Witness Name: Richard Pengelly

Statement No:

Exhibits:

Dated:

UK COVID-19 INQUIRY

WITNESS STATEMENT OF RICHARD PENGELLY CB

I, Richard Pengelly, will say as follows: -

1. I have written this statement to the best of my recollection of events and key decisions as they occurred. Given the rapidly evolving situation during the pandemic, it is inevitable that some of my recollections may be incomplete. My views set out below are based on the Department's position on these issues during my tenure as Permanent Secretary of the Department throughout the specified period. I have sought input from policy and professional colleagues across the Department of Health to help prompt my recall of events. Information about decisions and the decision-making process set out in this statement, as requested by the Inquiry, has been provided by the appropriate policy expert or lead official within the Department of Health and agreed by me.

Section 1: Introduction

2. On 1 July 2014, I took up post as Permanent Secretary in the then Department of Health, Social Services and Public Safety – renamed in 2016 as the Department of Health (both iterations of which I will refer to as "the Department"). I remained in this post until 4 April 2022, when I moved to the post of Permanent Secretary in the Department of Justice. Prior to July 2014, I had been Permanent Secretary in the Department for Regional Development (now the Department for Infrastructure).

3. As Permanent Secretary of the Department of Health and the Chief Executive of Health and Social Care (hereafter referred to as "the HSC") my main responsibilities, both before and after the collapse of the power sharing Executive in January 2017, involved providing leadership and direction to the Department and the HSC system to ensure that the Department's statutory responsibilities under the Health and Social Care (Reform) Act (Northern Ireland) 2009 and the Health Minister's (hereafter referred to as "the Minister") priorities were effectively discharged. The Act requires the Department to promote an integrated system of health and social care designed to secure improvement in: the physical and mental health of people in Northern Ireland (hereafter referred to as "NI"); the prevention, diagnosis and treatment of illness; and the social wellbeing of people in Northern Ireland. I was also the Department's Accounting Officer and the Principal Accounting Officer for the HSC responsible to the Northern Ireland Assembly (which I will refer to as "the Assembly") for the stewardship of the Department's resources including its allocated annual budget of approximately £6 billion. I was also responsible for the corporate governance of the Department, ensuring that effective governance procedures and practice was fully implemented. During the normal operation of the Assembly, when the Department had a Minister in place, I was also the principal policy adviser to the Minister in relation to the discharge of the Department's statutory responsibilities and functions. Prior to the pandemic the principal differences in my responsibilities as Permanent Secretary during the period leading up to the pandemic, when the power sharing arrangements were not in place, were influenced by the constraints placed upon the Department in relation to the exercise of its functions and related decisions which normally would have been taken by the Departmental Minister. During this period, the powers of the Department to exercise its functions were set out in Section 3 of the Northern Ireland (Executive Formation and Exercise of Functions) Act 2018, as exercised in line with guidance published by the UK Government. The Act and supporting guidance established the framework for decision making in NI departments during suspension. There were a range of general consequences for the Department arising from

the limitations on powers which could be exercised by the Department and from the fact that there was no Minister in place. The consequences included: the limited ability to take decisions; the policy and financial uncertainty; and constraints on opportunities to act on NI Executive (which I will refer to as "the Executive") cross-cutting issues.

4. The main difference between the role of the Department of Health Permanent Secretary in NI as compared to their counterpart in Westminster is that, while both roles cover the position of Accounting Officer of the respective Department and lead policy advisor to the Minister/Secretary of State, in NI (and, I understand, in Scotland and Wales), the post holder is also the Chief Executive of the Health and Social Care System (uniquely, NI has an integrated system of Health and Social Care). It is important to note that, unlike in England (where there is a separate post holder for Chief Executive of the NHS), the HSC system has no separate legal or organisational status and is effectively a collection of a number of individual organisations.

5. I understand that, in early 2021, in Whitehall a second Permanent Secretary post was created in the Department of Health and Social Care to focus on non-Covid related issues, leaving the first Permanent Secretary to prioritise his time on Covid work. We didn't follow this approach in NI, but instead adopted a working arrangement where I tended to focus on the governance, staffing, funding and delivery of health and social care services for both Covid and non-Covid patients (particularly as we moved into the rebuilding phase) with the CMO prioritising NPI matters such as regulations, test and trace and the vaccination programme. This is not to suggest I wasn't involved in NPI matters, but rather my engagement was more at the stage of the development of Executive papers and associated discussion, rather than at an earlier stage.

6. The Northern Ireland Civil Service follows the guidance set out in the Northern Ireland Civil Service Code of Ethics (RP/1 - INQ000400030) which states that:

> *individual civil servants are accountable to their Department's Minister, who in turn is accountable to the Assembly. All civil servants have a shared responsibility to support the work of the Executive as a whole, including the contribution of their Minister to the Executive.*

7. Similarly, Ministers are expected to adhere to the Northern Ireland Executive Ministerial Code which sets out the rules and procedures for the exercise of the duties and responsibilities of Ministers and junior Ministers of the Assembly. Taken together both documents provide a workable framework for conducting the business of good government in Northern Ireland (which I will refer to as "NI"), enabling senior civil servants to provide advice to Ministers or to implement policy in Northern Ireland, irrespective of whether individual Ministers may be in political or ideological opposition to each other. It is only when this framework breaks down that challenges to the power sharing arrangements present to senior civil servants.. Such challenges are usually met by dealing with contentious issues through tried and tested policy making procedures involving generating options to narrow the areas of difference and ultimately identify common ground to resolve such matters. Such approaches are adopted by senior civil servants whether they be serving governments based on a parliamentary majority, voluntary coalition or the power sharing arrangements unique to NI. Conducting business within a muti-party coalition can be a slow process due to the need for the senior civil service to engage with a range of Ministers on cross-cutting issues. In a time of emergency, such as the pandemic, where the situation is uncertain, evolving and often fast moving the process for engagement within a multi-party coalition Executive is not always conducive to the necessary rapid decision-making needed to respond to the threat to the health and wellbeing of the population arising from the pandemic. This on occasion made the role of the senior civil service, particularly the CMO and the Department's Chief Scientific Adviser (who I will refer to as "the CSA"), more challenging in reaching decisions by the Executive within a timeframe which provided feasible time to fully develop policy interventions and enact the associated regulations. This resulted in a pressurised working environment for both Ministers, professional advisers and civil servants.

8. In general, the Department's advice to the Executive Committee in relation to key decisions to be taken by the Executive was approved and submitted by the Departmental Minister to the Executive via the normal machinery of government arrangements for submitting papers. The Departmental papers covering public health protection policy matters were developed by officials within the Department's CMO Group based on the professional medical and scientific advice of the CMO and CSA drawing from a range of sources of information including the Scientific Advisory Group for Emergencies (which I will refer to as "SAGE") and the Department's Strategic Intelligence Group (which I will refer to as "SIG"). I worked alongside CMO and CSA in discussing and refining this advice with the Minister, supported by his Special Adviser, in the usual way that policy advice is developed within departments albeit working at a faster pace due to the evolving situation resulting from the pandemic. I had

no specific role in providing advice directly to the First Minister, deputy First Minister or other Executive Ministers. Where necessary I would engage with senior civil servants from other Executive departments on aspects of shared departmental interest and represented the Department on inter-departmental groups such as the Civil Contingencies Group (Northern Ireland), which I will refer to as "CCG(NI)", and the Executive's Covid-19 Taskforce. While I was not party to bilateral communications between the Minister and his Special Adviser my impression in general was that he supported the Minister during the pandemic no differently than during normal times by adding the political dimension to the advice and assistance available to Ministers expected from Special Advisers. I have no recollection of any other Special Adviser having a particularly prominent role – and I had no bilateral dialogue with any Adviser on pandemic related issues (other than one occasion when the Education Minister's SPAD contacted me to request a meeting between his Minister and the CMO).

9. I am married to one of the Special Advisers to the then First Minister during the pandemic. There were no specific rules in respect of this issue, but rather it is covered, as with all issues, by the NICS Code of Ethics. The pandemic did not alter this, and the relationship was not an additional line of communication between the Department and the First Minister.

Section 2: Mandatory Coalition and Executive Decision Making

10. The system of government in NI, often referred to as mandatory coalition, and how the functioning of this form of government, unique within the UK, impacted upon the decision making of the Executive Committee during the pandemic is an area of the response to the pandemic which will be of interest to the Inquiry and the public.

11. In my view the interaction between the UK Government, the Irish Government and the NI five main political parties which resulted in the 'New Decade New Approach' Agreement contributed to the newly formed Executive's ability to move smoothly into the role of government in early-2020 notwithstanding the pressures of combatting the pandemic which soon consumed the normal business of government. 'New Decade New Approach' was published by the UK and Irish Governments to pave the way for the restoration of the devolved government following several months of discussion with the NI five main political parties in late 2019. The Agreement committed to a multi-year Programme for Government, underpinned by a multi-year budget and legislative programme. The parties agreed that the immediate priorities for the restored Executive would be: transforming the health service with a long-term funding strategy; immediately settling the ongoing pay dispute with the trade unions

representing the HSC Agenda for Change workforce; introducing a new action plan on waiting times; and delivering reforms of health and social care as set out in the Bengoa 'Systems, Not Structures: Changing Health and Social Care' report [RP/2 - INQ000185456 (DoH Ref: RS0034)], the 'Health and Wellbeing 2026: Delivering Together' report [RP/3 - INQ000185457 (DoH Ref: PM0352)] and 'Power to People: proposals to reboot adult care and support in NI' report [RP/4 - INQ000191268]. The indications were therefore encouraging in January 2020 that progress would be made but unfortunately this was soon overtaken by the onset of the pandemic and the resulting diversion of energy and resources at all levels of government in NI to manage the response to Covid-19. I welcomed the restoration of the Executive, and specifically the commitments made in 'New Decade New Approach'. With the benefit of hindsight, it was fortuitous that the Executive was restored simultaneously with the onset of the pandemic as it is difficult to see that we could have performed effectively during the initial stages of the pandemic without a functioning government as the NI Civil Service would have been operating under the provisions of the NI (Executive Formation and Exercise of Functions) Act 2018 which restricted the decision-making powers of Departments. A more hands-on approach to governing NI from Westminster both at governmental and parliamentary levels would have been needed. This would have required emergency legislation to be passed amidst the other administrative and legislative pressures placed on the UK Government in the early period of the pandemic.

12. The fact that the NI's five main political parties had been engaged in intensive discussions with the UK and Irish Governments immediately before the pandemic, to iron-out the 'New Decade New Approach' Agreement, had helped to create a climate of cohesion between the Ministers forming the new Executive. This is likely to have assisted the restored Executive's capacity to take decisions although making decisions related to pandemic policy interventions broke new ground and was not an easy matter for governments of any complexion to address across the UK and internationally. The talks between the five parties in late-2019 had also involved senior officials from the NI departments in providing briefings about the priorities and challenges facing departments. This in my view, also helped to assist cohesion within the incoming Executive, by continuing to build relationships between the politicians and the senior civil service who had previously worked together prior to suspension of the Executive in 2017 and had maintained contact throughout the period of suspension.

13. There are two key documents which set out the arrangements to ensure the effective functioning of the Executive, these are the NI Executive Ministerial Code [RP/5 - INQ000103602 (DoH Ref: PM0006)] and the NI Civil Service Code of Ethics [RP/1 - INQ000400030]. This did not differ during the pandemic.

14. While the NI Executive Ministerial Code and the NI Civil Service Code of Ethics set out the formal system and body of rules to ensure the good governance of NI, of equal importance is the way in which the machinery of government implements these rules in order to make government work effectively. In particular, the machinery of government affects the functioning of the Executive in relation to: the collective responsibility of the Executive; the interaction between Ministers and senior officials, including the timeliness of the submission of papers to the Executive; the interaction between Ministers from the different political parties which comprised the Executive; the impact that making decisions on the basis of mandatory coalition in NI had on the Executive's response to the pandemic; the political considerations which informed the positions adopted by Ministers in the response to the pandemic; and, the use made of the cross community vote procedure in decision-making in response to Covid-19.

15. Paragraph 2.4 of the NI Ministerial Code [RP/5 - INQ000103602 (DoH Ref: PM0006)] requires Departmental Ministers to bring to the Executive matters deemed to be cross-cutting, significant or controversial. Having regard to this requirement, the Department, through the CMO and CSA, provided public health and scientific advice to inform the Executive's decisions on a wide range of policy issues, including: the timing of the introduction of non-pharmaceutical interventions (NPIs); the relaxation of NPIs based on the weekly estimates of R and regular reviews of NI specific modelling. This advice informed Executive decisions on NPI countermeasures and included information on the trajectory of the pandemic in NI and approaches to contain and mitigate the impact, including relative and cumulative impact of the virus based on evidence from SAGE.

16. Therefore, during the pandemic key policy decisions in respect of NPIs were taken by the Executive or the Minister of Health on the basis of medical, scientific and other expert advice submitted to Ministers. In practice, the majority of advice on NPIs given to Ministers was developed by the CMO, CSA and other policy lead officials in this area. Similarly, decisions taken by the Minister concerning the delivery of health and social care services were also informed by advice provided by the Department's lead policy officials and senior colleagues from arms length bodies such as, for example, the Health and Social Care Board (HSCB) in relation to the commissioning of critical care for Covid-19 patients and the Business

Services Organisation for the procurement and distribution of personal protection equipment (PPE) to the HSC. Overall, my role was to ensure that the advice met the needs of Ministers to enable them to take decisions based on the advice provided to them and to ensure that the decisions were implemented by the Department.

17. I have set out, in paragraph 8 above, the Department's approach to the development, approval and submission of advice to the Executive, and the particular role of CMO and CSA. I do not recall having any concerns as to the extent of the responsibilities held by the CMO or the CSA other than the impact on their wellbeing of long working hours and the stressful situation of their being at the forefront of providing advice to the Executive.

18. I have no particular insights about how individual Ministers would have been influenced by political considerations in their approach to decision making and I have no reason to believe that either Ministers or officials engaged in any behaviours that would have seriously undermined the provisions of the Ministerial Code or the NICS Code of Ethics. The NI Executive Ministerial Code also provides for the cross-community vote procedure. The Executive Office has responsibility for advising the Executive on the operation of decision taking including the use of the cross-community vote procedure. I don't recall being aware of any concerns expressed by the Executive Office about the use of the procedure during the pandemic. It would be speculative to comment on the impact that making decisions on the basis of mandatory coalition in NI had on the Executive's response to the pandemic. That was and remains the de facto system of government in NI.

19. I believe that Ministers and officials joined together in the newly formed Executive in a spirit of goodwill and desire to deliver for the people of NI. However, notwithstanding the intent it was arguably inevitable that there would be some issues along the way, as demonstrated in several incidences which have been brought to my attention.

20. Firstly, Baroness Arlene Foster's statement provided to Module 1 of the Inquiry:

> *"...I was however conscious at times that the Senior Officials may have preferred meetings to be limited to officials only so that they could speak more freely…There is a balance to be struck between ensuring Ministers have as much information as possible, or that they feel they need, to make decisions for which they are accountable, and*

potentially hampering the operational work of officials". [RP/6 - INQ000205274, paragraph 19].

I can understand Baroness Foster's impressions about senior officials being reticent about speaking freely in front of Ministers. That is not an uncommon perception on the part of Ministers and more often than not it is more about the natural caution of senior officials in expressing themselves, in order to ensure that Ministers fully understand the advice being offered. I am unable to recall any incidence where I felt senior officials fell short of the standards expected in the provision of the information available to officials which would enable Ministers to make effective and properly informed decisions; nor any time when Ministerial action/intervention actively hampered the operational work of officials (as distinct from legitimate Ministerial requests for information etc, having an impact on workloads for officials and hence the pace at which issues were taken forward). I accept the concerns expressed by Ministers about the timely submission of papers to the Executive. As I have stated above this was mainly due to the pressurised and evolving situation which meant that officials were keen to ensure that the information in the papers submitted to the Executive was as up to date as possible in the circumstances surrounding the frequent meetings of the Executive during the pandemic. As a general observation, I would offer my view that papers were generally produced more quickly by officials than would normally have been the case, however the pace at which events were moving meant that the time between papers and advice being available and decisions being needed was under constant pressure – it is entirely natural and understandable for Ministers to be frustrated at such a scenario.

21. Secondly, in respect of [RP/7 - INQ000065748]: the notes of the Executive meeting on 30 March 2020, in which the then deputy First Minister is noted as saying *"DoH see Exec as thorn in side"* [RP/7 - INQ000065748]; I am not aware of any such view being held by officials in the Department. However, as indicated above at a purely practical level there would have been feelings of frustration about the decision-making process.

22. Thirdly, several WhatsApp messages seem to suggest some frustration with the nature of leadership and decision making at Executive Committee level. The WhatsApp messages are: (a) Sir David Sterling, former Head of the Northern Ireland Civil Service, on 16 March 2020 to CMO; (b) Sir David Sterling to CMO on 17/03/2020 08:01:46 [RP/8 - INQ000308444, page 1]; (c) Sir David Sterling on 17 March 2020 [RP/9 - INQ000308439, page 2]; (d) CMO in a WhatsApp message of 24/03/2020 [RP/8 - INQ000308444, page 3]; and (e) WhatsApp messages of 30 March 2020 between Mr Peter May, former Permanent Secretary of the

Department of Justice, and Sir David Sterling. While it is for those that were part of the message exchanges to clarify precisely what was meant, as a general observation I would record that conducting business within a muti-party coalition can be a challenging process due to the need for engagement with a range of Ministers on cross-cutting issues. In a time of emergency, such as the pandemic, where the situation is uncertain, evolving and often fast moving the process for engagement within a multi-party coalition Executive was not always conducive to the necessary rapid decision-making needed to respond to the threat to the health and wellbeing of the population arising from the pandemic. This resulted in a pressurised working environment for both Ministers and officials. In that sense, my own view is that the difficult nature of the decisions faced, and the structures within which they were required to be considered may have, at times, been misinterpreted as less than optimal leadership and decision making.

23. Fourthly, I have reviewed the following four exhibits In relation to policy differences between Ministers which came into the public domain and have considered to what extent there was a risk that public confidence would be undermined by Ministers publicly disagreeing with each other:

- the initial differences between the then First Minister and deputy First Minister regarding the closure of schools [see for example RP/10 - INQ000083098];
- statements by Ministers criticising other Ministers (for example or around 3 April 2020, the then deputy First Minister criticised the Health Minister's handling of outbreak. Speaking on BBC NI's The View programme the deputy First Minister commented that *"Slavishly following the Boris Johnson model, which has been too slow to act, means we are not as prepared as we could be"*. However, the deputy First Minister committed to working with the Health Minister going forward. The other parties have called for the Executive to collectively work together" [RP/11 - INQ000083114]);
- Ministers apparently contradicting collective messaging (for example, the NIO SitRep of 30 April 2020 records "*There has been some public debate on the relaxing of social distancing measures with Minister Poots stating publicly that bringing back "a little bit more normality"* was needed. This appears to contradict previous messaging from his colleagues in the Executive including the Health Minister" [RP/12 - INQ000083129];

- on or around 21 September 2020, "Economy Minister Diane Dodds warned that NI *"simply cannot afford another lockdown"*. This contrasts with Robin Swann's announcement today that a NI-wide 'circuit breaker' - a 'lockdown in all but name' - cannot be taken off the table" [RP/13 - INQ000083161].

24. The Department was committed to securing public confidence in NI in relation to the outworking of decisions taken by the Executive concerning restrictions and other interventions to address the impact of the virus. This was demonstrated in the Minister and CMO's numerous media briefings and communication with key stakeholders. In this respect I am not aware of any assessment of whether alleged breaches of rules and standards by any senior political figures or civil servants, or statements by Ministers criticising other Ministers, had any material impact on the maintenance of public confidence in NI. However, such incidences were unhelpful in that they temporarily obscured the key messages which we were attempting to put across to the public via the media. My own view is that it is inevitable that such public differences will have some impact on the public's perception of the appropriateness or legitimacy of any final decisions by the Executive and/or individual Ministers. That said, I don't have any insight as to the extent of that impact – particularly as regards the implications for the public behaviour (for example, in terms of adherence to any guidance and/or restrictions in place).

25. In terms of the impact on the public's confidence in the Executive Committee's decision making in relation to any suggestion that rates of transmission were higher in nationalist areas as compared to unionist areas, I believe that the Minister and CMO would have set out the factual position on the rates of transmission at a media briefing and would hope that anyone who felt aggrieved by this suggestion would have been reassured by their comments.

26. In respect of any perceived tension between the Department of Health and other Executive departments, I believe this simply reflected different policy responsibilities – and in particular the fact that, given the complexity of the challenges faced, no options were available that perfectly met the policy priorities of all departments. Thus detailed debate was often required before a collective view would have been agreed. This reflects the conducting of policy formulation within most government settings and did not impact upon the Executive's ability to formulate a collective response to Covid-19.

27. A further area that impacts upon the functioning of the Executive is the matter of the "leaking of Executive business". I am aware of the concerns of one or more Ministers about leaks of papers for the Executive [e.g. RP/14 - INQ000065724, RP/15 - INQ000065764 and RP/16 - INQ000065757] or of the content of Executive Committee meetings being passed to journalists, on occasions while the meeting was ongoing (e.g. RP/17 - INQ000048497, page 8). I would comment that leaks of this nature are clearly not conducive to a smooth decision-making process in that they often distract from the business in hand and potentially damage public confidence in government. I am not aware of a policy (whether informal or not) of leaking proposed policies or their amendment in order to test public reaction during the pandemic. Ministers will be better placed to assist the Inquiry with observations about the impact of leaking of information about Executive decision-making upon: the decision-making processes of the Executive; and relationships between members of the Executive Committee. In respect of the impact on relationships between members of the Executive and the civil service; I would comment that while on occasion officials were frustrated by leaks they nonetheless continued to discharge their responsibilities in serving the Executive.

Section 3: Fragility of the Health System

28. As stated above, during the period of the suspension of the Executive, the Department operated under the provisions of Section 3 of the NI (Executive Formation and Exercise of Functions) Act 2018. There were a range of general consequences for the Department arising from the limitations on powers which could be exercised by the Department and from the fact that there was no Minister in place. The consequences included: the limited ability to take decisions; and the policy and financial uncertainty and constraints on opportunities to act on NI Executive cross-cutting issues.

29. I am not aware of any detailed assessment of the principal impacts of suspension in terms of: the reform of health services; the ability of health services in NI to withstand the pandemic in relation to the provision of broader health services; or the long term consequences of the suspension which continued to shape the response to the pandemic after January 2020. The Department completed a wide range of policy development and review work in relation to the actions set out in the 'Health And Wellbeing: Delivering Together 2026' 10 year strategy to transform health services [RP/3 - INQ000185457 (DoH Ref: PM0352)]. The problem was that there was no Minister in place to approve the implementation of the recommendations set out in these reviews coupled with no additional resources to fund the changes. At the start of suspension the two pressing strategic issues facing the health

service were to reduce the number of patients waiting for elective care treatment, and to transform the delivery of services to better align capacity with demand moving forward (so that such numbers would not accumulate again). The Department had started to address these issues in 2016 with the publication of 'Health And Wellbeing: Delivering Together 2026' [RP/3 - INQ000185457 (DoH Ref: PM0352)], and as part of this the publication in February 2017 of an initial 'Elective Care Plan' [RP/18 - INQ000415918 (DoH Ref: PM0459)], to reduce elective waiting lists. The Department had estimated that approximately £1 billion of additional investment would be required in total over five years to increase elective care capacity in order to reduce waiting lists to an acceptable level where waiting time annual performance targets would be met. In addition to investment in elective care, significant additional investment was needed to implement the overall transformation strategy. While an additional £200 million was allocated to the Department during suspension, from the budget allocation to NI agreed under the Confidence and Supply Agreement, this was insufficient to make significant inroads to elective care waiting lists. However, it did enable, for example, very welcome investment in the HSC workforce and in the delivery of multi-disciplinary primary care services. Given the fact that NI entered the period of suspension with a large number of patients on elective care waiting lists it cannot be said that that period led to the problem, although it is fair to say it represents a missed opportunity to at least start to address the underlying causal factors. The problems that were experienced during the pandemic involved the increase in the number of patients already waiting for elective procedures due to the need to divert service delivery from routine primary care and elective care in order to provide the services required to treat Covid-19 patients. This problem had its roots in the combination of under-investment in elective care and reform to clear the backlog before the pandemic.

30. While it is speculative as to whether sufficient investment would have been made available, had the pandemic not occurred, by the newly formed Executive to take forward the transformation of HSC service delivery and reduce elective waiting lists, there was in January 2020, following the publication of the 'New Decade New Approach' Agreement, positive signs that the required investment would be forthcoming. The indications were therefore encouraging in January 2020 that progress would be made but unfortunately this was soon overtaken by the onset of the pandemic and the resulting diversion of energy and resources at all levels of government in NI to manage the response to Covid-19. However, it is important to note that some progress was made in implementing the priorities set out in 'New Decade New Approach' over the period until the Executive collapsed in February 2022 following the resignation of the then First Minister. For example, the pay dispute was settled in early-2020, new strategies and action plans to transform elective waiting times and the delivery of mental

health, cancer, stroke, breast assessment, urgent and emergency care and day case elective care services were published. The Executive also allocated funding for a new Graduate Entry Medical School at the Ulster University campus in Londonderry and an extra 900 nursing and midwifery undergraduate places over three years. While this progress was necessary and is to be welcomed, the delivery of a multi-year budget to secure reform of HSC service delivery and to reduce elective waiting lists has still not been achieved.

31. Given the commitments made in 'New Decade New Approach' I welcomed the restoration of the Executive and ensured that the incoming Minister would be well-briefed on the principal issues facing the Department in January 2020. Detailed first day briefing was prepared for the new Minister which identified the principal issues which needed immediate or speedy consideration as priorities for action. These included: addressing the funding gap in the Department's 2020/21 resource budget which was forecast as amounting to some £380 million; securing additional investment to reduce the number of patients waiting for elective care; and settling the pay dispute with the HSC Agenda for Change trade unions in order to bring to an end the industrial action.

32. The expert panel report titled "Systems, Not Structures: Changing Health and Social Care", published on 25 October 2016 (Bengoa Report) [RP/19 - INQ000191267] commented on the detrimental impact that substantial health inequalities (seen in NI) had on the operation of the HSC system. While the Department has not carried out an evaluation of whether the absence of power sharing (in terms of its impact on health services) contributed to the deepening of health inequalities in NI, its Information Analysis Directorate has provided the following update of the information published by the expert panel in 2016.

33. The Information Analysis Directorate has commented that the information in the expert panel's report appears to include the whole population and was based on figures from the 2011 Census where 20.7% of people had a limiting long standing illness. As such no 2019 update is therefore available, however the 2021 Census noted that almost 1 in 4 people (24.3%) had an illness or condition that limited their day-to-day activities (see below). Figures based on the adult population only (16+) are available from the annual Health Survey NI[1] (see

[1] Please note that results produced from survey sources (such as Health Survey NI) are based on data collected from a sample of the population and hence are subject to sampling error. This should be taken into consideration when interpreting the results.

Tables 1, 2 and 3 below) - these have remained broadly similar over the last few years with around two-fifths reporting a long-standing illness and less than a third having an illness/condition that limited their day-to-day activities. Therefore, given that the census and survey findings have remained broadly similar during the period between 2016 and 2020/21 it seems unlikely that one of the consequences of the absence of power sharing (in terms of its impact upon health services) resulted in the deepening of health inequalities in NI. Of course, had additional investment in health services been made available during the period of suspension the findings may potentially have improved by 2021.

Table 1

Health Survey NI **Respondents aged 16+**				
		2015/16	2019/20	2021/22
Long-standing illness		42%	43%	40%
Limiting long-standing illness		31%	30%	30%
NI Population Census (source: NISRA) **All ages**				
	2011			2021
% Residents day-to-day activities limited	20.7%			24.3%

34. The 2019/20 Health Survey NI found that 65% of people were either overweight or obese (see table 2 below).

Table 2

Health Survey NI **Respondents aged 16+**		
	2015/16	2019/20
Obese & overweight (combined)	61%	65%
Obese	26%	27%
Overweight	35%	38%

35. It remains the case that almost one in five adults in NI showed signs of a mental illness as the proportion scoring highly on the GHQ-12 (indicating possible signs of a mental illness) remained fairly similar between 2015/16 and 2019/20.

Table 3

Health Survey NI **Respondents aged 16+**		
	2015/16	2019/20
High GHQ12 score (possible indication of mental health problem)	18%	19%

36. The Personal Independence Payment (PIP[2]) was introduced in NI in June 2016 to replace Disability Living Allowance (DLA) for working age claimants. The process of moving working age claimants from DLA to PIP took place from June 2016 to November 2019. It would seem that the sum of DLA and PIP (11.5%) (see below) would appear to be the closest aligned comparison to the Expert Panel report's figure of 10.3% (although this figure itself may not be wholly comparable). Also, even though the Report appears to reference the entire population, it should be noted that there is no mention of the Attendance Allowance disability benefit for those over state pension age.

---

[2] Claimant figures used in calculations for DLA, PIP and AA are from the most recent published PSU benefit data (May 2023) for volumes at February 2019.MYE figures for 2019 used in calculations were accessed from NISRA data portal (https://data.nisra.gov.uk) on 5th December 2023. PIP was introduced in NI in June 2016 to replace DLA for working age claimants. The process of moving working age claimants from DLA to PIP took place from June 2016 to November 2019.
*DLA and PIP volumes have been summed to provide a proportion of the NI population.
Source Department for Communities (DfC) PSU

Table 4

Proportion of 2019 NI Population by disability benefit

Benefit	% of entire NI Population
DLA only	5.2%
DLA and PIP*	11.5%

37. In its submission to the 'NI Affairs Committee inquiry intofunding priorities in the 2018-19 Budget:Health' the British Medical Association (NI) commented that: "Northern Ireland currently has the worst performing health service in the UK, with none of the waiting list targets currently being met" [RP/20 - INQ000145896, page 2]. Immediately prior to the start of the pandemic, at 31 December 2019, the number of patients waiting for a first Outpatient or Inpatient/Day case admission in NI was 400,550 (211 patients per 1,000 population). When NI entered the second wave of the pandemic the number of patients waiting for a first Outpatient or Inpatient/Day case admission in NI had increased to 412,285 (217 patients per 1,000 population). By the end of the pandemic in June 2022 the number of patients waiting for a first Outpatient or Inpatient/Day case admission in NI had further increased to 505,298 (265 per 1,000 population). It should be noted that statistics are produced in relation to commissioning targets which differ across the UK nations and should be used only as an indication of the situation and trend in the separate nations. [RP/21 - INQ000276503 (DoH ref: PM2183), RP/22 - INQ000276504 (DoH ref: PM2184), RP/23 - INQ000276505 (DoH ref: PM2185), RP/24 - INQ000276506 (DoH ref: PM2188), RP/25 - INQ000276507 (DoH ref: PM2189), RP/26 - INQ000276508 (DoH ref: PM2190).

38. Prior to 2005, hospital waiting times in NI were accepted as being the longest in the UK. There were several factors that contributed to this, primarily the imbalance between capacity and demand. Overall demand for hospital based elective care services has increased and been impacted by demographic changes, particularly a growing, ageing population with more chronic health problems and complex health needs. By 2009, the situation had stabilised and with the continued use of non-recurrent funding to support waiting list initiatives, remained relatively stable until 2013. At this point, however, the wider national financial position led to a suspension of additional waiting listing initiatives and since then the annual budget allocated to the Department has not been sufficient to keep waiting times to an acceptable level and the backlog of patients waiting longer than ministerial targets has continued to rise. In addition, there was an increase in patients attending Emergency

Departments and requiring admission. This had a significant impact on planned elective activity as all too often planned elective procedures were cancelled to focus resources on emergency procedures.

39. In relation to the adequacy of HSC staffing numbers prior to the pandemic, the following information provides the relevant HSC workforce statistics prior to the start of the pandemic at 30 September 2019, compared to the position at 30 September 2023, and a view on the comparison of the workforce size between NI and Great Britain. The latest HSC workforce statistics were published on 22 November 2023 relating to the staffing position at 30 September 2023. The base figures cited in the table below can be found at the following link: https://www.health-ni.gov.uk/publications/northern-ireland-health-and-social-care-hsc-workforce-statistics-september-2023

Table 5

HSC Staff Group	*Whole-time Equivalent at 30th Sept 2019*	*Whole-time Equivalent at 30th Sept 2023*	*WTE Difference Sept 2019 - 2023*	*% WTE Difference Sept 2019 - 2023*
Registered Nursing & Midwifery	15,286.4	17,282.6	1,996.1	13.1%
Nurse Support Staff	4,407.6	4,397.3	-10.4	-0.2%
Medical & Dental *	4,468.8	4,962.7	493.9	11.1%

(Source: Human Resource, Payroll, Travel & Subsistence system (HRPTS) Figures exclude staff on career breaks, bank staff (due to the variable nature of their employment) and staff with a whole-time equivalent of less than or equal to 0.03. * Includes 141.5 WTE classed as Hospital/Community Dental staff in September 2019, and 144.7 WTE classed as Hospital/Community Dental staff in September 2023.)

40. The latest HSC vacancies in active recruitment (post count) were published on 22 November 2023 relating to the position at 30 September. The base figures cited in the table below can be found at the following link: https://www.health-ni.gov.uk/publications/northern-ireland-health-and-social-care-hsc-active-recruitment-statistics-september-2023

Table 6

HSC Staff Group	*Active Vacancies in Recruitment at 30th Sept 2019*	*Active Vacancies in Recruitment at 30th Sept 2023*
Registered Nursing & Midwifery	2,391	1,690
Nurse Support Staff	524	611
Medical & Dental [$]	219	334

(Source: HSC organisations [$] Note that these figures do not include openings in doctor in training programmes).

GB Comparisons of Table 5 and Table 6

41. Direct comparisons of nursing staff in HSC in NI and NHS in GB jurisdictions are not possible due to social services & social care integration in NI. Recent scoping work from the Office of National Statistics (ONS) has also highlighted that there are comparability issues with NHS/HSC workforce data generally across the UK in terms of methodology and inclusions/exclusions. I understand that there is a forthcoming ONS publication on this. There is no common definition for counting vacancies either. It should be noted that whilst NI may not have enough HSC staff in post to fill HSC active vacancies in the current configuration of healthcare services, pre and post pandemic, this may not mean that NI has a lower number of professionals per head of population when compared to GB. The Business Services Organisation publishes statistics on General Practitioners working in General Medical Services. Tables 8.2 in the GMS Annual Statistics gives GPs per 100,000 registered patients by UK region 2016/17 to 2022/23 - https://bso.hscni.net/directorates/operations/family-practitioner-services/directorates-operations-family-practitioner-services-information-unit/1776-2/

Table 7 (Table 8.2d: GPs per 100,000 registered patients by UK region 2019/20)

UK region	GPs	Registered patients	GPs per 100,000
NI	1,364	2,002,708	68.1
England	34,680	60,408,450	57.4
Scotland	4,471	5,769,985	77.5
Wales	1,978	3,242,360	61.0

Table 8 (Table 8.2g: GPs by 100,000 registered patients by UK region 2022/23)

UK region	GPs	Registered patients	GPs per 100,000
NI	1,448	2,041,188	70.9
England	35,222	62,404,796	56.4
Scotland	4,546	5,894,466	77.1
Wales	2,000	3,270,956	61.1

42. The Department's Information Analysis Directorate has compiled the following comparable population health statistics for 2019 across the 4 UK countries, where possible, to assist the Inquiry in assessing whether at the outset of the pandemic Northern Ireland had any particular health challenges or difficulties that were distinct from the rest of the UK.

(a) Smoking Mortality

In 2015-19, the smoking attributable death rate in Northern Ireland was 242 deaths per 100,000 population which was significantly higher than the rate in England where there were 212 deaths per 100,000 population in 2016-18. (Sources: DoH NI, Public Health England).

(b) Cancer

In 2016-18, Northern Ireland (84.2 incidences per 100,000 population) had the second highest rate of lung cancer incidence in the UK, which was significantly higher than the rate in England (76.5 incidences per 100,000 population), Wales (77.4 incidences per 100,000 population) and the UK average (79.0

incidences per 100,000 population). The rate was highest in Scotland (102.2 incidences per 100,000 population). (Source: Cancer Research UK).

At 31st March 2019, the prevalence of Cancer in NI was 2.6%, in terms of the number of patients recorded on the Cancer register for the Quality and Outcomes Framework (QOF). This compares to prevalence rates of 3.0% in England and 3.1% in Wales. QOF was retired in Scotland on 31 March 2016 and therefore this source of prevalence data no longer exists. QOF disease prevalence data relates to longstanding illnesses or conditions.

In 2017-19, Northern Ireland (63.8 deaths per 100,000 population) had the second highest rate of lung cancer mortality in the UK, which was significantly higher than the rate in England (53.0 deaths per 100,000 population), Wales (57.4 deaths per 100,000 population) and the UK average (55.5 deaths per 100,000 population). The mortality rate was highest in Scotland (76.4 deaths per 100,000 population). (Source: Cancer Research UK).

Bowel cancer is the 4th most common cancer in the UK, accounting for 11% of all new cancer cases in 2016-2018. In 2016-18, Northern Ireland (73.6 incidences per 100,000 population) had the second highest incidence rate of cancer in the UK, 7% higher than the rate in England (68.5 incidences per 100,000 population).

(c) Heart and Circulatory disease

In 2019, the age standardised death rate from all heart and circulatory diseases was 234 deaths per 100,000 population in NI which compares with 246 deaths per 100,000 population in England, 274 deaths per 100,000 population in Wales and 326 deaths per 100,000 population in Scotland. (British Heart Foundation Heart & Circulatory Disease Statistics 2021 - BHF).

The Global Burden of Disease Study 2019 (GBDS2019) estimates an age standardised prevalence of 533 persons per 100,000 inhabitants in NI for Cardiovascular Disease. GBDS2019 estimates rates of 560, 552 and 526 per 100,000 inhabitants for England Scotland and Wales respectively (British Heart Foundation Heart & Circulatory Disease Statistics 2021 - BHF).

At 31 March 2019, the prevalence of Coronary Heart Disease in NI was 3.7%, in terms of the number of patients recorded on the Coronary Heart Disease register for the QOF. This compares to 3.1% in England and 3.6% in Wales. QOF was retired in Scotland on 31 March 2016 and therefore this source of prevalence data no longer exists.

(d) Avoidable Mortality

In 2019, the avoidable mortality rate in Northern Ireland (255.4 deaths per 100,000 population) was 10% higher than the GB average (231.7 deaths per 100,000 population), and 14% higher than the rate in England (220 deaths per 100,000 population). (Source: DoH NI, ONS)

(e) Life Expectancies

Male life expectancy in Northern Ireland was 78.7 years in 2016-18, 0.9 years less than in England (79.6 years) and 0.6 years less than the UK average (79.3 years). Female life expectancy in NI (82.4 years) was 0.8 years less than in England (83.2 years) and 0.5 years less than the UK average (82.9 years). (Source: ONS)

In 2016-18, males in NI could expect to live on average for 61.7 years in good health, 1.4 years less than the UK average (63.1 years). Females in NI could expect to live on average for 61.8 years in good health, 1.8 years less than the UK average (63.6 years). (Source: ONS)

Male disability-free life expectancy in Northern Ireland was 60.9 years in 2016-18, 1.7 years less than the UK average (62.6 years). Female disability-free life expectancy in Northern Ireland was 61.0 years, 0.6 years less than the UK average (61.6 years).

(f) Longstanding/ Limiting longstanding illness

In 2019/20, it was estimated that 43% of the population in NI had a longstanding illness. This compares with England (43%, 2019), Scotland (47%, 2019) and Wales (48%, 2019/20).

In 2019/20, It was estimated that 30% of the population in NI had a limiting longstanding illness which was lower than in Scotland (35% in 2019).

Data sources: Health Survey Northern Ireland, Scottish Health Survey, Health Survey for England, National Survey for Wales

(g) Asthma, Diabetes and Dementia

QOF disease prevalence data includes the disease registers for Asthma, Diabetes and Dementia. Comparisons are made with the rates for England and Wales where possible. QOF was retired in Scotland on 31 March 2016 and therefore this source of prevalence data no longer exists.

At 31 March 2019, the prevalence of Asthma in NI was 6.2%, in terms of the number of patients recorded on the Asthma register for the Quality and Outcomes Framework. This compares to 6.0% in England and 7.1% in Wales.

At 31 March 2019, the prevalence of Diabetes in NI was 6.4%, in terms of the number of patients recorded on the Diabetes register for the Quality and Outcomes Framework. This compares to 6.9% in England and 7.6% in Wales. These are age-specific prevalence rates, calculated using the appropriate 17+ population (as the register only includes patients aged 17+).

At 31 March 2019, the prevalence of Dementia in NI was 0.7%, in terms of the number of patients recorded on the Dementia register for the Quality and Outcomes Framework. This compares to 0.8% in England and 0.7% in Wales.

(h) GHQ-12 (% with a high score (4 or higher) indicating potential mental health problem)

Just under a fifth of the population in NI (19%) had a high GHQ-12 score indicating a potential mental health problem. This was similar to Scotland (17%, 2019).

Data sources: Health Survey Northern Ireland, Scottish Health Survey

(i) Body Mass Index (BMI)

In 2019/20 it was estimated that 27% of the NI population were obese with a further 38% being classed as overweight. This was similar to Scotland (29% obese and 37% overweight) and England (28% obese and 36% overweight) in 2019.

Data sources: Health Survey Northern Ireland, Scottish Health Survey, Health Survey for England

Section 4: Population Screening Programmes

43. On 8 April 2020, the Health Minister announced that a number of routine screening programmes had been paused to allow staff and resources to be reallocated to tackling Covid-19 [RP/27 - INQ000215009].

44. In consultation with the Health and Social Care Board (HSCB), in mid-March 2020 the Public Health Agency (PHA) produced proposals in relation to the population screening programmes, in the context of the emerging Covid-19 outbreak in NI. The PHA proposals were to pause most screening programmes for a defined period (3 months initially) to release staff to undertake other duties related to the Covid-19 surge, but to complete screening investigations and ongoing surveillance monitoring for those who were under investigation for a potentially adverse screening result at that time. A paper on the risk assessment undertaken by the PHA for each screening programme was shared with HSC Gold in mid-March 2020 [RP/28 - INQ000346699 (DoH Ref: PM0375)]. Proposals [RP/29 - INQ000120730 (DoH Ref: 0142)] on the temporary cessation of population screening programmes were submitted to the Health Minister for consideration and decision, relating to the four broad categories of screening programmes: cancer screening; non-cancer screening; and antenatal and new-born screening programmes. The Health Minister agreed to pause certain screening programmes while maintaining those that are time critical and/or focussed on high-risk occupations. In the context of the emergency phase of the response to the pandemic there was no statistical modelling of the impact of pausing of screening programmes. The Department subsequently announced on 7 April 2020 that routine screening programmes had been temporarily paused to allow staff and resources to be reallocated to tackling Covid-19. The pause in screening was also intended to minimise risk to those people who attend screening programmes, in a higher-risk category from potentially contracting coronavirus, through maintaining social distancing.

45. In April 2020, a number of routine screening programmes were paused for 3 months. This pause affected 5 programmes, namely routine cervical screening, routine breast screening, bowel cancer screening, abdominal aortic aneurysm screening and routine diabetic eye screening and surveillance monitoring. Screening continued to be offered for people who required higher risk breast screening, diabetic eye screening for pregnant women, newborn bloodspot screening, newborn hearing screening, antenatal infections screening and smear tests for non-routine cervical screening. In June 2020, the PHA established a 'Screening Restoration Group' to coordinate the process of restoring screening programmes and individual programme-specific plans were developed. The group sought a consistent and, as far as possible an evidence-based approach, to ensure programmes were reintroduced in a planned and safe way. To this end, the restoration process was guided by the following principles, derived from Public Health England guidance.

- **Principle 1:** Emerging capacity, both within screening services and across the HSC in general, should be targeted at people assessed as 'higher risk'. The nature of this varies across the screening programmes. Restoration was therefore not been a simple 'recommencement' (based upon inviting those delayed longest first), but was based upon a risk assessed and phased approach within each programme.
- **Principle 2:** The benefits of screening should be greater than the clinical risks associated with Covid. This benefit/risk assessment varies between programmes and between groups of people eligible for screening.
- **Principle 3:** There must be adequate staffing and facilities to undertake screening, provide diagnostic services, and deliver high quality treatment and programme management thereafter. This needs to be supported by appropriate quality assurance arrangements to minimise risk and maximise benefits.

46. Applying these three principles, the decision was taken for cervical screening to be restarted at the end of June 2020, early July 2020 for abdominal aortic aneurysm, mid-July 2020 for breast screening and August 2020 for diabetic eye screening and bowel screening [PM/672 Wave 2 – RP/30 - INQ000276321 (DoH ref: PM2037)]. The timing of restoration was individualised for each programme in terms of, for example, redeployment of staff, capacity, vulnerable population and impact on facilities. The programmes were therefore restarted as to when they were individually ready to do so, rather than on any basis of one

being more urgent than others. In support of the restoration of services, individual screening restoration funding bids to cover items such as catch-up clinics, additional hours etc, were submitted to the Department, although these were all eventually withdrawn as the funding was found from within PHA resources. Progress updates were provided monthly to the HSC Rebuilding Management Board. Examples of the updates provided in July and September 2020 are provided in the attached exhibits [RP/31 - INQ000276322 (DoH ref: PM2038), – RP/32 - INQ000276323 (DoH ref: PM2039) , RP/33 - INQ000276324 (DoH ref: PM2040), RP/34 - INQ000276325 (DoH ref: PM2041)].

47. It is estimated that over 100,000 invitations for screening were not issued during the pandemic. The screening programmes continue to implement recovery plans, where appropriate and within ongoing budgetary constraints. The PHA continue to monitor any backlog as a result of the pause to screening services. For the Abdominal Aortic Aneurysm programme, it is anticipated that all existing delays within the programme will have been addressed by the end of the financial year March 2024. For Breast screening, the optimal screening interval is 36-month (called the round length). This means inviting people to have their next breast-screening appointment so that it occurs within 36 months of their previous screen. As of February 2023, the NI breast screening round length was 36 months plus 5 weeks. For Bowel screening, from end August 2022, the programme has fully recovered from the delays which arose during 2020. In Cervical screening, there remains a 5-month delay in the issue of routine letters to women to advise that their next test is due. While in Diabetic Eye Screening, the delays which arose from the pause during 2020 have not yet been recovered.

48. All population screening programmes had been restarted during Wave 2. It should also be noted that some of the previously paused screening programmes did have significantly increased activity with screening rates reaching pre-pandemic levels. However, for some screening programmes there is still a backlog due to the programme being paused during the pandemic. However, in relation to the Cervical Screening programme the backlog is expected to be completely removed quickly following the introduction of pHPV testing into the screening pathway in December 2023.

Section 5: Testing and tracing capabilities in NI

49. I understand that the extant position in early-2020 was that the plans in place to respond to a flu pandemic, set out in the UK Influenza Pandemic Preparedness Strategy 2011,

could have been adapted to address elements of a response that would similarly be required to deal with other emerging respiratory pathogens. In fact, the extant pandemic influenza plan in respect of specific elements of the response was not of material benefit as it was clearly written following the experience of the H5N1 pandemic and not for a pandemic as severe as Covid-19 with the extensive measures and interventions required including the "lockdown" and the scale up in diagnostic testing and contact tracing. However, the planning assumptions for a reasonable worst case influenza pandemic were used early in the pandemic to estimate the potential impact on the population and likely health service demands which enabled some early preparation when specific information on Covid-19 in respect of the severity of disease was uncertain.

50. In late January 2020 work was progressed by the HSC to develop SAR-CoV-2 testing capabilities within the Regional Virus Laboratory and to develop plans to enhance resilience in contact tracing and the wider public health response. As in the rest of the UK, the PHA was undertaking contact tracing for all cases of Covid-19 until 12 March 2020. There was a relatively small number of cases at this time therefore contact tracing had the potential to have significant impact on the course of the epidemic and in delaying community transmission. More generally, contact tracing is most effective when levels of community transmission and numbers of cases are lower. In mid-March 2020 the levels of community transmission were higher which meant, in general terms, the impact of contact tracing as an effective mitigation to help break chains of transmission and reduce spread was likely to be less. However, as there were many variables influencing and impacting spread and trajectory of the virus, it is not possible to accurately quantify or assess the impact of removing contact tracing on the trajectory of the virus.

51. On 12 March 2020, the UK Government decided at the COBRA meeting to move from the containment phase to the delay phase. This decision was underpinned by the UK-wide agreed Protocol for Moving from Contain to Delay [RP/35 - INQ000346695 (DoH Ref: PM0371)]. This was followed shortly afterwards on 23 March 2020 by the introduction of the first UK-wide lockdown. The decision to pause contact tracing was integrally linked to the decisions to move to the delay phase and to introduce population-wide lockdown measures. The decision to pause contact tracing was also informed by a number of other operational factors. This included optimising the use of available testing capacity. Testing capacity at this time was not sufficient to identify all cases that needed to be contact traced and available tests were prioritised for clinical care and in settings with vulnerable people such as hospitals and

care homes. This in turn impacted the effectiveness of contact tracing, as only a limited proportion of cases in the community were being picked up through testing. In addition, in the first wave, as case numbers increased rapidly, there were significant challenges in maintaining contact tracing at the intensity and scale required to ensure chains of transmission were interrupted as effectively as possible. The existing contact tracing workforce, resources and systems were not able to handle such a large spike in demand.

52. Following the pause in March 2020, contact tracing was re-introduced in NI on 27 April 2020 through a pilot phase, with the full launch on 18 May 2020. When re-established on 18 May 2020, contact tracing was maintained throughout the rest of the response. At times of very high prevalence, the efficiency and effectiveness of the service was reduced. It should be noted that this decision to reintroduce contact tracing was taken at a phase in the pandemic when there was no vaccine or specific treatments available. In combination with other NPIs the purpose of the Service was to interrupt chains of infection in order to limit community transmission. The overall aim of the Service was to assist in reducing the number of Covid-19 cases, severe disease, hospitalisations and deaths from the virus. The Service also aimed to help alleviate the associated pressures on the HSC's capacity. At that time this was considered a proportionate response to the pandemic, given the consequences of the infection spreading unchecked in the population.

Section 6: Did NI follow UK Government policy – January to March 2020

53. In a serious or catastrophic health emergency, the Health Minister is required to lead, direct and co-ordinate the response for NI, reporting as necessary to the NI Executive under the Northern Ireland Crisis Management Arrangements (NICCMA) Protocol. When an emergency requires a cross-departmental or cross-governmental response, a Minister-led strategic co-ordination group is responsible for setting the overall strategy for the NI response. This group, known as the Ministerially-led Crisis Management Group (CMG), may link with UK Government to feed into Cabinet Office Briefing Rooms (COBR) in the case of UK wide emergency situations. From January 2020 as the outbreak in China developed, all four UK CMOs came together to provide advice on the threat of the outbreak becoming a pandemic to their respective Ministers and governments. Furthermore, through the pandemic the four UK CMOs met each week to review data on disease activity, potential growth and direct health service pressures in each jurisdiction to provide advice to the respective UK Health Ministers and governments on the UK Covid-19 Alert level. Therefore, the decisions taken by the NI

Executive were based on the medical and scientific advice provided by medical and scientific advisers, both in NI and the UK as a whole. The NI Executive's mindset at the point of taking decisions, within the context of UK information sharing that I have described, was completely independent. In addition, the Executive adopted the agreed initial UK coronavirus action plan published on 3rd March 2020 with the priorities being "contain, delay, research, mitigate". My recollection is that the Executive was making decisions based upon medical and scientific advice or information submitted by the Department. I was not aware of any individual Minister being guided or making decisions based upon information available to them personally.

54. In respect of whether the assessment of the House of Commons Health and Social Care and Science and Technology Committee's report[3], equally apply to NI and what factors contributed, in NI, to any failure to adopt a more emphatic early policy, the position in NI was that the initial UK coronavirus action plan was adopted by the Executive in the early period of its response to the outbreak of the virus. I do not recollect any additional factors which contributed to NI not adopting a more emphatic early policy.

55. As set out in paragraph 51, on 12 March 2020, the UK Government moved from the containment phase to the delay phase, followed on 23 March 2020 by the introduction of the first UK-wide lockdown. The view within government at that time was that the strategy set out in the UK coronavirus action plan, published on 3rd March 2020, had been designed to take account of the possibility of stringent restrictions being introduced and to prepare for that eventuality. In response to the comments in the NIO SitRep dated 30 April 2020 where it is reported that *"Minister Swann said that the Executive would be developing its own plan in response to how the pandemic develops specifically in NI, highlighting that NI was 7-10 days behind the London curve as an example of why it had to be different"* [RP/36 - IN0000083129, page 4], I understand that community transmission in most parts of the UK including NI was behind the peak of the first wave in London, although difficult to quantify, and that the lag was measured in days. In general I understand that there was more in common in alignment of policy across the island of Ireland and the UK than differences. Where those differences existed, they were largely in relation to timing and or the extent of restrictions. In reaching these decisions Ministers in all jurisdictions took into consideration factors other than the health advice.

---

[3]"Coronavirus: lessons learned to date", published on 12 October 2021 [RP/37 - INQ000075336], paragraph 77

56. Officials were mindful of the time lag in the development of the pandemic in NI as compared to the rest of the UK [RP/12 - INQ000083129, page 4] in making assessments of ensuring the HSC's readiness for responding to increased service demand, for example, for critical care beds.

57. Ministers will be best placed to advise whether the Cabinet Office Briefing Room (COBR) meetings, and Ministerial Implementation Group meetings (MIGs) were an effective mechanism for discussion and debate and ensuring the involvement of the Devolved Administrations in decisions affecting them. I understand that sometimes the meetings were called at short notice, or communication on those invited to attend was not immediately clear and papers were at time circulated late although this may have reflected local NI arrangements for sharing. These issues reflected the fast pace of events and the need for an agile response which was not conducive to engagement. Although more time for Devolved Administration participants would have been welcomed by the respective jurisdictions, I understand that there was effective regular engagement with Ministers from the Devolved Administrations in other fora such as meetings chaired by the Chancellor of the Duchy of Lancaster, and UK Health Ministers regular engagement. In relation to Quad meetings (see for example [RP/38 - INQ000148325], page 15, paragraphs 62-63), Ministers will be better placed to assist the Inquiry in explaining whether they were effective and the extent to which they informed the response of the government in NI to the pandemic. The relationship between the NI Executive and the UK Executive was generally one of constructive engagement throughout the pandemic.

58. I have no particular insight into the then deputy First Minister's statement to Module 1 of the Inquiry which states: "*Actions by the British government, at times, hindered our ability to reach consensus. For example, regarding travel restrictions on the island of Ireland"* [RP/39 - INQ000183409, paragraph 27]. The UK Government's approach to the restrictions was one of a number of factors which the Executive was cognisant of in reaching agreement on restrictions in NI, but I do not recollect an incidence when it impacted the ability of the Executive Committee to reach agreement. Ministers will be better placed to assist the Inquiry on observations about the effectiveness of the Secretary of State for NI, the NI Office and/or the Minister for Intergovernmental Relations in facilitating intergovernmental relations during the pandemic and in coordinating the response of the Devolved Administrations. It is my view that in general the inter-governmental relationships and structures worked effectively following the initial steep learning curve as to how the emergency response protocols would work in

practice. Inevitably there were challenges which was to be expected given the nature of how devolved government operates in the United Kingdom. It is likely that observations of any mutual lack of trust or misunderstanding on the part of the UK government in terms of its dealings with the Devolved Administrations was to do with the different perspectives. Ministers will also be best placed to offer a view on the cohesiveness with the UK government or the other Devolved Administrations

59. I did not have contact with anyone from the UK government (between January 2020 and the decision to lock down) to expressing concern about the approach being taken within the UK government to respond to the pandemic.

60. I do not recall having any concerns about the approach being taken by the UK Government - at this relatively early stage in the pandemic we were aware that the position in GB was slightly different than in NI, and assumed the approach was being informed by relevant professional advice, as was the case in NI. I have no recollection of any concerns being expressed to me by the Health Minister or the CMO about the approach being taken by the UK government.

61. I am aware of the evidence which has been heard in Module 2 to date in relation to the response to the pandemic by the UK Government, the Scottish Executive and the Welsh Government, but I have not followed these hearings closely due to a range of factors (primarily the fact that I have now left the health sector, and the work pressures flowing from the absence of Ministers and then the recent preparations for the return of the NI Assembly). Accordingly, I have no observations to bring to the Inquiry's attention at this stage about learning derived from the evidence presented at these hearings.

62. I have no recollection of the precise timing of when I (or the Department) became aware that the UK government was planning to announce a lockdown on 23 March 2020 or of any contact in advance of this to warn NI that this was the course likely to be taken. However, a message from me to Sir David Sterling [RP/40 - INQ000308436, page 5] clearly suggests I had a sense of it on 22 March 2020. I can only speculate that this was based on a conversation with colleagues in the Department who had picked this up from GB colleagues. I was not part of any such dialogue and don't know any further details about it. At the time, I recall that my sense was we were on a trajectory to lockdown, but I would emphasise that this was not a deeply considered view based on a review of the underlying science or data, but rather a sense of the direction of travel. At that time, I don't recall reflecting on whether this could have

been avoided with earlier action, as the pressure to deal with the "here and now" issues was so great. Looking back, and again without reference to data, my instincts are that the lockdown could not have been avoided - at most the timing and/or duration of it may have been subject to influence.

Section 7: Jan-Mar 2020 - What we knew about the virus, Strategy and Planning

Awareness of the Threat from Covid-19 to NI

63. I am unable to recall the exact date that I first became aware of Covid-19 although this is likely to have been during the early to mid-January 2020 period arising from Departmental official information, or possibly earlier from reporting by the media. During January and February 2020, the broad understanding amongst senior officials in the Department was that NI was facing a major public health emergency and the initial likely strategic response would involve the activation of the Civil Contingencies Framework for NI (2011) [RP/41 - INQ000103600 (DoH Ref: PM0003)], published by the Executive Office (NI). The Department would provide strategic health and social care policy advice and/or direction in support of the efforts of others, including its associated agencies and ALBs in response to the emergency. The Department's preparedness for this was evidenced in the standing-up of HSC Silver (Tactical Command) on 22 January 2020 and on 27 January 2020, the activation of the Department's Emergency Operations Centre (EOC). The Civil Contingencies Framework for NI (2011) stipulates the roles and responsibilities of each arm of government in NI in responding to a potential emergency. The Executive Office and the Department fulfilled their respective responsibilities as part of the government machinery driving the response to the pandemic at this early stage. Ministers, as the ultimate decision makers, also had a central role and in my view the potential scale of the risks to public health were certainly being escalated to the Health Minister. Shortly after taking up post the Health Minister received a submission dated 22 January 2020, prepared by the Department's Health Protection Branch [RP/42 - INQ000103626 (DoH Ref: PM0024)] which provided an update on the Novel Coronavirus in China. On 24 January 2020 the Minister submitted an Urgent Written Statement [RP/43 - INQ000103599 (DoH Ref: PM0001)] to the Assembly on the response to Coronavirus.

64. From January 2020 as the outbreak in China developed, all four UK CMOs came together to provide advice to their respective Ministers and governments on the threat of the outbreak becoming a pandemic and the UK Covid-19 Alert level. My initial discussions with colleagues during January 2020 about the emerging threat was with the CMO, Professor Sir

Michael McBride. The Department's CMO Group (CMOG) was the principal source of information (including from SAGE) available to me and the Minister during January and February 2020 as to the outbreak being an issue of potential concern for the UK, including NI, as to the likely spread and impact of Covid 19. I have no recollection of whether I or the Department was aware of the work which was being undertaken by Professor Ferguson and colleagues at Imperial College, specifically Reports 1 to 3 and Imperial College's Report 4 (on or around 10 February 2020). If these reports were available to the CMO it is likely that he would have conveyed to me any key information related to NI contained therein.

65. The process by which the views, advice or minutes from SAGE were conveyed to me and Ministers involved the CMO and CSA providing medical and scientific advice to me and Ministers. The presentation of this advice would primarily have been in papers submitted to the Minister and to the Executive. The CMO and the CSA principally sourced their scientific advice from SAGE, although a range of other sources of evidence were considered, including from the World Health Organisation, European Centre for Disease Prevention and Control, The US Food and Drug Administration, and the wider scientific literature. As the pandemic progressed, evidence generated in NI was also considered. I am satisfied that that the way that the product of SAGE's work was conveyed was effective. I do not recollect any concerns expressed to me about the information provided by SAGE being overly "English-centric". Any initial limitations to the information provided by SAGE, for example in relation to providing NI specific advice, were addressed by the establishment of the Department's Strategic Intelligence Group and Modelling Group. I do not recollect having any general concerns about the NI Executive having sufficient access to the medical and/or scientific data and expertise available to and used by the UK government.

66. I also exchanged views on the developing situation with senior colleagues from other NI departments. This is reflected in the following WhatsApp messages sent between me and Sir David Sterling, the then Head of the NI Civil Service, on 6 February 2020:

> *"R, at WMC in London yesterday we got an update on Coronavirus. CMO said the Chinese government has not got to grips with this and that it will almost certainly become a global pandemic. He reckoned this will be with us for 6-7 months and that it will peak in around 3-4 months time. He said current UK pandemic flu plans were the appropriate response. I'm sure you're already aware of this. Just what we need.... D" [06/02/2020; 15:30:41. Sir David Sterling to Richard Pengelly] [RP/40 - INQ000308436, page 2] "Ta.*

Michael has been getting this from them. At one level, very worrying, although at peak time here will present "only" as a bad flu, as opposed to anything more sinister. That said, most folk I really appreciate how bad a flu (as opposed to a cold) can be. Estimates are that we are around 9 months away from vaccine. R." [06/02/2020; 15:34:27 Sir David Sterling to Richard Pengelly] "Ta, I reckon I've only had flu once in the last 30 years. Hit me just before Christmas years ago and I could barely get out of bed for about five days. I guess the problem will be if (when) it hits care homes and hospitals." [06/02/2020; 15:37:33 Sir David Sterling to Richard Pengelly] [RP/40 - INQ000308436, page 3]

67. This WhatsApp exchange between Sir David and me reflects the exchange of views and information with other senior colleagues at the 6 February 2020 which I have referred to above. Therefore, I was aware by 6 February 2020, and possibly earlier, on the threat of the outbreak becoming a pandemic and was likely to peak in around 3 to 4 months' time in May/June 2020. The comments about the potential severity of the outbreak as a "bad flu", which could also have resulted in a serious adverse impact on public health, reflected the absence of robust scientific information about the virus. In those early months of the pandemic there was a focus on our knowledge of how similar viruses had behaved in the past alongside the emerging evidence about this new virus. While these messages do not explicitly refer to the potential risk to hospitals and care homes, however, the fact that HSC Silver (Tactical Command) was stood-up on 22 January 2020 and on 27 January 2023, the Department's Emergency Operations Centre (EOC) was activated demonstrates the seriousness with which the HSC viewed the threat from the outbreak. The first cases of Covid-19 in the UK were at the end of January 2020 when two foreign nationals tested positive. The first presumptive positive case in NI was on 27 February 2020. I would have been aware of these cases either on the date they were made public or shortly before.

68. As of 25 February 2020, the role of the Executive Committee, in overseeing the Executive's ability to respond to the predicted global pandemic, was governed by the civil emergency strategic co-ordination arrangements known as the 'NI Central Crisis Management Arrangements' (NICCMA). The First Minister and deputy First Minister or the Executive Office may activate NICCMA following a request to do so from the Executive; the Lead Government Department; a senior representative from the NIO Briefing Room (NIOBR); a senior member of the Police Service of Northern Ireland (PSNI) involved in the Police led multi-agency GOLD

group; the local level coordinator; or in the absence of any such requests, whenever the Executive Office judges it appropriate to do so.

69. Given the timeframe related to the paper [RP/44 - INQ000205712] sent to the Executive Office's Board on 25 February 2020 in relation to "a strategic review of civil contingency arrangements across NI" stating that "*the Executive and wider society may not be prepared for or have the capacity and capability to deal effectively with, an emergency situation should a major contingency present*", it is possible that this assessment was commissioned by the Executive Office in response to one or all of the following communications:

- correspondence to The Executive Office on the 6 February 2020 from the Department to highlight the need for the Executive Office, Civil Contingencies Policy Branch (CCPB) to urgently consider sector resilience in the face of a growing threat from novel coronavirus;
- my briefing to the Permanent Secretaries Stocktake (PSS) meeting on 7 February 2020; or
- the presentation to CCGNI by the deputy CMO on 20 February 2020 [RP/45 - INQ000145666 (DoH Ref: PM0090)].

70. I was satisfied that the Department of Health and HSC were fully engaged by 25 February 2020 in preparing plans to respond to the health emergency within available resources but wouldn't have sufficient insight into the planning by other Executive departments to either agree or disagree with the assessment in The Executive Office's paper. The Executive Office is better placed to assist the Inquiry with understanding whether steps were taken to address any perceived structural weaknesses given the information available about the impending pandemic.

71. The letter of 6 February 2020 was sent by the Department's then Director of Public Health to the then Director Executive Support and Programme for Government, The Executive Office to assist with wider government co-ordination in NI; and to highlight the need for The Executive Office (CCPB) to urgently consider sector resilience in the face of a growing threat from novel coronavirus. The letter stated that, while activation of NICCMA had been considered by the Department, it was reasonable to withhold such a request until infections and their impacts were experienced in NI. The Department suggested that, to provide reassurances should an escalation of events require a request to implement NICCMA, it would

be helpful if The Executive Office would consider convening a multi-agency meeting to inform an assessment of sector resilience preparedness, capacity and capabilities across NI departments and agencies and the emergency services. To assist with this request, the Department provided the Executive Office with correspondence for issue on behalf of the CMO, also dated the 6 February 2020 to Executive departments and public authorities [RP/46 - INQ000176133 (DoH Ref: MMcB/0150)]. The purpose of this letter was to enable all Executive departments and public authorities to prepare to respond to all potential eventualities arising from the current outbreak and to recommend that each department had proportionate, appropriate and efficient arrangements in place, consistent with the key public health messages about novel coronavirus.

72. On 7 February 2020, at our regular weekly meeting (the Permanent Secretary Stocktake (PSS)) [RP/47 - INQ000185378 (DoH Ref: RP0005)], I informed my Permanent Secretary colleagues that urgent consideration was needed across Executive departments on sector resilience and wider strategic coordination across civil contingencies arrangements in the face of a growing threat from the novel coronavirus. However, as no cases had been reported across the UK, the Department did not consider it necessary to activate NICCMA at this time. I noted that this was an evolving situation and that preparedness across NI was critical. Departments needed to review business continuity arrangements to assess resilience preparedness, capacity and capabilities to assess the likely impact on the delivery of essential services. I reiterated that it may be prudent for the Executive Office to consider convening a multi-agency meeting to assess sector resilience and preparedness.

73. In taking these steps the Department was clearly signalling its concerns to the Executive Office (CCPB) and other Executive departments that the activation of the NICCMA arrangements would in all likelihood be imminently required and that in the interim all Executive Departments needed to consider, individually and collectively, urgently and proactively sector resilience and strategic coordination across civil contingencies short of the formal activation of NICCMA. If the Executive Office's paper was commissioned because of this correspondence, briefing or presentation it does indicate a positive response by the Executive Office to considering sector resilience under the civil contingency arrangements. The Executive Office is better placed to assist the Inquiry in its understanding of whether an assessment of sector resilience preparedness, capacity and capabilities across NI departments and agencies and the emergency services took place.

74. On 24 February 2020, the WHO published the report of its international mission to Wuhan, and advised that countries should:

> *"(1) Immediately activate the highest level of national Response Management protocols to ensure the all-of-government and all-of-society approach needed to contain COVID-19 with non-pharmaceutical public health measures; (2) Prioritise active, exhaustive case finding and immediate testing and isolation, painstaking contact tracing and rigorous quarantine of close contacts."*

75. I have no recollection of being aware of this report at the time. However, in response to the WHO report, CMO wrote on 25 February 2020 to the HSC with updated guidance [RP/48 - INQ000103641 (DoH Ref: PM0045)]. This letter updated the advice sent on 7 February 2020 and it stated: "*Based on the World Health Organization's declaration that this is a public health emergency of international concern, the UK CMOs had raised the risk to the public from low to moderate. This permits the government to plan for all eventualities. The risk to individuals remains low. The letter updates the list of countries from which travellers returning, and who experience symptoms, should self isolate and contact their GP to include Northern Italy (defined by a line above, and not including, Pisa, Florence and Rimini), Iran, Vietnam, Cambodia, Laos, Myanmar."*

Peak of the Virus

76. Around mid-February/early March 2020 CMO shared with me and other senior Departmental colleagues, in one-to-one oral briefing discussions, high level modelling information about potential hospitalisation rates and excess deaths which led me to conclude that NI would face significant challenges in controlling the virus once it reached NI; and the possibility that the fatality and hospitalisation rate could overwhelm the HSC. I understand that CMO obtained this information from public health modelling sources in England. On 1 April 2020 the Department announced [RP/49 - INQ000103652 (DoH Ref: PM0063)] the key consensus estimates of the NI modelling group, based on outputs from several different models, which informed intensive hospital planning for the forthcoming surge in Covid-19 cases. The modelling outcome set out a reasonable worst case scenario, based on a number of assumptions including social distancing measures producing a 66% reduction in contacts outside the home and workplace. In addition, it was anticipated that 70% of symptomatic cases would adhere to self-isolation. The modelling team's best judgement was that this would lead

to a peak number of 180 Covid-19 patients requiring ventilation and critical care beds during the first wave of the pandemic. The modelling assessed that the peak number of Covid-19 hospital admissions would be 500 per week. Under this reasonable worst case scenario, the projected number of cumulative Covid-19 deaths in NI over 20 weeks of the pandemic was calculated to be in or about 3,000. The modelling indicated that the peak of the first wave of the pandemic was expected to occur between 6-20 April 2020. Therefore, I was aware on 1 April 2020, and likely earlier than this in the days leading up to the publication of the key consensus estimates of the NI modelling group, that the peak of the virus in Northern Ireland would be sooner than May 2020.

Planning Activity January to March 2020

77. The threat from the virus was considered as a public health emergency and therefore the Department of Health was planning the strategic response to the outbreak in NI during January and February 2020 in line with the Department's Emergency Response Plan. I was kept fully informed by my senior colleagues about key information, produced both at UK Government and NI government levels, related to the threat and potential actions to ramp-up UK and NI preparedness for managing the response to the outbreak. I had regular meetings with senior colleagues to discuss the threat and the precautionary actions to be taken. The Minister was briefed by senior officials on the developing situation, including the potential scale of the risks. During late-January to early-March 2020 the risk of the outbreak becoming a pandemic was assessed as moderate, based on the advice of the UK CMOs. Therefore, commensurate with this assessment, I and my senior Departmental colleagues monitored closely the developing situation concerning the emergence of Covid-19 as a threat to public health across the UK. During the latter part of January 2020 the Department and the HSC took several steps to manage the response to the developing emergency. On 22 January 2020 HSC Silver (Tactical Command) Structures were formally stood up and on 27 January 2020, the Department's Emergency Operations Centre (EOC) was activated. On 30 January 2020 the World Health Organisation declared that the outbreak constituted a Public Health Emergency of International Concern, followed by its declaration on 11 March 2020 that the outbreak was a pandemic. On 18 March 2020, The Executive Office activated the NI Hub – the operations centre of CCG(NI). The Department embedded liaison officers in the NI Hub to assist in the coordination of quality and timely information to and from the Department's EOC.

78. As the situation developed during February 2020 my discussions with senior colleagues and the Minister intensified to include an exchange of views and information about managing the response to the outbreak. I also had discussions with the Chief Executives of the Department's main Arms Length Bodies which would take a central role in managing the response to the outbreak which included the HSCB, PHA and the six HSC Trusts.

79. On 17 February 2020 the CMO wrote to the HSCB's Chief Executive [RP/50 - INQ000130370 (DoH Ref: PM0206)] requesting detailed worked up integrated surge plans from community and primary care through to acute care including those areas where it was anticipated that there would be particular demands, such as critical care. The CMO's action demonstrated the understanding within the Department of the potential risk which Covid-19 would present to health and social care in NI. The HSCB Chief Executive replied to the CMO on 20 February 2020 [RP/51 - INQ000130371 (DoH Ref: PM0207)] and advised that surge planning was underway and that the HSCB and PHA had established a regional operational Surge Planning Subgroup to ensure that there was an appropriate and proportionate level of HSC preparedness across the HSC in response to Covid-19. On receipt of the HSCB and PHA initial surge plans the CMO commissioned further work to quality assure and address identified gaps in the initial surge plans, recognising that the lack of specificity at this time of the potential health and social care service pressures made surge planning problematic. This work culminated in the publication on 19 March 2020 of the Health and Social Care (NI) Summary Covid-19 Plan for the period Mid-March to Mid-April 2020 [RP/52 - INQ000130410 (DoH Ref: PM0300)]. The HSC planning commissioned on 17 February 2020 was not designed to explicitly prepare for the first lockdown announced on 23 March 2020 but rather to prepare for what was later termed the reasonable worst case scenario.

80. In a reasonable worst case scenario if NI failed as a community to take action to slow down the transmission of the virus in line with the recommended public health guidance. Up to 80% of the NI population would be infected during the pandemic. Up to half of these may occur in a period of three weeks centred around the peak. If social distancing and other measures were implemented by the population, with a combined effect they could reduce the peak by some 50% and reduce deaths by up to a third. Planning assumptions also indicated that 8% of infected people would require hospitalisation, 0.7% would require critical care, and 1% would die – although these figures would vary highly depending on age and other health factors. Importantly, it was predicted there may be 21% health and social care staff absence during the peak weeks of an unmitigated pandemic (without social distancing and other reduction measures being implemented). An absence level such as this would require a

flexible staffing policy involving: current staffing levels to be augmented from areas of reduced activity, for example from theatres; some nursing care being delivered by non-ICU trained staff; and, the normal nurse to patient ratios of 1:1 may be reduced.

81. The Plan summarised the key actions taken by the HSC from mid-March to mid-April 2020 to ensure that there was sufficient capacity within the system to meet the expected increase in demand from patients contracting Covid-19 during this period. The key actions covered: Covid-19 Testing; PPE guidance; Primary and Community Care; Covid-19 Centres; Community Pharmacy; Dental Services; Homeless People; People in Transit; Adult In-patient Care; Critical Care; Care for Pregnant Women; Equipment; Home Ventilation; Single organ support; Outpatients, day cases, inpatient and diagnostic services; Remote working; Discharge Planning for Patients in Hospital; Social Care and Children's Services; Adult Mental Health & Learning Disability Social Work & Social Care Service; and Prison Health Care. On 26 March 2020, I wrote [RP/53 - INQ000325159 (DoH Ref: PM0147)] to all HSC staff setting out the next phase of emergency planning for the initial surge in demand during the first wave of the pandemic. The letter summarised the extensive planning and investment underway across the HSC system designed to increase capacity.

82. The planning work set out above was developed alongside the UK-wide Coronavirus Action Plan, published on the 3 March 2020, which set out what the UK as a whole had already done, and planned to do further, to tackle the current Coronavirus outbreak. The planning work was required irrespective of whether the Contain phase in NI had at that point been passed. The COBR(M) decision on 11 March 2020 to move from the Contain phase to the Delay phase [RP/54 - INQ000083097] was a further indication of the need to ensure that the planning by the Department and the HSC was at an advanced stage of preparedness.

83. In respect of the Executive meeting on 2 March 2020, I understand that the then First Minister and deputy First Minister had requested that the Health Minister and CMO provide an update to the Executive at this meeting. This was the same day as the Minister made an Urgent Oral statement to the Assembly [RP/55 - INQ000103638 (DoH Ref: PM0042)] and the day before the UK Covid action plan was published. At the meeting CMO provided an update which in effect outlined the potential impacts and observed that the Executive *"…need to plan and prepare for all eventualities."* [RP/56 - INQ000065694]. I understand that CMO's reference to the "need to plan and prepare for all eventualities" was to impress upon Ministers the scale of what potentially lay ahead and to impress upon them the need to plan and prepare across all of government given what he anticipated as the imminent challenges would be

notwithstanding the uncertainties at that time. The Department's urgency in responding to the situation which was unfolding is set out above in the planning commissioned from the HSC.

84. I have given consideration to the following four exhibits within the context of the strategy that the Department was following in March 2020:

- the Health Minister stated "we have been preparing for past 7 weeks" [RP/57 - INQ000065689, page 7];
- the Justice Minister "Exec always seems to be reacting not leading" [RP/57 - INQ000065689, page 10]; the Infrastructure Minister "we are mismanaging" [RP/57 - INQ000065689, page 33]; the Minister for the Department of Agriculture, Environment and Rural Affairs (DAERA) "as an Exec, we are behind the curve. Need to get ahead" [RP/58 - INQ000065737, page 25]; and,
- in his letter of 29 March 2020 to the First Minister and deputy First Minister, the Health Minister noted: '.....That said, I do feel that we – as a system – have largely been in reactive mode. That is not meant as a criticism, but rather a recognition of the inherent speed and uncertainty with which events have been unfolding…'' [RP/59 - INQ000023229].

85. I have no particular insight into the observations of these Ministers, and I do not believe that the Department of Health was mismanaging the situation. In response I would bring to the Inquiry's attention the strategic planning that was put in place to prepare for the pandemic that I have outlined above. This clearly demonstrates that within the Department and the HSC planning was sufficiently underway to enable the HSC to be in a state of readiness by late-March 2020 to effectively manage the response to the pandemic. In respect of [RP/58 - INQ000065737, page 8] which refers to the information concerning the worst case scenario modelling, presented by the Health Minister to the Executive Committee on 19 March 2020, in my view the seriousness of the situation had crystalised before this date given the emergency planning underway from February 2020 set out above. I therefore have no insight into the Minister for the Department of Agriculture, Environment and Rural Affairs' (DAERA) view that the Executive was "behind the curve" as from the Department's standpoint emergency planning was being taken forward.

86. The position on planning for the response to the outbreak as at 6 February 2020 was on the basis of the Department's Emergency Response Plan (ERP) 2019. The ERP defines the structures, systems and processes involved in responding to an emergency such as a flu pandemic. It was this response plan that was activated in January 2020 through February 2020 in response to the emergence of the SARS-CoV-2 virus which is responsible for the disease that became known as Covid-19. The Emergency Response Plan is designed to be modular in structure and therefore flexible and scalable, capable of escalation and de-escalation. It sets out how the Department will carry out effectively the responsibilities and functions associated with its role as Lead Government Department. It describes the key processes and disciplines necessary in planning for and responding to health crises. The design of the Emergency Response Plan is based on the principle of preparation, response and recovery to enable an effective joint response to and recovery from any emergency. It provides assurance in the ability of the Department to deal with a range of HSC emergencies in NI, from short term emergencies which are sudden, unexpected and relatively brief, to longer term 'rising tide events' such as pandemic influenza.

87. I understand that significant learning was taken from the H1N1 pandemic both internally for the Department and how it organised itself as well as for the wider HSC system in relation to issues such as the use of data, surveillance, implementation of a new vaccine, investment in training and effective communications to both HSC and the public. The lessons from the H1N1 pandemic, in conjunction with the Hine Review [RP/60 - INQ000188791 (DoH Ref: PM5059)] contributed to the Department's revised ERP. For example, it reflected the new roles and responsibilities brought about by changes to the HSC landscape post April 2009 and established formal on-call arrangements [RP/61 - INQ000188792 (DoH Ref: PM5060), RP/62 - INQ000188795 (DoH Ref: PM5061), RP/63 - INQ000188796 (DoH Ref: PM5062)].

Asymptomatic Transmission of the Virus

88. I don't recall the date when I became aware that Covid-19 was being transmitted asymptomatically. Information and advice about asymptomatic transmission of the virus would have been brought to my attention by the CMO. I understand that in the early months of the pandemic there were gaps in the knowledge available to medical and scientific advisers concerning this new virus including symptomatic infection. However, my knowledge of asymptomatic transmission would have been informed by the introduction of NPIs and through interventions such as the Department's first Covid-19 Test, Trace and Protect Strategy [RP/64

- INQ000120704 (DoH Ref: PM0053)], published towards the end of the first lockdown on 27 May 2020. The Strategy set out a programme of actions, recognising that testing and contact tracing had a key role in reducing the spread of the SARS-CoV-2 virus, and in doing so, preventing serious illness.

Herd Immunity

89. The development of "herd immunity" was never considered as a viable strategic response to the pandemic by the Department or the Executive. The Executive's objective was to flatten the epidemic curve. The term 'flattening the curve' was a way of trying to express the middle path of three possible options. The purpose of NPIs during the pandemic was to achieve this middle path and to allow time to better understand the severity of the pandemic, build additional capacity in health and social care, and develop new treatments and vaccines. This approach in view of our level of knowledge and the lack of availability of viable alternatives at the time such as a vaccine or effective treatments, seemed the most realistic option.

90. As SARS-CoV2 was a new virus many of the important policy decisions early in the pandemic had to be taken when much less was known about the virus, including modes of transmission, the relative importance of asymptomatic infection, common transmission settings, and severity of disease and mortality across the population including those most at risk. At this early stage in the first wave there was no means to measure levels of antibodies against the virus, or to assess the extent of immunity, and there was limited virus testing to assess incidence and prevalence. In addition, there was a clear view that allowing the pandemic to spread unabated would have resulted in hospitals being overwhelmed in the short term, and substantial mortality. It was also the case that the population had not previously encountered the virus, had little or no immune protection, and the number of people experiencing severe disease and deaths was likely to be high. The level of transmission in the early stages of the pandemic required the extensive use of NPIs and "lockdown" to get R below 1, the approach which had been agreed by the Executive. This was necessary to prevent excessive deaths and to prevent the health service being overwhelmed. However, as the pandemic proceeded, the Department was clear that a high level of population immunity was needed to allow other measures to be completely relaxed. The Executive's strategic intent was to achieve a high degree of population immunity through the Covid-19 vaccination programme, as quickly as possible, with restrictions as limited as possible, while avoiding the hospital system becoming overwhelmed. It was also recognised that in addition to high uptake

of the vaccination, natural exposure to the virus would also contribute to levels of population immunity, although this was never part of the strategic response of the Executive.

91. I have no particular insight in respect of the notes kept by the then First Minister, or on her behalf, from a meeting on 14 March 2020 concerning observations about herd immunity, including "*herd immunity - can't keep people cocooned for 16 weeks*" [RP/65 - INQ000203348, page 4], and am therefore unable to assist the Inquiry as to whether the First Minister was reflecting the strategy of not suppressing the virus, aiming for a later peak and thereby facilitating herd immunity.

Section 8: CCGNI & NI Prep 18 months behind GB

92. In this section I set out my *views* on the timeliness of the activation of the emergency management structures, the role played by Ministers and the functioning of the Executive. In respect of these issues I have considered the following exhibits:

- on 10 March 2020, the then First Minister is noted as saying *"Civil Contingencies – have we got plans to handle"* [RP/66 - INQ000065695];
- on 10 March 2020, the then deputy First Minister was noted as saying *"Exec approach needs to kick in – all need to contribute"*;
- on 10 March 2020, the First Minister was recorded as saying *"advice to organisations/companies…who leads on advice…some trying to use politics (?) to give advice"* [RP/66 - INQ000065695];
- WhatsApp message of 17 March 2020, Andrew McCormick stated: *"FM and dFM could surely decide and state that all Covid-19 response and planning is cross cutting and subject to CCG NI"* [RP/67 - INQ000308415, page 1]. Sir David Sterling replied "*That would be the sensible approach and I will push this tomorrow"* [RP/67 - INQ000308415, page 1]; and,
- on 19 March 2020, Sir David Sterling outlined how the Executive Committee would function to respond to the pandemic [see RP/58 - INQ000065737, pages 13 to 14].

93. During January and February 2020, the broad understanding amongst senior officials in the Department was that NI was facing a major public health emergency and the initial likely strategic response would involve the activation of the Civil Contingencies Framework for NI (2011) [RP/41 - INQ000103600 (DoH Ref: PM0003)], published by the Executive Office. The Department would provide strategic health and social care policy advice and/or direction in support of the efforts of others, including its associated agencies and ALBs in response to the emergency. The Department's preparedness for this was evidenced in the standing-up of HSC Silver (Tactical Command) on 22 January 2020 and on 27 January 2020, the activation of the Department's Emergency Operations Centre (EOC). On 9 March 2020 the Department activated Health Gold Command in line with the guidance set out in its Emergency Response Plan 2019 [RP/68 - INQ000184662].

94. The Executive Office had charge of the oversight of the activation of civil contingency arrangements. The arrangements for activation of NICCMA, including the NI Hub, are addressed in a memo to the HOCS from CCPB on 30 January 2020. In relation to civil contingencies, a decision to activate the NICCMA arrangements in NI needed to be taken at the appropriate time and to be proportionate to the level of threat and response then required. The Executive Office is better placed to assist the Inquiry in understanding the extent to which such arrangements would be needed and the factors that it considered in waiting until 18 March 2020 to stand-up the NI Hub. Standing-up the NI Hub would likely have resulted in initiating business continuity arrangements to redeploy staff across Executive departments from other priority work to resource the crisis management structures. Therefore, this was a decision balanced between activating the Hub at the appropriate possibly earlier point against moving to business continuity and the resulting impact on other important work. The Department was focused on ensuring that the HSC was ready to respond to the pandemic and playing its full part in updating the Executive on the urgency of the situation as it evolved. It is therefore a matter of conjecture as to whether the Department's planning would have been enhanced by standing-up the NI Hub earlier or would have assisted the Executive Committee.

95. The first meeting of CCG(NI), in response to the pandemic was held on 20 February 2020. This is earlier than 16 March 2020, when the Executive Committee agreed upon the phased activation of NICCMA to deal with the impacts of Covid-19 [RP/69 - INQ000048447]. The Executive Office convened CCG(NI) in order to bring all departmental Permanent Secretaries together in its role to coordinate the overall response to the pandemic by the NI Executive. At this first meeting the Department's Deputy CMO gave a presentation [RP/45 - INQ000145666 (DoH Ref: PM0090)] to CCG(NI) on the Novel Coronavirus and NI's

Preparedness. Further daily meetings of CCG(NI) were chaired by the Head of the Civil Service (HOCs) and were attended by me. The Executive Office activated the NI Hub, the operations centre of CCG(NI) on 18 March 2020 and this remained activated until June 2020. The Department embedded liaison officers in the NI Hub to assist in the coordination of quality and timely information to and from the Department's EOC. The Executive Office is better placed to assist the Inquiry with providing advice concerning: the reasons for standing down CCG (NI) and scaling down the NI Hub on or around 21 May 2020 [see RP/70 - INQ000065778, page 2]; what, within the government in NI, replaced the work of the NI Hub or provided the day to day strategic response as between June and October 2020; and the role of the NI Hub and its operations after October 2020.

96. I am unable to assist the Inquiry with any specific insight into what Andrew McCormick was advocating in his WhatsApp message of 17 March 2020. The Civil Contingencies Framework (2011) stipulates the roles and responsibilities of each arm of government in NI in responding to a potential emergency. The Executive Office and the Department fulfilled their respective responsibilities as part of the government machinery driving the response to the pandemic at this early stage. Ministers, as the ultimate decision makers, also had a central role in managing the response to the pandemic. I am unable to assist the Inquiry with any specific insight into the then First Minister's comments concerning "advice to organisations/companies…who leads on advice…some trying to use politics".

97. I am unable to recollect any specific input from the Department in respect of the plans, outlined by Sir David Sterling at the Executive Committee meeting held on 19 March 2020, indicating how the Executive Committee would function to respond to the pandemic [RP/58 - INQ000065737, pages 13 to 14]. However, the plans set out a logical approach as to how the Executive Committee would conduct its business within the context of the NICCMA. The Executive Office is better placed to assist the Inquiry in understanding whether there were plans in place, before 19 March 2020, for how the Executive would function in the event of a pandemic, and why this decision was not taken before 19 March 2020.

98. The public in NI were informed about the prospects of a pandemic in a series of statements by the Health Minister to the NI Assembly. On Friday 24 January 2020, The Minister made an urgent Written Statement [RP/43 - INQ000103599 (DoH Ref: PM0001)] to update Members on the global impact of the virus, and the response to date. The gravity and rapid development of the evolving situation was illustrated in further statements by the Minister dated 26/02/20, 28/02/20, 2/03/20, 09/03/20 and 19/03/20 [RP/71 - INQ000103636 (DoH Ref:

PM0040), RP/72 - INQ000103637 (DoH Ref: PM0041), RP/55 - INQ000103638 (DoH Ref: (PM0042), RP/73 - INQ000103639 (DoH Ref: PM0043) and RP/74 - INQ000103640 (DoH Ref: PM0044)].

99. During my preparations for Module 1, I recollect seeing the internal Executive Office document dated 20 January 2020 [RP/75 - INQ000092712], which stated that "EU exit preparations meant that NI [sic: was] more than 18 months behind the rest of the UK in terms of ensuring sector resilience to any pandemic flu outbreak". As the document appears to relate to non-health sectors, I have no particular insight into the comment, and I would suggest that the Executive Office is better placed to assist the Inquiry in respect of its general assessment of sectoral resilience as stated. However, I am aware that the impact of taking forward a major policy initiative such as EU exit resulted in the reprioritisation of other policy work across Executive departments to enable staff resources to be allocated as necessary in order to ensure that EU Exit was delivered on time. In respect of the health sector, the Department has not undertaken any analysis or other exercise to determine the impact on its pandemic response caused by the EU Exit. It should be noted that some elements of EU Exit preparations within the Department created additional public health and system resilience such as improved emergency response capability as a result of training and exercising of staff across the Department as part of Yellowhammer. This generic emergency response preparation placed the Department in a stronger position to activate its Emergency Response Plan, and to set up and staff the Emergency Operations Centre in the early stages of the pandemic.

Section 9: Contact with Sir Chris Wormald and Jim Breslin pre-January 2020

100. I had no contact with Sir Chris Wormald (Permanent Secretary, Department of Health and Social Care) at any stage during the pandemic. In the early stages of the pandemic, I had two conference calls with Simon Stevens (Chief Executive, NHS England) and my counterparts in Scotland and Wales (one in March and one in April 2020). These were in my role as HSC Chief Executive rather than Permanent Secretary and focussed on the operational pressures facing the service, rather than discussion of policy responses, etc.

101. Throughout April, May and the early part of June 2020, I had a brief weekly telephone call with Jim Breslin (Secretary General, Department of Health, Republic of Ireland) where we

shared an overview of the pressures on our respective systems, and our overview of issues. Prior to this, I don't recall any dialogue with Mr Breslin on pandemic related issues.

Section 10: Virus Suppression, Public Behaviours & Modelling

102. During the period January to March 2020, and throughout the pandemic, the Department's primary objective was to minimise the health consequences; save lives by preventing severe disease and deaths; prevent the health service from being overwhelmed; and ensure that people could receive the care they required. It was recognised from early in the outbreak that this was a highly transmissible respiratory virus and while it was initially hoped that the outbreak might be contained and of limited duration, this rapidly proved not to be the case. In relation to suppression of the virus, it was recognised that NPIs had significant societal, educational, and economic consequences. Therefore, for Executive Ministers, in March 2020 the choices in respect of NPIs represented a series of difficult decisions about the least-worst options. As such the Executive had agreed that NPIs individually and collectively would only remain for as long as was necessary to protect the public and the health service from being overwhelmed. To assist with this decision making and to ensure openness and transparency about the basis on which these decisions would be made, on 12 May 2020 the Executive published a paper entitled "Executive Approach to Decision-Making" [RP/76 - INQ000137371 (DoH Ref: MMcB5001)]. This paper set out the five 'Guiding Principles' for future Executive decisions on regulations. Principle 2, Protecting healthcare capacity, stated: *the healthcare system should have sufficient capacity to treat Coronavirus patients while phasing in the reintroduction of usual health and care services. The system should not be allowed to be overwhelmed by a second or subsequent wave of the pandemic.* This reflected concerns regarding a second wave happening later in 2020. Modelling at the end of March/start of April 2020 indicated that we would potentially face a second surge, which later became known as a second wave.

103. In respect of whether the information conveyed at the SAGE meeting on 10 March 2020 [RP/77 - INQ000061522], as to likely transmission in the UK, impacted upon the thinking of the NI government: I understand that the initial estimates of the potential impact of the pandemic in NI were based on the SAGE (SPI-M-O) consensus estimates of the 2 March 2020 extrapolated for the NI population. On the 1 April 2020 the Department announced the consensus estimates of the NI modelling group based on the outputs from several different models (see paragraph 78 above). This informed further intensive hospital planning for the anticipated surge in Covid-19 cases.

104. In relation to consideration being given by the Department on the impact of "behavioural fatigue" on the population of NI: CMO had access to evidence on the effectiveness of NPIs and behavioural interventions. This information, informed by CMO's discussions with the CSA and Deputy CMOs, informed the advice to the Health Minister and consequently to the Executive in NI. Behavioural considerations were addressed along with enforcement through the cross-government Adherence Group established by the Executive Office.

105. During the pandemic there were a number of sources of evidence on public adherence to NPIs including survey results and analysis of open-source mobility data via Google. On 20 April 2020 a new Coronavirus (Covid-19) Opinion Survey was launched by the Northern Ireland Statistics and Research Agency (NISRA) to measure how the Covid-19 pandemic was impacting on people's lives and behaviour in NI. Approximately 22,000 people participated in the survey, providing data on a wide range of relevant topics. The reports focused on behaviours such as Hygiene Behaviours, Social Distancing, Face Coverings and Slowing the Spread of Coronavirus (Covid-19). The Department also commissioned Queen's University Belfast (QUB) to conduct a contact matrix survey and the Executive Office commissioned Ipsos Mori to also conducted surveys. Adherence was reasonably good on the part of most of the public.

106. In addition, a Memorandum of Understanding was entered into on 7 April 2020 by the Departments of Health, and their respective agencies, from NI and the Republic of Ireland. The Memorandum, 'Covid-19 Response – Public Health Cooperation on an All-Ireland Basis' [RP/78 - INQ000130355 (DoH Ref: PM0171)], focussed primarily on the following key areas: modelling, public health and NPI measures; common public messages; behavioural change; research; and ethics. Consistent with the MOU, there was for example, very close and effective cross border cooperation by the public health organisations and Departments from both jurisdictions to address high transmission rates in certain border counties. This involved joint public health messaging and evidence-based intervention to affect behaviour change to reduce community transmission.

Section 11: Northern Ireland-Republic of Ireland Cooperation & Single Epidemiological Unit

107. In this section I set out my views on whether the island of Ireland should have functioned as a single epidemiological unit during the pandemic; and the extent of the cooperation between NI and the Republic of Ireland to address the impact of the pandemic.

108. Ministers will be better placed to assist the Inquiry concerning any consideration that was given within the Executive as to whether NI might have an 'island advantage' if it aligned its policies or approaches more closely with the Republic of Ireland. It was not my role as Permanent Secretary to offer advice about aligning the approach in NI with that of the Republic of Ireland, which strays well outside the area of health policy. That said, there may be a health input to the consideration of the wider issue, but no specific policy papers were requested from, or prepared by, the Department on such a harmonisation approach, nor does the Department understand that any such papers were developed by the Executive Office. In relation to this I have no recollection of whether consideration was given to the cross-border animal health model in the context of Covid-19.

109. At various times, the epidemiology differed between NI and the Republic of Ireland as it did between the various parts of the UK, and indeed within regions at the individual county level. At other times the epidemiology in NI was much closer to that of the Republic of Ireland than the rest of the UK. That the island of Ireland acted as a single epidemiological unit throughout the pandemic was recognised at an early stage and was a point made repeatedly by CMO and CSA throughout the pandemic. The SAGE comments in its paper of 12 May 2020 [RP/79 - INQ000346698 (DoH Ref: PM0374)] were echoing points made by CMO and CSA at SAGE and other fora. A decision to pursue a joint Northern Ireland/Republic of Ireland response would have been a political one requiring the agreement of the NI Executive and the Republic of Ireland's Government and also a matter to be resolved between the Republic of Ireland and the UK government. In my view, the complexity of the associated issues means that the optimum point for consideration of them would not be in the pressurised environment of a pandemic response, but rather at a much more benign time.

110. The Republic of Ireland and NI are separate jurisdictions, each with an elected Government and respective Ministers accountable for policy decisions in their own jurisdiction. The constitutional position is that NI is aligned with the United Kingdom in terms of its response to health emergencies. The Government in the Republic of Ireland had its own separate advisory structures and committees in addition to European expert advisory structures such as the European Centre for Disease Control. While there were some differences in interpretation of emergent science, data and emphasis, the advice was generally broadly

consistent and the public health advice and introduction of NPIs in both jurisdictions was broadly aligned with some differences in timing and extent as determined by policy decisions.

111. Examples of policy alignment between NI and the Republic of Ireland include: the travel Data Sharing Agreement between the Public Health Agency in NI and the Minister for Health (Republic of Ireland) Ireland on 15 October 2021 [RP/80 - INQ000346692 (DoH Ref: PM0366)]; the NI Covid Proximity App was the first globally to function as a cross jurisdictional app. Interoperability with the Republic of Ireland proximity app to exchange anonymised location and proximity information was particularly important due to the existence of the land border and regular cross border interactions; and at certain points during the pandemic high community transmission was observed in some Border Counties. This was discussed at the weekly NI/Republic of Ireland CMO meeting and joint actions was agreed. For example, in response to high case numbers in the council areas of Donegal in the Republic of Ireland and Derry and Strabane in NI there was joint messaging by the CMOs on the high levels of transmission. This was underpinned by joint work between the PHA in NI and the Heath Service Executive in the Republic of Ireland.

112. The advice given to respective Ministers to inform policy decisions in each jurisdiction was based on the trajectory of the pandemic, relevant modelling, and health service pressures in each jurisdiction at points in time. Consequently, advice and subsequent policy decisions by Ministers, for example on the use of NPIs, will have necessarily differed at various points. In addition, Ministers were considering not only the health consequences but also the wider societal and economic factors within their respective pandemic responses. These policy differences were understandably the subject of media coverage and commentary by independent and academic authorities and wider political commentary. At various times there was at least the potential to dilute important public health key messages and much effort was required to ensure there was public understanding of the rationale for public health advice and policy decisions in respective jurisdictions and where these differed and why.

113. In respect of time constraints on the ability of NI Ministers to respond to Covid-19 interventions announced by the Republic of Ireland's Government, it is likely that this was due to the Irish Government's desire to control and manage the flow of information to the media. One example of this was the difference in the timing of the decision on schools' closure between NI and the Republic of Ireland which was subjected to political and media commentary.

114. Exhibit [RP/81 - INQ000232525] concerning the note of the meeting of 12 March 2020, held between the then Head of the Civil Service, the First Minister and the deputy First Minister records the difference in the timing of the introduction of restrictions, including closure of schools, between NI and the Republic of Ireland. The health advice which informed the decision by the Executive to close schools in NI and the timing of closure was based on a range of factors, including the expert medical and scientific advice available from the SAGE; European Centre Diseases Prevention and Control Guidance; Public Health England and the consideration of that evidence by the CMO. The decisions taken by the Republic of Ireland were based on advice which it had commissioned. There was concern that introducing restrictions precipitously, not based on the NI medical and scientific advice provided to the Executive, would potentially result in an unplanned response to the pandemic by undermining the emergency planning that was underway and potentially result in panic. The fact that the Covid-19 outbreak had progressed further in the Republic of Ireland (and in some other European countries) may have influenced those countries to close schools earlier than was decided in NI. I do not recollect any consideration given between January and March 2020, to seeking agreement about closing NI's border or seeking to agree a border closure which applied to the whole of the island of Ireland.

Northern Ireland – Republic of Ireland Co-operation and Information Sharing

115. The North South Ministerial Council operates on both a plenary and sectoral level. The plenary level involves engagement of the heads of government and their respective ministerial teams. I can understand the observation of the Finance Minister, on 10 March 2020, at an Executive Committee meeting that *"North/South Ministerial Council is overly bureaucratic.* Need to be able to react" [RP/66 - INQ000065695]. The North South Ministerial Council was not designed to be a body which reacts to civil emergencies. The sectoral engagement is at departmental level working on shared policy responsibilities.

116. The health administrations in NI and the Republic of Ireland, working through the sectoral engagement, have worked together on longstanding cross-border cooperation in the delivery of health services such as the All-island Childrens' Heart Disease Network and the joint funding of the North West Cancer Centre. It was therefore expected that this cooperation would be extended to combatting Covid-19 as evidenced when Ministers from the NI Executive and the Republic of Ireland Government met on 14 March 2020 to discuss North-South cooperation in dealing with the pandemic. At that meeting the Ministers affirmed that:

"*everything possible will be done in coordination and cooperation between the Irish Government and the NI Executive and with the active involvement of the health administrations in both jurisdictions to tackle the outbreak. Protection of the lives and welfare of everyone on the island is paramount, and no effort will be spared in that regard*".

117. This affirmation was brought into effect in the form of a Memorandum of Understanding (MOU) entered into on 7 April 2020 by the Departments of Health, and their respective agencies, from NI and the Republic of Ireland. The Memorandum, 'Covid-19 Response – Public Health Cooperation on an All-Ireland Basis' [RP/78 - INQ000130355 (DoH Ref: PM0171)], focussed primarily on the following key areas: modelling, public health and NPI measures; common public messages; behavioural change; research; and ethics. While cooperation on commissioning modelling did not occur due to other competing priorities and capacity constraints, the health bodies did share information and data during the pandemic.

118. The MOU was not a substitute for extant arrangements for engagement at official and Ministerial level between respective jurisdictions. Rather the MOU provided an additional framework underpinning these arrangements. Given the demands of the pandemic response it was not possible to formally access the effectiveness of the MOU. The Department is not aware of any similar agreements between the other nations of the UK or an assessment of their effectiveness which may provide comparative analysis. Following a request by the Health Minister, and discussions between the CMOs for NI and the Republic of Ireland, the Institute of Public Health Ireland was asked to prepare and coordinate a Rapid Review assessment of the effectiveness and contribution of the MOU to the strategic and operational response to the Covid-19 pandemic. This work did not progress, and the draft terms of reference were not finalised. Even though there was no formal record or assessment of the outcomes of the MOU, there was very effective cooperation, regular engagement, and continued close working relationships at official level between the two jurisdictions throughout the pandemic as set out below. The professional collaboration historically and during the pandemic between the CMOs, their respective teams and public health agencies was effective and of significant benefit during the pandemic.

119. In practical terms the sharing of information and collaboration between respective CMO offices and officials in the two Departments of Health was very effective during the pandemic. While not formally meeting in North South Ministerial Council format, the two health departments had weekly meetings jointly chaired by the CMOs of NI and the Republic of

Ireland. The meetings were attended by the CSA from NI, Deputy CMOs from both jurisdictions and respective subject-specific policy lead officials. Data was shared in relation to the pandemic trajectory and information concerning the policies covering international travel in relation to border health measures. An academic qualitative review of public health policies for Covid-19 in NI and the Republic of Ireland was undertaken during the first wave of the pandemic [RP/82 - INQ000137387 (DoH ref: MMcB052)]. This study concluded: *"that notwithstanding the historical and constitutional obstacles to an all-island response to Covid-19, there is evidence of significant public health policy alignment brought about through ongoing dialogue and cooperation between the health administrations in each jurisdiction over the course of the first of the first wave of the pandemic."*

Barriers to Co-operation and Information Sharing

120. I am not aware of any diplomatic barriers to cooperation. CMO and CSA are better placed to assist the Inquiry in assessing whether there were any practical barriers to obtaining cooperation such as different technical medical and scientific systems. Ministers are better placed to assist the Inquiry in assessing whether there was any broader reluctance on the part of the Republic of Ireland to share information or to further cooperation with NI for political reasons.

121. I am not aware of comparative analyses of health outcomes being 'actively discouraged' between administrations, north and south as referred to in exhibit "Obstacles to Public Health that even pandemics cannot Overcome: The Politics of Covid-19 on the Island of Ireland" [RP/82 - INQ000137387]. The position is that there are no structural arrangements in place to facilitate this. The All-island Children's Heart Disease Network provides a potential model for cooperation on the analysis of outcomes. This cross-border service, involved hospitals in Belfast and Dublin submitting comparative data on procedures to the UK National Cardiac Disease Audit in the period before surgery was ended in the Belfast Trust.

Data Comparisons

122. In general terms, data comparisons between NI and the rest of the UK are likely to be somewhat more reliable as data collection and flows were similar. The Department's view throughout the pandemic was that the virus proceeded largely in a similar way across the island of Ireland, with transmission higher at some points in NI and at some points in the Republic of Ireland. Given freedom of movement across the Northern Ireland/Republic of Ireland border it is unsurprising that this was the case. At times the Department was

concerned at the possibility for transmission from the Republic of Ireland to NI given policy differences, and at times Republic of Ireland officials indicated that they were concerned about the reverse case.

123. Differences in testing strategy and test numbers between NI and the Republic of Ireland make comparisons of case numbers across the two jurisdictions problematic and papers have been produced on this matter, for example [RP/83 - INQ000346713 (DoH Ref: PM0410)]. The Department's view is that this is an example of a flawed analysis which does not take into account differences in testing. When there is more testing, more cases will be detected. In general, testing was higher in NI than in the Republic of Ireland throughout the pandemic, and this was the case for the period included in the paper. Therefore, any analysis which relies on case numbers, but which fails to take testing differences into account is liable to give rise to misleading results.

124. The attached paper RP/83 - INQ000346713 (DoH Ref: PM0410)], based on genetic sequencing data, indicates a much more complex picture across the course of the pandemic which is more aligned with the Department's view at the time. Infection moved both ways, from NI to the Republic of Ireland and from the Republic of Ireland to NI, and the balance of directional flow varied at different times during the pandemic. This paper (and the Department's view at the time) does not support NI as a major source of transmission to the Republic of Ireland during the first year of the pandemic.

125. I am not aware of any work at official level to examine whether greater harmonisation or co-operation with the Republic of Ireland might have produced better outcomes in NI. I understand that due to the different systems for capturing data related to testing and the reporting of deaths in NI and the Republic of Ireland it has not been possible to carry out research aimed at understanding the impact of Covid-19 along the Irish border. The lack of comparable data was a limiting factor during the pandemic and means that it is difficult to also assess whether the Republic of Ireland had better outcomes and reduced deaths from Covid-19.

Section 12: Clinically Vulnerable & Section 75 Groups

126. The Department played a significant role in providing public information and communications on the risks to public health, the rationale for NPIs and the benefits of these to the community, and in particular to those people who were most vulnerable to the virus and

who stood to suffer particular disadvantage due to their medical condition in the event that there was a lockdown. The Department's response to the pandemic in these areas contributed to our approach to providing targeted advice and guidance to those of all ages at very high risk in the community as to how they might shield themselves so as to avoid contracting the virus. The Executive Office is better placed to assist the Inquiry in providing information in relation to data collection about other groups within Northern Irish society who stood to suffer particular disadvantage in the event that there was a lockdown.

127. Work in this area was led from within the Department's CMO Group. The designation of the Clinically Extremely Vulnerable (CEV) categories of medical conditions, was informed by the information and advice provided via the Department's participation in the UK National Clinically Extremely Vulnerable Group. Public Health England and SAGE guidance in relation to concerns about the risk of high mortality among the clinically extremely vulnerable as a consequence of Covid-19 infection also informed the development of the Department's policy in this area.

128. Work across the four UK jurisdictions to develop guidance and specific supports for the Clinically Extremely Vulnerable proceeded at a rapid pace during March 2020 before the first lockdown. The CMO for England circulated a short briefing note for the Prime Minister in respect of shielding, and this was shared with the other UK CMOs on 15 March 2020 RP/84 - INQ000346717 (DoH Ref: PM0433)]. There were also direct communications between the Executive Office and the cabinet office on the policy intent of having a UK-wide approach to the shielding policy [RP/85 - INQ000346719 (DoH Ref: PM0434)]. Work in this area was led by a combination of advisers from within the CMO Group and policy staff from the Department's Primary Care Directorate. The advisers led on definitional issues, whilst the Primary Care Directorate team led on the overall policy and operational issues, such as using the available data for the issuing of advice letters (in partnership with the HSCB and HSC Trusts) to the CEV population, and the establishment of supports for the CEV population. The work on these supports was carried out in partnership with other stakeholders such as the Department for Communities.

129. The CMO and Deputy CMOs were fully engaged in the UK CMOs and the UK expert panel review of emerging evidence and discussions to identify those most at risk. This work also considered approaches to protect the most vulnerable including the ongoing review of the appropriateness and proportionality of these measures given the significant impact in terms of loneliness, isolation and mental health. In concert with other UK nations, the CMO

advised on the recommendations in relation to "shielding and the CEV cohort". The Department's approach was informed in due course by its participation in the UK National CEV Group and consideration of SAGE guidance.

130. The definition of CEV initially used by all four jurisdictions in March 2020 was agreed by the four UK CMOs. However, it remained the case that each of the administrations could diverge from this definition if it so wished. Under the UK wide criteria General Practitioners also had a degree of flexibility to include patients they judged to be at high risk in the supports provided for the CEV. People living with other underlying health conditions were identified at a UK-wide level as part of a wider clinically vulnerable group. The clinically vulnerable were not included in the shielding group but were advised to follow strict social distancing measures instead.

131. The development of policy interventions to identify potential mitigations to assist CEV people moved forward at pace around the date of the first lockdown and into the early months of the pandemic. I am unable to be precise about the extent to which this work started before the first lockdown. The interventions included:

- in the absence of specific vaccines or medical treatments shielding advice was introduced by the Department on 25 March 2020. Letters were issued through GPs to those identified as clinically extremely vulnerable [RP/86 - INQ000130313 (DoH Ref: PM0058), RP/87 - INQ000120706 (DoH Ref: PM0059), RP/88 - INQ000130388 (DoH Ref: PM0242)] via HSC Trusts to specific patient groups, who were known to them in March 2020. The bulk of letters were issued on 27 March 2020 by GPs. This letter advised individuals who fell into this group to 'shield' themselves by staying at home and avoiding all face-to face contact for the next 12 weeks. The letter provided information about actions to take in order to do so; how to access further information and support, including through the NI Community Helpline; advice on indoor exercise and mental health tools as well as providing general information on the pandemic response;
- information and guidance for people who were CEV, and for those who were in the wider clinically vulnerable category, was also available on the NI Direct website, which was the primary source of advice and guidance for the public over the course of the pandemic and which

provided signposting to other sources for advice and support, including support for mental health and well-being, such as the Minding Your Head website. Information was also available via the 'Covid-19 NI' app, with an on-line version of the app also available;

- the Northern Ireland Covid-19 Community Helpline, managed by AdviceNI, was available 7 days a week to support anyone who was feeling isolated or vulnerable, (whether or not they had received a shielding letter) and to provide support with accessing food and other essentials such as medicines. Early in the pandemic arrangements were put in place to collect and deliver medication to patients who were isolating or shielding. The Community Helpline was able to connect people to a range of practical and emotional support services, including local volunteer supported shopping and local or community food support organisations;
- the Department for Communities played a key role in arrangements to support communities and people during the pandemic, including food box deliveries to those who were unable to access food through online shopping, family, friends or local support networks and those who were shielding. The Department of Health worked with the Department for Communities in putting in place arrangements for priority access to online grocery shopping slots for those who were CEV, in place from early May 2020 until shielding paused on 31 July 2020. There is an extensive active network of community and voluntary organisations in NI which to some extent helped to identify hardship within communities and to target assistance. For example, Departmental funding of £600,000, which covered the period from December 2020 to 31st March 2021 enabled charities to deliver a range of key services to support people living with cancer during the pandemic;
- tailored information and self-help guides from local mental health and well-being charities were available at the Covid-19 Virtual Wellbeing Hub, which launched in mid-June 2020. These resources were designed to help promote positive mental health and well-being both during and after the Covid-19 pandemic.

Section 75 Duties

132. The Executive discharged its duties under section 75 of the NI Act 1998 in relation to impact assessments prior to the imposition of the lockdown, by inserting text in the Explanatory Note for each set of restriction regulations explaining that *"No impact assessment has been prepared for these Regulations*". During wave 1, the accompanying Explanatory Memoranda outlined that the public health restrictions and requirements introduced by the principal Regulations were part of a range of measures designed to assist and support efforts to protect the population of NI by seeking to limit the spread of coronavirus disease. It was further stated that, given the rapidly evolving global situation regarding the spread of coronavirus disease, there had been no assessment of equality, regulatory, or financial impacts in relation to the Statutory Rules.

133. From the second Review of the Health Protection (Coronavirus, Restrictions) (Northern Ireland) Regulations 2020 [[RP/89 - INQ000400102 (DoH Ref: PM0399)] and thereafter throughout Wave 1 of the pandemic RP/90 - INQ000346706(DoH Ref: PM0400)], RP/91 - INQ000346707 (DoH Ref: PM0401), RP/92 - INQ000346708 (DoH Ref: PM0402)] and subsequent waves, the Executive papers considered not only the impact of the Coronavirus pandemic itself but also the measures put in place to control the spread of infection. The wider health, societal and economic impacts of the regulations were integral to weighing up the continuing necessity and proportionality of the restrictions and were also part of the consideration of each individual new measure proposed. This information was supplemented by the Monitoring of 'Making Life Better' Indicators and supported by a number of pieces of work taken forward at the UK level by the Department of Health and Social Care and Public Health England, including work to examine the apparent disproportionate impact of Covid-19 on the BAME population as well as marginalised groups such as the Roma community. I am not aware of any additional impact assessments concerning the restrictions imposed at the end of December 2020 upon vulnerable population groups within NI or upon those who stood to be disproportionately affected by them. The findings of the survey [RP/93 - INQ000344088 (DoH Ref: PM0060)] carried out by the Patient and Client Council in July 2020 into into the views and needs of the CEV population, was a regular factor in influencing the Department's thinking, from summer 2020, in relation to the CEV population including decisions on pausing shielding and the updating of guidance for the CEV population, for example at Christmas 2020.

Mitigating steps to provide assistance to vulnerable people

134. It is regrettable that the Executive was unable to follow the optimum approach in discharging its duties under section 75 of the NI Act 1998 when making decisions about NPIs including the overall imposition of the lockdown, This was due to the volatile environment

within which policy related to the restrictions was being developed and the need for the Executive to move quickly in taking decisions in order to save lives and protect the health service. However, the Executive did take mitigating steps to provide assistance to people in Section 75 groups as set out below.

135. On 9 April 2020, Executive Ministers announced the following spending allocations to support the most vulnerable in society.

136. £15.3 million had been identified to support initiatives for the most vulnerable in society including a weekly food box service for over 10,000 people, grants for older people and support for the homeless. An additional £10 million was provided towards further interventions to support vulnerable members of society; and an additional £0.4 million went to the Youth Service to support the Department for Communities' provision of food for vulnerable young people.

137. The Health Minister, in partnership with the Education Minister, outlined a package of measures, worth around £12 million, to support vulnerable children and the children of key workers. They included:

- a bespoke Approved Home Childcare Scheme aimed at enabling key workers to have their childcare needs met in their own homes;
- enhanced support for registered childminders who provided childcare for key workers and vulnerable children;
- support for registered daycare settings to remain open for key workers and vulnerable children in locations where key worker parents needed them most and for those settings which had been forced to close;
- childcare advice and guidance for parents who were key workers, including a helpline; and
- advice and guidance for registered settings and providers.

138. The Infrastructure Minister and Agriculture, Environment and Rural Affairs Minister put further community transport measures in place to ensure vulnerable people in rural areas isolated as a result of Covid-19 had access to vital services:

- community transport operators were able to repurpose Dial-A-Lift services to help the most vulnerable, such as the elderly and the disabled, to access shops and services for everyday requirements;

- instead of transporting people to services, services would be transported to the most vulnerable.

139. The DAERA Minister also announced that £200,000 had been allocated to the emergency 'Coronavirus Community Fund'. The Community Foundation NI considered applications for grants up to £10,000 to community organisations to deliver targeted practical support for the vulnerable and isolated, especially in rural areas and for those of all ages who were at increased risk due to poor mental health and wellbeing.

140. On 23 April 2020 the Department, in partnership with the Department for Communities launched a jointly funded remote interpreting service for sign language users [RP/94 - INQ000346720 (DoH Ref: PM0435)]. The service enabled British Sign Language (BSL) and Irish Sign Language (ISL) users to access NHS111 and health and social care services during the pandemic. The service was available 24 hours a day, 7 days a week. Throughout the pandemic, the Department's Family and Children's Policy Directorate and the Mental Health and Capacity Unit worked with a range of partners to develop mitigations for children's services and mental health services. This included, for example: guidance for looked after children services; educational support for looked after children and their carers; working with the Executive Information Service to run a social media campaign in June and July 2020 to promote Childline, the NSPCC helpline and the 24 hour Domestic and Sexual Abuse helpline; changes to mental health service provisions, changes to protocols and measures required to ensure mental health services could be delivered during the pandemic; and support for autistic people to present clarity and flexibility in adhering to travel restrictions.

141. On 29 April 2020 the Health Minister in partnership with the Justice Minister issued guidance on maintaining contact between parents and children during Covid-19.

142. The PHA also worked to consider the impact of Covid-19 on key public health services, and to target at-risk groups to reduce the risk of harm as far as possible.

Coronavirus Related Health Inequalities Report

143. On 17 June 2020 the Department published the 'Coronavirus Related Health Inequalities Report' [RP/95 - INQ000103718 (DoH Ref: PM0209)]. This report presented an analysis of Covid-19 related health inequalities by assessing differences between the most and least deprived areas of NI and within Local Government District (LGD) areas for Covid-

19 infection and admission rates. The information in the report relates to the position as at 26 May 2020.

144. The report [RP/96 - INQ000103719 (DoH Ref: PM0210)] was prepared by the Department's Information Analysis Directorate following a discussion with me [RP/97 - INQ000130379 (DoH Ref: PM0212)] and approval from the Minister in submission SUB-1522-2020 [RP/98 - INQ000130380 (DoH Ref: PM0213), RP/99 - INQ000137392 (DoH Ref: PM0214)].

145. The key findings from laboratory completed tests were as follows. The infection rate in the 10% most deprived areas (379 cases per 100,000 population) was a fifth higher than the rate in the 10% least deprived areas (317 cases per 100,000 population) and two-fifths higher than the NI average (272 cases per 100,000 population). The rate among females (308 cases per 100,000 population) was a third higher than males (234 cases per 100,000 population).

146. The infection rate among those aged over 65 was almost two-fifths higher in the 10% most deprived areas (1,027 cases per 100,000 population) than the rate in the 10% least deprived (750 cases per 100,000 population) and almost three-quarters higher than the NI average. While infection rates were highest in the 10% most deprived areas for under 65s, over 65s, and all ages; the 10% least deprived areas had the second highest infection rate for over 65s and all ages.

147. The rate in urban areas was 90% higher than the rate seen in rural areas, however the rate was highest in mixed urban/rural areas (398 cases per 100,000 population).

148. Of those testing positive, more than a quarter (27%) were admitted to hospital for treatment, with males (39%) being twice as likely to be admitted as females (19%), and those in the 10% most deprived areas 37% more likely to be admitted than those in the 10% least deprived areas.

149. The key findings from admissions to hospital were as follows. The admission rate for Covid-19 (confirmed or suspected cases) in the 10% most deprived areas (581 admissions per 100,000 population) was almost double the rate in the 10% least deprived areas (317 admissions per 100,000 population).

150. The rate for under 75s in the most deprived decile (369 admissions per 100,000 population) was approximately two and a half times that in the least deprived decile (150

admissions per 100,000 population). In comparison, the 75 and over rate for the most deprived decile was almost two-fifths higher than in the least deprived decile. While deprivation was found to be an important factor of the likelihood of admission, age was found to have a greater impact. The standardised admission rate for the population aged 75 and over (2,255 admissions per 100,000 population) was 9 times that for the under 75 population (249 admissions per 100,000 population). [RP/99 - INQ000137392 (DoH Ref: PM0214)]

151. The Department commissioned the Institute of Public Health in Ireland (IPHI) to provide high level monitoring of the wider evidence base in relation to the impact of the pandemic, and the measures to address it, on indictors within the overarching public health strategy for NI, 'Making Life Better'. The first two reports were produced in May 2020 [RP/100 - INQ000276461 (DoH Ref: PM2153), RP/101 - INQ000276462 (DoH Ref: PM2154)]. and the third report in July 2020 [RP/102 - INQ000276463 (DoH Ref: PM2155)]. Further reports were produced throughout 2020 and 2021. Although these reports were not shared directly with the Minister, they were shared with senior officials within the Department and were used to inform the development of papers submitted to the Executive reviewing the coronavirus restrictions regulations. The level of detail provided in the papers to the Executive varied, for example, some of the papers focused on specific issues, such as physical activity and other papers summarised the evidence at a high level.

Section 13: Health Protection (Coronavirus, Restrictions) Regulations

152. In this section I set out my understanding of the process concerning the making of and amendments to the Health Protection (Coronavirus, Restrictions) Regulations in relation to the Department's engaging with the Executive and the NI Assembly. I have also commented on assessments made of the impact of the regulations on society.

153. Section 48 and Schedule 18 of the Coronavirus Act 2020 amended the Public Health Act (NI) 1967 RP/103 - INQ000391221]. to provide powers for the Department of Health to make regulations in response to the Covid-19 pandemic. Under this primary legislation the Department was alone empowered to make and amend secondary legislation to bring into effect statutory non-pharmaceutical interventions. However, the responsibility for decisions to introduce statutory non-pharmaceutical interventions lay with the Executive, as these restrictive measures impacted across the wider society and economy of NI and therefore were significant, controversial and cut across the responsibilities of two or more Ministers. In many cases the impacts of the restrictions fell within the policy remits of other Executive Ministers.

For example the Minister and the Department for Communities and the Minister and Department for the Economy had joint lead policy responsibility for restrictions affecting the hospitality and retail sectors.

154. The Executive Committee's urgent decision mechanism exists to allow a decision to be taken without waiting for consideration at the next Executive Committee meeting. The relevant Minster must set out in writing to the First Minister, the deputy First Minister and the Secretary to the Executive the decision to be taken and, so far as is practicable, the background to the issue, the views of any other Ministers with a relevant interest, the position of any other interested administrations and the consequences of deferring the decision in question pending the next Executive Committee meeting and of not taking it at all. The First Minister and deputy First Minister, acting jointly, will consider the decision in consultation with the responsible Minister, and notify him/her of the outcome of their consideration of the matter. In light of the rapidly changing circumstances, I considered that the use of the urgent decision making mechanism in relation to the NPI regulations was appropriate.

155. Therefore, the Department, with Executive agreement, introduced the series of regulations titled The Health Protection (Coronavirus, Restrictions) Regulations (Northern Ireland) 2020. These Regulations made provisions to enable a number of public health measures to be taken to reduce the public health risks posed by the spread of Covid-19. The Regulations provided for a range of restrictions and closures, as well as requiring persons to stay home by prohibiting them from leaving the place where they lived except for limited purposes (such as shopping for basic necessities, exercise, to seek medical assistance or to provide care or assistance) and banning public gatherings of more than two people. These required periodic review as specified in each regulation.

156. In each review, the Department provided an assessment of the change in case levels over that period and addressed the following issues: the number of new positive cases; Rt[4]

---

[4] [4] In epidemiology, the basic reproduction number, denoted R0 of an infection is the expected number of cases directly generated by one case in a population where all individuals are susceptible to infection. The definition assumes that no other individuals are infected or immunized (naturally or through vaccination). In reality, varying proportions of the population are immune to any given disease at any given time. To account for this, the effective reproduction number (Rt) is used, which is the average number of

for cases; Rt for admissions to hospital; the conversion rate of case numbers to hospital admissions; modelling scenarios for the time ahead; the prevalence of relevant variants; and the case numbers per hundred thousand of the population, broken down by district council area.

157. Due to the nature of the pandemic and the urgency in which the regulations had to be made, it was often the case that scrutiny of the regulations by the Assembly's Health Committee took place after the regulations came into operation. Departmental officials were invited to attend the Health Committee sessions to provide verbal evidence regarding the advice and information which informed the Executive's decisions.

158. In respect of whether Ministers were sufficiently informed as to the impact of NPIs, in relation to CMO's statement to Module 1 of the Inquiry [RP/104 - INQ000203352, paragraph 66]. it is my view that certainly by 12 May 2020 if not earlier, the Executive in publishing its 'Coronavirus Executive Approach to Decision-Making' document demonstrated that it was informed as to the impact of NPIs. This document set three key criteria for the Executive to consider in making its decisions: the most up-to-date scientific evidence; the ability of the health service to cope; and the wider impacts health, society and the economy.

159. I understand that at the Executive meeting on 7 May 2020 two papers were discussed: one that set a high-level approach as to how the Executive could ease restrictions and when, and the other a more detailed Department of Health paper. The Department's paper explained the principles and approach that was applied to this second review, and would continue to apply to subsequent reviews, of the Health Protection (Coronavirus restrictions) (Northern Ireland) Regulations 2020. Ministers are better placed to assist the Inquiry in assessing whether the comments of CMO and the Justice Minister ("....CMO said his approach was to consider the cumulative impact and provide risk/benefit analysis to provide structure & qualitative advice" [RP/14 - INQ000065724, page 6]. The Justice Minister was recorded as not being not happy with that approach and as suggesting that the papers were contradictory and amounted to "....an a-la-carte approach, which is what they would not do" [RP/14 - INQ000065724, page 8]) was indicative of a broader problem whereby Ministers wanted

---

new infections caused by a single infected individual at time t in the partially susceptible population. When Rt is less than 1, the number of cases will begin to rise more slowly and / or decline.

scientific information or advice to be more specific or directory as to what the politicians should do.

160. In relation to the E (20) 128 (C) Point in Time Review of the Executive's COVID 19 Strategy [RP/105 - INQ000065637] to inform the relaxation of restrictions, the position was that in May 2020 the Executive agreed a five-stage plan, 'Coronavirus – Executive Approach to Decision-Making' [RP/76 - INQ000137371]. This plan set out how NI would move out of NPIs, and the approach that would be taken when deciding how to ease NPIs and wider restrictions. The Executive had determined that in reaching such decisions the three key criteria would be: the most up-to-date scientific evidence; the ability of the health service to cope; and the wider impacts on our health, society and the economy. Therefore, informed by the Department's medical and scientific advice, the Executive continued to consider the public health response, while also recognising the importance of keeping society and the economy as open as possible. Critical to achieving this aim was the robust and sustained public health response to the pandemic which, in addition to the central role played by NPIs, included, for example, the successful development and roll-out of the immensely important Covid-19 Vaccination Programme, innovations such as the workplace testing programme for key sectors of the economy, and extending population access to the 'StopCOVID NI' Proximity App as part of the NI Test, Trace Protect Strategy [RP/64 - INQ000120704 (DoH Ref: PM0057)].

Section 14: CCGNI and NI Hub

161. I have set out previously – at paragraph 95 – details of the standing up, and subsequent standing down, of CCGNI and the NI Hub. While the Executive Office is better placed to assist the Inquiry in its understanding of the role and effectiveness of CCGNI and the NI Hub, my overall impression of CCGNI, through my regular participation in it, was that it was a useful information sharing forum, which facilitated all parties hearing the same message at the same time (i.e. avoiding both the inefficiency and risk of distortion arising from the repetition of points at a series of sequential bilateral discussions) particularly given the speed at which events were unfolding. In this context I feel it was a reasonable place for discussion. As far as decision making goes, this was not a strong feature of the group – but a relevant associated issue is whether this was a reluctance/inability to take decisions, or rather that decisions were not elevated to the group, but properly taken elsewhere (i.e. by individual Ministers/departments or the Executive). From the Department's perspective, I feel the lack of decision making was very much a consequence of the latter point, and I don't recall any

decisions that were elevated to the group from the Department. I recall some minor frustration by participants about the frequency of meetings when CCGNI was meeting every day (given other demands on their time) – but my view is that in an emerging and dynamic situation there is never a standard right answer to frequency, and it was not unreasonable to err on the side of too frequent at that stage, as long as meetings are properly managed so that their length doesn't extend beyond what is necessary – which I felt was the case. Having the opportunity for information exchange is, I believe, always valuable in such situations. I wasn't as closely involved in the workings of the NI Hub, and have no insights to offer as to its effectiveness.

Section 15 Planning for Wave 2

162. Throughout the spring of 2020 the Department was planning for the second wave which we fully anticipated [RP/106 - INQ000103613 (DoH Ref: PM0015)]. This assessment was also reflected in advice that the Department provided to the Executive as reflected in the then deputy First Minister's comments on 7 April 2020, at the Ad Hoc Committee on the COVID-19 Response when she said: "*Based on the recent modelling, it looks as though we will potentially face a second surge, and, if that is the case and we have another peak, we need to prepare for that now and for what is coming down the line.*" [RP/107 - INQ000371421 (DoH Ref: COMMS121)]. The Department's preparation for a second wave built on the decisions taken earlier in 2020 to increase HSC capacity for the first surge of Covid-19 cases. This included: the selection of the Belfast City Hospital's tower block as the location for NI's first Nightingale Hospital for the anticipated surge of Covid-19 patients requiring intensive care. In parallel to the Nightingale Hospital facility, assessments of options for reconfiguring other HSC hospital sites to increase critical care capacity were undertaken.

163. On 15 April 2020 the Minister commissioned [RP/108 - INQ000120712 (DoH Ref: PM0086), RP/109 - INQ000120813 (DoH Ref: PM0269), RP/110 - INQ000120814 (DoH Ref: PM0270)] a rapid review of PPE to focus on the appropriate receipt, storage, distribution, and use of PPE across the HSC system. The terms of reference for the Rapid Review included an assessment of readiness for continuing response during the pandemic wave at that time and by way of preparation for a second wave of Covid-19. A Review Panel led by the Department's Internal Audit carried out the Rapid Review with input from across the HSC system The final report was submitted to the Minister on 14 May 2020 [RP/111 - INQ000130338 (DoH Ref: PM0087), RP/112 - INQ000120815 (DoH Ref: PM0271), RP/113 - INQ000120816 (DoH Ref: PM0272), RP/114 - INQ000120817 (DoH Ref: PM0273), RP/115 -

INQ000120820 (DoH Ref: PM0274), RP/116 - INQ000120821 (DoH Ref: PM0275), RP/117 - INQ000120822 (DoH Ref: PM0276), RP/118 - INQ000346690 (DoH Ref: PM0277)]

164. The Department's Top Management Group established a project in May 2020 to assess the impact of Covid-19 on HSC services delivery to inform the production of a 'Rebuilding HSC Services Strategic Framework'. The main impact on services was a downturn in activity resulting in increased waiting times to access services. The project aimed to prioritise the services, projects and programmes that should be resumed as Covid-19 patient numbers began to stabilise. The project also recommended changes to the HSC governance arrangements to make these as efficient as possible within the challenging situation for service delivery arising from the pandemic. The changes to the governance arrangements were also informed by the findings of a series of reviews, including:

- an 'in-flight' assessment of the Health & Social Care service coordination in response to the pandemic [RP/119 - INQ000130392 (DoH Ref: (PM0228)], which reviewed the Department's emergency management structures.
- A debrief of Health Silver, organised and facilitated by the Health and Social Care Board [RP/120 - INQ000188798].
- A review of the Emergency Operations Centre, established by Emergency Planning Branch, to engage with key stakeholders to examine its effectiveness internally as well as how it interfaced with the Northern Ireland Hub and Health Silver [RP/121 - INQ000188797].

165. The Department was committed throughout the pandemic to learning lessons from the evolving situation within Care Homes and used this knowledge to further strengthen its response. On 2 June 2020 [RP/122 - INQ000103701 (DoH Ref: PM0127)] the Minister announced that a Rapid Learning Initiative was underway, to identify lessons from Care Home experiences of Covid-19. This initiative was designed to obtain input from the Care Home sector and from across the Health and Social Care system. On 17 June 2020 [RP/123 - INQ000103712 (DoH Ref: PM0169)] the Minister announced plans for a new framework for nursing, medical and multidisciplinary in-reach into Care Homes. He had asked the Chief Nursing Officer to co-design this new framework in partnership with the Care Home sector for the provision of clinical care. This framework would include examining how the Department would expand nursing, medical and multidisciplinary support, clinical leadership and specialist

skills in collaboration with care home staff, building on the important role of GPs in Care Homes. On 24 June 2020 the Minister announced that a new group had been established to learn from the Care Home experiences of Covid-19 [RP/124 - INQ000103713 (DoH Ref: PM0170)]. The group was chaired by the Deputy Chief Nursing Officer and included representation from the independent care home sector, the Health and Social Care system and the Royal College of Nursing. The Group was directed to take forward the Rapid Learning Initiative on Care Home experiences.

166. Later in 2020, in the context of a continued increase in new cases of Covid-19 in NI, to reflect on the key issues influencing provision of the contact tracing service and to provide assurances on the capacity of the contact tracing system, a Rapid Review of the contact tracing service (CTS) and its delivery model was commissioned by CMO in autumn 2020. This Rapid Review subsequently reported on 12th October 2020. The Rapid Review was underpinned by a key assumption that there would be a significant escalation in Covid-19 infections over the weeks and months ahead (from Autumn 2020) and that in order for the service to be effective, positive cases had to be contacted within 24 hours and their close contacts within 48 hours of notification to the contact tracing system. The main purpose of the Rapid Review was to support the ongoing and future delivery of the contact tracing function by looking at the elements of the CTS that had worked well, and to consider what measures were required to effect improvements in the service with a focus on more efficient and effective contact tracing processes, supported by appropriate technology and the provision of high quality management information to support oversight of the service.

Section 16: Wave 1 Covid-19 Strategy and Relaxation of Restrictions

167. The Executive's approach to the first wave of the pandemic was to focus on the public health response to mitigate the impact of Covid-19 in respect of the implementation of NPIs. The Executive's decisions concerning population-wide NPIs were informed by the medical and scientific advice provided by the Department. The medical and scientific advice provided by the Department included data and information concerning the local NI context of the trajectory of the pandemic including: estimates of R; local modelling; and analysis of the scale of pressure faced by the HSC system. The medical and scientific information and advice

presented to the NI Executive by the Department was also informed by the available information on the trajectory of the pandemic across the UK and the Republic of Ireland.

168. I am not in a position to offer an assessment of the Executive's actions. Aside from such an assessment straying outside the role of a civil servant, due to my focus on DoH matters I was not fully briefed on all issues that were in play.

169. In May 2020 the Executive agreed a five-stage plan for how NI would move out of NPIs and lockdown, and the approach that would be taken when deciding how to ease NPIs and wider restrictions (see paragraph 160 above). The paper was published on 12 May 2020 to assist with decision making and to ensure openness and transparency about the basis of decisions. I am unable to recollect whether there was a decision taken to omit from the plan indicative dates as to when restrictions might ease. However, as stated below on 25 June 2020, the Executive agreed an indicative timeline of further relaxations.

170. Up until August 2020 there had been a gradual relaxation of restrictions, with Executive decisions guided by the plan published by the Executive in May 2020. On 25 June 2020, the Executive agreed an indicative timeline of further relaxations during June, July and August which would be implemented if the R rate remained below 1. However, by mid-August 2020 there were signs that the number of Covid-19 cases was again on the increase. The increased cases of Covid-19 was likely due to people being to mix in social settings as society began to open-up following the end of the first lockdown. At their meeting on 20 August 2020 the Executive considered two papers - one tabled by the Health Minister, the first review of the Health Protection (Coronavirus, Restrictions) (No. 2) Regulations (NI) 2020 [RP/125 - INQ000276510 (DoH Ref: PM2192)]; and the other tabled by the then First Minister and deputy First Minister. The Department's review paper recorded concerns about significant local rises in virus transmission, signalling the potential need for local restrictions, but recommended that a voluntary approach be adopted at that stage. The Department also proposed tightening restrictions on indoor and outdoor gatherings, both in public spaces and private dwellings, as a matter of urgency to reduce virus transmission. These proposals were presented in the paper from the First Minister and deputy First Minister on the same day. The Executive agreed to tighten restrictions on gatherings, and the amendment regulations came into force from 25 August 2020.

171. In respect of the DAERA Minister appearing to have said that the Executive was following science *"currently unproven, best guess". The CSA "respectfully disagrees re*

science - always based on uncertainty…decisions shd be informed by science, but need to take other considerations into a/c - economic" [RP/126 - INQ000065730] and that there was "no science, just assumptions…want to see science - didn't get science. Sick of assumptions from experts" [RP/127 - INQ000065753]: my view is that decisions taken by the Executive concerning NPIs were collective decisions based on the ability of the health service to cope; and the wider impacts on health, society and the economy.

Section 17: Wave 2

August to October 2020

172. In a joint statement on 9 August 2020, the CMO and the CSA warned against carelessness and fatigue. In their statement the CMO and CSA highlighted their concerns about the increase in confirmed Covid-19 cases and the R number. They recognised the sacrifices already made by many to protect those more vulnerable to the effects of the virus and themselves. Expressing concern about the consequences of a sharp peak in cases in the autumn and winter they asked for continued vigilance and adherence to the public health advice. [RP/128 - INQ000276514 (DoH ref: PM2196)].

173. Unfortunately, the concerns expressed by CMO and CSA proved to be accurate and over the course of the autumn and winter of 2020 the Executive incrementally approved the reintroduction of restrictions to combat the spread of the virus and to prevent the health service from being overwhelmed by excessive demand from Covid-19 patients. Purely from the point of view of Covid-19 transmission in the short term, retention of restrictions would have ameliorated the extent of the pandemic in the autumn and winter. However, this would have been at the cost of increased harms in other areas as a consequence of the restrictions. Decisions about the balance required were a matter for the Executive, taking into account advice from the Department in addition to other considerations.

174. The views of the Department on the "Eat Out to Help Out" scheme were not sought, and the Department itself did not seek and was not given any specific medical / scientific advice in relation to this scheme. The decision to implement the "Eat Out to Help Out Scheme" was largely a decision made at a UK level and implemented in NI by the Department of Economy. The CMO / CSA advice was consistently that any measure which increased contacts between individuals in indoor settings would have some impact in increasing virus transmission, but that advice acknowledged that decision making needed to also take into account wider factors including economic and societal considerations. However, at the time

of the scheme the CMO and the CSA did express concern about the progression of the pandemic and advised that Ministers should reconsider their decision to reopen non-food serving pubs and bars in NI on Monday, 10 August 2020 [RP/129 - INQ000353628 (DoH ref: CSA2015)].

175. Given the numerous changes which occurred in August – September 2020 (including "Eat out to help out", schools reopening, and return to work after summer holidays) and lack of granular data, it was not possible to assess any specific impact of the "Eat Out to Help Out" scheme on virus transmission. The Department did not consider if it was possible to analyse the impact that 'Eat Out to Help Out' had on the increase in virus transmission in autumn 2020, as the interconnection of this with other factors (such as schools reopening, etc.), meant that it would not have been possible to isolate the increase as a consequence of the Eat Out scheme.

176. I understand that in October 2020 the Framework for Decision Making was introduced to 'reset' the Executive's approach to the introduction and easing of restrictions. Prior this decision there had been a progressive rise in Covid-19 cases following the introduction in September 2020 of the localised restrictions in those local areas with the highest Covid-19 case incidence. There was no reticence on the part of the Department in identifying particular locations by reference to transmission rates.

177. The increase in virus transmission in autumn 2020 was in all likelihood inevitable, given limited population immunity, ease of transmission and increased interactions indoors as weather worsened, although the relaxation of measures around this time would have somewhat accelerated the process. However, I am unable to provide an evidenced-based opinion, based upon my knowledge and belief, as to the extent to which these factors contributed to the mortality rates as seen at January 2021 or would have achieved a better outcome.

178. The Minister of Health submitted a paper to the Executive on the 13 October 2020 [RP/130 - INQ000276523 (DoH ref: PM2206), RP/131 - INQ000276521 (DoH ref: PM2204), RP/132 - INQ000276522 (DoH ref: PM2205) , RP/133 - INQ000276526 (DoH ref: PM2209)] which summarised the further progression and current state of the pandemic. The paper confirmed that the Covid-19 pandemic in NI had reached a phase of exponential growth and that immediate consideration and decisions were required by the Executive to prevent the hospital system being overwhelmed, and to prevent adverse direct and indirect health

consequences, including significant morbidity and mortality from Covid and non-Covid related conditions as a consequence of the impact on health and social care services. The paper confirmed that there was evidence that the household restrictions applied on a postcode basis and subsequently NI-wide had had some impact on reducing transmission and slowing the rate of increase in new cases. The paper also indicated that NI had also begun to see some of the counter effects of Executive decisions on the opening of higher and further education colleges and "wet pubs" as well as some seasonal impacts.

179. From a scientific perspective the paper indicated that it was unlikely that the then current NI-wide restrictions combined with an extension of the additional measures introduced for from 1 October in Derry City and Strabane local government district would be sufficient to bring R back to less than 1 and highly improbable that this would reduce R to less than 0.7. A significant package of interventions would therefore be required to prevent a further exponential rise in transmission of the virus and that no single wider interventions was likely to be sufficient. A package of measures with a level of adherence similar to the impact of the full lockdown in late March 2020 was now required. The paper outlined in detail the significant challenges faced by the health service and community care including Care Homes. The paper drew parallels with a comparable period in Wave 1 when R was significantly above 2 and the decision to move to a complete lockdown on the 28 March 2020. Modelling was presented for a range of scenarios including reducing R to 0.7 or 0.9 for varying periods of time of between three and six weeks to illustrate the impact of difference decisions.

180. The Department of Health's paper presented four options for the Executive to consider:

- Option 1) an intervention to include the following components[5] to commence as soon as possible but no later than 16 October 2020 and lasting for between three to six weeks;

---

[5] Maintenance of then existing household restrictions. Bubbling to be limited to a maximum of 10 people from 2 households. No overnight stays in a private home unless in a bubble. Work from home unless impossible to do so. Closure of schools with delivery of distance learning

- Universities and further education to deliver distance learning to the maximum extent possible

- Option 2) four-week intervention with the same restrictions as in Option 1 but with school open in weeks one and four;
- Option 3) six-week intervention with same restrictions as on Option 1 but with schools open in week one and weeks four to six;
- Option 4) six-week intervention to allow for other minor relaxations or reduced compliance compared with Wave 1.

181. The paper [PM/X - INQ000276523 (DoH ref: PM2206)] concluded that both the CMO and the CSA recommended Option 1, an intervention to include the measures listed in the paper for implementation as soon as possible and no later the 16 October 2020. It was suggested that this should ideally last for a period of six weeks or between four and six weeks to prevent the health service being overwhelmed and avoid direct and reduce indirect adverse health consequences including excess deaths. I agreed with this advice and recommendation.

182. The Executive discussed the Department's paper and a further paper submitted by The Executive Office, "Consolidated Impact Assessment and Proposals for Restrictions" paper. This Executive Office paper summarised the proposals in the Department's paper alongside consideration of the economic impact of restrictions. The Executive Office paper recommended that the Executive agree that interventions aimed at a major reduction in the rate of transmission were needed immediately; and that the Executive consider the options on what those interventions should be.

183. The deputy First Minister advised the Executive meeting that the Health Minister's paper had been largely transcribed into the Executive Office's consolidated paper with some

---

Closure of the hospitality sector apart from deliveries. Closure of indoor shopping centres and retail which cannot be accessed from outside. Closure of close contact services apart from those meeting essential health needs. No indoor sport of any kind or organised contact sport involving household mixing other than at elite level, No mass events involving more than 25 people regardless of risk assessment (except for allowed outdoor sporting events). Churches remain open for private prayer. Wedding ceremonies to be limited to 25 people with no receptions. Funerals to be limited to 25 people with no pre- or post-funeral gatherings. No unnecessary travel.

amendments, including reference to sales of alcohol in off licenses and supermarkets ending at 8.00 p.m., and indoor shopping centres to remain open, combined with urgent engagement with the retail sector to ensure that it was doing everything it could to help suppress the virus.

184. The substantive discussion at the Executive was of the recommendations included in the Executive Office paper. The minutes of the Executive meeting describe the discussions which took place and the decisions agreed by the Executive. The minutes also record a number of different concerns raised individually by the Minister of Agriculture, Environment and Rural Affairs; the Minister of Justice; the Minister for Infrastructure; the Minister for the Economy; and the Minister of Education. These included concerns about the proposed restrictions: the scientific basis for the restrictions; the impact on weddings and funerals; the economic impact; and the educational impact. However, the Executive agreed a four-week period of interventions, which took regulatory effect from the 16 October 2020, and which was scheduled to expire at midnight on 12 November 2020. This was subsequently announced, and regulations drawn up alongside appropriate public messaging. The decisions taken by the Executive at this meeting included an extended half term school holiday for two weeks. The trajectory of the pandemic remained under close review during the four weeks with weekly publication of the R paper and regular update presentations by the CMO and the CSA to the Executive.

185. I am unable to assist the Inquiry with any specific insight into the DAERA Minister's comments at the Executive meeting on 8 October 2020. The suggestion made at the Assembly's Health Committee meeting on 15 October 2020 that modelling work had significantly underestimated the development of the pandemic in Northern Ireland at that point was not correct.

November 2020

186. The background to the Executive meeting of 9 November 2020 is set out in the following paragraphs. On 9 November 2020, an update was provided to the Executive by the Health Minister, the CMO and the CSA which included developments in the Covid-19 pandemic, including the R number; the position in Care Homes; number of deaths; admissions to hospitals; contact tracing figures; capacity of the testing system. At this meeting the Minister provided a paper modelling the course of the pandemic and recommended to the Executive

that an intervention to reduce R to 0.7 was required as soon as possible to prevent the hospital system from being overwhelmed and to prevent deaths [RP/134 - INQ000276539 (DoH ref: PM2220)]. The paper recommended that the four-week circuit breaker restrictions introduced on 16 October 2020 (see paragraph 184 above) should be extended for a further two weeks. The discussion of the Minister's paper of 9 November 2020 continued in reconvened Executive meetings on the 10th, 11th, and 12th of November 2020. It is understood that these additional meetings were required to enable the Executive to reach agreement on the Minister's recommendation. The Executive minutes of 9 November 2020 record the following: *"The deputy First Minister advised of her and the First Minister's wish to achieve Executive consensus on the way* forward. All Ministers gave their views on the paper provided by the Minister of Health; and on proposed approaches to COVID related measures to ensure protection for the health service while recognising the importance of facilitating economic activity. Ministers discussed a range of proposals regarding amendments to the restrictions currently in place, and the partial reopening of some sectors of the economy, and the potential risks associated with each position, including of no decision being taken on extending the regulations."

187. While initially some Executive Ministers supported the Minister's proposal, it failed to pass a cross community vote. Following this impasse, written correspondence was received from Conor Murphy MLA, Minister for Finance [RP/135 - INQ000276540 (DoH ref: PM2221), RP/136 - INQ000276541 (DoH ref: PM2222)], Nicola Mallon MLA, Minister of Infrastructure [RP/137 - INQ000276542 (DoH ref: PM2223)] and Naomi Long MLA, Minister of Justice [RP/138 - INQ000276543 (DoH ref: PM2224)]. On 10 November 2020 the Minister for the Economy, Diane Dodds MLA, introduced a paper entitled "Economic Impact of the Four Week Circuit Breaker and Proposed Recommendations (DFE)". On 11 November 2020 the CMO received a Joint Letter from the Finance and Justice Ministers [RP/139 - INQ000276544 (DoH ref: PM2225)]. On 11 November 2020 amended proposals from the Economy Minister entitled "'Executive Options Outline", were circulated. A subsequent proposal from the Health Minister [RP/140 - INQ000276691 (DoH ref: PM2372)] which responded to the latest proposals from the Economy Minister proposed that the Executive should agree a one week extension of the restrictions, but this also failed to secure the agreement of the Executive. On 11 November 2020 the Health Minister wrote to Executive colleagues commenting on proposals from the Justice Minister and highlighting the need to respect the Ministerial code with regard to Executive decisions [RP/141 - INQ000276545 (DoH ref: PM2226)]. The same day there was further discussion on proposals which had been made by the Justice Minister.

188. At the conclusion of the meeting on 12 November 2020 the Executive agreed a paper brought by the Economy Minister, which provided for a one-week extension of the four-week circuit breaker restrictions with a partial reopening of some sectors from 20 November 2020[6] including:

a. Close contact services including driving instructors would reopen by appointment on 20 November 2020;
b. Hospitality would reopen on a graduated basis, with unlicensed premises such as cafes and coffee shops opening on 20 November 2020, with restricted opening hours to 8.00pm. This would not include the purchase or consumption of alcohol on such premises;
c. Support would be provided for mitigations to reduce risk within the hospitality sector, including improved ventilation and requirements for the recording of customer information for contact tracing purposes;
d. Pubs and bars would be permitted to sell sealed off-sales on 20 November 2020; and
e. The remaining restrictions, which came into being on 16 October 2020, would be extended and come to an end at midnight on 26 November 2020, leaving all elements of hospitality including hotels able to open on 27 November 2020.

189. The Executive also agreed steps in relation to financial support for affected businesses; vaccination; strengthening adherence/compliance to restrictions; contact tracing; testing; and other mitigating measures for the hospitality sector. The final minutes of this Executive meeting record the range of opinions expressed by Executive Ministers regarding this decision. In this instance the minutes of the Executive meeting record that the Minister of Health had supported the Executive's decision, to agree a one-week extension to restrictions, as a compromise measure, but that his preference would have been for a two-week extension of the regulations as outlined in his original paper. The minutes of the meeting also record the advice provided by the CSA and the CMO.

---

[6] The Health Protection (Coronavirus Restrictions) (No.2) (Amendment No.15) Regulations (Northern Ireland) 2020

190. I understand that the Executive's difficulty in reaching agreement was in relation to Minister's wanting to ensure that the eventual decision taken by the Executive took into account a range of factors including protecting the health service and the potential impact on the economy and the community of an extension to the four-week circuit breaker. I am not aware of broader Ministerial concerns about the quality of the modelling. The scientific modelling, produced by the Modelling Group, did not provide estimated data or information about the potential impact of restrictions on individual business sectors.

191. The tone of the Executive meeting on 9 November 2020 was captured by the Minister in his statement on 13 November 2020 [RP/142 - INQ000276546 (DoH ref: PM2227)] in which he remarked: "*this has not been a good week for the Executive. Whilst the pandemic has undoubtedly confronted us with many immensely difficult decisions, the people and businesses of Northern Ireland deserved so much better than the leadership and political stewardship they were given. There is huge work required to repair the damage that has been caused but I would urge Ministers to look forward to the very real issues at hand rather than repeat the arguments that have been exhausted over recent days. At the forefront of all our minds is that the pandemic remains an immediate and serious public health threat. We must also remember why we decide to take the decisions we do.*"

192. The background to the Executive meeting of 19 November 2020 is set out in the following paragraphs. I understand that. following the cross community vote at the Executive meeting on the 9 November 2020, the Minister decided not to include specific recommendations in the paper submitted for the 19 November 2020 Executive meeting, as he was of the opinion that specific recommendations would again potentially result in a cross-community vote without proper consideration being given to the contents of the paper, such was the political tension at that time. By not including a recommendation the Minister aimed to ensure that the entire Executive would consider the full paper and its contents.

193. The paper presented to the Executive meeting on 19 November 2020 was titled "Modelling the course of the COVID pandemic and the impact of different interventions and recommendations" [RP/143 - INQ000137370 (DoH ref: MMcB038)]. This paper outlined the current position and likely course of the pandemic. The paper confirmed that while there had been a reduction in cases per day of approximately 50% since the introduction of restrictions on 16th October 2020, numbers of cases, admissions and hospital inpatients, ICU occupancy and deaths remained at a relatively high level. Indeed, these numbers were higher than was

reached in Wave 1, and were declining only very slowly, and as a consequence of this, the hospital system and staff remained under very significant pressure. The paper highlighted that the planned relaxations of the next two weeks, agreed by the Executive on the 12 November 2020, beginning from 20th November 2020 would result in R rising significantly above 1, with a subsequent increase in cases, admissions, inpatients, and ICU occupancy becoming apparent in December 2020. The Minister indicated that this likely course had been considered by the Modelling Group and was presented along with the paper. The paper highlighted that the Executive had a number of possible actions and interventions to consider, and these were outlined. It was highlighted that if no intervention occurred in late-November 2020 it was likely that the hospital system would be overwhelmed in mid-December 2020 with a significant increase in Covid and non-Covid deaths, and that even a full lockdown beginning around the 14 December 2020 would be insufficient to prevent the then current levels of hospital pressures being significantly exceeded.

194. The Minister's paper [see exhibit PM/X – INQ000137370 (DoH ref: MMcB038)] highlighted that the only intervention which has been proven to date to effectively reduce transmission of the pandemic involved the use of restrictions, and in summary, that a two-week period of restrictions to start on the 27 November 2020 would offer the best prospect of avoiding the need for further interventions before January 2021. The paper highlighted that the experience from NI and discussions at SAGE suggested that non-essential retail and churches contribute around 0.2 to R, and that the opening of schools contributed around the same value. Most effective intervention would therefore involve closing these sectors along with close contact services, leisure, and entertainment sectors. The modelling paper demonstrated the impact with and without schools closed. The paper also recommended that individuals should work from home where possible, and otherwise stay at home except for certain purposes. The paper further highlighted the importance of securing maximum public adherence. The paper concluded with the recommendation that the Executive consider the information in the paper and conclude on the appropriate response. The Executive discussed the paper and then the meeting adjourned briefly to enable the Minister, the CMO and the CSA to provide a summary of their proposals for the Executive to consider. These were then discussed, and the final decisions of the Executive were recorded in the Executive minutes.

195. The Executive decided to introduce significantly tighter restrictions for two weeks from the 27 November 2020[7]: The Executive also agreed that the Minister for Health would make a statement [RP/144 - INQ000276547 (DoH ref: PM2228)] to the Assembly and that these restrictions would be communicated as a time limited "circuit breaker" to end on 10 December 2020. During this two-week circuit breaker schools would remain open and from 27 November 2020, a controlled 'click and collect' service for retail would be able to operate.

December to January 2020

196. The background to the decisions taken by the Executive in December 2020 is set out in the following paragraphs.

---

[7] Closure of all retail except essential retail that was permitted to stay open in March. Off licences will remain open, with an 8pm closing. Closure of close contact services, and driving instruction (not motorcycles), except close contact for Film and TV production; those ancillary to medical, health and social care services; and elite-sports therapeutic services - i.e. – as 13 October- 19 November. Closure of all hospitality (except for accommodation for essential travel). Takeaway and delivery, and food and drink in motorway services, airports and harbour terminals remain open. Closure of all leisure and entertainment (to include all soft play areas, gyms, swimming pools etc). Sporting events only permitted for elite sports. Individual/household outdoor exercise and school PE to continue. Elite sports events behind closed doors without spectators. No household gatherings of more than one household, other than current arrangements for linked households (bubbles), with current exceptions for caring, maintenance, house moves, etc. Closure of places of worship, except for weddings, civil partnerships and funerals. Remain with 25 max for weddings and funerals. Stay at home, work from home if at all possible, otherwise only leave for essential purposes such as education, healthcare needs, to care for others or outdoor exercise. Schools and childcare to remain open. Universities / FE to provide learning at distance except where it is essential to provide it face to face. Public parks and outdoor play areas remain open. Stay at home in guidance, with liaison with PSNI on policing and police visibility.

197. The Executive's rationale for the decisions taken in December 2020 was informed by the evolving situation as indicated in the modelling presented to it and the evidence on the new variant[8] of Covid-19. The modelling in the weeks leading up to Christmas 2020 indicated increasing rates of transmission of the virus. Following discussion at the Executive's emergency meeting on Sunday 20 December 2020, the Executive agreed that the Christmas Bubbling arrangements which had been agreed at the Executive meeting of 3 December 2020 would be amended to reduce the permitted period from five days to one day, with flexibility on which day between 23 and 27 December 2020 people could come together, to accommodate those working on Christmas Day. The Department's advice to the Executive was set out in a paper [RP/145 - INQ000276560 (DoH Ref: PM2240)]. The paper recommended: a reduction in Christmas bubbling arrangements; further engagement between the Education and Health Departments around the return to school in January 2021; and emphasised the stay at home message to the public. The Department also submitted papers [RP/146 - INQ000276561 (DoH Ref: PM2241) on travel guidance for discussion at a meeting on 21 December 2020. The Executive agreed that "guidance should immediately be developed and issued advising against all but essential travel between NI and Great Britain and the Republic of Ireland, with immediate effect. This should include asking all new arrivals here to self-isolate for 10 days following entry to NI; and would be kept under regular review to ensure it remained appropriate." [RP/148 - INQ000065741 and RP/149 - INQ000065742]. Further measures were introduced in January 2021 to strengthen travel restrictions. It is a matter of speculation as to whether more could have been done to try to reduce the spread of the new variant by the use of travel restrictions. However, despite the action taken by the Executive in November and December 2020, by around the 20 January 2021 the number of people in hospital reached the highest levels at any time during the pandemic. The Executive ultimately had responsibility to decide the Christmas arrangements for Northern Ireland. Ministers are better placed to assist the Inquiry in understanding why the NI Executive did not endorse the joint statement to be issued by all UK jurisdictions regarding restrictions over the Christmas 2020 period [see RP/38 - INQ000148325, paragraphs 139-140]. However, a consistent UK-wide approach to the restrictions for the Christmas 2020 period would only have been appropriate if transmission of the virus had been broadly at the same level in each jurisdiction. The Department of the Economy and the Department of Finance will be better placed to assist the Inquiry in its

---

[8] The variant has been named as 'VUI – 202012/01' (the first Variant Under Investigation in December 2020).

understanding of the comments of the then First Minister, at the Executive Committee meeting on 17 December 2020, indicating a lack of planning as to the funds which would be required for the restrictions referred to [RP/150 - INQ000116295].The First Minister said, "*terrible position – asking business to close – 4 weeks, review for 2 further weeks – but don't know how we can pay – need to reflect on that".*

198. In the run-up to Christmas the Department modelled a range of scenarios including the impact of implementing restrictions or not relaxing restrictions in the pre-Christmas and immediate post-Christmas period, and the results of this modelling were provided to Ministers. There was no particular pressure to take an approach consistent with that of the UK Government by imposing restrictions after rather than before Christmas. There is no doubt that the imposition of restrictions before Christmas would have been more effective in reducing the incidence of Covid-19 in the post-Christmas period. However, in making decisions about the timing of restrictions Ministers needed to balance this with other factors, including economic impacts and impacts on family life at an important time of the year.

199. At Executive meetings on 23 and 24 November 2020, the First and deputy First Ministers provided updates on discussions with the UK Government and other devolved administrations about Christmas restrictions. On 24 November 2020 a UK Government press release [RP/151 - INQ000276548 (DoH ref: PM2229)] announced the "UK-wide Christmas arrangements agreed by the UK Government and the Devolved Administrations." The minutes of the Executive meeting on the 26 November 2020 record that the deputy First Minister "*briefed the Executive on agreement reached by COBR on a common approach to Christmas in the context of COVID-19, advising of matters to be decided on by each administration, including Christmas Bubbles, and restrictions and arrangements for Christmas. She advised that the views of the Chief Medical Officer and the Chief Scientific Adviser would be sought; and that account would be taken of the arrangements to be put in place by the Irish Government.*"

200. On 3 December 2020, the Executive considered two papers prepared by The Executive Office focusing on restrictions from 11 December 2020 and Christmas 'Bubble Arrangements' respectively. Both papers included the advice of the CMO and the CSA in respect of each of the possible restrictions including potential relaxation of some restrictions. The Executive meeting also considered a paper from the Department for the Economy on the

economic impact of restrictions. These papers reflected discussions which had been ongoing between the UK Government and the Devolved Administrations for several weeks and which were aimed at aligning Christmas arrangements across the UK four jurisdictions, focusing on domestic settings, household bubbling and with a preference for a short period of time for relaxation of restrictions, possibly from 24 to 27 December 2020. However, it remained the responsibility of the Executive to ultimately decide the Christmas arrangements for NI. The R paper [RP/152 - INQ000276549 (DoH ref: PM2230), RP/153 - INQ000276551 (DoH ref: PM2231)] presented at the meeting records that the estimate of R was around 1 (0.9 to 1.1). The paper advised "*Given the current restrictions, we anticipate that numbers will decline slightly or remain stable until shortly before Christmas 2020 when they will begin to rise again. The rate of increase will depend on how much Rt increases following the 11 December 2020. If Rt can be maintained at 1.6 or below, then intervention would not be required until the end of December/beginning of January. However, if Rt was to rise as high as 1.8 then intervention would be required a few days earlier than this*." The minutes of the modelling group [RP/154 - INQ000276552 (DoH ref: PM2232)] held on 1 December 2020 record that an R of 1.8 would represent a doubling time of one week.

201. The Executive's decision recorded in the minutes of the 3 December 2020 meeting about Christmas 'Bubbling' was that this would be one bubble over Christmas with up to two other households from 23 to 27 December 2020. The Executive also noted the detail of additional supports and advice for the vulnerable, and noted that advice for Care Homes, residents and families would be developed. These minutes also recorded the Executive's decisions on restrictions from 11 to 19 December 2020 (inclusive) including the opening-up of non-essential retail, close contact services, sport and leisure activities and places of worship. The details of these changes to restrictions and of planned Christmas Bubbling arrangements were announced in an Executive Office press release [RP/155 - INQ000276553 (DoH ref: PM2233)] on 4 December 2020.

202. The Department's Modelling Group met on 15 December 2020 [RP/156 - INQ000276554 (DoH ref: PM2234)]. The minutes record that the Group considered various scenarios which were variously, based on: (i) no intervention; (ii) restrictions being implemented from 26 December 2020; or (iii) restrictions being implemented from 2 January

2021. Under the 'no intervention" option, the likelihood was that the hospital system would be faced with occupancy greater than 6,000 Covid hospital inpatients by the end of January 2021 against a capacity of 2,900 beds across the HSC sector. On 17 December 2020 the Executive considered a paper submitted by the Department on post-Christmas restrictions. The paper [RP/157 - INQ000276555 (DoH ref: PM2235), RP/158 - INQ000276556 (DoH ref: PM2236)] offered options including taking no action or implementing restrictions from one of the following dates: 19 December 2020; 26 December 2020; or 2 January 2021. The paper highlighted that the R number for new cases was now between 1.0 and 1.2 with both the 7 and 14 day incidence increasing to 175 and 340 per 100k respectively. This indicated a disappointing impact of the two weeks of restrictions introduced on 27 November 2020. The paper outlined the existing pressures and impact on the health system. It also anticipated the impact of a surge of cases post-Christmas and outlined the need for action to prevent the hospital system becoming overwhelmed and the need to reverse the current trend. The minutes record that the Executive agreed the introduction of extensive restrictions[9], which amounted to a lockdown, from 26 December 2020 for a period of six weeks (subject to review after four weeks. The Minister issued a press release [RP/159 - INQ000276557 (DoH ref: PM2237)] detailing the restrictions coming into effect for six weeks from 26 December 2020[10]. The

---

[9] The Health Protection (Coronavirus, Restrictions) (No.2) (Amendment No.24) Regulations (Northern Ireland) 2020

[10] Closure of hospitality and non-essential retail with a stricter demarcation between essential and non-essential retail than that deployed during the recent circuit breaker. Click and collect retail will not be permitted, and homeware will not be categorised as essential retail. Off sales (including from bars) will be permitted from 08:00 on Monday to Saturday, and from 10:00 on Sunday, until 20:00 on any day. Hospitality businesses will only be allowed to offer takeaway and delivery food. Closure of close contact businesses. Places of worship can remain open under strict conditions. In addition, there will be a one-week period of additional restrictions from 26 December 2020 to 2 January 2021. Between 20:00 and 06:00 during this period all businesses which are able to remain open as part of the restrictions must close between these hours. No indoor or outdoor gatherings of any kind would be permitted after 20:00 and before 06:00, including at sporting venues. Outdoor exercise would be permitted only with members of your own household. No household mixing would be permitted in private gardens or indoors in any setting between these times, except for emergencies or the provision of health or care services or where households have chosen to form a Christmas bubble for a period of time between 23 to 27 December with provision for travel a day either side when absolutely necessary.

announcement of these changes in restrictions for NI [RP/160 - INQ000276558 (DoH ref: PM2238)] was a day in advance of similar steps by the UK Government, Scottish and Welsh administrations on 19 December 2020.

203. Prior to these announcements the First Minister and deputy First Minister met with the other administrations and the Chancellor of the Duchy of Lancaster on the morning of 19 December 2020. The readout from that meeting [RP/161 - INQ000276559 (DoH ref: PM2239)] records that attendees received a briefing on the changing epidemiology. In the South and South East of England and London disease activity was increasing significantly despite Tier 3 restrictions, by up 50% in some areas within the last week, with growth in younger age groups and also more concerningly in 60+ age group. At this time hospital activity was increasing considerably. South Wales was also experiencing similar pockets of increased disease activity and hospital pressures.

204. At the meeting, the UK CSA gave a short update on the new variant which was that there was increased transmissibility but as yet there was no evidence on whether the increased transmissibility was impacting the clinical disease pattern or of an impact on immune response or vaccine response. Experiments and scientific work were continuing in these regards. The meeting was told that the Prime Minister would announce at 4 pm that afternoon the following measures for England: South/South East/ London – new enhanced Tier 4 restrictions, to come in at midnight on 20 December 2020[11]. This was to be a similar lockdown to that in November 2020: with a strong stay at home message; the closure of all non-essential retail and personal services; and that Christmas arrangements would not go ahead as planned, and people were asked not to extend bubbles further beyond what they already had in place; that churches should remain open for worship in a Covid secure environment; travel would be restricted to within Tier 4 areas (into regulation); in the rest of England – tiers as they currently were, with a strong emphasis on 'stay at home'; and that there were to be 3x household bubbles for Christmas Day only. It was further indicated that the above was subject to ongoing discussion and could be refined through the day prior to the PM's announcement.

205. The Executive held an emergency meeting on Sunday 20 December 2020. The meeting considered an update paper [RP/145 - INQ000276560 (DoH ref: PM2240)] submitted

---

[11] SI 1611

by the Department. The paper outlined the evidence on the new variant[12] of Covid, based on evidence from Public Health England. On 17 December 2020, the Belfast Virology Laboratory had reported that it had detected four positive cases with an unusual test profile which may be indicative of the new variant. The paper recommended: a reduction in Christmas bubbling arrangements; further engagement between the Education and Health Departments around the return to school in January 2021; and emphasised the stay at home message to the public. Following discussion, the Executive agreed that the Christmas Bubbling arrangements which had been agreed at the Executive meeting of 3 December 2020 would be amended to reduce the permitted period from five days to one day, with flexibility on which day between 23 and 27 December people could come together, to accommodate those working on Christmas Day. I understand that the Executive was concerned about getting an appropriate approach to allow people to come together over the Christmas holiday period while at the same time continuing to protect the health service.

206. At a meeting on 21 December 2020 the Executive agreed that "*guidance should immediately be developed and issued advising against all but essential travel between Northern Ireland and Britain and the Republic of Ireland, with immediate effect. This should include asking all new arrivals here to self-isolate for 10 days following entry to Northern Ireland; and would be kept under regular review to ensure it remained appropriate*." This was in response to a paper submitted by the Minister [RP/146 - INQ000276561 (DoH ref: PM2241).

207. On 22 December 2020 the Executive agreed an Executive Office paper which clarified a number of definitions and decisions with regard to the six weeks of restrictions which were to begin on 26 December 2020. Clarification included the definition of essential retailing and hardware, as well as decisions regarding, for example, non-essential retailing and horse racing.

208. On 23 December 2020 the Joint Biosecurity Centre [RP/162 - INQ000276563 (DoH ref: PM2243)] in its report to the four UK CMOs concluded that "*a COVID-19 pandemic is in general circulation; transmission is rising exponentially, and it is highly likely that across much*

---

[12] The variant has been named as 'VUI – 202012/01' (the first Variant Under Investigation in December 2020).

of the UK, the NHS will exceed its assumed COVID-19 contingency capacity in the next 21 days". The same update was repeated on 29th December 2020.

209. The Department's Modelling Group met twice over the new year period, on 29 December 2020 [RP/163 - INQ000276564 (DoH ref: PM2244)] and 5 January 2021 [RP/164 - INQ000276565 (DoH ref:PM2245)]. At the first meeting the minutes record that there was limited information on the prevalence of the new variant (Alpha) in NI. The group agreed that the latest estimate of the R number was above 1 - between 1.4 - 1.8 for cases. The R number, based on hospital admissions, was agreed as 1.0 - 1.2. It was agreed that a reasonable scenario would be for the R number to remain at 1.4 to 1.8 for two weeks before reducing to 0.8 to 1.0 as the latest restrictions took effect.

210. On 29 December 2020 the Minister wrote to the Minister for Education [RP/165 - INQ000276566 (DoH ref: PM2246)] to provide an update on the pandemic over the holiday period. On the same day, the CMO and the CSA wrote to the Permanent Secretary in the Department of Education [RP/166 - INQ000276567 (DoH ref: PM2247)] to ask that "*careful consideration should be given to the other options which have been highlighted before,* including an extension of the Christmas holidays, face to face teaching for key years only, alternate weeks of distance learning and face to face teaching, and half classes only to be taught face to face on alternate weeks." This was in advance of a meeting held on 30 December 2020, attended by the CMO, the CSA and Department of Education officials.

211. On 4 January 2021, the Joint Biosecurity Centre issued their update which largely repeated their updates of 23 and 29 December 2020, and concluded that "*a COVID-19 pandemic is in general circulation; transmission is rising exponentially; it is almost certain that across much of the UK the NHS will exceed its assumed COVID-19 contingency capacity in the next 21 days; and there is a material risk of healthcare services being overwhelmed in England, Wales and Northern Ireland.*" [RP/167 - INQ000276568 (DoH ref: PM2248)]. The 4 UK CMOs and the NHSE Medical Director met and agreed the following update: "*There has been sustained pressure on the health systems across the four nations now for a number of weeks and this is still increasing in many parts of the country. They considered the impact of the new variant and the fact there is currently very high incidence rates in the community, with continued rises almost everywhere, on a background of already high Covid caseloads. In the light of this they are no longer confident that the health system can handle a sustained rise in cases and if this happened, there is a material risk of the NHS being overwhelmed in many geographies within 21 days without further action. There is, therefore, unanimous agreement*

that we should advise Ministers that all 4 nations of the UK should move to alert level 5 as soon as is operationally feasible." [RP/168 - INQ000276569 (DoH ref: PM2249)]. On the same day the Prime Minister announced that everyone in England must stay at home, except for permitted reasons during a new coronavirus lockdown expected to last until mid-February 2021. All schools and colleges were directed to close to most pupils and switch to remote learning from 5 January 2021.

212. An emergency meeting of the Executive was held on 4 January 2021. The deputy First Minister advised that this meeting had been convened in light of very serious developments in the Covid-19 pandemic and advised of a call earlier in the day involving herself, the First Minister, the Minister of Health, the First Ministers of Scotland and Wales and the Chancellor of the Duchy of Lancaster in relation to the progression of and response to the pandemic. The Executive noted the public expectation that decisions would emerge from the meeting and it was agreed that: "*a public statement should emphasise the fact that the Executive had made a pre-emptive move to introduce restrictions from 26 December, but that further measures, to include an extension of remote learning and the translation of the Stay at Home message into enforceable regulations had been agreed; the 'Stay at Home, Save the NHS' message; that a further meeting would take place the following day to consider the detail of the additional restrictions; and that a statement would be made in the Assembly on Wednesday 6 January.*"

213. The meeting of the Department's Modelling Group on 5 January 2021 recorded that the seven day average of new cases had tripled over the Christmas period [PM/X – RP/164 - INQ000276565 (DoH ref: PM2245)]. However, there was some evidence in recent data that the trend in case numbers and the positivity rate was starting to level off. The group agreed that the R number was between 1.5 and 1.9 for new cases and 1.2 to 1.4 for hospital admissions. The Group estimated that the number of hospital inpatients with Covid-19 would rise to at least 700, but potentially could exceed 2,000 by mid to late January 2021.

214. On 5 January 2021 the Executive considered a paper from the Department on strengthening restrictions [RP/169 - INQ000276571 (DoH ref:PM2251)]. In the week prior to this Executive meeting there was engagement between the Departments of Health and Education around the impact of schools re-opening on R and the health system. The Department's paper did not make recommendations on schools but commented "*The Executive has agreed the continuation of Education must be a priority however it must be noted that closure of schools and a switch to remote learning for all pupils would lead to a faster reduction in Rt. This would reduce the likely required duration of these most stringent of*

restrictions." The Department's paper set out a number of options for tightening restrictions. The Executive minutes for this meeting recorded that the Executive agreed that the additional restrictions outlined in Annex B of the paper should be introduced with effect from Thursday 7 January 2021; that a power for the Police Service of Northern Ireland to direct persons home should be reintroduced; that a requirement should be introduced for all employers to conduct a risk assessment where employees were required to be in premises away from their home for work; that these restrictions would be in place until 6 February 2021 with a review point of 21 January 2021, in line with the restrictions agreed prior to Christmas; and that work on reducing crowding in retail settings would be progressed.

215. At the same meeting the Minister for Education submitted a paper on education provision during lockdown. The paper recommended that "*all mainstream education providers, including pre-school education settings, primary and post primary schools required to provide remote learning at home to their pupils rather than face to face teaching in school until the half term break in the middle of February*."

216. On 21 January 2021 the Executive considered a paper concerning the sixth review of the Coronavirus (No 2) Regulation [RP/170 - INQ000276572 (DoH ref: PM2252)] submitted by the Department and agreed that the current restrictions should be extended until 5 March 2021 (a four-week extension) and that the restrictions should be reviewed on or before 18 February 2021.

Section 18: The Executive Covid Taskforce

217. The Department's position on the establishment of the Executive Covid Taskforce, in December 2020, is set out in the memo dated 28 November 2020 [RP/171 - INQ000303611 (DoH Ref: PM0458)] SUB 2204, sent by the Health Minister to the then First Minister and deputy First Minister. My understanding was that the proposal to establish the Executive Covid Taskforce was an attempt to break down silos across Executive departments in order to further improve the effectiveness of the response to the pandemic in NI. I do not recall whether the Executive Covid Taskforce model was designed to reflect any changes at the UK Government level.

218. The Department had misgivings, as set out in the Health Minister's memo, about the impetus behind the establishment of the Executive Covid Taskforce. The Department was concerned that in establishing the Taskforce, the Executive Office appeared to place the

emphasis on the role of the interim Head of the NI Civil Service in heading the Taskforce whereas the Department at the outset would have emphasised the challenges to be addressed by the Executive in assessing the options to enhance the extant collaborative working across Executive departments. However, the Department went on to fully participate in the Taskforce and contributed to its work – I was the Department's representative and attended meetings of the Taskforce. For example, the Department contributed to the development of the 'Moving Forward: The Executive's Pathways Out Of Restrictions' document published on 2 March 2021 [RP/172 - INQ000276577 (DoH Ref: PM2257)]. Overall, the Taskforce played a useful strategic role in further strengthening the collaboration across Executive departments which had been developed and embedded during the first and second waves of the pandemic in 2020.

Section 19: 'Moving Forward - The Executive's Pathway out of Restrictions

219. The development of the document 'Moving Forward: The Executive's Pathways Out Of Restrictions', published on 2 March 2021 [RP/172 - INQ000276577 (DoH Ref: PM2257)], was consistent with the approach taken by the Executive since the establishment of the Executive Covid Taskforce in December 2020. This approach aimed to ensure effective collaboration across Executive departments in producing strategic plans such as 'Moving Forward: The Executive's Pathways Out Of Restrictions'. The approach set out in this document to easing restrictions, based on medical, scientific and other sectoral advice, whilst providing mitigating support to sectors and individuals across the community seemed to me to provide an appropriate route map which could be easily understood by all sectors and individuals. With the benefit of hindsight the document could potentially have been enhanced by providing more information about how the Executive had taken into account that the pandemic and the measures taken to counter it had disproportionately affected or disadvantaged particular groups of people within the community. However, it is important to note that Executive departments with responsibility, for example, for vulnerable people, children and persons with disability, introduced mitigating measures where possible to ease the impact of the pandemic on these groups. In respect of this I have referenced above the mitigating measures introduced by the Department (see paragraphs 134 to 142).

220. From 8 March 2021 to 24 May 2021 the Executive, in a series of decisions and announcements, incrementally eased or removed the restrictions that had been introduced from August 2020 at the start of the second wave of the pandemic to help protect the population and the health service from the impact of Covid-19. To a large extent these

decisions were informed by papers tabled at Executive meetings by the Executive Office, which in turn had been informed by the Executive Office-led Covid-19 Cross-Departmental Working Group and CMO and CSA advice. The Executive Office is better placed to assist the Inquiry in understanding whether the strategy in 'Moving forward: The Executive's pathway out of restrictions' was broadly adhered to and to what extent were there tensions between Ministers having regard to the economic consequences of maintaining restrictions. In my view the information provided by the Department of Health demonstrates that the strategy was adhered to by the Department and I do not recall seeing any assessment indicating that there was not broad adherence across other Executive departments. With regard to tensions between Ministers about the economic consequences of maintaining restrictions, while there was robust debate within the Executive about this, the resulting decisions on increasing or easing restrictions were collectively agreed by Ministers.

221. In respect of the comments the Justice Minister, at the Executive meeting on 4 March 2021, in respect of the pathway being "*shot in the knees*" [RP/173 - INQ000065711]: I'm unable provide the Inquiry with any insight into what the Justice Minister was conveying other than the concerns that she expressed as set out in this exhibit.

Section 20: "Building Forward – Consolidated Covid Recovery Plan"

222. Individual Executive departments were responsible for implementing their respective interventions set out in the Executive's 'Building Forward – Consolidated Covid Recovery Plan' [RP/174 - INQ000101002]. A Covid-19 Recovery Taskforce led by the Executive Office was set up to monitor overall progress in implementing the interventions. The Taskforce membership included a senior official from each Executive department. Executive departments provided update reports to inform the taskforce of progress in relation to the interventions in the Recovery Plan. I understand that the Executive Office continued to monitor progress across the actions until March 2023, with updates provided by Executive departments. The interventions which the Department of Health has responsibility for implementing were subsumed into the Department's business priorities.

Section 21: Retirement of Sir David Sterling

223. I understand that two recruitment competitions were run to appoint a substantive successor to Sir David Sterling as Head of the NI Civil Service, as the first competition was abandoned before it concluded. For the second external recruitment competition, the successful candidate was announced by the Executive Office on 10 June 2021. I have no particular insight into why it took from April to December 2020 to find an interim Head of the Civil Service as a replacement for Sir David. The loss of a senior leader with Sir David's experience would be challenging at any time, but Sir David's retirement came at a particularly difficult time for the NI Civil Service and represented a significant loss to the Service of an individual with wide experience and a track record of sound leadership. The delay in appointing the interim Head of the Civil Service is likely to have had some short-term effects on the functioning of the Executive Office at a time of considerable pressure experienced by officials. Colleagues in the Executive Office are better placed to assist the Inquiry in assessing any consequences arising from the delay. From my perspective, the most noticeable gap following Sir David's retirement was in terms of the leadership of the Permanent Secretary group, and in particular in ensuring that the group maintained a corporate and collaborative approach to issues – as opposed to seeing all issues from a departmental perspective.

Section 22: The Public Health Agency

224. In general terms the responsibility for public health policy and oversight of implementation resides with the Department of Health, with expert advice to inform public health policy development received from a number of sources including primarily the PHA in NI. Operational delivery in in normal circumstances resides with the relevant public health body in each UK jurisdiction.

225. As with all public health bodies and agencies across the UK and internationally, the PHA faced significant and sustained challenges in its role in responding to the pandemic particularly given the intensity of the response required and its duration. The Department and the PHA had by comparison significantly less resource available to it as compared to other UK jurisdictions. At the onset of the pandemic the PHA had a number of staff vacancies and interim appointments in key roles. Recruitment challenges and planned staff retirements were also reflected in vacancies in key roles in the Department at the onset of the pandemic.

226. The PHA leadership team, the Department's CMO Group and the CMO by necessity and building on long established working relationships worked very closely as a collective

leadership team to provide mutual support and assistance to ensure that the public health response was appropriately directed and coordinated, and that the PHA was best placed to meet emerging and evolving challenges and the many demands faced over the course of the pandemic.

Section 23: Following the Science, SIG (SIG), Modelling, the R Number & Systems for Recording Deaths

227. In the early weeks of the pandemic the Department introduced two initiatives to strengthen the scientific expert advice available in NI to inform the advice given to senior officials and the Executive in relation to formulating the policy response to the pandemic.

228. Firstly, the CMO agreed a proposal by the CSA to establish a NI Group, the Strategic Intelligence Group (SIG), for the purpose of specifically focusing on scientific evidence. The SIG was therefore a key source of effective advice and expertise to inform the policy response to the pandemic. It was established in March 2020 and chaired by the CSA. The details of its membership and terms of reference are provided in [RP/175 - INQ000103642 (DoH Ref: PM0047)]. The SIG was to consider scientific and technical evidence emerging from SAGE and other sources alongside NI data on the trajectory of the pandemic, much of which also fed into NI modelling. The evidence and analysis considered by the SIG contributed to the formulation of advice in papers which the Department submitted to the Executive to help inform its decision making during the pandemic, particularly in respect of the potential impacts of Covid-19 in NI and the approaches to mitigating these. The papers submitted to the Executive were recorded by both the Department and The Executive Office.

229. Secondly, the Department identified a lack of independent modelling capacity in the PHA as a deficit and the CMO asked the CSA to establish a Modelling Group in March 2020. Membership of the Modelling Group was drawn from a range of organisations, including several senior staff from the PHA along with others from Queens University Belfast, Ulster University, HSC Trusts and the Strategic Investment Board. The Modelling Group considered modelling from a range of sources (including its own modelling) and agreed R value(s) (or more correctly an R Range) weekly, or as required for most of the pandemic. SPI-M and the Four Nations Modelling Group were attended by PHA and Departmental staff who fed back to and participated in modelling group discussions. The terms of reference for the Modelling Group can be found at [RP/176 - INQ000137356 (DoH Ref: MMcB027)]. The Modelling Group considered scenarios and provided estimates of the potential effects of various interventions

or counterfactual cases, which informed discussions at the SIG, and in turn the advice which was provided by the CMO and the CSO to the Health Minister and the NI Executive. Outputs of the Modelling Group were at an NI level and also informed HSC specific modelling and planning in relation to service demand and system capacity.

230. Executive Ministers and senior officials working in Executive departments directly involved in managing the policy response to the pandemic were aware of the existence of the SIG and the Modelling Group although it is unlikely that there was a high awareness of the composition and the detailed work of both groups. I expect that a similar level of awareness among external stakeholders would also have been the case. The fact that the membership of the Modelling Group was drawn from several external organisations meant that its role would have been understood by the medical and scientific community in NI. The work of both groups was well known amongst the relatively sizeable group of colleagues within the Department and across the HSC who were involved in managing the policy response and/or engaged in high level planning of the service delivery response to the pandemic.

231. There was transparency about the output from the SIG in formulating the Department's advice to the Health Minister and the Executive although Executive papers were not released in the public domain. For example, the Health Minister and the CMO provided regular briefings to the Assembly's Health Committee and Covid-19 Ad Hoc Committee which included output from the SIG. There are two press releases which provide an indication of the transparency around the work of the SIG. On 13 May 2020, the Minister announced that the expansion of testing for care home residents and staff would be informed by advice being prepared for Government and the NHS by SAGE and the Department's SIG [RP/177 -INQ000103693 (DoH Ref: PM0117)]. On 21 May 2020, the Department referred to the Executive having recently announced that people consider wearing a face covering in places where there are difficulties social distancing, such as on public transport or in retail environments. This advice was recommended by the SIG [RP/178 - INQ000371418 (DoH Ref: COMMS118)].

232. I am satisfied that the SIG and the Modelling Group made an effective contribution to the NI policy response to the pandemic and that the modelling of data in NI provided a reliable basis for decision-making by the Executive, based on medical and scientific advice. This remained as my view over the course of the pandemic. It should be noted that following the initial months of the pandemic the Executive took into account other sources of information related to economic and social factors in reaching decisions about the restrictions. I am also satisfied that in my discussions with the Health Minister and CMO concerning the formulation

of policy the output from the SIG and the Modelling Group was presented coherently. I find it difficult to make a general assessment of the extent to which senior civil servants and Ministers had a sufficient 'scientific mindset' and grasp of the scientific, medical and mathematical concepts in order to understand the advice that they were provided with. In general, I found the output from both groups set out in papers submitted by the Department to the Executive to be presented coherently. This evidence-based presentation enabled Ministers and senior officials to understand the data underpinning the advice, including those of us who perhaps did not have a full scientific mindset.

233. The medical and scientific advice submitted to Ministers to inform policy decisions was based on the trajectory of the pandemic, relevant modelling, and health service pressures at points in time. In addition, Ministers were considering not only the health consequences but also the wider societal and economic factors within their respective pandemic responses.

234. The basic or effective reproductive number was one of a variety of data sources used as part of epidemiological modelling to support understanding of the pandemic and to assess scenarios based on the potential impact of different interventions. Other important information that was considered alongside the R number included hospital admissions, hospital bed occupancy, demands for respiratory and critical care support, and mortality data. Using the basic or effective reproduction number to understand how an infectious agent may move through a population is challenging with the development of new variants, changing population immunity, and uncertainties about behaviours. However, it was it was an important tool alongside the other data sources to assist the Executive in making decisions about increasing and easing restrictions. I do not recollect any issues caused by the publication of two R numbers as referred to in the witness statement from Holly Clark, Deputy Director of the Constitution and Rights Group, NIO to Module 2C which states: *"it was agreed that each administration would continue to publish the R number in respect of their nation, but that publications would also note the estimate which had been calculated, but not published, by SAGE"* [RP/38 - INQ000148325, paragraph 162].. The CMO and CSA are better placed to assist the Inquiry in respect of this matter.

235. In my view, the fact that the Executive regularly made decisions about increasing and easing restrictions throughout the pandemic, based on information derived from the R number and other data sources, suggests that Ministers had a clear understanding of how the R number was calculated.

236. In respect of the notes of the Executive Committee meeting on 9 July 2020 which record that the Health Minister told the Executive that the use of the R number was being suspended and the Department was looking to use a wider set of figures [RP/15 - INQ000065764], I understand that the Health Minister reported at this meeting that the use of the R number was suspended, not because the calculation of the R number was unsatisfactory, or that it changed, but because, at that point, case numbers were low. Instead of referring to the R number the Department started referring to case numbers.

Systems for Recording Deaths during the pandemic.

237. I considered the announcements communicating the mounting death toll of people who had contracted the virus and had sadly lost their lives during the pandemic as a matter which required robust assurance of the reliability of the data being released to the public. In response to the "Rapid, Focused External Review of Public Health Agency" [RP/179 - INQ000001196] (PHA Rapid Review) concerning the gathering of data in NI in relation to daily death figures, I would comment that throughout the pandemic the PHA provided relevant clinical data, including data on deaths, to contribute to the NI Covid-19 Dashboard, which the CMO commissioned with the agreement of the Minister. The responsibility for collating clinical data remained with the PHA.

238. In the initial months of the pandemic some data was not readily available and there were considerable difficulties accessing data to understand the developing situation. This was compounded by data collection issues, for example the fact that testing capacity was limited early in the pandemic. NI was no different from other parts of the UK in this regard. From the start of the pandemic there was a need for data on levels of community transmission, data on healthcare pressures, and on disease severity including deaths. These data were not readily available, and systems had either not yet been established or if established were not linked. I understand that this is considered more fully in the UK CMO Technical report (chapter 4, pages 121-161)–[RP/180 - INQ000217254]. CMO and CSA are better placed to assist the Inquiry in assessing whether this impacted upon the modelling of data and the extent to which it impacted upon the Executive's response to the pandemic.

239. At the outset of the pandemic, the established system for monitoring and reporting on deaths in NI was through the General Register Office (GRO); data reporting was based on death certification and by necessity included a lag time in reporting as following each death,

certification needs to be completed, the death reported to the GRO, and the data analysed and reported. This system continued to operate throughout the pandemic and remained the definitive source of reporting on deaths occurring in NI.

240. In a rapidly evolving context at the outset of the pandemic the PHA established an additional reporting system to capture information on deaths occurring in HSC settings (reporting based on deaths in individuals within 28 days of a positive test). This reporting and monitoring system was established by PHA in a timely manner and it mirrored similar reporting systems established in other UK countries. The Department supported PHA as this data stream was established.

241. Care homes are formally regulated in NI and deaths occurring in care home settings are reportable to the health and care systems regulator (the Regulation and Quality Improvement Authority), as 'notifiable events'. As the pandemic progressed, the Regulation and Quality Improvement Authority was able to provide a continuing data stream on deaths occurring in these settings.

242. As summarised above, there were a number of systems in place and developed at pace to capture and record information on deaths occurring during the pandemic – these included systems operated by the General Register Office, PHA, HSC Trusts and the Regulation and Quality Improvement Authority/Care Homes. Some of these systems were established and operating before the pandemic, others were established at pace in the early stages of the pandemic. In the context of data relating to deaths in NI: because there were a number of systems operating and being established, and each was based on different reporting requirements, there was potential for confusion in the early stages of the pandemic. It was the Department's experience that all parties worked together to address and resolve any particular areas in which there was a lack of clarity.

Reporting of data during the pandemic

243. This was a highly complex and fast evolving situation, and as such the PHA worked closely and at pace with public health and policy colleagues across all UK nations to agree definitions and associated systems to capture information on cases, contacts, deaths, hospitalisations etc. The approach adopted by PHA was similar to that taken by the other public health bodies/agencies in the UK. Throughout all phases of the pandemic, PHA continued to work closely with Departmental officials and colleagues across all UK nations to both capture and report public health information relating to progress of the pandemic.

244. Throughout the pandemic new data sources and information flows were established and developed. The data available to the Department particularly in the first few months of the pandemic, were very limited compared to what became available in later months and years. Development of the NI Covid-19 dashboards was central to public transparency and helped engage the public with the public health interventions required to mitigate effects of the pandemic. The PHA did not have a system to facilitate public reporting and sharing of data (relating to cases, contacts, outbreaks etc) when the pandemic commenced, the Department requested its Information and Analysis Directorate (IAD) to develop a system to facilitate public reporting of information relating to the pandemic and this was subsequently established.

Section 24: Legislation and regulations: their proportionality and enforcement

245. The Health Protection (Coronavirus, Restrictions) Regulations (NI) 2020 provided for enforcement of the relevant provisions by the Police Service of NI, the Harbour Police, or persons designated by the Department including District Councils. The Regulations were passed on 28 March 2020 in response to the anticipated incidence and spread of Covid-19 in NI, which was deemed as a serious and imminent threat to public health. The criminal sanctions required to enforce the Regulations reflected the seriousness of the threat to society at that time. It should be noted that this was a time of significant public concern, when the full impact of the policy response to the pandemic through the use of medical countermeasures, such as vaccines and drugs treatments was not clear. The provision for the use of criminal sanctions was therefore considered a precautionary and proportionate measure as a backstop to deal with a potential minority who would not comply with restrictions. The main approach to securing compliance with restrictions was based a positive public health response involving: guidance; messaging and communication; sharing information with the public; and engagement with various sectors. Following the first wave this involved a risk based approach to restrictions enabling service providers to risk assess facilities and events. I understand that the Executive looked at the potential of Financial Penalty Notices as a possible enforcement

option but following advice from the Justice Minister this was not considered a viable option. The response by the public to the introduction of NPIs was mixed; for the majority of the population adherence was remarkable, with high levels of support throughout the pandemic. However, there was clear evidence of patchy or poor adherence by a minority of the population, and overall levels of adherence showed a tendency to decline as the pandemic proceeded. The Department took account of evidence emerging from the Scientific Pandemic Insights Group on Behaviours (SPI-B) when submitting briefing papers to the Executive which included advice in relation to behaviour interventions to improve adherence, including the approach to enforcement alongside encouragement and education through public messaging.

246. I am unable to assist the Inquiry with understanding Mr Chris Stewart's comments to Sir David Sterling: on 14 May 2020 Mr Chris Stewart observed to Sir David Sterling]: "You heard PSNI views this morning. Enforcement is all but over, so we now rely almost exclusively on clear messaging and civic responsibility" (14/05/2020 10:52:02 [RP/181 - INQ000308457, page 23]).

247. Following the Executive's agreeing the Regulations the Department expected that they would be enforced by the designated bodies in line with their established procedures for regulatory enforcements. However, as reflected in the exhibits referred to above, the extent to which the Police Service of NI (PSNI) were able to carry out this function soon became challenging. The Chief Constable's letter of 17 April 2020 to the Health Minister [RP/182 - INQ000272708] sets out the PSNI's view of the limitations on its role in the enforcement of the Regulations at that time which broadly remained its view over the period of the pandemic. There were concerns within the Executive, particularly in the Department, about the limitations on the enforcement of the Regulations. The Health Minister and senior officials engaged with senior PSNI officers in an attempt to be responsive to PSNI's concerns but unfortunately this did not improve the position. As the pandemic progressed public messaging was therefore the main vehicle to both inform and persuade the public of the need to adhere to the Regulations in order to combat the virus. In September 2020, the Executive established a working group on compliance and enforcement of the regulations [RP/183 - INQ000048488] led by the Junior Ministers within the Executive Office. This group continued with the approach of public messaging as the main strategy for convincing the public of the need to adhere to the Regulations coupled with engagement with sectoral representative bodies to further raise awareness and compliance. I am unable to assist the Inquiry in understanding why such a group had not been established prior to September 2020.

Section 25: Funding the Response to the Pandemic

248. As is the case for all departments, the general means of funding to the Department is through the Department of Finance in NI. The Department is provided with an opening budget and any easements are declared or additional funding requirements are bid for through " In-year Monitoring Rounds" (normally in June, October and January). Transfers of funding both between other NI departments and from other UK departments (via HM Treasury) are also processed through the Department of Finance at a Monitoring Round.

249. The pandemic covered a number of financial years, and the impact of the pandemic is still ongoing. Covid-19 commenced in the 2019/20 financial year, and the main impact of Covid-19 was within the 2020/21 and 2021/22 financial years. I understand that there were still significant Covid related costs being incurred in 2022/23.

250. During this period, additional funding exercises were commissioned by the Department of Finance to determine requirements and redistribute ring fenced Covid-19 funding in addition to and/or alongside Monitoring Rounds. The Department also received a Budget Cover Transfer (BCT) directly from the Department of Health and Social Care for Covid-19 Testing during the pandemic. This Budget Cover Transfer supplemented the general funding arrangements underpinning the National Testing Programme across the four UK nations whereby, in summary, NI and the other Devolved Administrations received a Barnett (population-based) share of National Testing Programme capacity in lieu of the consequential funding they would otherwise have received from health spending in England. Outputs funded under the National Testing Programme, managed centrally by Department of Health and Social Care, included for example delivery of the public facing COVID-19 PCR testing sites and the supporting laboratory processing capacity, and procurement of new COVID-19 test technologies (for example Lateral Flow Devices).

251. While Covid-19 commenced in 2019/20 and some Covid-19 related costs materialised in that year, these costs were contained within existing budgets. In 2020/21 the Department received £989 million of additional resource Covid-19 Funding. However, final spending on Covid-19 exceeded this budget by £11.1 million, with the overspend authorised by the Department of Finance. In 2021/22 the Department received £610 million of additional resource Covid-19 Funding, including a Budget Cover Transfer of £49 million in relation to Covid-19 Testing, and the underspend against this was £3.3 million. Resource spending included: support for the health and social care workforce, including a one-off

acknowledgement payment for service during the pandemic; support for additional service delivery, including testing and contact tracing; support for independent providers of health and social care; purchase and consumption of PPE; revenue costs associated with capital works; and additional support costs including increased cleaning.

252. Capital funding of £70 million was provided in 2020/21, with an underspend of £2.4 million declared at year end. In 2021/22 the Department received an additional £15.7 million of capital in relation to Covid-19, reporting an underspend of £1.5 million at year end. Capital spending included purchase of medical equipment including oxygen generators, capital works to provide necessary adaptations to facilities, ICT to support homeworking and other IT infrastructure developed as part of the Covid-19 response, such as the Track, Trace & Protect Contact Management System. No resource funding requests made by DoH during the pandemic were refused however a bid for Capital funding was refused by the Department of Finance in September 2020. The Department of Finance referenced the Department's capital underspend in the previous year and advised the capital bids would be considered pending an assessment of the Department's capital spending plans against the capital budget allocation for that year. A paper was provided to the Department of Finance and the funding was subsequently allocated in the October 2020 Monitoring Round.

253. Funding for individual initiatives was considered in line with the guidance issued by the command and control structures and later the Covid-19 Finance Process and Approvals Guidance [RP/184 - INQ000130406 (DoH Ref: PM0296)]. I do not believe that finance had an impact on the decision making process during the period (11 January 2020 to 18 March 2022, as the overarching assumption was that the funding required for the necessary response would be made available. However, the availability of surplus funding at the end of 2020/21 did lead to additional responses to the pandemic that may not otherwise have been undertaken.

254. Capital funding of £70 million was provided in 2020/21, with an underspend of £2.43 million declared at year end. This underspend relates to £1.65 million being held as unallocated Covid capital funds at end year with a further underspend of £0.782 million reported by Health organisations in their final year end spend returns. The underspend relates primarily to equipment, IT and capital works.

255. In 2021/22 the Department received an additional £15.7 million of capital in relation to Covid-19, reporting an underspend of £1.5 million at year end. This underspend, relating to

capital works schemes and IT related schemes, was £0.37 million being held as unallocated funds at year end with a further £1.1 million reported by Health organisations in their final year spend returns. Capital spending included purchase of medical equipment including oxygen generators, capital works to provide necessary adaptations to facilities, ICT to support homeworking and other IT infrastructure developed as part of the Covid-19 response, such as the Track, Trace & Protect Contact Management System. No resource funding requests made by the Department during the pandemic were refused, but a bid for Capital funding was rejected by the Department of Finance in September 2020 [RP/185 - INQ000394319 (DoH Ref: PM0353)]. The Department of Finance referenced the Department's capital underspend in the previous year, and advised the capital bids would be considered pending an assessment of the Department's capital spending plans against the capital budget allocation for that year. A paper was provided to the Department of Finance and the funding was subsequently allocated in the October 2020 Monitoring Round.

256. Funding for individual initiatives was considered in line with the guidance issued by the command-and-control structures and later the Covid-19 Finance Process and Approvals Guidance issued by the Department [RP/184 - INQ000130406 (DoH Ref: PM0296)]. Early in the pandemic the Department of Health was given assurances by the Department of Finance, both written [RP/186 - INQ000370677 (DoH Ref: PM0354)] and oral, that its Covid-19 funding needs would be met.

257. This assurance was passed on to Health and Social Care organisations and in 2020/21 funding was then provided in accordance with applications made via Covid-19 funding templates. In 2021/22 the process returned to the normal allocation process whereby appropriate funding needs for the Health and Social Care Trusts were assessed by the Health and Social Care Board and notified to the Department. Also in line with normal processes, the needs of other Arm's Length Bodies (which were comparatively minimal) were advised directly to the Department. In both years all funding needs were met in full. In the 2022/23 financial year no additional funding was provided to the Department specifically for Covid-19. However, Health and Social Care organisations were again assured that their Covid-19 funding needs would be prioritised and all requirements (again assessed via the former Health and Social Care Board in the case of the Health and Social Care Trusts) were fully met in the period covered by this statement (Q1 of 2022/23).

258. I am unable to provide any particular insight into the comments of the then First Minister in her statement to Module 1 of the Inquiry [RP/6 - INQ000205274, paragraph 32], that *"in or around March 2020, the reliance on UK government to bring forward the economic package to support lockdowns including the closure of schools and businesses was one factor that limited NI in making decisions about the imposition of Non-Pharmaceutical Interventions before the UK government".* It seems likely that the timing of any consideration by the Executive of the need for an economic package in March 2020 to mitigate the impact of NPIs, would have been concurrent with similar considerations taking place at UK Government level and in the other devolved administrations. The policy response to the virus in March 2020 was set out in the UK Government's Action Plan, published on 3 March 2020, containing the strategic approach of 'Contain, Delay, Research, Mitigate'. The legislation providing for NPIs was published later in March 2020.

259. The Department of the Economy and the Department of Finance will be better placed to assist the Inquiry in its understanding of the comments of the then First Minister, at the Executive Committee meeting on 17 December 2020, indicating a lack of planning as to the funds which would be required for the restrictions referred to [RP/150 - INQ000116295].The First Minister said, *"terrible position – asking business to close – 4 weeks, review for 2 further weeks – but don't know how we can pay – need to reflect on that".*

260. In my view the level of funding available from the UK government did not prevent the NI Executive from taking any significant steps it wanted to in order to respond to the pandemic.

Section 26: Controlling NI's Borders

261. The pandemic placed significant pressures on Executive Ministers to demonstrate that they were in control of all aspects of the policy response including key areas such as controlling international travel which was deemed to be an NPI of central importance. It is therefore understandable that Executive Ministers were at times frustrated by what they clearly felt was less than satisfactory consultation by the UK Government in respect of international travel interventions.

262. I am satisfied that at official level the policy interventions and operational changes which the Department and other governmental partners implemented to control NI's borders were broadly effective in delivering their respective public health protection objectives within the fast moving and evolving situation of the pandemic. This includes: how the arrangements

for controlling NI's borders operated in practice in relation to the risk based framework Red-Amber-Green (RAG) for reopening travel that also enabled border and safety readiness; Northern Ireland/Republic of Ireland cross-border co-operation; and the operation of the Common Travel Area during the pandemic.

263. Border policy and operations are UK Government reserved matters. It is therefore a matter for the UK Government and the Republic of Ireland's Government to determine whether there was greater scope for the United Kingdom and the Republic of Ireland to cooperate in relation to border control. However, health policy is a devolved matter, which in NI is the responsibility of the Department, and as such the UK Government had an obligation to consult the Devolved Administrations, including the NI Executive, on health protection measures at the border. The Department's responsibilities included: the maintenance of public health information and advice in relation to travel to and from NI and within the Common Travel Area; and liaison with Home Office (Border Force) in relation to compliance by Carriers/Operators (airlines and cruise operators) to NI in relation to restrictions and information to passengers. Some aspects of policy in this area could be deemed to be cross-cutting between the UK Government and the Devolved Administrations. For example, in NI the enforcement of measures was the responsibility of the Home Office Border Force and the Police Service of NI, with the Public Health Agency providing advice in relation to Port Health.

264. The temporary modification of the Public Health Act (NI) 1967 by the Coronavirus Act 2020 gave the Department the primary powers to make International Travel regulations. This enabled NI to stand up proportionate border health measures, which were subject to public health advice at that time and Executive agreement. The Department's policy development underpinning these Regulations was therefore informed by information on the risks, associated with international travel, provided from UK Government national analysis e.g., Joint Biosecurity Centre, which took account of the reliability of epidemic surveillance data and quantitative information about numbers. This information was reviewed and considered by the CSA/ CMO, and advice was subsequently provided to the Health Minister. The Department also considered any information available on international travellers entering the Republic of Ireland before transiting to NI, although the extent of this information varied during the course of the pandemic.

265. The Health Protection (Coronavirus, International Travel) Regulations (NI) 2020 came into operation on 8 June 2020. The Regulations applied in relation to travellers arriving into NI from outside the Common Travel Area CTA) which includes the UK, ROI and the Crown

Dependencies (Jersey, Guernsey and the Isle of Man). Intra CTA travel was exempt from the requirements under the Regulations unless a person had been outside the CTA within the last 14 days of entry into NI. The regulations required a person arriving into NI who had been outside the CTA within the last 14 days to complete a UK passenger locator form and to self-isolate.

Section 27: Care Homes

266. From the onset of the pandemic the Department recognised that nursing and residential care homes would be at the forefront of the battle against Covid-19. The Department was focused on both limiting infections and their impact in care homes as well as ensuring care homes could continue to function as an important part of the wider health and social care system. The Department and several of its Arms Length Bodies were responsible for the policy, planning and operational response to addressing the impact of the pandemic on care homes in NI. The Department worked with the independent care home providers and other key stakeholders to provide guidance, support, equipment workforce interventions and funding to care homes. At the start of the pandemic the Department asked the Health and Social Care Board to draw up a surge plan for social care [RP/187 - INQ000120731 (DoH Ref: PM0146)], which was reviewed, revised and agreed with the Department. This supplemented the Department's published 'Health and Social Care (NI) Summary Covid-19 Plan for the Period Mid-March to Mid-April 2020' [RP/188 - INQ000103714 (DoH Ref: PM0201)] and provided a framework for responding to pressures and maintaining services and was underpinned by plans in each HSC Trust.

267. The Executive did not take decisions on the policy and operational response to the pandemic in care homes, including the response to transmission of the virus. The Executive was very concerned about the response to the pandemic across the entire health and social care system and alert to the action taken by the Department to support care homes including access to personal protective equipment for care home staff and the testing programme. In the early weeks of the pandemic the Health Minister gave regular updates to the Executive on the position in care homes and the action taken by the HSC. On 17 April 2020 the Health Minister provided an overview paper to the Executive on care Homes, updating them on reporting of deaths, PPE, testing and measures under development to support care Homes [RP/189 - INQ000103672 (DoH Ref: PM0092) and RP/190 - INQ000103673 (DoH Ref: PM0093)]. Subsequently, action 112 of the Executive's Covid-19 Action Plan (May 2020) requested quantitative information on the actions taken within care homes to reduce infection

and their effect. The Health Minister submitted a paper to the Executive in July 2020 [RP/191 - INQ000103717 (DoH Ref: PM0208)] which set out a timeline of the range of actions taken to respond to the Covid-19 pandemic in care homes and provided information on the course of the infection in Care Homes over the same period. A further Executive Paper was produced by the Department in November 2020. This paper provided the Executive with an update on measures to support and protect care homes as Covid-19 continued to spread in the community and as infection levels in care homes continued to rise [RP/192 - INQ000103674 (DoH Ref: PM0094)]. Testing for Covid-19 was therefore part of a package of comprehensive measures for Care Homes in NI, recommended and advised by the Department from early in the pandemic. Care Home residents were identified as a priority group for testing, as evidenced in the early prioritisation criteria which were agreed for the region on 17 March 2020 and included in the first Interim Protocol for Testing, operational from 20 March 2020 [RP/193 - INQ000120705 (DoH Ref: PM0056)].

Section 28: PPE

268. There was a significant and intensified demand for Personal Protective Equipment (PPE) across all HSC settings at a time when the global supply chain was experiencing extreme pressure due to the huge uncertainties associated with a ban on the export of PPE by China, a leading global provider. Concerns were escalated to the Department around the supply and availability of PPE, both within HSC Trusts, but also within parts of the HSC which would normally not use PPE daily, for example, Community Pharmacies or those who would normally source their own supplies, such as GP practices and dentists and the Independent sector (Care Homes).

269. The approach taken to address the issues raised, particularly around supply, was to explore every viable channel both locally and internationally to procure PPE. A focus was also placed on maximising the opportunities to strengthen the local supply position and the repurposing of local manufacturing in conjunction with Invest NI (the investment and trade arm of the Department for the Economy) and which supported engagement with businesses in this area.

Section 29: Public Health Messaging

270. Communications work by the Department during the Covid-19 pandemic fell into three main categories:

- proactive messaging, principally led by the Health Minister, CMO, CSA and the Head of the NI vaccination programme. This included regular press conferences, press releases, media interviews and briefings and social media content dealing with the threat posed by the virus to the NI population, the actions the public could take to protect themselves, and the Covid-19 regulations put in place by the NI Executive. Dedicated sections of the Department's NI website and NIDirect were regularly updated with Covid-related material.

- partnership working on public communications with a number of public sector/Government bodies including the Executive Office, the Public Health Agency and HSC Trusts. The Executive Office had the lead role on the public information campaign on Covid-19 safety steps, while the Public Health Agency led on the public information campaign on vaccination. Monitoring of message effectiveness across these campaigns helped inform ongoing communications by the Department and partner bodies. The Department also participated in regular UK-wide comms discussions, led by Cabinet Office. The Department also helped ensure strategic co-ordination of messaging across NI's HSC system, for example, on pandemic related service pressures and on Covid-19 safety messages from health care professionals, and

- intensive reactive communications work, with a high volume of queries to the Department's press office reflecting media and public interest in the trajectory of the Covid-19 virus, the various public health measures taken in response and the impact of the pandemic on health and social care services. The Department also took steps to counter disinformation during the pandemic including, for example, in "mythbuster" and "factfile" briefings published on specific issues.

271. The proactive messaging together with the partnership working on public communications worked well in maintaining consistent and persistent communication with the public about the threat from the virus to the NHS and the need to protect vulnerable people. Public messaging across the UK, including the Devolved Administrations and the Republic of Ireland, was broadly aligned and similar, providing advice on respiratory hygiene, ventilation

and social distancing which was modified throughout the pandemic. Each nation adapted the specific wording of the advice for its local population.

272. In NI, local engagement and market research was commissioned by The Executive Office to ascertain the most effective approach. This was subsequently considered by the CMO and CSA who provided public health and scientific input to the proposed approach and core messages. I have no particular insight into the absence of press conferences specifically orientated at children and young people, or indeed other population groups. On reflection, press conferences targeted at specific groups might have provided an additional layer of public information messaging. This approach was adopted in relation to the vaccination programme in the targeting of groups where there was initially low update of the vaccine. In relation to changes to the statutory framework (as it related to the care and protection of children) the Department's officials liaised at key points prior to and following the making of the regulations with the NI Commissioner for Children and Young People, the Children's Law Centre, the Voice of Young People in Care, the NI Human Rights Commission, Fostering Network (NI) and the British Association of Social Workers (NI). Discussions also took place with representatives of the Health and Social Care Board, the HSC Trusts, voluntary adoption agencies and the NI Courts and Tribunal Service. The detailed insight and feedback provided by these organisations informed the drafting of both the regulations and guidance. Liaison also took place with the four independent fostering organisations in NI, AccessNI and the Regulatory and Quality Improvement Authority, particularly during post-implementation monthly monitoring.

Section 30: Lessons Learnt

273. In respect of the overall response of the NI Executive to the pandemic my broad view is that the Executive provided an effective response. Executive departments worked collaboratively and diligently to deliver public services within an unprecedented and challenging environment. There was good and effective collaboration across the Health and Social Care sector with staff consistently displaying high standards of care for patients and clients in the most difficult of circumstances. I would highlight the following activities as having made an invaluable contribution to the combatting of Covid-19:

- the medical and scientific advice provided by CMO and CSA (informed by the work of the Strategic Intelligence Group, the NI Modelling Group and

SAGE) which made a significant contribution to planning the response to the pandemic;

- the four UK CMOs working together to review data on disease activity, potential growth and direct health service pressures in each jurisdiction to provide advice to the respective UK Health Ministers and governments on the UK Covid-19 Alert level;
- the sharing of information and collaboration between respective CMO offices and health officials in NI and the Republic of Ireland;
- the proactive messaging the Health Minister, CMO, CSA and the Head of the NI vaccination programme, together with the partnership working on public communications, worked well in maintaining consistent and persistent communication with the public about the threat from the virus to the NHS and the need to protect vulnerable people;
- the planning work by the Department's officials and HSC staff culminating in the Health and Social Care (NI) Summary Covid-19 Plan and the Strategic Framework for Rebuilding HSC Service Delivery was very effective in enabling the HSC to ramp-up treatment services for Covid-19 patients while maintaining business continuity within the available resources; and
- the strategic interventions such as the NI Covid-19 Regulations; the NI Test and Trace Programme and the NI Vaccination Programme.

Section 31: Richard Pengelly use of communication devices, apps, notebooks, etc

274. Information concerning my use of communication devices, apps, notebooks, etc., messaging platforms and the retention of records during the Specified Period is as follows.

275. The NICS issued me with the following mobile device(s) for use in my capacity as Permanent Secretary:

- an iPhone; and
- an iPad.

276. I used WhatsApp and text messages in my professional capacity as Permanent Secretary during the Specified Period, only on my NICS-issued iPhone, to communicate with Ministers, special advisers and senior civil servants concerning the pandemic:

Table 9: Use of Messaging Platforms during the Specified Period

	WhatsApp	SMS Messages
Names of individuals with whom you communicated and the purpose	**2. David Sterling** – for information sharing **3. Ian Young** – for information sharing **4. Jayne Brady** – for information sharing **5. Robin Swann**- for information sharing	**6. Anne Kilgallen** – for information sharing **7. Cathy Jack** – for information sharing **8. David Gordon** – for information sharing **9. Jayne Brady** – for information sharing **10. Jennifer Welsh** – for information sharing **6. Jenny Pyper** – for information sharing **7. Karen Pearson** – for information sharing **8. Michael Bloomfield** – for information sharing **9. Michael McBride** – for information sharing **10. Neil McGuckian** – for information sharing **11. Patricia Donnelly** – for information sharing

		12. Peter May – for information sharing **13. Robin Swann –** for information sharing **14. Roisin Coulter –** for information sharing **15. Shane Devlin –** for information sharing
The names of groups you were part of and the purpose	**11. Michael McBride, Richard Pengelly, & Ian Young –** for information sharing **12. Robin Swann, Mark Ovens, Michael McBride, Ian Young, Richard Pengelly, & David Gordon –** for information sharing **13. Permanent Secretary Stocktake Group, "PSS (Covid 19)"*** – for information sharing	

Note: * indicates that any messages which formed part of this group communication have not been retained on my devices see para 293. (although I understand the relevant messages may be available to the Inquiry from other members of the groups)

277. I am not aware nor do I believe that any of the Messaging Platforms used on Ministers' NICS-supplied devices or personal mobile device(s) were an alternative to formal or minuted meetings.

278. I did not use any personal devices for official communication.

279. I am unable to assist the Inquiry in providing an explanation of the reference made to "chat" (for example, [RP/194 - INQ000065769, page 20]) in the handwritten notes of Executive Committee meetings.

280. I do not recall any decisions being taken on any form of messaging platform, as opposed to such media being used for general conversation – it is my understanding that any and all decisions were officially documented through formal minutes of meetings or in response to submissions sent by officials.

281. I am still in possession of, and still using, the mobile devices I used during the pandemic. However, I do not have a complete record of all messages sent or received in the relevant period, as my normal practice, which applied both before and during the pandemic, was, from time to time, to delete chats that became excessive in length, as my experience was they became unwieldy to navigate. This reflected my clear belief that they did not represent any form of decisions that had to be maintained for the official record – as all such items were recorded separately. I have provided screen shots/logs for all messages related to the response to the pandemic that are still within my possession on my NICS-supplied device.

282. It is my normal practice to use a personal notebook as part of my work routine. Such notebooks are used to capture points that arise during meetings/discussions etc to assist me in managing the flow of those meetings/discussions – i.e. it is not intended to be a complete record of every meeting/conversation I have, nor a comprehensive record of every component of those discussions that are recorded. The main aim is to help me in the flow of the meetings as they take place, and the notes are not intended to be a substitute for the official record of such meetings/discussions, where one is appropriate. Copies have been provided to the Inquiry.

Statement of Truth

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

Signed: Personal Data

Dated: 19/03/2024