
23 **A.** Than --
24 **Q.** Than in wave 1.
25 **A.** Than in wave 1, yes.

1 **Q.** We've seen from the evidence that there was clearly
2 concern in wave 2 -- and we've seen it -- you have the
3 concern at the time that the stay-at-home message wasn't
4 working; correct?
5 **A.** It wasn't -- yes, it wasn't working as effectively as in
6 wave 1, yes.
7 **Q.** As effectively?
8 **A.** Yes.
9 **Q.** Of course.
10 So one can assume, then -- well, perhaps one can't
11 assume, Professor Young.
12 Let me ask you whether or not the concerns about
13 public confidence, for example, around decision-making
14 might be borne out in terms of people not adhering to
15 measures in the way that they had done in wave 1?
16 **A.** My -- and this is an opinion rather than borne out by
17 evidence, okay? My opinion was that during wave 1 there
18 was a very acute level of worry and concern about the
19 implications of the pandemic, and that that resulted in
20 a very, very high level of adherence among the general
21 population to messaging, and messaging was clear and
22 consistent, and I'm not aware of any significant
23 departures from that in Northern Ireland during wave 1.
24 By the time we reached the autumn of wave 2, there
25 had been time for a lot more critical opinion to emerge,

1 and that included less consistent messaging, probably,
2 from people in positions of influence.
3 You have highlighted politicians at some stage, but
4 there were also other influencers, if I can use that
5 term, people with constituencies and audiences, some
6 scientific, some general members of the public, popular
7 in other spheres, who were expressing significant
8 reservations about a range of the responses to the
9 pandemic, whether it be wearing face coverings or the
10 need for social distancing or lots of other things. And
11 all of that I think fed into less adherence to the
12 messaging, including the stay-at-home message, during
13 the second wave than in the first wave.
14 I don't think inconsistency, observed inconsistency
15 disagreements, among political leaders was helpful in
16 terms of public confidence, but I think that the
17 difficulties and challenges to public confidence had
18 a significantly broader basis than just, for example,
19 decision-making at the Executive and how that was
20 portrayed.
21 **Q.** If you're right about the idea that it was just
22 generally becoming more challenging to promote adherence
23 during the second wave, one assumes it wouldn't help
24 having decision-makers themselves making public the fact
25 that they were in disagreement?

1 **A.** No. And I've already said that I don't think that was
2 helpful.
3 **Q.** Yes. I won't press you on that, but can I just go back
4 again to the epidemiological question of the week when
5 restrictions lapsed and there was obviously an increase
6 in people going to shops and all the rest of it, that
7 25% increase in cases, you said at the outset you would
8 start to see the consequences of that --
9 **A.** Yeah.
10 **Q.** -- a couple of weeks down the line in respect of
11 admissions to hospitals and then a much longer period of
12 time, potentially if one was looking at the fatality
13 rate; is that correct?
14 **A.** That's correct, yes. I mean, typically around ten days.
15 Now, it depends a bit where the increase in cases is
16 occurring. If the 25% increase in cases in that week
17 was predominantly in young people, then there would have
18 been very few direct hospital admissions which would
19 have resulted from that, but still those young people,
20 by virtue of mixing with older people at home or
21 elsewhere, would have led to increased cases in older
22 segments of the population, and it's that which would
23 have led through, possibly after slightly further delay,
24 to an increase in hospital admissions, with all of the
25 consequences that flowed from that, including,

1 unfortunately, deaths.
2 Q. Okay. I didn't want to make it too simplistic, but
3 insofar as one can see, then, the peak reached in
4 January 2021, in your opinion was that attributable to
5 the measures that were in place over the Christmas
6 period or was it a cumulative effect of everything that
7 had happened in the course of December, or something
8 different entirely?
9 A. The cumulative effect of what had happened from the end
10 of September meant that we had a very high baseline
11 running into the two weeks before Christmas.
12 The observed consequences in January were
13 predominantly a result of the two weeks before
14 Christmas.
15 Q. Thank you, Professor.
16 I think just to -- I think to square that, if we
17 just go to the -- I think this is the final document,
18 INQ000422563.
19 Forgive me, that's the wrong document. It's
20 INQ000276571, and paragraph 3, please.
21 So I think we see, in fact, that that is essentially
22 the demonstration of the advice that you had been giving
23 for some time leading up to that period?
24 A. Yes, I mean, unfortunately. And those consequences need
25 to be weighed up with the benefits to the economy and

1 broader society and family relationships of having those
2 relaxations in the pre-Christmas period, yes.
3 Q. Just in terms of the general point --
4 A. Yes.
5 Q. -- and of course that's a matter of balancing up
6 different considerations, but I think it is right
7 there's no doubt that the advice that you gave before
8 Christmas was that this would effectively be the
9 outcome?
10 A. The modelling which was conducted by my colleagues and
11 myself -- working with me, to whom I'm very grateful,
12 was in general very good and, you know, this was in line
13 with what we had suggested would be likely to happen
14 based on our modelling. Unfortunately close to the
15 upper end of --
16 Q. Yes.
17 A. -- of the limits.
18 Q. That's what I was going to ask you. The modelling did
19 in fact foretell what would happen in terms of that peak
20 in January 2021?
21 A. Yes, we were always very keen to say, and I need to
22 repeat it, modelling is not a prediction.
23 Q. Yes.
24 A. But in fact what happened was very much in line with the
25 modelling that was done, yes.

1 **MS DOBBIN:** Right. I think, my Lady, if I break off there,
2 I think there are some other questions from other
3 core participants.
4 **LADY HALLETT:** I think there is a question on which I have
5 given permission a minute ago.
6 Thank you, Ms Campbell.
7 **MS CAMPBELL:** Thank you, my Lady, and we all know the risks
8 of asking a question that you've only just identified
9 but I'll do my best.
10 **Questions from MS CAMPBELL KC**
11 **MS CAMPBELL:** Professor Young, I want to revisit with you
12 just briefly the period of September to October 2020,
13 and we're very familiar now with where the peak starts
14 to rise on some of the charts that we've looked at in
15 your evidence this afternoon.
16 In order to assist you, I wonder if we can look at
17 paragraph 121 of your statement.
18 121 deals, at the outset, with the SAGE meeting of
19 21 September 2020. It will come up in a moment.
20 **(Pause)**
21 Sorry, I should say -- it would be helpful if I gave
22 a page number -- it's page 44.
23 **(Pause)**
24 There we are. The very top paragraph, you were
25 asked about this briefly just after the break this

1 afternoon, and the point that we are interested in, we
2 have the 21 September SAGE meeting which, as you've set
3 out, recommends the consideration of a package of
4 measures, including a circuit-breaker, such were, if you
5 like, the statistics and the modelling at that point in
6 England.
7 Do you recall that portion of your evidence?
8 A. Yes.
9 Q. You were asked about it in the context of paragraph 422
10 of the Chief Medical Officer's statement, which in fact
11 correlates almost precisely with your statement at 121,
12 so there is that, if you like, comfort for you.
13 But this statement makes clear that on 21 September
14 we have SAGE recommending consideration of a package of
15 measures, including a circuit-breaker, which as we know
16 went on to become, if you like, controversial in the
17 context of Northern Ireland. You say:
18 "At that stage hospital pressures in
19 [Northern Ireland] remained relatively modest, and it
20 was not until early October that the [Chief Medical
21 Officer] and I advised that significant intervention was
22 required ..."
23 App you did so at the Executive meeting of
24 8 October. Do you see that?
25 A. Yes.

1 **Q.** Now, building on your evidence that really early
2 intervention is better intervention, that's what you've
3 told us this afternoon, the earlier the better, and to
4 some extent Northern Ireland had benefited from earlier
5 intervention in March 2020 and we saw that when we
6 looked at the graph of wave 1, here we are in September,
7 the R number is consistently above 1, and on
8 21 September SAGE is recommending a series of measures
9 including and up to circuit-breakers.
10 Now, the rule still applies really for
11 Northern Ireland: early intervention is better
12 intervention, isn't that right?
13 **A.** Yes, it applies everywhere, yes.
14 **Q.** If it is the case, as you say in your statement here,
15 using your words, it was not until early October that
16 the CMO and you advised that significant intervention
17 was necessary, and you did so at the meeting of
18 8 October, there will have been a period of slippage
19 from 21 September until the papers that you exhibit in
20 this statement are drafted, 6 October, 7 October and the
21 meeting of 8 October. Do you see the point?
22 **A.** So a couple of comments on that. So, first of all, what
23 SAGE recommended on 21 September was consideration --
24 **Q.** Yes.
25 **A.** -- of the measures, and indeed the measures were

1 considered, and I think if we look at -- and I think,
2 from memory, it's the Executive meeting of 24 September,
3 we tabled SAGE's advice along with discussion of the
4 epidemiological position within Northern Ireland, and
5 the current state of play.
6 So all of that information was provided. The timing
7 of interventions and, you know, what I've said and what
8 I agree with is that earlier -- the earlier the
9 intervention and the more stringent it is, and the
10 longer it lasts, the better, in terms of the
11 transmission of the virus, but that needs to be weighed
12 up against the other considerations around
13 an intervention, including the extent to which it's
14 likely to be accepted by the public, and the economic
15 damage, the damage to society, and the educational
16 damage that would result.
17 So the timing of a recommendation coming forward,
18 which came forward from the department, not from myself
19 and the CMO, but it was a recommendation in line with
20 our advice which came through on 8 October, but the
21 information, all of the information from SAGE and about
22 the epidemiology of the pandemic, had been made very
23 clear to the Executive at earlier meetings.
24 **Q.** In fact if we look at the handwritten minutes or the
25 handwritten notes, I should say -- and I don't ask for

1 them to be put up -- the CMO makes clear in this meeting
2 of 8 October that he had never been so concerned as he
3 was until that point, okay? It may be that you don't
4 recollect that at this juncture.
5 Certainly taking him at his word, by 8 October there
6 was a sense of urgency in relation to decisions that
7 needed to have been taken.
8 **A.** Well, I think as we saw earlier in my evidence, both the
9 CMO and I were very keen on an intervention at the
10 meeting on 8 October and would have supported it, in
11 terms of the short to medium impacts on transmission of
12 the virus. I think that's the meeting where there was
13 quite a lot of pushback, and we'd have to get the
14 minutes up and have a look at it in terms of the
15 damaging nature of the intervention or response which we
16 were asking for.
17 So, you know, there was a degree of urgency, there
18 was a sense that the hospital system would have
19 difficulty coping with the pressures probably in
20 two weeks' time. In fact the pressures became much
21 worse later that autumn and winter than we had even
22 anticipated.
23 **Q.** Finally, given that that urgency was there on 8 October,
24 and given that the warnings had been clear at least from
25 21 September at that SAGE meeting, was there a window of

1 opportunity in which earlier intervention in that period
2 of time would have been better intervention for autumn
3 and winter 2020?
4 **A.** I think if you go back to look at the minutes of the
5 SAGE minute from 21 September and the modelling which
6 was presented to SAGE at that time through SPI-M, it
7 didn't flag up particular concerns about
8 Northern Ireland, but did flag up considerable concerns
9 about other parts of the UK. So where we were in terms
10 of the epidemic curve was not the same, I think, as it
11 was in parts of Great Britain. But the general concept
12 that the earlier the intervention, the more stringent
13 the intervention and the longer it lasts is better in
14 terms of the short to medium-term impacts of virus
15 transmission. That's absolutely true, and it was true
16 then, as it was true at other parts of the epidemic.
17 **MS CAMPBELL:** Thank you.
18 **LADY HALLETT:** Thank you, Ms Campbell.
19 Thank you very much for your help, Professor Young,
20 I'm very grateful.
21 **THE WITNESS:** Thank you.
22 **LADY HALLETT:** I'm not sure whether I can give you any
23 undertakings of not imposing on you again, but thank you
24 for your help so far.
25 **THE WITNESS:** Okay, thank you.

1 **(The witness withdrew)**
2 **MS DOBBIN:** I'm going to let Professor Young go. I think he
3 can be excused.
4 **LADY HALLETT:** Thank you.
5 **MS DOBBIN:** My Lady, there is a short matter that arises
6 about the witness list for tomorrow. You were due in
7 fact to hear a marathon five witnesses tomorrow, and one
8 of those witnesses has been taken ill, that's
9 Mr Conor Murphy, who you were due to hear from. I think
10 he has made an announcement himself that he has been
11 advised by his doctor, pending some medical tests coming
12 back, that he has informed the Inquiry that he won't be
13 able to attend the hearing tomorrow on medical advice.
14 So, my Lady, we will revisit that with you, but
15 certainly for the purposes of tomorrow he has been stood
16 down.
17 **LADY HALLETT:** Okay. If it ends up that we finish the
18 hearings here and he can't give evidence, is the
19 material that he provides material that can be covered
20 in other ways, including obviously his written
21 statement?
22 **MS DOBBIN:** Yes, and I think there are other witnesses to
23 whom we could put questions that might help illuminate
24 some of the points he has made.
25 **LADY HALLETT:** I'm sure the core participants will help if

1 they can, if there are any matters they want to ...
2 Thank you very much, 10 o'clock tomorrow, please.
3 **(4.30 pm)**
4 **(The hearing adjourned until 10 am**
5 **on Wednesday, 8 May 2024)**
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