Witness Name: ROBIN SWANN, MLA

Statement No:

Exhibits: 155

Dated: 15 January 2024

UK COVID-19 INQUIRY

WITNESS STATEMENT OF:

Robin Swann

Minister of Health (11 January 2020 – 27 October 2022)

Department of Health, Northern Ireland

UK COVID-19 PUBLIC INQUIRY

MODULE 2C RULE 9 REQUEST – M02C-RSW-001

DEPARTMENT OF HEALTH (NI)

Contents

WITNESS STATEMENT OF ROBIN SWANN

1. I, Robin Swann, former Minister of Health for Northern Ireland, make this statement in response to the request from the UK Covid-19 Public Inquiry ("the Inquiry"), dated 17 October 2023 under Rule 9 of the Inquiry Rules 2006 (SI 2006/1838), requiring me to provide the Inquiry with a witness statement in respect of specified matters relating to Module 2C.

SCOPE OF THIS STATEMENT

2. This statement is provided from the perspective of my former role as Minister of Health in relation to the Department of Health's decision-making by the government in Northern Ireland during the Covid-19 pandemic between early January 2020 until the Covid-19 restrictions were lifted in Northern Ireland in March 2022.

3. The Covid-19 virus represented the biggest threat to public health since the conception of our National Health Service. Many people lost their lives in Northern Ireland, across the United Kingdom, and across the world. So many families were left grieving. Those who were lost and those who mourn them must be at the forefront of our minds in any assessment of how Governments responded to the pandemic. We must never forget the toll that Covid took.

4. Throughout the Rule 9 request I have been asked to consider many exhibits; some of these exhibits are handwritten documents kept by, or on behalf of, The Executive Office who later drafted the minutes of the Executive meeting. I would like to state at the outset that, in many instances, the author of the document remains anonymous. Where appropriate I have provided my recollection of the context.

A. MY ROLE

1. Professional Background

5. I was first elected to the Northern Ireland Assembly at the 2011 election, representing North Antrim, and was re-elected in 2016, 2017 and 2022. From 6 April 2012, I served as the Ulster Unionist Chief Whip, which I retained until I was elected unopposed as the Ulster Unionist Party leader in April 2017. I resigned from that position in November 2019.

6. I served as the Chairman of the Committee for Employment and Learning from 27 February 2013 until the Committee was dissolved on 30 April 2016 when the

Department of Employment and Learning was closed, and its mandate transferred to other departments.[1] During the short 2016 Assembly mandate I was Chairperson of the Public Accounts Committee which commenced the Inquiry into the Renewable Heat Incentive scandal. From 11 January 2020 until 27 October 2022, I served as Minister of Health.

7. The table below sets out the entirety of my roles in office between 2011 and 2022.

Period	Position	Office/Committee
31/03/2020- 28/03/2022	Committee Member	Ad Hoc Committee on the COVID-19 Response
11/01/2020 - 27/10/2022	Minister of Health	Department of Health
31/05/2017 - 13/01/2020	Committee Member	Northern Ireland Assembly Commission
31/05/2016 - 25/01/2017	Committee Member	Committee for Agriculture, Environment and Rural Affairs
25/05/2016 - 25/01/2017	Committee Chair	Public Accounts Committee
25/05/2016 - 25/01/2017	Committee Member	Chairpersons' Liaison Group
12/05/2016 - 25/01/2017	Committee Member	Business Committee
01/03/2016 - 30/03/2016	Committee Member	Concurrent Committee of the Committee for Enterprise, Trade and Investment and the Committee for Agriculture and Rural Development
30/06/2015 - 30/03/2016	Committee Member	Committee for Agriculture and Rural Development
09/02/2015 - 14/09/2015	Committee Member	Assembly and Executive Review Committee
10/09/2014 - 30/03/2016	Committee Member	Chairpersons' Liaison Group
02/09/2013 - 10/09/2014	Committee Chair	Chairpersons' Liaison Group
09/04/2013 - 05/11/2013	Committee Deputy Chair	Committee Review Group
27/02/2013 - 30/03/2016	Committee Chair	Committee for Employment and Learning
27/02/2013 - 01/09/2013	Committee Deputy Chair	Chairpersons' Liaison Group
25/02/2013 - 11/03/2013	Committee Member	Committee for the Office of the First Minister and deputy First Minister
11/02/2013 - 04/07/2014	Committee Member	Concurrent Committee of the Committee for Agriculture and Rural Development and the Committee for Health, Social Services and Public Safety
21/01/2013 - 04/07/2014	Committee Member	Committee for Agriculture and Rural Development
23/11/2012 - 03/02/2013	Committee Deputy Chair	Ad Hoc Committee on Conformity with Equality Requirements, Welfare Reform Bill
23/05/2011 - 04/03/2013	Committee Member	Committee for Culture, Arts and Leisure

[1] This was as a result of the reduction in the overall number of Ministerial Departments in Northern Ireland.

23/05/2011 - 03/12/2012	Committee Member	Committee for Agriculture and Rural Development
12/05/2011 - 30/03/2016	Committee Member	Business Committee

Source: MLA Details: Mr Robin Swann (niassembly.gov.uk)

2. Ministerial Role and Responsibilities

8. In a ministerial role, a Minister will exercise the functions assigned to the ministerial office that they hold and have full executive authority within any broad programme agreed to by the Northern Ireland Executive and endorsed by the Northern Ireland Assembly. As a Minister I am expected to act in accordance with the Northern Ireland Executive Ministerial Code [Exhibit RS/1 INQ000199191]. The functions of a department are at all times exercised subject to the minister's direction and control as per Article 4 of the Department's (Northern Ireland) Order 1999. Ministers are accountable to the Northern Ireland Assembly for the decisions and actions of their departments and agencies, including the stewardship of public funds and the extent to which key performance targets and objectives have been met. Under paragraph 2.4 of the Ministerial Code, ministers are required to bring matters deemed to be crosscutting, significant or controversial to the Northern Ireland Executive.

9. Alongside the role I had in managing the Covid-19 pandemic, I was responsible for a number of legislative changes and policy initiatives during my tenure. Upon taking up post in January 2020 the pressing issue was the industrial action by health service workers which was ultimately resolved.

10. In line with my ministerial role in implementing the vision set out in Health and Wellbeing 2026: Delivering Together (a 10-year approach to transforming health and social care in Northern Ireland) I progressed legislation to close the Health and Social Care Board. This involved my approval at all stages of the legislation's passage through the Northern Ireland Assembly from First and Second Stage in March 2021 with Committee Stage in September 2021. Consideration Stage and Further Consideration Stage followed in November 2021 with Final Stage in December 2021. Royal Assent was given on 2 February 2022, immediately prior to the Assembly's collapse on 3 February 2022, resulting in the Health and Social Care Act (Northern Ireland) 2022.

11. Aligned with the work to close the Health and Social Care Board and the transfers of its functions in the main back to the Department, in October 2020 I approved a

programme of work to develop a new planning model for the Health and Social Care system. This was based on an integrated approach in the line with the vision outlined in *Delivering Together.*

12. I promoted and progressed the mental health agenda, most notably by initiating work, on and subsequently approving, the:

- Mental Health Action Plan (including Covid-19 recovery plan);
- 10-year Mental Health strategy;
- Mental Health Support Fund (£16m);
- Establishment of the community Perinatal Mental Health Service, and
- Appointment of a Mental Health Champion.

13. In September 2020 I announced that I would bring forward reform to adult safeguarding in Northern Ireland. Following a public consultation, I agreed the Final Policy Proposals to develop the draft Bill in July 2021 and officials continue to develop the draft Bill based on this mandate.

14. In September 2021, I introduced the Adoption and Children Bill, a substantial and complex piece of primary legislation which strengthens the statutory framework for adoption and children's social care in Northern Ireland, improving safeguards for vulnerable children and enhancing support for eligible children and young people, carers and families. Over the subsequent 7 months, I led on the plenary debates for each of the Bill's legislative stages in the NI Assembly, culminating in its Royal Assent in April 2022.

15. I also introduced 'Daithi's law', formally known as The Organ and Tissue Donation (Deemed Consent) legislation, to the Assembly in 2021 and it received Royal Assent on 8 February 2022. This law changed organ donation from an opt-in to an opt-out system for the way consent is granted and follows similar law changes in Wales, England and Scotland.

16. I also led through the Assembly, by means of the legislative consent procedure, the Medicines and Medical Devices Act 2021. This was needed to agree the Department of Health as the appropriate authority for the regulatory provision governing human medicines which are transferred matters to Northern Ireland, following the withdrawal of the United Kingdom from the European Union. United Kingdom-wide Primary

legislation was needed to ensure that the United Kingdom could continue to update and amend regulations relating to human medicines. The Bill was first debated and agreed in the Northern Ireland Assembly in June 2020 and further amendments were debated and agreed in November 2020. The Medicines and Medical Devices Act 2021 received Royal Assent on 11 February 2021.

17. In respect of the United Kingdom exit from the European Union I also engaged regularly with United Kingdom Ministers and provided updates to the Executive on the implications of European Union Exit for the Department of Health. This included issues relating to the availability of and regulatory framework for medicines and risks of divergence between Northern Ireland and Great Britain in respect of the Northern Ireland Protocol.

18. I launched a number of consultations including the Reform of Adult Social Care Public Consultation in January 2022, the consultation on the potential introduction of Minimum Unit Pricing for Alcohol in February 2022 and the consultation on the regulation of pharmacy technicians in Northern Ireland in March 2022. Reform of Adult Social Care was a New Decade New Approach Agreement [Exhibit RS/2 INQ000391422] commitment which I continued to drive forward during the period of the pandemic.

19. I announced two statutory public inquiries into allegations of abuse at Muckamore Abbey Hospital and Urology Services at the Southern Trust, appointing chairs and agreeing terms of reference for each. I also upgraded the Independent Neurology Inquiry to a statutory public inquiry. In addition to announcing these two inquiries, I also made 6 written statements and gave oral evidence (in May 2021) to the Infected Blood Inquiry and reviewed the Northern Ireland Infected Blood Payment Scheme. I increased payments to align with other United Kingdom schemes, including the introduction of enhanced financial support for some Hepatitis C beneficiaries and new bereaved payments.

3. Role of Department of Health

i. Overview of the Department of Health

20. The Northern Ireland Executive is comprised of nine departments, each with a ministerial lead. The Department of Health is one of those nine. The Department's statutory responsibilities under the Health and Social Care (Reform) Act (Northern

Ireland) 2009 are 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;
- The prevention, diagnosis and treatment of illness, and
- The social wellbeing of people in Northern Ireland.

21. The Department discharges these responsibilities, both by direct Departmental action and through its Arm's Length Bodies[2], by developing appropriate policies; determining priorities; securing and allocating resources; setting standards and guidelines; securing the commissioning of relevant programmes and initiatives; monitoring and holding to account its Arm's Length Bodies; and promoting a whole system approach.

22. Prior to April 2022 the Department's principal service delivery objectives for Health and Social Care commissioners and Trusts were set out in detail in the annual Health and Social Care Commissioning Plan Direction. The annual Health and Social Care Commissioning Plan Direction was issued by the Department to the Health and Social Care Board, which was the Arm's Length Body jointly responsible with the Public Health Agency for the commissioning of health and social care services in Northern Ireland. Following the dissolution of the Health and Social Care Board in March 2022, its functions were, in the main, transferred to the Department except for Social Care and Children's functions, as described above, and its staff were transferred to the Health and Social Care Business Services Organisation. This dissolution meant that there was no longer any requirement for the Department to issue an annual Health and Social Care Commissioning Plan Direction.

ii. Emergency Response Role

23. In April 2010, in line with Cabinet Office best practice guidance, the Department defined its Lead Government Department role [Exhibit RS/3 INQ000145671] for responding to the health consequences of emergencies arising from chemical, biological, radiological and nuclear incidents; disruptions to the medical supply chain; human infectious diseases; and mass casualties.

24. The Civil Contingencies Framework for Northern Ireland (2011) [Exhibit RS/4 INQ000103600], published by the Executive Office, also required the Department to

[2] There were 17 Arm's Length Bodies during the pandemic, reduced to 16 following the dissolution of the Health and Social Care Board in March 2022.

maintain, review and update its Emergency Response Plan [Exhibit RS/5 INQ000184662], described further below, and to test and exercise the plan response arrangements. This was to ensure the Department's ability to deliver an effective response to minimise the health and wider impacts of the emergency on society, given that it had been designated lead Government department. The Department will also provide strategic health and social care policy advice and/or direction in support of the efforts of others, including its associated agencies and Arm's Length Bodies in response to emergencies for which it had been designated lead. This is necessitated when an emergency has been categorised as Serious or Catastrophic and requires a cross-departmental or cross-governmental response.

iii. Emergency Response Plan

25. The Emergency Response Plan 2019 was activated in January 2020 and it defines the structures, systems and processes involved in responding to an emergency. 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 effectively carry out 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 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 Health and Social Care emergencies in Northern Ireland, from short term emergencies which are sudden, unexpected and relatively brief, to longer term 'rising tide events', such as pandemic influenza.

26. Within the Emergency Response Plan, the oversight of managing an emergency falls to Health Gold Command which consists of two key elements: the Strategic Cell and the Emergency Operations Centre. The Strategic Cell provides strategic health and social care policy advice to the Minister. It also provides health, social care and public safety advice, direction and leadership to Health and Social Care organisations and to other departments and organisations. The second element, the Emergency Operations Centre, is responsible for management of the flow of information into and out of the Strategic Cell between the Department and Health and Social Care sector, and the wider Northern Ireland Executive departments and United Kingdom Government. Activation of the Emergency Operations Centre is not reliant on the full activation of both key elements of the Health Gold Command structure and can operate without

activation of the Strategic Cell in lower-level emergencies requiring a degree of central co-ordination. However, the Strategic Cell requires the support of the Emergency Operations Centre to function.

27. An extraordinary meeting of the Top Management Group was held on 4 March 2020. A note of that meeting [Exhibit RS/6 INQ000103631] which confirmed the Top Management Group's agreement to full activation of the Health Gold Command was circulated the following day, advising that the Strategic Cell had been convened and would have its first meeting on 9 March 2020. On 9 March 2020 the Department activated Health Gold Command in line with the guidance set out in its Emergency Response Plan 2019 [Exhibit RS/5 INQ000184662], regarding the levels and approvals necessary to stand up.

28. The Strategic Cell met formally for the first time on 9 March 2020 [Exhibit RS/7 INQ000103632] in response to the growing threat to Northern Ireland from the virus. It had regular meetings and operated for the first four months of the pandemic during the initial emergency response phase of the pandemic, holding its last meeting on 16 June 2020. The Strategic Cell was chaired by the Chief Medical Officer or a deputy from the Department's Top Management Group. The meetings were conducted based on a set agenda. The membership of the Strategic Cell included Top Management Group senior officials and the Department's professional officers from the medical, nursing and social care disciplines. I received regular verbal updates and written submissions from officials.

29. Alongside the meetings of the Strategic Cell, the Department's Permanent Secretary chaired a regular early-evening teleconference meeting. This meeting involved the Top Management Group senior officials, the Department's professional officers, chief executives from the Health and Social Care Trusts, Health and Social Care Board, the Public Health Agency and Business Services Organisation. The purpose of this meeting was to supplement the Strategic Cell meetings by providing the chief executives from the Health and Social Care organisations with the ability to directly input into information sharing and reflect on the progress of urgent regional operational issues requiring resolution. I received regular verbal updates and written submissions from officials.

30. The diagram at [Exhibit RS/8 INQ000103633] provides the overall organisational structure for Health Gold Command[3] which was comprised of the Strategic Cell and of 13 subject-specific policy cells. The remit and staffing for each of these policy cells is provided in the document at [Exhibit RS/9 INQ000103634]. These policy cells were mainly chaired by lead officials from the Department's business areas who were also members of the Strategic Cell. Additional Grade 7 officials and their teams (which had been recently recruited to manage health service transformation projects) were immediately redeployed to the policy cells upon their arrival in the Department. The redeployment of these staff resulted in the Department's acute health services transformation programme being paused from April 2020 to the summer of 2021.

31. Each policy cell was responsible for monitoring the impact of the pandemic in specified service delivery/policy areas, responding to issues escalated to Health Gold by Silver. As the impact of the pandemic began to take hold and became pervasive across the Health and Social Care system, the cells also developed new policies or responses designed to mitigate or address the new and complex issues faced by Health and Social Care. Policy recommendations and advice prepared by the policy cells for the Minister to approve were cleared by the Strategic Cell before I received them. The clearance of policy recommendations was given either verbally at Strategic Cell meetings or via email, which often included a draft Ministerial submission, circulated amongst the Cell's membership in between meetings. The Strategic Cell worked at pace logging its decisions and actions [Exhibit RS/10 INQ000130312].

iv. Ministerial Role

32. I have described above some of the key legislative changes and policy initiatives I promoted and progressed during my tenure and this statement details my work on Covid-19. In brief, however, as Minister of Health, I was required to lead, direct and co-ordinate the response for Northern Ireland, reporting as necessary to the Northern Ireland Executive under the Northern Ireland Central Crisis Management Arrangements Protocol [Exhibit RS/11 INQ000103601].

[3] This was the structure between March 2020 and June 2020 when the Rebuilding Management Board was established. It provided direction to the Health and Social Care Board, the Public Health Agency, the Health and Social Care Trusts and the Business Services Organisation in the context of rebuilding health and social care services coming out of the first COVID-19 wave and effectively managing further COVID-19 surges.

4. Senior Civil Servants

33. The table below provides the name and role of each member of the Department's senior civil servants with whom I worked most closely between January 2020 and March 2022:

Name	Role
Mr Richard Pengelly	Permanent Secretary
Dr Michael McBride	Chief Medical Officer
Mr Sean Holland	Deputy Secretary, Social Services Policy Group
Prof. Charlotte McArdle	Chief Nursing Officer
Mrs Deborah McNeilly	Deputy Secretary, Resource and Corporate Management Group
Mr Jackie Johnston	Deputy Secretary, Healthcare Policy Group
Mrs Sharon Gallagher	Deputy Secretary, Transformation, Planning and Performance Group
Mr Dan West	Chief Digital Information Officer
Mrs Cathy Harrison	Chief Pharmaceutical Officer
Mr David Gordon	Director of Communications

5. Special Adviser

34. As Minister I appointed Mark Ovens as my Special Adviser in accordance with the Code Governing the Appointment of Special Advisers [Exhibit RS/12 INQ000400094]. The Code states that: [4]

> 1. A Special Adviser is appointed by the Minister as Appointing Authority;
> 2. The Appointing Authority must ensure that the appointment is made in accordance with the law and with the terms of this Code, and
> 3. The legal framework governing employment in Northern Ireland applies to the appointment of Special Advisers, including anti-discrimination laws.

35. Mark was my Special Adviser from 11 January 2020 until the end of my term in office on the 27 October 2022. Special Advisers are an additional resource for a Minister, who can provide advice from a more political viewpoint than a civil servant. However, while Special Advisers work closely with civil servants, they are not civil servants. Special Advisers can act on behalf of their Minister; they can convey their Minister's views, instructions and priorities to officials including on issues of presentation. In doing so they must take account of any priorities that their Minister has set. For example, Special Advisers can request officials to prepare and provide information and data for Ministers, including internal analyses and papers and they can review and comment on – but not change, suppress or supplant – advice submitted to Ministers by civil servants. Just as the Ministerial Code of Conduct [Exhibit RS/1

[4] Department of Finance – The Code Governing the Appointment of Special Advisers (2020).

INQ000199191] sets out the ethical standards required of Ministers when acting in their capacity as a Minister of the Northern Ireland Executive, there is a similar Code of Conduct for Special Advisers [Exhibit RS/13 INQ000400121].

B. IMPACT OF THE ABSENCE OF POWER SHARING

36. I believe it is important to consider the context of early 2020. There had been no functioning Assembly or Executive in place for over three years. Departments were without Ministers for the entirety of this period and the legal decision-making ability of the senior Northern Ireland Civil Service was very limited. Even before 2017, the political environment in Northern Ireland had often been unstable.

37. On the 14 May 2020 when I addressed the Northern Ireland Assembly's Ad Hoc Committee on Covid-19 [Exhibit RS/14 INQ000185381] I highlighted key areas where I believed collective past political/Governmental failings left health and social care vulnerable to the pandemic. I believed then, and still do, that over the previous decade Stormont had let the Northern Ireland Health Service down by not looking after health and social care as well as it could, and should, have done. It is my view that whilst Health was a devolved matter during this period, there was very limited local control over finances, vital services were underfunded, short term decisions were made instead of longer-term planning and difficult decisions were avoided. Social care was particularly neglected with a lack of proper pay and career structures, leaving our care homes exposed.

38. Underfunding and persistent single year budgets saw healthcare surviving hand to mouth, with a limited ability to plan strategically and deliver better services. The annual setting of single year budgets, which were sometimes only finalised months into the financial year, led to retrograde short-term decisions being taken. As health and social care ran on close to empty for 10 years, it meant that there was limited capacity, resilience or flexibility when it was needed most. Accordingly, when the pandemic struck, we were left with no option but to do our best to free up capacity and procure essential equipment at pace.

39. I remain of the opinion now that the lack of a recurrent budget had an adverse effect on the readiness of public services to prepare for a whole-system civil emergency. The Department of Health has been faced with single year budgets since 2015/16. With single year budgets the funding position is only known for 12 months which means the

focus is on the short term. When single year budgets are coupled with funding provided on a non-recurrent, or single year basis the position is exacerbated as you cannot make commitments over a number of years with no funding guaranteed. This had impeded long term financial planning and resulted in a focus on the short term. All recurrent funding received by the Department in recent years had been used to fund the costs associated with maintaining existing models of service and associated cost pressures. During this time, there has been limited budgetary cover to also fund service improvements. Single year injections of transformation funding, whilst successful in part, were not sufficient to embed the systemic change required due to their short-term nature. A recurrent multi-year funding commitment would have better supported the planning, delivery, and sustainability of our services. It would have also enabled us to develop plans to transform our services fully given that a multi-year budget guarantees funding over a number of years which enables long term planning and the ability to enter into commitments over a number of years as the funding has been assured.

40. In 2021 a judicial review was taken against the Department, and in his affidavit a Departmental official made a number of comments with which I agree, and which highlight the importance of a multi-year budget in order to make sustained progress and transformation. Given that I concur with these comments, I repeat them below:

> "*The Department has been increasingly reliant on securing non-recurrent additional funding during in-year monitoring rounds to support the ongoing running costs to maintain existing services. This is far from ideal in terms of the planning and management of services. Non-recurrent funding cannot be used to invest in staff or services as there is no guarantee that it will be available in future years. As well as being faced with consecutive single-year budgets, the Department has needed to identify significant reductions in costs on an annual basis. The resultant impact is a focus on measures which can be taken to reduce costs, rather than on strategic measures which have been recommended for the transformation of service delivery models which could deliver increased capacity and efficiency in the longer term.*
>
> *The effect of these challenging financial circumstances is a very limited scope for in-year additional initiatives to counter rising hospital waiting times and growing pressures elsewhere in the system. Since 2015 the annual budget allocated to the Department has not been sufficient to keep waiting times to an*

acceptable level. There has been an acknowledgement that there is an imbalance between patient demand for many elective specialties in Northern Ireland and the available recurrently funded capacity. While doctors, nurses, other health professionals and managers have made every effort to ensure that any negative impact on patients has been kept to a minimum, waiting times have continued to grow to a level where many believe that they are now out of control, will take years to stabilise and even longer to return to their pre-2015 levels.

Significant additional investment and new ways of working to deliver services will be needed to achieve the necessary turnaround. A multi-year budget approach is needed to secure a recurrent funding source to increase the capacity of our elective care system, whether in-house or through increased use of the independent sector, and to enable us to invest in the staff and infrastructure required.

In January 2020 the Northern Ireland Executive committed, through the New Decade New Approach agreement, to tackle unacceptably long elective care waiting lists. This indicated the new Executive's support for the Department's existing ten-year transformation strategy: Health and Wellbeing 2026: Delivering Together. In order to achieve this, it was envisaged that spare capacity across the United Kingdom and the Republic of Ireland could be used; however, it was recognised that this would take sustained investment over a number of years. Aside from the challenges presented by Covid-19, the single year funding approach means that the Department cannot develop the long-term approach that is essential to taking this work forward.

What is needed at a minimum is a recurrent source of earmarked funding, agreed in advance, to close the capacity gap and address the patient backlog. Longer term surety of funding at a significant scale will enable innovations both in-house and with independent sector providers."

1. Bengoa Report

41. The Bengoa Report [Exhibit RS/15 INQ000185456] and the Delivering Together report [Exhibit RS/16 INQ000185457], published in 2016 just before the three-year Assembly hiatus, on transforming Northern Ireland's health service were produced against a backdrop of rising demand for health and social care services, and an associated

deepening shortfall in actual Health and Social Care capacity. As a result, too many people were having to wait too long for treatment and waiting times in Northern Ireland had become by far the worst in any region of the United Kingdom; this was still the case at the start of the pandemic. The recommendations and actions within these reports, which included a renewed focus on reconfiguration, population health and workforce, were unable to be developed and progressed in the absence of the local political structures.

42. The Bengoa Report, in particular, highlighted a number of substantial health inequalities in Northern Ireland, including a reduced life expectancy for men and women living in the most deprived areas in comparison with those living in the least deprived areas. The initial delivery program for Bengoa set out a number of steps that were to be achieved, but the target dates did not extend substantially post 2018. [Exhibit RS/17 INQ000400096]; [Exhibit RS/18 INQ000400097]. After the initial delivery programme, I believe the majority of the recommendations from Bengoa required the political leadership of a Minister as they required political sign off. In the absence of a Minister, I believe the strategic reforms that could have been achieved could not be delivered. The absence of a Minister of Health and Executive during that period undoubtedly delayed much-needed progress and therefore the absence of power-sharing impacted upon the health inequalities that the Bengoa report identified. I believe that the statistics in [Exhibit RS/15 INQ000205179] at page 16 are based on the 2011 census and included the whole population. As such there is no direct comparison from the end of 2019/start of 2020 but the annual health survey of respondents aged 16+ indicates that the figures are broadly the same, if not slightly increased. Therefore, to the best of my knowledge, I do not believe that the health profile of people in Northern Ireland had improved between the publication of the Bengoa Report in October 2016 and the onset of the pandemic in February/March 2020.

43. I am unable to comment directly on how health care services in Northern Ireland performed during the pandemic in comparison to other parts of the United Kingdom as I understand that direct comparisons of staff are not possible because of the integration of social services and social care. A comparison of General Practitioners per 100,000 registered patients by United Kingdom region indicates that only Scotland has more General Practitioners than Northern Ireland [Exhibit RS/19 - INQ000400098]. My concern was always how Northern Ireland was coping and performing. However, it is clear that our health care services were under huge strain at various points in the

pandemic and it is only through the dedication and work of our health care professionals that there were not more deaths.

2. System fragilities

44. The political and Governmental limbo between 2017 and 2020 prevented progress towards a multi-year budget, which in turn inhibited the ability to take any long-term strategic decisions. In the Judicial Review mentioned above, the Departmental official's affidavit describes the impact the lack of an Executive had on elective care, in terms which I fully agree:

> "*As part of the implementation of Delivering Together, the Department published an Elective Care Plan on 21 February 2017 [Exhibit RS/20 INQ000400119]. The Plan set out the approach to redressing the waiting list crisis through major reform and transformation to sustainably improve elective care services and build capacity.*
>
> *The collapse of the Northern Ireland Executive in 2017 was a significant contributory factor to the inability to implement the 2017 Elective Care Plan. While transformation funding was made available, this was only for a two-year period, which did not allow for long-term, or even medium-term planning.*
>
> *Since then, the number of patients waiting has increased as the health service deficit has increased. Waiting lists are now at a level where they will take years to stabilise and even longer to return to their pre-2015 levels. With the pressures of maintaining services in this period, allied to the impact of the pandemic, there is a real risk of burnout among staff. Significant additional investment and new ways of working to deliver services will be needed to achieve the necessary turnaround.*"

45. In addition, when I took office there was ongoing industrial action by healthcare workers which required my immediate attention to rebuild relationships and trust. I would contend that it is entirely possible that if there had been a functioning Executive during the period 2017 and 2020, that the industrial action would have been avoided. Issues relating to lack of reform, pay parity and patient safety meant a demoralised workforce, that felt undervalued, and sparked the industrial action. Without a functioning Executive, the restoration of pay parity sought by Health workers could not

be delivered by Departmental Officials. The absence of a functioning Executive prolonged the industrial action, which is evident given the swift resolution of the issues, once government in Northern Ireland was restored. However, that loss of confidence from staff, the depletion of staff, as well as the inevitable disruption to the delivery of core health and social care services, inevitably had a negative effect on the resilience of the local health and social care system as it entered the pandemic phase. The proper financial recognition of our staff would have seen a stronger, more resilient workforce.

46. I took office with the initial challenge of resolving the industrial action; by that stage it took a lot of time and commitment from all sides to resolve. There were also additional cultural challenges as to how any Department responded to having a Minister back in post and the additional mechanisms, and work, that came from having an Executive/Assembly/Health Committee back in place.

47. If there had been political leadership during the 3 years, 2017-2020, I believe that transformation would have taken place, in line with the recommendations of the Bengoa and Delivering Together Report, and that this would have placed the Health Service in a better position to continue with core work, both before and during the pandemic. Implementation of the recommendations would have meant that the Health Service would have been in a better position to continue with core work such as the further introduction of Multi-Disciplinary Teams in Primary Care and the further development of overnight elective care and day case units. I also consider that it would have permitted the development of green/non-covid sites more quickly than we were able to do so.

48. While the medical staff we have in Northern Ireland are excellent, as evidenced by their work during the pandemic, it cannot be denied that the numbers are inadequate. This is evident from the New Decade New Agreement which set out a key priority of providing a further 900 pre-registration nursing and midwifery training places over a 3-year period, commencing in 2020/21. It is also evident in the difficulties experienced by some Trusts in Northern Ireland retaining and recruiting staff as well as the current difficulties in respect of some General Practitioner Contracts [Exhibit RS/21 INQ000400099].

3. Assembly Return

49. Having been without an Executive for 3 years where there had been high levels of political disagreement and public display of those disagreements, it was going to be challenging to establish a 5-party mandatory coalition, who had been brought together on the back of the "New Decade, New Approach" document which was co-authored by the British and Irish Governments, rather than the five parties. At the establishment of the Executive, it was, initially, in my opinion, difficult for some Ministers and parties to move away from the antagonistic approach that had been evident though the preceding 3 years.

C. THE OUTSET OF THE PANDEMIC

50. Initially Covid-19 was treated very much as a "health" issue, as other Ministers were settling into new roles with their own challenges, priorities and expectations that had been raised from the New Decade New Approach Agreement. It was never envisaged when we took up office that there would be a widespread lockdown which would affect all parts of society, the economy and the education system.

1. Preparatory Work Pre-2020

51. In March 2018, the Department, along with the Department of Justice and The Executive Office, had formally established a Civil Contingencies Group Northern Ireland pandemic flu Northern Ireland sub-group to engage as part of the United Kingdom-wide Pandemic Flu Readiness Board. The Northern Ireland sub-group was placed under the auspices of the Civil Contingencies Group Northern Ireland. A draft Bill was produced that detailed a menu of options to be used in an emergency situation. These options were intended to be measured and proportionate and a means to protect society as a whole. This work proved critical during the emergence of Covid-19 as the draft Bill was the basis of the Coronavirus Act 2020. The Coronavirus Act received Royal Assent in March 2020 and contained a number of legislative measures that provided the Department and other Executive departments in Northern Ireland with the necessary emergency powers to act in a quick and effective way to deal with the evolving and severe pandemic.

52. Following Operation Cygnus in 2016 work to build resilience and increase emergency preparedness was undertaken by the Department and this provided a good foundation for action during the Covid-19 pandemic. It was not possible to use all the plans for the Covid-19 response because it was a new virus and required a slightly different

response; however, they were a good base from which to work. Where pandemic flu plans [Exhibit RS/22 INQ000185380] could be used they were deployed, for example:

- Previous learning on reducing the risk of transmission through good infection prevention and control practices were employed e.g., hand and respiratory hygiene advice (e.g., 'Catch it, bin it, kill it');
- Using the Pandemic Flu Bill draft legislation to support the response to a future influenza pandemic as a starting point for the development of the Coronavirus Act, which supported thousands of retired healthcare workers across the United Kingdom returning to the frontline to help battle the COVID outbreak, and
- Previous learning on activating Surveillance and modelling.

2. Early 2020

53. During Module 1 I became aware of an internal document from The Executive Office dated 20 January 2020 [Exhibit RS/23 INQ000092712] which stated that "EU exit preparations meant that Northern Ireland [sic: was] more than 18 months behind the rest of the UK in terms of ensuring sector resilience to any pandemic flu outbreak." I consider that this comment referred to non-health sector resilience and, with the benefit of hindsight, I believe it explains why the other Departments were not as prepared as the Department of Health and why they were reliant on the Department of Health to assist in their response. I believe the document acknowledges that time and resources had been utilised in preparation for European Union exit rather than pandemic preparedness.

54. Between late-January and early-March 2020, while the risk of the outbreak becoming a pandemic was assessed as moderate, based on the advice of the United Kingdom Chief Medical Officers, the Department commenced planning for the anticipated surge in demand for healthcare services arising from the outbreak. Alongside this, the Chief Medical Officer commissioned the Health and Social Care Board and the Public Health Agency to initiate surge planning for the health service in Northern Ireland.

55. On the 6 February 2020, to assist with wider government co-ordination in Northern Ireland, the Director of Population Health in the Department wrote to the then Director of Executive Support and Programme for Government, in The Executive Office, to highlight the need for the Civil Contingencies Policy Branch in The Executive Office to urgently consider sector resilience in the face of a growing threat from novel coronavirus. In the letter it stated that, while activation of Northern Ireland Central

Crisis Management Arrangements had been considered by the Department, it was reasonable to withhold such a request until infections and their impacts were experienced in Northern Ireland [Exhibit RS/24 INQ000218470].

56. The Department suggested that, to provide reassurances should an escalation of events require a request to implement Northern Ireland Central Crisis Management Arrangements, it would be helpful if The Executive Office would consider convening a multi-agency meeting in order to inform an assessment of sector resilience preparedness, capacity and capabilities across Northern Ireland 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 Chief Medical Officer, also dated the 6 February 2020, to Departments and public authorities. The purpose of this letter was to enable all Northern Ireland Executive Departments and public authorities to prepare to respond to any and 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. I understand that this request was reiterated by Richard Pengelly, Permanent Secretary in the Department of Health, the following day at the Permanent Secretaries Stakeholder Group.

57. It was not the case that steps were not being taken to control or prevent Covid-19 spreading to, or in, Northern Ireland. The Emergency Operations Centre in the Department of Health was activated on 27 January 2020 and Health Silver on 22 January. The Public Health Agency and Health and Social Care Board were working closely with the Trusts, Port Health and primary care to make them aware of the incident and potential symptoms of the virus. The Public Health Agency was also working with Universities and Educational Establishments, and with the Chinese community.

58. Equally, it was also the case that it was considered inevitable that Covid-19 would spread to Northern Ireland; I believe the approach was "when not if" as the severity was still not manifestly evident.

59. I am uncertain as to whether the meeting requested in [Exhibit RS/24 INQ000218470] took place. As far as I understand, this was a meeting that did not involve me, and would have taken place between officials, and so it is my view that the Department of Health would be better placed to advise of the details of the meeting.

60. On the 12 February I attended a Cabinet table-top exercise on the coronavirus response, 'Operation Nimbus'. The invitation was originally extended to the Secretary of State and the First and deputy First Minister but the First and deputy First Minister agreed that I should represent the Northern Ireland Executive; a point I consider supports my belief that initially Covid-19 was considered a 'health' issue. The aim of this exercise was to "rehearse Ministerial-level decision making for the United Kingdom's pandemic preparedness and response within the context of the current novel Coronavirus outbreak."

61. The objectives were:

- To expose the potential scale and range of impacts arising during a pandemic and relate this to the current novel Coronavirus outbreak.
- To identify the likely type and range of decisions that would need to be made by Ministers at key points during a pandemic.
- To rehearse the structure, process and protocols for supporting critical, strategic decision making in the response to a novel Coronavirus outbreak in the UK.

62. From memory the meeting took the form of a simulated Cabinet Office Briefing Room meeting where we worked through the context, choices and consequences for a small number of difficult topics, including caring for the sick in hospitals and the community, and Staff absences and impacts on essential services.

63. 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." The following day the Chief Medical Officer wrote to the Health and Social Care system updating advice issued on the 31 January and 7 February [Exhibit RS/25 INQ000400100].

64. You [the Inquiry] have advised me that, on the 25 February 2020, a paper was sent to The Executive Office Board in relation to "a strategic review of civil contingency arrangements across Northern Ireland" 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" [Exhibit RS/26 INQ000205712]. Unfortunately, I was not aware of this paper until it was presented in this evidence and I do not believe it was brought to the attention of the Executive Committee.

65. The Executive Committee held its first substantive discussion about Covid-19 on 2 March 2020 and during that discussion, the Chief Medical Officer observed: "most people – minor illness like cold. 98% will get better. 5% hospital care.... Fatality rate - cd be 2-3%...Modelling -UK/ROI - widespread…Not inevitable. Need to be prepared for weeks/months…Peak could last for 15 weeks. 50%+ of population cd be affected - but lot of minor cases v mild. Planning - 50%+ infected…Need to plan and prepare for all eventualities." [Exhibit RS/27 INQ000065694]. From a Department of Health and Health and Social Care perspective, there was a high level of urgency and activity from early preparations, but even as the conditions and outcomes were described by the Chief Medical Officer here, I am not entirely sure that the overall impact on society was fully understood by other Ministers and Departments as in my opinion they still perceived this as a health issue that would only impact hospitals.

66. It is my opinion that only at the Executive Committee meeting on the 10 March 2020 was there a realisation and acceptance that the response to Covid-19 was going to have to be more than simply a health response and that all Ministers and Departments would have a role to play. However, even at that time there was not a clear understating of what that response would be.

67. On the 11 March 2020 COBR(M) took the decision to move from the Contain phase to the Delay phase; Northern Ireland followed suit.

3. Early measures in the Republic of Ireland

68. On the 11 March 2020, when the Republic of Ireland announced a package of measures, including the closure of schools, colleges and childcare facilities; cancellation of all indoor mass gatherings of 100 people and outdoor gatherings of over 500 people, I had not received any medical or scientific evidence on Covid-19 and its transmission to validate the decision that the Republic of Ireland Government had taken, and, as [Exhibit RS/28 INQ000083097] records we (the Northern Ireland

Executive and the Northern Ireland Office) had received "very little notice". As Health Minister I did not receive any advance warning of their announcement. I believe that the Republic of Ireland may have decided on this package of measures at the time they did because they were concerned around large scale events and international travel specifically around St. Patrick's Day.

69. When I "clarified that containment measures are working in NI and following RoI position would crash the NHS and create unnecessary panic and fear" [Exhibit RS/29 INQ000232525] this was in relation to the potential immediate closure of childcare and schools without warning or preparation as it would have had a detrimental and immediate effect on staff availability in the healthcare sector.

4. Dependency on the United Kingdom Government

70. At that point Northern Ireland did not have its own modelling group, so all our data was being supplied via the United Kingdom networks and advisory bodies. A modelling group was established under the Chief Scientific Adviser at the end of March 2020.

5. Community Testing

71. As in the rest of the United Kingdom, the Public Health Agency were 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 testing and subsequent 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.

72. On the 12 March 2020, the UK Government decided at the Cabinet Office Briefing Room meeting to move from the containment phase to the delay phase. This decision was underpinned by the United Kingdom-wide agreed Protocol for Moving from Contain to Delay [Exhibit RS/30 INQ000346695]. This was followed shortly afterwards on 23 March 2020 by the introduction of the first United Kingdom-wide lockdown. The

decision to pause testing and contact tracing at this stage in mid-March was integrally linked to the decisions to move to the delay phase and to introduce population wide lockdown measures.

6. Northern Ireland Strategy

73. At the Executive Committee meeting on the 16 March 2020, I stated that I was relying on the advice I received from my Departmental officials [Exhibit RS/31 INQ000065689, page 7] and in the early stages of the pandemic I feel that, in the main, all the Ministers did so. While there is a handwritten record of the Finance Minister making the comment that "people following own science" [Exhibit RS/31 INQ000065689, page 33] it is my belief that this comment was more personal and political and demonstrates the challenges of a five-party mandatory coalition government, who were still relatively new to working with each other, following three years of no government.

74. Equally, the Justice Minister and the Infrastructure Minister commented, respectively, that the "Exec [*sic*] always seems to be reacting not leading [Exhibit RS/31 INQ000065689, page 10] and "we are mismanaging" [Exhibit RS/31 INQ000065689, page 33] (again from the handwritten document) but my understanding of the note here, and my recollection of the meeting, is that this was in reference to the potential closure of schools specifically and not the overall management of Covid-19. This is an example of what I said at the start of my statement on the context of a document which is not a verbatim record of what was said and potential for its content to be misrepresented. If taken as recorded in this document then it is a sentiment I shared, as evidenced by my letter to the First and deputy First Minister of the 29 March where I noted we were in 'reactive mode'; see further below.

75. I believed on 16 March 2020 that Northern Ireland was not in a place to introduce a lockdown, either in the preparations of all the Departments or in the financial support that would be available for individuals and businesses, because at that stage we were dependent on Her Majesty's Government financing a Covid-19 response. I stated that, "we have been preparing for past 7 weeks" [Exhibit RS/31 INQ000065689, page 7] but, in my opinion, as there were so many unknowns it was impossible to gauge if the actions being taken across the health service were going to be sufficient. However, our health service was able to flex and adapt throughout the pandemic at different times. This is perhaps most evident in the ability, and willingness, of health care staff to work wherever they were needed most. This meant that staffing in those areas under pressure was augmented by staff from areas of reduced capacity, such as

theatres. Health and Social Care Trusts worked in partnership with care homes to ensure adequate staffing and Trusts also stepped in to provide thousands of hours of free staffing time to homes that needed it. The Department of Health was able to drive an initiative to recruit former health care professionals back into the service and, where the skillset was appropriate, individuals were placed in independent care homes [Exhibit RS/32 INQ000103694]. It is important to note that this was only possible because of our health care staff.

76. At a meeting of the Executive on 16 March a paper from the First and deputy First Minister [Exhibit RS/33 INQ000086883] explained that, on the basis of scientific and clinical advice "the United Kingdom has moved from the 'containment' phase, where for the most part daily life was 'business as usual', into the 'delay' phase where a number of measures aimed at slowing the spread of the virus will be implemented over the coming days…" The purpose of the paper was to facilitate Executive consideration of the wider non-health response to Covid-19 and in particular the phased activation of the strategic emergency co-ordination arrangements within government namely the Northern Ireland Central Crisis Management. It was agreed by the Executive Committee on 16 March to implement a phased activation of the Northern Ireland Central Crisis Management Arrangements to deal with the impacts of Covid-19 [Exhibit RS/34 INQ000048447].

77. On 19 March at the Executive meeting the Agricultural Minister stated "as an Exec [*sic*], we are behind the curve. Need to get ahead" [Exhibit RS/35 INQ000065737, page 25]. I do not consider that we were 'behind the curve' any more than any other health care system in the United Kingdom, rather that the unique position of only having been in existence a short time presented challenges other jurisdictions did not have. It is my opinion that the speed at which decisions needed to be taken, both in complexity and effect, were challenging to a process which was set up to deal with, and manage, a five-party mandatory coalition, particularly one that had only been in existence for a short while at that stage. This is reflected in my letter of 29 March 2020 to the First and deputy First Minister in which I 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…" [Exhibit RS/36 INQ000023229]. It is a sentiment perhaps shared by officials in The Executive Office when they referenced being 18 months behind the rest of the United Kingdom in terms of ensuring non-health sector resilience [Exhibit RS/23 INQ000092712].

78. Had we activated the Northern Ireland Central Crisis Managements Arrangements earlier and stood up the Northern Ireland Hub sooner this may have assisted the other Departments in their preparations for what would eventually be required of them.

79. An action log was created as part of the civil contingency structures and an entry for the 6 April 2020 states that the first actions were generated on 18 March 2020. While the entry may have been made on the 6 April 2020 my reading of this document is that the actions allegedly for the Department of Health on the 18 March 2020 were actions that already been taken and are a record of those actions. The other actions I feel may have been covered if Departments had not lost the 18 months referenced in The Executive Office document due to European Union exit preparations [Exhibit RS/23 INQ000092712].

80. I would note, however, that it was only during Module 1 of the Covid Inquiry that I learnt officials in The Executive Office believed non-health related sector resilience was 18 months behind the rest of the UK, even from what was required under the Pandemic Flu preparations. In hindsight I now believe this is why the focus was on Health as other Departments sought to bring together and develop their plans for what they needed to do in their responses – plans that should have already been in place. More often than not direction was sought from the Department of Health which resulted in an additional workload for the Department of Health at a time when capacity was already stretched. One such example is when dog groomers were proposed as an essential service but the request for advice on how the dog groomer could provide their service, with the least possible risk came to the Department of Health.

81. At an Executive Committee meeting held on 19 March 2020, when Sir David Sterling, then Head of the Civil Service, outlined how the Executive Committee would function to respond to the pandemic [Exhibit RS/35 INQ000065737, pages 13 to 14] I believe this was the first I had heard of those plans. However, that would not have been surprising as the Head of the Civil Service would have been more aware of what was needed by way of the rhythm of meetings and decisions that would be needed, led by the First and deputy First Minister. How the Executive would function was outside of my role and responsibility as this lay with the First and deputy First Minister.

82. It was following a Cabinet Office Briefing Room meeting on the 19 March 2020 that I fully realised the potential level of deaths should no action be taken. I reported to my

Executive colleagues that same day that the worst-case scenario for Covid-19 in Northern Ireland was 32,000 new cases per day with but with intervention that figure would be reduced to 10,000. I described those figures as "scary numbers" [Exhibit RS/35 INQ000065737, page 8]. At that point Northern Ireland was still reliant on the United Kingdom-wide modelling as our own modelling group was only established at the end of March 2020.

83. A House of Commons Health and Social Care and Science and Technology Committee's report titled "Coronavirus: lessons learned to date", published on 12 October 2021, states at paragraph 77 that, "[T]he initial UK policy was to take a gradual and incremental approach to introducing non-pharmaceutical interventions … and adopted by the governments of all of the nations of the United Kingdom. It is now clear that this was the wrong policy, and that it led to a higher initial death toll than would have resulted from a more emphatic early policy." While the approach may have been adopted by all the United Kingdom nation it is my opinion that the quoted paragraph of the report fails to recognise the difference in the initial lag in cases between Northern Ireland and the rest of the United Kingdom. It is well known that the first case in Northern Ireland was confirmed on 27 February 2020 in comparison with the first confirmed case in England of 30 January 2020. I consider that this lag in cases between Northern Ireland and the rest of the United Kingdom gave Northern Ireland an initial advantage in the timing of decisions and actions in comparison to the rest of the United Kingdom, with Northern Ireland going into lockdown at an earlier stage of the initial wave than the rest of the United Kingdom. However, while there was an initial lag in cases in Northern Ireland this was not the case for the entire pandemic as there were times when Northern Ireland was ahead of the rest of the United Kingdom in terms of progression. It was for this reason that the Northern Ireland-specific modelling was so important in guiding advice to decision makers.

84. The approach taken by the Northern Ireland Executive reflected the advice received from official scientific advisers, both in Northern Ireland and the United Kingdom as a whole, and was dependent on the associated financial supports from Her Majesty's Government. It is not the case that I had been "slavishly following the Boris Johnson model" as stated by the deputy First Minister [Exhibit RS/37 INQ000083114, page 2] but I would note that when she made this comment, she followed it up later by saying that she would support me in my role **[Exhibit RS/37 INQ000083114, page 4].**

D. HERD IMMUNITY

85. Herd Immunity was never considered as an appropriate response to the pandemic by me nor by my Department. I did not receive a request, at any point, from any other Minister, including the First Minister, to consider it.

E. THE FIRST LOCKDOWN IN NORTHERN IRELAND

86. I became aware that the United Kingdom government planned to announce a lockdown on 23 March 2020 following a communication from the Cabinet Office Briefing Room on that date [Exhibit RS/38 - INQ000052692].

87. Following the announcement of a United Kingdom-wide lockdown by the Prime Minister on the 23 March, I received advice on the potential transmissibility and fatality levels of Covid-19 and considered that, to ensure our Health Service was best equipped to cope with the projected numbers of patients, it was necessary to have a lockdown in Northern Ireland. I believed then, and still do now, that the only measure that could have prevented a lockdown was the introduction and utilisation of a vaccine or medication and neither of those were available at that time. With the lockdowns in Great Britain and the Republic of Ireland I am of the opinion that Northern Ireland would not have been able to avoid its own lockdown.

88. While Northern Ireland's preparation and planning for epidemics were linked into that of the United Kingdom's response, we were not tied to their decisions and so there were deviations across all 4 nations in the United Kingdom. At this point the scientific data we received was coming from the rest of the United Kingdom as we had not yet set up our own modelling group. We were also reliant on the financial supports from Her Majesty's Government, and I can only assume that if the Northern Ireland Executive had taken a different approach or not enacted United Kingdom wide support measures, for example furlough, we would not have received the equivalent financial support or intervention.

89. One example of an area where Northern Ireland did deviate from the rest of the United Kingdom was the designation of people with Motor Neurone Disease as clinically extremely vulnerable from the 2 April 2020. The inclusion of Motor Neurone Disease in the Northern Ireland definition of Clinically Extremely Vulnerable was intended to offer additional reassurance to this population of approximately 140 people in Northern Ireland at any one time [Exhibit RS/39 INQ000348674].

1. Vulnerable Groups

90. In considering lockdown the Executive did focus on vulnerable groups and additional support and programmes were developed and delivered by the Department of Communities through local councils and voluntary and community sector. I can only comment on the response of the Department of Health as individual ministers are better placed to answer for their own departments which, in turn, will give a more accurate Executive-wide picture; however, I have provided some examples later in this statement of the assistance provided by various departments individually and collaboratively.

91. The Department of Health did take into consideration the impact on those groups under its preview, particularly those who received 'shielding letters'. The letters offered advice on staying safe; how to access further information and support, including through the Northern Ireland Community Helpline; advice on indoor exercise and mental health tools and enabled those in receipt of a letter to access support schemes being offered to the most vulnerable by the Department for Communities [Exhibit RS/40 - INQ000130315].

92. On 27 May 2020 the Chief Medical Officer emailed [Exhibit RS/41 - INQ000348701] the Chief Executive of the Patient and Client Council asking that the Council undertake research to "inform the relaxation of some of the current restrictions around outdoor exercise and possible subsequently meeting family outdoors in small numbers with appropriate safeguards and precautions." The email indicates that the proposed research was supported by me and by the First Minister and deputy First Minister of Northern Ireland.

93. I published a statement encouraging people who were Clinically Extremely Vulnerable, and those supporting them, to participate in the survey, the aim of which was stated to 'understand the impact shielding has had on individuals, to inform the steps and processes that must be considered now and in the future, and to ensure that the voice of those impacted by shielding was heard' [Exhibit RS/42 -INQ000348702].

94. The final Patient and Client Council survey report [Exhibit RS/43 INQ000344088] was published in July 2020. The findings of the survey indicated that fear of Covid-19, and the risk it represented, was the dominant concern among those surveyed. In addition, shielding appeared to have had detrimental social and psychological effects on a

significant group of respondents, although relatively very few of those surveyed mentioned a need for professional support or counselling. The survey found that those who were shielding prioritised being kept informed with clear advice and guidance, along with the scientific rationale for this advice. A considerable number of respondents felt that the shielding community was often 'forgotten' or 'ignored' as changes to guidance and restrictions for the wider population were announced. The need for the provision of updated advice and guidance to Clinically Extremely Vulnerable people was kept under continuous review and took account of the research undertaken by the Patient and Client Council including the mental health impact of shielding.

95. In addition to the above the Department also engaged at an early stage with AgeNI, the leading charity for older people in Northern Ireland, and the Commissioner for Older People. I also met with the Commissioner for Older People in July 2020.

2. Health Protection (Coronavirus, Restrictions) Regulations (Northern Ireland) 2020

96. Section 48 and Schedule 18 of the Coronavirus Act 2020 amended the Public Health Act (NI) 1967 [Exhibit RS/44] 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.

97. The 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 consider the use of the mechanism was necessary.

98. In this instance, I wrote to the First and deputy First Minister requesting the use of the urgent decision mechanism on the 28 March to allow the Regulations to come into effect as soon as possible rather than wait to allow them to be discussed at the next Executive meeting on the 30 March. The Regulations reflected the policy discussions and agreement reached during meetings of the COBRA (M) Committee in recent weeks, in which the Devolved Administrations participated. They reflected the agreed 'four nations' approach that had been adopted and followed closely the form and content of similar Regulations that had been made in England – The Health Protection (Coronavirus, Restrictions) (England) 2020, subject to differences between the two legal systems, for example the penalties applicable.

99. While the urgent decision mechanism allowed me to make and lay the Regulations in the Assembly that day, they were still subject to the Confirmatory control procedure in the Assembly. This meant that while they could be made, and brought into operation, they would cease to have effect unless approved by resolution of the Assembly within a specified period (28 days).

100. The introduction of the first "lockdown" in Northern Ireland was earlier in the first wave compared to some other parts of the UK. At the start of the pandemic it was not known how long it would take for specific medical countermeasures to be introduced, such as vaccines and new drug treatments. Neither was it known how long non-pharmaceutical interventions would have to be used or to what extent there would be compliance with these.

101. The regulations introduced to put non-pharmaceutical interventions on a statutory footing were subject to regular reviews. Each review considered the public health implications and any potential emerging equality issues would have been reflected in the reviews. In the circumstances it was, however, not possible to carry out an Equality Impact Assessment on those individuals or groups with protected characteristics.

102. I understand the Health Intelligence Unit in the Public Health Agency developed an evidence overview on inequalities at the start of the pandemic which was shared

across the Department and used to inform policy as appropriate. In addition, the Public Health Agency also undertook work in relation to the impact of face-coverings and the consequences particularly in respect of existing health inequalities, for example the effect on the deaf community. The Public Health Agency also carried out some analysis on the impact of the self-isolation guidance and this demonstrated that children from lower socio-economic groups were disproportionately impacted.

i. Other Regulations

103. While it was not possible to carry out equality impact assessments on all legislation enacted, prior to the making of the Children's Social Care (Coronavirus) (Temporary Modification of Children's Social Care) Regulations (Northern Ireland) 2020, departmental officials conducted equality impact screening in accordance with guidance produced by the Equality Commission for Northern Ireland and in keeping with section 75 of the Northern Ireland Act 1998. A further equality screening exercise was conducted before the extension of the operational period of the Regulations for a further six months. In both cases, it was concluded that a full Equality Impact Assessment was not required. Rural needs impact screening was also conducted prior to both the making and the extension of the Regulations and no adverse impacts were identified.

104. In order to ensure the Regulations would achieve their intended effect of enabling essential children's social care services to continue to be delivered during the pandemic in a safe manner to protect vulnerable children, their families/carers and social workers, departmental officials liaised at key points prior to, and following, the making of the Regulations with:

- The Northern Ireland Commissioner for Children and Young People;
- The Children's Law Centre;
- The Voice of Young People in Care;
- The Northern Ireland Human Rights Commission;
- Fostering Network (Northern Ireland), and
- The British Association of Social Workers (Northern Ireland).

105. Discussions also took place with representatives of the Health and Social Care Board, the Health and Social Care Trusts, voluntary adoption agencies and the Northern Ireland Courts and Tribunals Service. On the basis of those discussions, amendments were made to the draft Regulations, including the removal of a provision granting the

Department the power to extend the modifications contained in the Regulations by a further 3 months after the expiry of an initial period of 6 months. This clearly limited the period for which the Regulations would have effect and meant that the Department would have to bring new Regulations to the Assembly if it wished to make provision beyond the 6-month expiry date.

106. Officials also took on board a range of suggestions relating to the draft guidance, including amending some of the timescales set out in the guidance relating to undertaking reviews and representations/complaints procedures, and strengthening key messages on how the flexibility provided by the Regulations should be exercised.

107. Before extending the operational period of the regulations, officials again consulted the NI Commissioner for Children and Young People and notified other key stakeholders, including the Northern Ireland Human Rights Commission and Children's Law Centre. In written evidence provided to the Health Committee, the Commissioner and the Northern Ireland Human Rights Commission indicated that, overall, they were content for the Regulations to be extended.

108. The Department also carried out equality screening on Covid-19 guidance for residential children's homes, foster care, supported accommodation for children aged 16+ and young adults, and adoption services. The screening exercises were completed between May 2020 and July 2020 and concluded that the guidance would have no impact, or minor positive impacts on looked after children and young people, including those children with a disability within the looked after child population. This conclusion was reached on the basis that a primary aim of the guidance was to facilitate the continued provision of safe care, and to protect the health and wellbeing of children, young people, their parents and carers.

3. Length of the restrictions

109. In her statement provided to Module 1 of the Inquiry, the former First Minister, Baroness Arlene Foster, expressed her belief that there was insufficient research and consideration given to the unintended consequences of a lengthy period of lockdown. This is a sentiment I share, and it is a frustration that more had not been done following on from the recommendations of Operation Cygnus and the views of officials in the Northern Ireland Civil Service that "Northern Ireland was more than 18 months behind the rest of the United Kingdom in terms of ensuring sector resilience…" [Exhibit RS/23 INQ000092712, page 2]. I consider that the insufficient research and consideration

of a long lockdown is directly linked to the lack of an Executive from shortly after the recommendations of Operation Cygnus were published. This, combined with European Union exit preparations and a general lack of resources as reported in [Exhibit RS/23 INQ000092712, page 2], meant that key preparation was not undertaken immediately. Once the Executive reformed in January 2021, the threat of a pandemic was viewed, in the early days, I believe as a health matter, particularly given that the majority of ministers were new to their departments. There was a period of 'settling in', 'finding our feet' and learning to work together. As described above, the Department of Health did write to The Executive Office on the 6 February requesting urgent consideration of sector resilience.

F. AMENDMENT OF REGULATIONS

110. Immediately after the Health Protection (Coronavirus, Restrictions) Regulations (Northern Ireland) 2020 were made on the 28 March 2020 there was no formal mechanism to take forward amendments and any requests were considered. As early as 6 April 2020, at a Civil Contingency Group (Covid-19 Response) meeting requests were made to allow access to churches and graveyards and it was agreed that, when reviewing the legislation, The Executive Office would consider relaxing restrictions to permit this.

111. By 7 May 2020 I proposed a structured formal review mechanism whereby input from other Departments could be provided with a coordinating role being played by The Executive Office, which was adopted. This would allow any requests to ease restrictions from other sources to be considered by their lead Department and priorities assessed at that point. You [The Inquiry] have suggested in your questions to me that the minutes of the Executive Committee meeting on 7 May 2020 [Exhibit RS/45 INQ000065724] indicate a tension between the Chief Medical Officer, with his approach of "consider[ing] the cumulative impact and provide risk/benefit analysis to provide structure & qualitative advice" [Exhibit RS/45 INQ000065724, page 6], and the Justice Minster, who considered the papers under discussion as being contradictory and amounting to "an a la carte approach, which is what they would not do." [Exhibit RS/45 INQ000065724, page 8].

112. I do not recall tension between the Justice Minister and the Chief Medical Officer rather that in this meeting two documents were being 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 of Health'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 [Exhibit RS/46 INQ000400102]. I recall some general frustration around that time as the documents under consideration had already been leaked to the media and were being discussed on the radio at the same time they were being discussed in the Executive.

113. In advance of the Executive Committee meeting of 4 June 2020, Ministers received a "Point in Time Review of the Executive's Covid-19 Strategy" [Exhibit RS/47 INQ000065637]. I consider the purpose of this paper was to provide an update across the Executive to show what steps the other Departments were taking, and where there were still actions to be taken, as much of the focus up until that point had been on what the Department of Health had been doing. This 'Point in Time Review' offered an overall update of Northern Ireland's Covid-19 strategy and was not, as such, a health update. My focus was always on the health response to the pandemic and I was reliant on the other Ministers considering their own sectors.

G. CIVIL CONTINGENCY ARRANGEMENTS IN THE FIRST PART OF THE PANDEMIC

114. The Northern Ireland Hub's objectives included, "support[ing] the Executive and the Civil Contingencies Group to make timely and informed decisions in response to the strategic management of any Covid-19 outbreak here…" [Exhibit RS/48 INQ000145786, page 11]. It is important to note here that the Northern Ireland Hub is a body within The Executive Office and not the Department of Health. However, I think the Hub developed more into an information sharing unit that produced SitReps. In the "Response to Covid-19 Lessons Learned review of the Department of Health's Emergency Operation Centre, I stated that, "The role and value of the Northern Ireland Hub was not clear." [Exhibit RS/49 INQ000400103] I recall that the First and deputy First Minister raised an issue with the Hub as a member of its staff incorrectly relayed an internal Executive discussion to the Northern Ireland Secretary of State. I cannot recall the specifics but the issue was the incorrect message rather than the Secretary of State being informed. Therefore, as I stated in the Lessons Learned document, "There is a need for clarity about which officials should get access to certain pieces of information."

115. The "C3 Covid-19 Response: Lessons Learned Review and Future Roadmap" [Exhibit RS/50 INQ000023223] found that the Civil Contingencies Group was not an effective forum for debate and decision-making and also that it did not use the SitRep as a basis for its decision-making. I believe I only attended one or two of the initial meetings of the Civil Contingencies Group and, when there, I found the focus to be on information sharing rather than decision-making. It was not a forum which could add structure or provide operational advice to Executive decision, especially around non-pharmaceutical interventions.

116. Following the publication of the Lessons Learned Review I was not part of any change process but was informed of changes having been made. I cannot recall what the changes were and have been unable to locate any details of same. However, I am confident that the Department of Health should be able to explain the details of these changes.

117. When the Civil Contingencies Group was stood down and the Northern Ireland Hub scaled back the Executive was informed of the decision by the Head of the Civil Service and were not asked; I can only assume that it was because numbers were declining at that point as the Executive was not given any details on the reasons. The First and deputy First Minister may be able to provide reasons.

118. In her statement to Module 1, the former First Minister, Baroness Arlene Foster, provides, "… 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" [INQ000205274, paragraph 19]. She referenced a balance to be struck between ensuring Ministers had the information necessary to make decisions and potentially hampering the work of officials; however, I am not aware of any specific instances in the Department of Health where Ministerial involvement "potentially hampered the operational work of officials." I do recall anecdotal feedback from the then Permanent Secretary, Richard Pengelly, that questions I had been asked at an Executive meeting by a Minister were a repeat of ones he had been asked by one of their colleagues at a Civil Contingencies Group meeting that morning, so there was a sense of duplication.

119. The situation where officials did not speak as freely as they may have done so because of the presence of a Minister could have arisen, for example, in the new Rebuilding Management Board in the Department. I requested the Terms of Reference be amended to allow me to attend if a situation necessitated it, or the Board felt it was

necessary. I never exercised this right, nor was my attendance required [Exhibit RS/52 INQ000137398]. Instead, the Management Board was chaired by the Permanent Secretary and its membership was drawn from the Department's senior officials and other senior staff from across the Health and Social Care system, reporting directly to me.

H. OVERARCHING VIEW

120. I have commented above that to begin with, due in part to the fact that we were a newly formed Executive, the threat of a pandemic was viewed very much as a health matter and the cross-cutting effects of a potential pandemic were not fully recognised; for example, but not restricted to, the economic and educational effects of a national lockdown. As it became apparent that we were entering a pandemic I did think, and state, that the Executive was in a reactive mode. Some of my ministerial colleagues were of the same opinion, the Justice Minister stating, "Exec [*sic*] always seems to be reacting not leading [Exhibit RS/31 INQ000065689, page 10] and the Infrastructure Minister, "we are mismanaging" [Exhibit RS/31 INQ000065689, page 33]. As the pandemic progressed, however, the Executive's approach became Executive-wide and I have outlined below some of the actions taken by the Executive, and by its individual members and Departments, both during and after the first wave of the pandemic, in terms of its response strategy.

121. During the first wave the majority of the decision papers presented to the Executive were medical and scientific advice and recommendations presented by the Department of Health. I believe that this approach changed after the second wave as The Executive Office led more on the tabling of decision papers for Executive meetings; where appropriate these would have contained Department of Health's medical and scientific advice. Other Departments also increasingly provided advice directly to the Executive on social and economic issues that would have an impact on the decisions of the Executive in relation to imposing and lifting restrictions.

122. I welcomed this change in approach as it meant The Executive Office was the lead department, in collaboration with all the other departments, in preparing and submitting papers to the Executive for consideration. I consider that this was the correct role for The Executive Office as I believe it was, and remains, best placed to ensure that the Executive was given comprehensive advice about the likely impact of its decisions on all aspects of social and economic life in Northern Ireland affected by the pandemic. If

The Executive Office could be given the necessary statutory authority and resources to be ready, in the event of any future emergency, to take forward urgent legislative changes arising from Executive decisions, including making and amending regulations and leading on Assembly scrutiny procedures, then I believe that this would result in a more coherent approach where roles and responsibilities would be clear from the outset.

1. Analysis and Review

123. I cannot recall the Executive carrying out a review of its response during the first wave. As I said in my statement to the Inquiry for Module 1, I do recall that in the margins of meetings there was a discussion about the possibility that a Table Top exercise would be carried out in the summer of 2020, which would draw from lessons learnt across all departments, and that this could be used to prepare for a potential autumn wave of Covid-19. My understanding was that this Table Top exercise may have been suggested by either the Head of the Civil Service or colleagues in The Executive Office. My recollection was that this exercise had been mooted to happen during summer 2020, however this was postponed to later in the autumn after summer recess. Ultimately the Table Top exercise did not happen. The reasons for this are unknown to me. This I believe was a missed opportunity for a joined-up approach that would have involved all departments.

124. The Department of Health did carry out a number of reviews of its response to the first Covid-19 wave, including:

- an 'in-flight' assessment of the Health & Social Care service coordination in response to the pandemic [Exhibit RS/53 INQ000188799], which reviewed the Department's emergency management structures;
- A debrief of Health Silver, organised and facilitated by the Health and Social Care Board [Exhibit RS/54INQ000188798], and
- 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 [Exhibit RS/55 INQ000188797].

125. These reviews highlighted both what went well and where things could be improved. One of the outworkings of the 'in-flight' review of the Department's emergency management structures was the recommendation to stand down first the strategic cell in June 2020 and then the Emergency Operations Centre in August 2020 moving to

more business continuity arrangements, with Health Service (including Covid-19) aspects being overseen by a Rebuilding Management Board, chaired by the Permanent Secretary. This move, along with the integrated Covid-19 Gold Command Structures, established in autumn 2020, to manage the second wave of the pandemic also addressed the point made in the Health Silver debrief report that Covid-19 was no longer an 'emergency' but rather it needed to be incorporated into a new way of doing business. The structures that replaced Health Gold took a more integrated approach than had been taken during the initial emergency response phase, with subject specific cell membership drawn, not only from the Department, but also from counterparts in the Health and Social Care Board, Public Health Agency and Business Services Organisation.

126. Following the stand down of the Emergency Operations Centre, the Emergency Planning Branch established a review team to engage with key stakeholders to examine the effectiveness of the Emergency Operations Centre internally as well as how it interfaced with the Northern Ireland Hub and Health Silver. A total of 20 lessons and recommendations were identified during the review period [Exhibit RS/55INQ000188797]. The majority of the lessons identified were around early engagement with key partners on situational awareness as the emergency evolved, establishing good communications internal and external to the Department, specifically in establishing effective reporting rhythms and developing accurate, timely and relevant Situational Reports from Health and Social Care and Departmental Arm's Length Bodies. Other lessons covered training, resources and defining responsibilities for managing Personal Protective Equipment during a pandemic, including when and how the emergency stockpile is to be used. I understand that these lessons and recommendations are all being considered by the Department's Emergency Planning Branch and are being incorporated into the next iteration of the Departmental Emergency Response Plan, which is currently in progress.

127. In addition to these reviews a number of specific reviews were conducted by the Department of Health, including a review of contact tracing [Exhibit RS/56INQ000183433], a rapid learning review of domiciliary care [Exhibit RS/57INQ000276420], a rapid review of changes in health and social care pharmacy services [Exhibit RS/58 INQ000276491], and a rapid review of personal protective equipment [Exhibit RS/59 INQ000120712, Exhibit RS/60 INQ000120813, Exhibit RS/61 INQ000120814].

2. Vulnerable Groups

128. As detailed above, the Patient Client Council undertook research into the views and needs of the Clinically Extremely Vulnerable population and the Department endeavoured to incorporate these findings into further advice and guidance. The Department also worked with the Executive Information Service to run a social media campaign in June and July 2020 to promote Childline, the National Society for Prevention of Cruelty to Children helpline and the 24 hour Domestic and Sexual Abuse helpline. The Department provided funding to the National Society for Prevention of Cruelty to Children to support a four-week awareness raising campaign in March 2021 to encourage families who needed additional support during lockdown to reach out for help at an early stage and encourage collective responsibility in continuing to report concerns regarding the safety of a child.

129. As outlined in my statement for Module 1 of the Inquiry I announced a number of financial support packages to the care home sector in April 2020 [Exhibit RS/62 INQ000185428 and Exhibit RS/63 INQ000185465], June 2020 [Exhibit RS/64 INQ000185429 and Exhibit RS/65 INQ000185472] and October 2020 [Exhibit RS/66 INQ000185430 and Exhibit RS/67 INQ000185478], amounting to £6.5 million, £11.7 million and £27 million respectively. I also established a fund to meet high level outcomes to support carers in undertaking their caring role, to the value of £4.4 million [Exhibit RS/68 INQ000185444] and a £10 million Cancer Services Support fund [Exhibit RS/69 INQ000185445 and Exhibit RS/70 INQ000185485] as well as a £10 million fund to support mental health charities.

130. The Department also took a number of decisions and actions which would have positively impacted on the needs of populations who were disadvantaged in the context of health inequalities. This included decisions and actions in partnership with other departments, particularly the Department for Communities and Department of Education. This was in a context where Executive Ministers collectively agreed a number of spending allocations which would be of benefit to the same groups.

131. In April 2020, in partnership with the Education Minister, I outlined a package of measures, worth around £12 million, to support vulnerable children and the children of key workers [Exhibit RS/71 INQ000400104]. 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.

132. On 23 April 2020 I launched, jointly funded with the Department of Communities, a remote interpreting service for sign language users [Exhibit RS/72 INQ000346720]. The service enabled British Sign Language and Irish Sign Language users to access NHS111 and health and social care services during the Covid-19 pandemic. The service was available 24 hours a day, 7 days a week.

133. On 29 April 2020, along with the Minister of Justice, I issued guidance on maintaining contact between parents and children during Covid-19, stating that the mandatory stay at home message does not apply to children moving between households.

134. Executive colleagues also had support packages for their stakeholders. The Infrastructure Minister, Nichola Mallon and Agriculture, Environment and Rural Affairs Minister, Edwin Poots, put further community transport measures in place to ensure vulnerable people in rural areas isolated as a result of Covid-19 have 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, and
- Instead of transporting people to services, services would be transported to the most vulnerable.

135. The Minister for Agriculture, Environment and Rural Affairs announced £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 [Exhibit RS/71 INQ000400104].

I. DECISION-MAKING AFTER MARCH 2020

1. Planning for a Second Surge

136. Modelling at the end of March/start of April indicated that we would potentially face a second surge [Exhibit RS/73 INQ000103652] and preparation, on a number of levels, began at that time. On 15 April 2020 I commissioned [Exhibit RS/51 INQ000205274, Exhibit RS/52 INQ000137398, Exhibit RS/53 INQ000188799] a rapid review of Personal Protective Equipment to focus on the appropriate receipt, storage, distribution, and use of it across the Health and Social Care 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.

137. I also gave approval for work to begin on exploring the site and specification for a second regional Nightingale facility in April 2020 in advance of the anticipated second wave of Covid-19, which was believed could coincide with winter pressures. This included assessment of a number of potential sites and the identification of the most suitable clinical and technical requirements [Exhibit RS/74 INQ000276382].

138. In July 2020, the Critical Care Network Northern Ireland asked Health and Social Care Trusts to provide an updated local surge plan to realign capacity with demand in the event of a second surge of Covid-19 to respond to a Health Gold request. The Second Wave Surge Plan mapped the critical care bed need from 88 critical care beds at steady state through to 110 beds at medium surge, 134 beds at high surge and 158 beds at extreme surge.

139. The Department of Health also changed its approach to the management of the second, and further waves of Covid-19, by moving from the initial changes to the governance, staffing and structures of the Department at the start of the emergency to the establishment of the 'Rebuilding Management Board' in June 2020. Alongside this the Department revised the arrangements for managing the Department's response to the surges in demand for health and social care services from Covid-19 patients. Previously this response was managed through Health Gold during the first wave, but the Department's approach was revised during autumn 2020, in anticipation of the further surges expected over the winter months of 2020/21. This change involved the Department taking a business continuity approach to managing the response to the second wave, instead of the emergency management approach which had been adopted during the first wave.

140. The primary purpose of these arrangements was to effectively manage future Covid-19 waves, including the second wave, by avoiding duplication of effort, simplifying the decision-making process, and ensuring sustainable working arrangements. The new arrangements involved the establishment of an integrated Covid-19 Gold Command Group, consisting of senior Departmental officials, alongside senior Health and Social Care Board and Public Health Agency officials. This Covid-19 integrated Gold Command Group was chaired by the Permanent Secretary [Exhibit RS/75 INQ000137358, Exhibit RS/76 INQ000137359, Exhibit RS/77 INQ000137360, Exhibit RS/78 INQ000137361].

2. Decision Making for Northern Ireland

i. Indicative Dates

141. As I have alluded to, Northern Ireland, and the other devolved nations, were not tied to decisions of the United Kingdom Government. On the 11 May the United Kingdom published its Covid-19 recovery plan; the following day the Northern Ireland Executive published its Coronavirus Executive approach to decision-making document. While both plans favoured a phased approach to the lifting of restrictions, in comparison to the United Kingdom, Northern Ireland did not lift any at that stage and also did not allocate provisional dates for the relaxation of restrictions. We subsequently moved to a position of giving indicative dates in June 2020 [Exhibit RS/79 INQ000048475] which was reinforced with messaging that, as indicative dates, they may be subject to change, depending on the trajectory of the number of cases. This did lead to tensions between some Ministers and their stakeholders who thought the dates should be final irrespective of the number of cases or the progress of the virus. However, being tied to "indicative" dates would have had a detrimental impact as to the Northern Ireland Executive's overall response and long-term recovery of Northern Ireland.

ii. Expert advice

142. From the notes in the evidence provided [Exhibit RS/80 INQ000065730] it would appear that the Agricultural, Environment and Rural Affairs minister had concerns that the expert advice provided was not sufficiently certain, as he is recorded as saying the Executive was following science "currently unproven, best guess." However, decisions had to be made on the best advice available. When dealing with what was a novel virus and using Non-Pharmaceutical Interventions that had never been practised or used on such a large scale, the desire for the science to be without any degree of uncertainty was unrealistic. It is perhaps best captured by the World Health

Organisation's Dr Mike Ryan when he said, "Perfection is the enemy of the good when it comes to emergency management. Speed trumps perfection … The greatest error is to be paralyzed by the fear of failure. If you need to be right before you move, you will never win."

143. While there was criticism from the Agriculture, Environment and Rural Affairs Minister that there was "no science, just assumptions…want to see science - didn't get science. Sick of assumptions from experts" [Exhibit RS/81 INQ000065753] this was not a view I shared by, nor do I believe that it is representative of, the other Ministers. Science is based on assumptions and is "the systematic study of the structure and behaviour of the physical and natural world through observation, *experimentation,* and the testing of theories against the evidence obtained"[5]. I consider that is how the Chief Scientific Adviser and Chief Medical Officer provided their advice in the case of a novel virus and Non-Pharmaceutical Interventions which were also novel in their application in Northern Ireland.

3. Increasing Numbers

144. Beginning in August 2020 the number of Covid-19 cases began to rise again. I believe this was due to a number of reasons. The "Eat Out to Help Out" scheme was introduced in August 2020 and this likely caused some increase in the rates, but it is not possible to separate out its effects from other factors including waning immunity, schools returning and people moving back indoors as the weather changed. It was in light of the increasing the numbers that the Executive decided not to permit 'wet pubs' to reopen in spite of pressure to do so.

145. There was always a resistance to, and non-compliance with, protective measures at some level and this was perhaps particularly so among younger people. With the benefit of hindsight, I do believe that other communication channels could have been used to disseminate advice and Covid-19 messaging specifically to younger people.

146. I consider, in deciding whether to ease restrictions over the summer months, ministers had to make balanced decisions based on a number of factors; these included complicated issues such as the social impact of maintaining restrictions, the educational impact on children and students, and the economic impact on businesses of more prolonged closures. It also had to be considered whether there would have

[5] science - definition of science in English from the Oxford dictionary (ucl.ac.uk)

been widespread lack of adherence to protective measures without the 'summer break', in essence behavioural fatigue.

147. Non-pharmaceutical interventions are most effective when adherence is highest and there were several sources of evidence about the levels of public adherence to non-pharmaceutical interventions, including survey results and analysis of open source mobility data (via Google). A Covid-19 Opinion Survey was launched by the Northern Ireland Statistics and Research Agency in April 2020 which was designed to measure how the pandemic was affecting people's lives and behaviour in Northern Ireland. It ran on a weekly basis with the questionnaire updated every 4 weeks to reflect any new areas of interest. The Department also commissioned Queen's University Belfast in May 2020 to conduct a contact matrix survey and I believe Ipsos Mori also conducted surveys on behalf of The Executive Office.

148. The Executive made an attempt in summer 2020 to introduce localised restrictions by utilising Post Codes as a means to manage a more localised response but this approach failed to produce the required targeted effect and, unfortunately, due to a larger increase in cases resulted in a wider response. However, the more targeted response did have an effect when there was an increase in cases in Derry City & Strabane and Donegal Council areas, where a cross border messaging campaign was utilised and restrictions were focused on a council area rather than by postcode. As I stated above the relaxation of restrictions in the summer months had to be made by ministers on a balance of consideration of a number of factors, including the social impact of maintaining restrictions, the economic impact on businesses and also whether, without a relaxation in the summer months, when people could meet outside, would result in behavioural fatigue if, and what ultimately became a case of when, restrictions had to be reinstated. Decisions the Executive took as a whole on easing restrictions were based on a consideration of all issues.

149. As the Northern Ireland Hub was a body of The Executive Office and not the Department of Health, I cannot recall its specific role after October 2020. As I have stated above, I did not think the Hub's role and objectives were clear. I have asked officials within the Department of Health for information relating to the Hub's role from October 2020 and have not received a response.

4. October 2020

150. In October 2020 the Framework for Decision Making was introduced and this acted as a 'reset' of the Executive's approach. The aim was to have a more formalised and structured response to both the introduction and easing of non-pharmaceutical interventions and I believe it did provide greater structure. However, there were still occasions when other pressures or events led to the Executive stepping outside that format. Following this 'reset' I am unclear as to the role played by the Northern Ireland Hub over and above supplying a written summary of actions taken and data trends from a number of sources to the Executive. As the Hub was a structure in The Executive Office, and not the Department of Health, the First and deputy First Minister may be able to provide information on the Hub's role.

151. On 8 October 2020, I provided an update to the Executive along with the Chief Medical Officer and the Chief Scientific Adviser 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 the meeting I provided a paper which modelled the course of the pandemic [Exhibit RS/82 INQ000276520, Exhibit RS/83 INQ000276521, Exhibit RS/84 INQ000276522]; I was extremely concerned about the situation, as reflected in my recommendation to the Executive that an intervention to reduce R to 0.7 was required as soon as possible in order to prevent the hospital system from being overwhelmed and to prevent deaths. Transmission rates had increased at this point because schools were back, the weather was changing, immunity was waning in those who had had covid-19 in wave 1, and people had started returning to the workplace. Roll out of the vaccination programme did not begin until December 2020.

152. At the Executive Committee meeting on the 8 October 2020, the Agriculture, Environment and Rural Affairs minister commented that, "people are not listening to us…not going after where problem exists. Afraid to say where problem is" [Exhibit RS/85INQ000065756]. I believe the Minister's comments at that time were based on his false interpretation that there was a greater incidence of covid in nationalist areas; this was countered in the media by myself and the Chief Medical Officer and Chief Scientific Adviser.

153. There was a suggestion, by Mr Pat Sheehan, MLA, at a Health Committee meeting on the 15 October that the modelling had underestimated the development of the pandemic at that point; however, the modelling referred to was from March/April and

referenced 300 cases but in October there were 900 cases and the modelling data had changed in that time. Therefore, I consider this to be a misperception on the part of the Health Committee member.

154. The Executive had introduced localised restrictions with effect from 16 September 2020 in areas of Northern Ireland where infection rates were highest and rapidly rising. These related to mixing of households, tightening the existing restrictions on the number of people permitted to gather indoors and outdoors in private dwellings. Visits to Care Homes and hospitals were also curtailed across Northern Ireland at this time. The areas covered by the localised restrictions were the Belfast City Council area, Postcode area BT28, Postcode area BT29, the town of Ballymena and Postcode area BT43. This reflected the population flows and public transport linkages and Belfast identity of these specific districts. The restrictions were to be kept under review and it was decided that areas would be added or removed from the list as required. The restrictions were subsequently announced [Exhibit RS/86 INQ000276519] and regulations drawn up alongside appropriate public messaging. BT60 was added to the areas under local restriction effective from 18 September 2020 due to escalating infection rates in this postcode area. There was no fear of identifying locations by reference to transmission rates but problems with postcodes became an issue as they were not sufficiently geographically defined to be a means of managing a more focussed approach to restrictions.

155. However, by mid-October there had been a progressive rise in the number of cases in spite of restrictions on household mixing having been extended to the whole of Northern Ireland on the 22 September and additional localised restrictions introduced in the Derry City and Strabane Council area on 1 October 2020. I submitted a paper to the Executive on the 13 October 2020 [Exhibit RS/87 INQ000276523, Exhibit RS/83 INQ000276521, Exhibit RS/84 INQ000276522, Exhibit RS/88 INQ000276526], which summarised the further progression and current state of the pandemic. It drew on the weekly R papers and presented 4 options for the Executive to consider:

- An intervention to include the following components[6] to commence as soon as possible but no later than 16 October 2020 ad lasting for between three to six weeks;

[6] 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;

- 4 week intervention with the same restrictions as in Option 1 but with school open in weeks one and four;
- 6 week intervention with same restrictions as on Option 1 but with schools open in week one and weeks 4 to 6, and
- Six week intervention to allow for other minor relaxations or reduced compliance compared with wave 1.

156. The Chief Medical Officer and the Chief Scientific Adviser recommended the first option and ultimately 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.

157. This decision was the right one at that time; there was evidence that the household restrictions applied on a postcode basis, and subsequently Northern Ireland wide, had had some impact on reducing transmission and slowing the rate of increase in new cases. However, there were also indications that Northern Ireland had started 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. While schools were closed from the 16 October for 4 weeks, one of those weeks was the half term break which reduced the actual delivery of distance learning to 3 weeks.

J. EXECUTIVE MEETINGS IN NOVEMBER 2020 AND CHRISTMAS DISCUSSIONS

1. Executive Meetings

158. The restrictions introduced on the 16 October were due to expire at midnight on the 12 November. I gave an update to the Executive on the 9 November, along with the Chief Medical Officer and the Chief Scientific Adviser, 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.

Closure of schools with delivery of distance learning;
Universities and further education to deliver distance learning to the maximum extent possible;
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, and
No unnecessary travel.

I 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 [Exhibit RS/89 INQ000276539]. The paper recommended that the four-week circuit breaker restrictions introduced on 16 October 2020 should be extended for a further two weeks. With the benefit of hindsight, we should have sought to impose longer restrictions from 16 October rather than seeking to extend them as extension of the restrictions was a controversial proposal but at the time the decision on restrictions for a shorter period was what was achievable. The existing restrictions had been imposed with an indicative end date and this meant that some Ministers, and their associated stakeholders, had an expectation that the Executive would stick to the set date rather than consider the trajectory of the virus and the number of cases, as was always intended. Discussion of this paper continued in reconvened Executive meetings on the 10, 11 and 12 of November 2020; these additional meetings were required to enable the Executive to reach agreement on my recommendation.

159. While initially some Executive colleagues supported my proposal, it failed to pass a cross community vote[7] on the 9 November and it was not until the 12 November that 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.

160. On the 19 November I presented a paper to the Executive meeting on 19 November 2020 entitled "Modelling the course of the COVID pandemic and the impact of different interventions and recommendations" [Exhibit RS/90 INQ000048498]. 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 20 November 2020 would result in R rising significantly above 1, with

[7] A cross-community vote in the Executive excludes the vote of those Ministers who do not designate as Unionist or Nationalist.

a subsequent increase in cases, admissions, inpatients and ICU occupancy becoming apparent in December 2020.

161. 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. The paper explained that the only intervention which had been proven 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. I concluded the paper with the recommendation that the Executive consider the information in the paper and decide on the appropriate response.

162. It was following the deployment of a cross community vote at the meeting on the 9 of November, that I took the decision not to include specific recommendations in the paper for the 19 November, as I was of the opinion that specific recommendations would again 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. My not including a recommendation was to ensure that the entire Executive would have, and did take, the time to consider the full paper and its contents. The Finance Minister wrote to me criticising that, "This paper does not contain a recommendation from you as Health Minister or from the Chief Medical Officer or Chief Scientific Adviser. This is not sufficient and falls short of what is expected from a Health Minister when the Executive is expected to make decisions to steer society through the coronavirus pandemic." [Exhibit RS/91 INQ000130122]. However, I feel it was an appropriate and proportionate response to allow the Executive to have a discussion.

163. Overall, I feel that the majority of Ministers felt the modelling was effective and appropriate. While there may have been some complaints about flaws in it, and frustration from Ministers because of the uncertainties associated with modelling (I understand that the modelling in relation to Covid-19 had to take account of numerous uncertainties, ranging from uncertainties about virus characteristics, immunity following vaccination or natural infection, individual and population behaviours (including adherence to non-pharmaceutical interventions), I believe these complaints

were based on a misunderstanding as to what modelling seeks to achieve: the scientific modelling in relation to covid-19 was not intended to look to, or understand, the impact on certain businesses; instead it was to indicate the range of possible outcomes in different scenarios.

2. Christmas

164. In November the Executive was already keenly aware that Christmas was approaching and a SitRep dated 17 November 2020 [Exhibit RS/92 INQ000065956] recorded that "The Executive will do all it can to "protect" as much of the Christmas period as possible". Christmas, and the family time associated with it, was a factor and concern as to what the decisions the Executive would take and how family gatherings at Christmas could be balanced with suitable precautions. The year had been difficult for all, restrictions had been tolerated, Christmas is traditionally a family time, and the Executive did not wish to have to impose restrictions if at all possible but were acutely aware that restrictions would have to be made at some point.

165. 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 [Exhibit RS/93 INQ000276548] announced the "UK-wide Christmas arrangements agreed by the UK Government and the Devolved Administrations."

166. 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 Chief Medical Officer and the Chief Scientific Adviser 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 United Kingdom 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 Northern Ireland. Devolved Administrations were always

able to diverge in their approaches and did so earlier in 2020, as explained above. Consistency across the UK would only have been appropriate if the pandemic had been at exactly the same stage in each jurisdiction at the same time.

167. The Executive's decision, recorded in the minutes of the 3 December 2020 meeting [Exhibit RS/94 INQ000048501], 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 [Exhibit RS/95 INQ000276553] on 4 December 2020.

168. On 17 December 2020 the Executive considered a paper submitted by the Department on post-Christmas restrictions. The paper [Exhibit RS/96 INQ000276555 and Exhibit RS/97 INQ000276556] 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, indicating 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[8], which amounted to a lockdown, from 26 December 2020 for a period of 6 weeks (subject to review after 4 weeks). I issued a press release [Exhibit RS/98 INQ000276557] detailing the restrictions coming into effect for six weeks from 26 December 2020. The announcement of these changes in restrictions for Northern Ireland [Exhibit RS/99 INQ000276558] was a day in advance of similar steps by the United Kingdom Government, Scottish and Welsh administrations on 19 December 2020.

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

169. The Executive held an emergency meeting on Sunday 20 December 2020. The meeting considered an update paper [Exhibit RS/100 INQ000276560] submitted by the Department which recommended a reduction in Christmas bubbling arrangements agreed on the 3 December; 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.

170. On 28 October 2020 in a 'Health 4 Nations' chat the suggestion of a joint statement around Christmas from all 4 jurisdictions of the United Kingdom was first mooted to me. I stated that we would be interested in that conversation but it would need to be at First and deputy First Minister level. I subsequently discovered that a joint statement to be issued by all United Kingdom jurisdictions regarding restrictions was then proposed on 16 December 2020 [Exhibit RS/101 INQ000091442]. The Northern Ireland Office and the Chancellor of the Duchy of Lancaster encouraged alignment with the statement but the Northern Ireland Executive refused to endorse it.

171. With differing approaches taken around the 4 nations regarding Christmas because of the different trajectory of the virus in each jurisdiction the Northern Ireland Executive adopted a different approach regarding non-pharmaceutical interventions over the Christmas period and publishing our own statement on the 21 December.

172. It was not until the 24 December that I became aware that a joint statement was not going to happen. At that point I sent a WhatsApp to the "Health 4 Nations Group" stating that "it didn't issue as our dFM refused to sign at the last minute for political reasons, would it be possible to resurrect it for today's mtg and issue from the 4 of us? …" [Exhibit RS/102 INQ000095177]. I was not made aware of what the specific 'political reasons were on which the deputy First Minister refused to sign, but I still thought that a joint UK message would have been beneficial.

3. Travel

173. I submitted papers [Exhibit RS/103 INQ000276561, Exhibit RS/104 INQ000290213] on travel guidance for discussion at a meeting on 21 December 2020 and 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." [Exhibit RS/105 INQ000065740 and Exhibit RS/106 INQ000065742]. I believe the Executive adopted and took the decisions in accordance with, and appropriate to, the advice which I received both from the Chief Medical Officer/Chief Scientific Adviser and legal.

K. THE EXECUTIVE COVID TASKFORCE

174. The Executive Covid Taskforce was established in December 2020, introduced at the same time as the appointment of the Interim Head of the Civil Service, Ms Jenny Pyper, and I understood it as a means of producing a more co-ordinated approach across the Executive following what had been a difficult period in November 2020. This was a Northern Ireland Executive-specific approach and, as far as I am aware, did not reflect any changes at a United Kingdom government level. As the First Minister indicated, the remit of the Executive Covid Taskforce was intended to look at recovery and other events, such as Brexit and severe weather events.

175. When the proposal for an Executive Covid Taskforce was presented at the Executive meeting on the 3 December 2020 the Justice Minister and I both raised a number of concerns regarding its terms of reference and who would lead specific workstreams. This was recognised by the interim Head of the Civil Service as she commented that the paper was "…rough and ready, needs refinement" [Exhibit RS/107 INQ000065721, page 9]. I was initially concerned that the creation of the Executive Covid Taskforce was an attempt by The Executive Office to assume control of the vaccine program which would not have been appropriate as the vaccine programme was a pharmaceutical intervention, which could only be delivered by health professionals and the Department of Health had the ability to activate all parts quickly. However, from a meeting and subsequent engagement with interim Head of the Civil Service this was proven not to be the case.

176. Following the creation of the Executive Covid Taskforce I believe it evolved to allow senior civil servants to have further engagement among themselves outside pre-existing structures and allowed more effective cross-Departmental collaboration. The involvement of Junior Minister allowed stakeholders to have a closer engagement with The Executive Office than previously but from [Exhibit RS/108 INQ000212399] I am now aware that this may have caused lines of communication to be perceived to blur.

177. I went on to seek the assistance of other Ministerial colleagues through the Executive Covid Taskforce in establishing the Managed Isolation system and wrote to The Executive Office and the Departments of, Economy and Infrastructure [Exhibit RS/109 INQ000400105, Exhibit RS/110 INQ000400107, Exhibit RS/111 INQ000400106]; however, in general, it was my experience that the Taskforce still sought the Department of Health's help and guidance. I also note from WhatsApp messages from the then Permanent Secretary of the Department of Health, Mr Richard Pengelly, updating me after a meeting of the Executive Covid Taskforce on the 9 June 2021 "Not discussed at ECT. But nothing much is - they worked hard to stretch today's meeting out to 35 mins2", and, "Interestingly, none of the "ECT updates" presented to the Exec is ever presented to, let alone discussed by, ECT." These would indicate that, at least at times, the remit and objectives of the Taskforce were either not clear or not followed.

L. 2021 AND BEYOND

1. Early 2021 Restrictions

178. The Executive were fully aware that the restrictions imposed at the end of December would have a disproportionate impact on certain groups. In terms of full equality impact assessments, given how quickly Covid-19 was spreading these proved impossible to do. However, the restrictions recognised the vulnerabilities and provided a number of exceptions, for example:

- Leaving your home to provide care or assistance to a vulnerable person, including social services (this recognised the importance of allowing vulnerable adults, such as those with autism or a learning disability to move between houses for respite care);
- Providing emergency assistance; to avoid injury, illness or risk of harm (including domestic abuse);

- Providing accommodation for those already resident; for work-related purposes; for vulnerable people; for those in emergency situations; and people unable to return to their main address;
- Attending mental health or Alcoholic Anonymous meetings provided appropriate social distancing and hygiene measures were in place;
- Special schools remained open and vulnerable children and children of key workers were able to attend school for supervised learning;
- Free school meals provision continued in the form of direct payments to families who were entitled, and
- Childcare, both formal and informal, was permitted.

179. In addition to these exemptions, in January 2021 I allocated an additional £1.754 million to allow the hospice service to respond to increased costs of personal protective equipment, deep cleaning, the purchase of additional video and IT equipment and to support a move to more services being provided in people's homes [Exhibit RS/112 INQ000188805 and Exhibit RS/113 INQ000185483]. In March 2021, I allocated a further £1.3million to support NI hospices [Exhibit RS/114 INQ000185440 and Exhibit RS/115 INQ000185484].

180. On 22 March 2021 I issued a Ministerial direction to establish a fund to meet high level outcomes to support carers in undertaking their caring role, to the value of £4.4m. The Carers Support Fund provided support for organisations working for and with carers. The funding provided improved access to and availability of advice services for carers, enhanced provision of and access to practical supports, the provision of a listening ear service, increased short-break capacity and self-advocacy training [Exhibit **RS/68** INQ000185444].

181. On 31 March 2021 I also wrote to the Executive and circulated a paper detailing my proposal to establish a £10m Cancer Services Support fund [Exhibit RS/61 INQ000185445 and Exhibit RS/70 INQ000185485] which was to support cancer charities in undertaking their role in supporting HSC services. I also proposed establishing a £10m fund to support mental health charities [Exhibit RS/116 INQ000185446], a one-off award of £15m to HSC Charitable trust funds and £1.3m support for NI hospices [Exhibit RS/117 INQ000185447 and Exhibit RS/118 INQ000185486] (as noted above). Their approval was sought and subsequently provided on the same date.

2. "Moving Forward: The Executive's Pathways Out of Restrictions"

182. 'Moving Forward: The Executive's Pathways Out Of Restrictions' document was developed by The Executive Office's Covid Taskforce in collaboration with departments including the Department of Health. The Executive Office led on its initial development then involved other departments in refining the approach. The Department contributed to the development of the document when it was brought by The Executive Office to the weekly Covid-19 Cross-Departmental Working Group, led by The Executive Office. There were focused meetings of the working group around the issue of vulnerabilities, and this was followed by specific, direct engagement by The Executive Office with the Chief Medical Officer and the Deputy Chief Scientific Adviser.

183. The Executive published its "Moving Forward: The Executive's pathway out of restrictions" [Exhibit RS/119 INQ000104467] on 2 March 2021. This was meant to be a collective approach but, from recollection, the Democratic Unionist Party stated that if it would have been different had it been solely a "Democratic Unionist Party" position paper. From that point, it was never sold, nor I believe accepted, as a public document that portrayed the position of all 5 parties in the Executive.

3. Building Forward – Consolidated Covid Recovery Plan

184. The purpose of the cross-cutting Recovery Plan was to accelerate economic, health and societal recovery in the short term so that Northern Ireland could emerge stronger post pandemic. It focussed on the delivery of 83 key interventions over a 24-month period. In developing the Recovery Plan, emphasis was on cross-departmental priorities which would accelerate recovery across four main areas in 24 months: economic growth; tackling inequalities; health of the population; and green growth and sustainability. Each Recovery Accelerator comprised of a number of interventions, which were put forward by Departments. In total there were 83 distinct interventions; however, due to the cross-cutting nature of this Recovery Plan some interventions featured in more than one Recovery Accelerator.

185. The Department of Health was responsible for 17 actions to progress the recovery of Health and Social Care services in the short (6 months) and medium terms (12 months); these were initially contained within the Department's Rebuild Framework, 'Building Better, Delivering Together' [Exhibit RS/120 INQ000276344] and were also

included in the 83 interventions in the Recovery Plan. These actions include the recovery of cancer services; restoration of elective care; support for mental health services service; the reform of adult social care services and the further roll-out of multi-disciplinary teams.

186. A Covid-19 Recovery Taskforce led by The Executive Office was set up across all Departments with Senior Civil Service membership. I recall receiving a draft update that sought to:

- Provide an update on the implementation of the interventions under each of the four recovery accelerators;
- Provide an update on stakeholder engagement and equality considerations;
- Inform on the funding position of the Recovery Plan; and
- Set out the next steps and seek approval for proposed changes to the Recovery Plan.

187. I believe that implementation of each intervention was monitored by individual action owners and I would have received updates on progress collated by the Transformation Directorate within the Department of Health.

M. RETIREMENT OF SIR DAVID STERLING

188. Sir David Sterling retired at the end of August 2020 but no successor was appointed until 1 December 2020 when Ms Jenny Pyper was appointed interim Head of the Civil Service; a post she held until September 2021 when Ms Jayne Brady took up post. An interim Head of the Civil Service was necessary as the First and deputy First Minister were unable to appoint a successor, in September 2020, from those who had applied. I did not receive, and am not aware of any of the wider Executive receiving, a full explanation as to why a successor was not appointed in September 2020 and why it then took so long to appoint an interim Head of Civil Service and, eventually, a permanent one. The inability to appoint a successor was concerning as it served as yet another example of a dysfunctional Executive when the recruitment and appointment of a Head of the Civil Service lay solely with the First and deputy First Minister [Exhibit RS/121 INQ000400108].

189. I do not believe that the time taken to appoint Ms Pyper as interim Head of the Civil Service had a material impact on the overall response of the Northern Ireland Executive to the Covid pandemic as Sir David Sterling's retirement had been well

known in advance. I assume the Executive Office would have had in place contingency arrangements to cover any timeframe when there would not have been a Head of Civil Service and the First and deputy First Minister would have been fully aware of these.

N. SCIENTIFIC AND MEDICAL ADVICE TO MINISTERS

190. "Following the science" became a common refrain during the pandemic. In my opinion it was a phrase used to indicate that the Executive was taking decisions based on scientific and medical advice and data, rather than being tied to a date-led approach.

191. I wrote to the Executive Committee on 29 March 2020 stating the importance of ensuring that Department of Health work "is fully and properly connected to the higher level Executive Office for managing the broader societal response to, and impacts of, this issue [Exhibit RS/36 INQ000023229]." In the early onset of the pandemic, I was concerned that there was a danger that other Ministers saw the pandemic solely as a health issue and at that stage had not appreciated the need for a cross-departmental whole-government response. This was exacerbated by the fact that as an Executive we were all still learning to work with each other and settling into our own Departmental roles.

1. Department of Health Covid-19 Dashboard

192. It was important to have reliable and exact figures about the number of daily deaths in Northern Ireland was crucial to ensure that both the Executive and the public were informed and were able to see what decisions were being made, the reasons as to these decisions, and the effect these decisions had. Between 24 March and 19 April 2020, the Public Health Agency published a daily bulletin which provided a summary of the information to date including the number of new cases, the number of tests reported and, in due course, the number of deaths. It was replaced by the Department of Health's Dashboard on 19 April 2020.

193. The Department of Health was responsible for the development and management of the Covid-19 Dashboard which was the primary vehicle for the collation and dissemination of all official pandemic-related data and analysis. In line with the Northern Ireland Civil Service policy and practice, it was designed to the requirements of the pillars of the Code of Practice for Statistics [Exhibit RS/122 INQ000092790] in terms of trustworthiness, quality and value. Although the Dashboard was based on similar information published by other United Kingdom jurisdictions, the information for

Northern Ireland also included useful health service data about capacity and availability.

194. In order to collect relevant and standardised data from Health and Social Care Trusts, the Health and Social Care Board and the Public Health Agency, the Department established a Data Coordinating Group on 18 March 2020. Membership of that group consisted of Information leads in the relevant organisations and it was chaired by the Principal Statistician of the Hospital Information Branch in the Information & Analysis Directorate in the Department. This information was primarily used to create analyses and statistics for publication on the Department's Covid-19 Daily Dashboard of Statistics. A summary of the data items collected is set out in [Exhibit RS/123 INQ000400122].

195. Several systems and processes were developed and utilised by the Department to collate the relevant data for this Dashboard. The then Health and Social Care Board was tasked with developing a process specifically to collate Hospital Bed Occupancy data for Covid-confirmed and non-confirmed patients to help assess pressure on hospital services and this information was forwarded to the Department for publication on the Covid-19 Dashboard.

2. The Strategic Intelligence Group

196. The Strategic Intelligence Group was established in April 2020 following the Chief Medical Officer's approval of the Chief Scientific Officer's proposal to establish a group in Northern Ireland to focus specifically on scientific evidence. The specific role of the group was to consider the scientific and technical concepts and processes that were key to understanding the evolving Covid-19 situation, potential impacts in Northern Ireland, and the approaches to mitigating these. Its role was not public facing but an advisory forum for the Chief Medical Officer and the Chief Scientific Adviser to receive and apply the advice coming to the four nations from the Strategic Advisory Group for Emergencies and other appropriate sources of evidence and information, including from the Republic of Ireland. This information was then used by the Chief Medical Officer and Chief Scientific Adviser to advise me and the Executive and inform our decision making. It was also used by the Chief Medical Officer and the Chief Scientific Adviser in their public and media briefings.

197. The Group never expressed any difficulties to me in gaining data for their modelling that would have required my intervention and therefore it would be my opinion that there was no detrimental effect on the Executive.

198. The Strategic Intelligence Group was effective during the pandemic and should be a key recommendation that its structures and format be established in any future pandemic, as I believe its composition reflected differing views and knowledge rather than being restricted to the Northern Ireland Civil Service.

3. The Public Health Agency

199. The Public Health Agency is an Arms-length Body of the Department and has a pivotal role to play in the response to incidents and outbreaks. The role of the Public Health Agency was central to the pandemic response in Northern Ireland. The Department took a number of actions to increase the capacity within the Public Health Agency; for example, immediately prior to the pandemic there was a joint Chief Executive of the Public Health Agency and Health and Social Care Board and when the postholder indicated her intention to retire an experienced interim Chief Executive was appointed.

200. The Public Health Agency played a key role in contact tracing as we placed our contact tracing function within it and upscaled their structure instead of contracting the role out, as was done elsewhere. In autumn 2020 the Department and the Public Health Agency jointly commissioned to carry out a rapid, focused external review of the PHA's resource requirements to respond to the Covid-19 pandemic over the following 18 - 24 months. The final recommendations were to:

- Strengthen the public health system in Northern Ireland;
- Strengthen health protection capability within the PHA;
- Develop science and intelligence capability [in the PHA], and
- Build a modern, effective and accountable organisation (the PHA).

201. These were accepted by the Department and Public Health Agency and I agreed to the establishment of comprehensive programme management arrangements to oversee the reform and transition of PHA to a new operating model.

4. Receipt of Scientific and Expert Advice

202. Scientific and expert advice was primarily provided to me in briefings and meetings with the Chief Medical Officer and Chief Scientific Adviser in preparation for developing papers and in discussions prior to the Executive meetings.

203. The information and advice received from the Strategic Advisory Group for Emergencies was effective although, as I stated in my evidence during Module 1, I do believe that Northern Ireland should have a formal place in all appropriate structures. Without a 'seat at the table' for Northern Ireland (and other devolved administrations) it is possible the Scientific Advisory Group for Emergencies could become too 'England-centric' although at no point were any concerns raised with me that this was the case during the Covid-19 pandemic. I would reiterate that Northern Ireland should have a formal place in all appropriate future structures.

204. Some data available to the United Kingdom government was not always readily available to the devolved administrations and had to be specifically requested. I can recall that there were issues in respect of accessing data around international travel restrictions, but cannot remember the specifics, and do not have documents which could refresh my memory. The Department of Health should be able to provide the Inquiry with this information.

5. The 'R' Number

205. The R number was one of the measures used to advise the Executive on decisions in relation to the implementation and easing of restrictions. I believe that what "R" meant as a measure was widely understood. I do not believe there were ever any concerns raised regarding the reliability of the 'R number' in Northern Ireland except where the case numbers were too low, nor do I believe that the fact we published 2 'R' numbers – the first being our own calculation and the second one a Cabinet Office/Scientific Advisory Group for Emergencies calculation – caused any issues.

206. You note in one of your questions to me that the Chief Scientific Adviser gave a presentation to the Executive Committee on the R-number on the 11 June 2020. The record of the meeting notes the deputy First Minister asking how the R number is measured and the Chief Scientific Adviser replying with a "… wide range of data feeds, 911 calls, hosp [sic] admissions etc" [Exhibit RS/124 INQ000065729]. My recollection is that the Chief Scientific Adviser had explained previously to the Executive how the R number is calculated.

207. I reported at the Executive meeting on the 9 July 2020 that the use of the R number was suspended, and the Department was looking to use a wider set of figures [Exhibit RS/125 INQ000065764]. This is 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 we started referring to case numbers. I would note, again, my concern that the notes taken at Executive meetings do not necessarily reflect the full conversation, engagement or nuances of the discussion.

208. Modelling of case numbers and potential hospital admissions based on different R values were presented to the Executive in regular Department of Health papers which were used to demonstrate how a change in R would have an effect.

209. In addition to scientific and medical advice and knowledge, the Executive Committee used a number of polls to track how restrictions and regulations were adhered to. Available technology such as 'google tracking' was used to show public footfall in Northern Ireland for a period of time.

210. Overall, I felt well-supported by the Chief Medical Officer and the Chief Scientific Adviser and others, including departmental officials, as necessary. My working relationship with the Chief Medical Officer and Chief Scientific Adviser was such that exchanges could be had and challenges made without offence being taken of the position challenged.

211. There were complaints from Ministers about the late arrival of briefing papers or proposals prior to an Executive meeting [for example [Exhibit RS/126 INQ000065718] but this was to ensure that they were as relevant as possible to allow informed decisions to be taken on the most up-to-date information available. Officials in the Department of Health worked long hours during the Covid-19 pandemic and in April 2021 I wrote to the First and deputy First Minister, copied to my Executive colleagues, highlighting that staff in the Department of Health were beginning to show serious signs of fatigue and stress, with some highly critical senior staff absences [Exhibit RS/127 INQ000145663]. I was extremely concerned about the wellbeing of my staff. Whilst the Department had sought to bring in additional staff resources through loans and transfers from other departments, aside from some isolated cases of relatively short-term help (for which I was grateful), there had been nothing in the way of material long term assistance.

6. Understanding of Scientific, Medical and Mathematical Concepts

212. The Executive and senior Civil Service colleagues bring different skill sets and mindsets to the table and this ensured that there was sufficient challenge and discussions that reflected as wide as range of views as possible. Difficult scientific, medical and mathematical concepts were broken down and explained at length, in a comprehensive and concise manner.

213. I was concerned, however, that at one meeting a Minister seemed unaware that their decisions had implications. In the Executive meeting on 11 March 2021, the Deputy Chief Scientific Advisor stated that it was a "Question of how many deaths/illnesses was acceptable to Mins – for Mins to decide" and the Economy Minister is noted as having said "Responsibility with Mins? We have decided to be guided by health advice – not for us to decide on level of deaths" [Exhibit RS/128 INQ000065704, page 4]. From the notes of that meeting it would appear that I was not the only one concerned at this reaction as the Justice Minister is noted as saying she was "confused re DfE reaction – always aware of impact of our decisions. Want to get back to normality, we all struggle, but aware our decisions will result in some deaths/illness." [Exhibit RS/120 INQ000065704, page 5].

214. Group think was not something that the Northern Ireland Executive could be accused of.

O. RELATIONSHIP WITH THE UNITED KINGDOM

215. It was stated at the Executive meeting on 20 April that, "NI has an advantage as it is behind other countries" [Exhibit RS/129 INQ000065691]. The time lag was referred to in a Northern Ireland Office SitRep, dated 30 April 2020, and highlighted as a reason why Northern Ireland had to be different and why we had to develop our own plan.

216. While there is no doubt that the time lag was advantageous at times; for example, it allowed the Executive time to engage with stakeholders in formulating a response; it was also a disadvantage. Messaging issued by Her Majesty's Government, covering all of the United Kingdom, was not immediately relevant in Northern Ireland. Equally, when the rest of the United Kingdom were ready to ease or lift restrictions, there was pressure from certain stakeholder groups, and some Ministers, to do likewise in Northern Ireland rather than making decisions based on the level of the virus in Northern Ireland. If we had introduced restrictions earlier in Northern Ireland, it is

possible that the public would not have followed them at that time as the sense of immediacy would not have been present due to the low case numbers.

1. Mechanisms for Communication with the UK Government

217. At times I felt the early Cabinet Office Briefing Room meetings to be an awkward construct with Her Majesty's Government Ministers in the room while devolved administrations were present either on a phone line or remote link. I believe that that hybrid approach detracted from the ability of the devolved administrations to fully participate. Early notification and access to Cabinet Office Briefing Room meetings were also cumbersome; my invitations for the initial meetings were issued through The Executive Office, and at one point the secure link in my own Department in Castle Buildings, was deemed a risk and the Chief Medical Officer and I had to use a secure telephone line in Stormont House (the Northern Ireland Office). It was not until the Prime Minister took the Chair of the Cabinet Office Briefing Room meeting that the First and deputy First Minister started to attend. I believe that if the Prime Minister and First and deputy First Minister had been around the table from the start that this would have strengthened earlier engagement and a stronger cohesion.

218. In the early stages of the pandemic and specifically around international travel and border controls there were a number of occasions where Her Majesty's Government made 'England only' announcements without any involvement of the devolved administrations. In Professor Ailsa Henderson's expert report [Exhibit RS/130 INQ0000269372] the point is made that in the first two months of the pandemic it was almost never the case that an England-only matter was identified as such [Exhibit RS/130 INQ0000269372, page 49]. In Professor Henderson's evidence for Module 2 on the 9 October 2023 she also comments that "data was not uniformly accessible" and was often "England-only data" (page 144). Unfortunately, I believe this was due to a distrust between Her Majesty's Government and some of the devolved administrations as to who would be seen to make the announcement first. The impact of this behaviour left me in a position that other Executive Ministers may have believed that I had failed to brief them rather than that I had not been briefed by Her Majesty's Government. As I noted this was more apparent around international travel, as initially Her Majesty's Government side was not led or represented by the Health Minister whereas the devolved administrations were.

219. In [Exhibit RS/131 INQ000148325, page 15, paragraphs 62-63] reference is made to the Covid-19 quad meetings being the primary form of engagement with the government in the Republic of Ireland. It is stated that these were attended by the Secretary or Minister of State for Northern Ireland, depending on availability, the Irish Minister for Foreign Affairs and the First and deputy First Ministers. It is also stated that during the specified period, the respective Health Minister from the Republic of Ireland and Northern Ireland also attended these meetings. Unfortunately, until I had sight of the document, I was unaware that such a body had been established and I do not recall receiving any feedback from it.

220. In terms of the United Kingdom involving Northern Ireland Ministers or senior civil servants in decision-making that impacted Northern Ireland, from a health perspective I believe that there was positive engagement between Northern Ireland and United Kingdom Government Ministers and civil servants, for example on Personal Protective Equipment, vaccine deployment and testing.

221. Northern Ireland also made use of the Military Aid to Civil Authority Protocol on a number of occasions. This involved liaison with the Northern Ireland Office and the Ministry of Defence for transfer of these patients by Military transport. The Department also coordinated the transfer of non-Covid seriously ill patients from Northern Ireland for treatment in specialist hospitals outside the jurisdiction as required. I also requested military assistance on a number of occasions throughout the pandemic, for example in April 2020 to redistribute medical equipment between hospitals across Northern Ireland and to provide technical advice and assistance to explore the potential for the development of the proposed temporary Nightingale Hospital facility. In January 2021 I requested Combat Medical Technicians to assist across the health and social care system and in March 2021 to roll out Northern Ireland's Covid-19 vaccination programme.

2. Effectiveness of Communication

222. The deputy First Minister commented in her Module 1 statement that, "Actions by the British government at times, hindered our ability to reach consensus. For example, regarding travel restrictions on the island of Ireland" [INQ000183409, paragraph 27]. However, I do not recall any decisions by Her Majesty's Government, including on travel restrictions, which impacted on the Executive reaching a consensus.

223. In terms of the effectiveness of the Secretary of State for Northern Ireland; the Northern Ireland Office and the Minister for Intergovernmental Relations, in facilitating intergovernmental relations during the pandemic and in co-ordinating the response of the devolved administrations, I cannot recall ever having to seek the assistance of these offices and therefore am not in a position to make judgment. This is primarily due to the open and regular engagement that there was between the health ministers of the 4 nations from the onset of the pandemic where there were regular, at least weekly, meetings.

224. Due to the regularity of these meeting, at least initially, from a health perspective the relationship between the health ministers of the 4 nations was built on trust and mutual respect: we were all facing the same challenges and were able to have open and frank discussions. Unfortunately, as the Secretary of State for Health of Her Majesty's Government changed, so too did the frequency and opportunity of the meetings. I continued to have a good relationship with Sajid Javid, following his appointment in June 2021, but was unable to secure meetings with either Thérèse Coffey or Steve Barclay following their respective appointments.

3. North/South Ministerial Council

225. The North/South Ministerial Council was described by the Finance Minister at an Executive Committee meeting on the 10 March 2020 as, "overly bureaucratic. Need to be able to react" [Exhibit RS/133 INQ000065695]. While this comment was made at a time when I had yet to attend a North South Ministerial Council meeting, once I did begin to attend them, I found them vey formal. I felt that Ministers were heavily scripted with agreed lines prepared beforehand. North South Ministerial Council sectoral meetings continued throughout the pandemic and, once they moved online, I found them more workable. The withdrawal of the Democratic Unionist Party from the North South Ministerial Council meetings in October 2021 did not affect meetings on health matters as they agreed that these should continue. Their withdrawal, however, did increase the content of the North South Ministerial Council Inland Waterways meetings on Waterways as, other than the health meetings, these were the only ones that continued. Any items that needed agreed or ratified in any other North South sector were passed to the Waterways meetings.

P. RELATIONSHIP WITH REPUBLIC OF IRELAND

226. On taking up office, and as we entered the pandemic, the preparation work that had taken place was based around Northern Ireland being part of a United Kingdom

approach, due to our operational, political and financial structures being recognised and established as such. I believe it would have been challenging, if not impossible, for a newly established five-party Executive, in the face of a pandemic, to begin to realign these established and recognised structures and try and create new ones, at a time when Her Majesty's Government and the Republic of Ireland were managing their own response to Covid. I do not believe that the establishment of such an approach had been explored by any of my predecessors. I sought, where possible, to use the bodies that were already in place, alongside the strong working relationships between the two Chief Medical Officers, the Public Health Agency and the Health Services Executive.

1. Agricultural System

227. Within agriculture there is a premise of the island of Ireland as a single epidemiological unit; this is based on being able to restrict movement of animals onto the island without a quarantine period being in place. In animal health, while there is much in common between the lists of notifiable diseases in Northern Ireland and the Republic of Ireland, there are also animal diseases which are only notifiable within one of the two jurisdictions. Even where there is commonality within each jurisdiction in terms of an animal disease being notifiable, there can be, and often are, differences in relation to surveillance, control or steps toward disease eradication [Exhibit RS/134 INQ000400109].

228. While this has been established practice for animals it would neither have been practicable or possible to introduce for people on the scale that would have been necessary primarily because of the Common Travel Area which allows British and Irish citizens to move freely and reside in either jurisdiction and enjoy associated rights and privileges.

2. Memorandum of Understanding – 7 April 2020

229. Under the terms of the Memorandum of Understanding entered into on 7 April 2020 by the Departments of Health, and their respective agencies, from Northern Ireland and the Republic of Ireland: 'Covid-19 Response – Public Health co-operation on an All-Ireland Basis' [Exhibit RS/135 INQ000130355], the two Departments had weekly meetings jointly chaired by the Chief Medical Officers of Northern Ireland and the Republic of Ireland. The meetings were attended by the Chief Scientific Adviser from

Northern Ireland and Deputy Chief Medical Officers from both jurisdictions and respective subject-specific policy lead officials.

230. The Memorandum of Understanding set out the main agreed areas for cooperation in response to the pandemic and allowed data and information sharing, public messaging, engagement at official level and an operational sharing of practice between officials at policy level, which were not covered elsewhere. It was not a substitute for extant arrangements for engagement at official and Ministerial level between respective jurisdictions; instead, the Memorandum provided an additional framework underpinning these arrangements.

231. Given the demands of the pandemic, I understand there is no formal record or assessment of the outcomes of the Memorandum, or review of it to identify and areas for closer working, but I believe there was very effective cooperation, regular engagement, and continued close working relationships at official level between the two jurisdictions throughout the pandemic. The professional collaboration historically and during the pandemic between the Chief Medical Officers, their respective teams and public health agencies was effective and of significant benefit during the pandemic. I believe it delivered what it was designed to outside the other established structures of the North/South Ministerial Council as it allowed engagement without party politics or intergovernmental concerns.

232. At various times, the epidemiology differed between Northern Ireland and the Republic of Ireland as it did between the various parts of the United Kingdom, and indeed within regions at the individual county level. At other times the epidemiology in Northern Ireland was much closer to that of the Republic of Ireland than the rest of the United Kingdom. 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 the Chief Medical Officer and the Chief Scientific Adviser throughout the pandemic. The Scientific Advisory Group for Emergencies comments in its paper of 12 May 2020 [Exhibit RS/136 INQ000346698] were echoing points made by the Chief Medical Officer and the Chief Scientific Adviser at the Scientific Advisory Group for Emergencies 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 Northern Ireland Executive and the Republic of Ireland's Government. No specific policy papers were requested or prepared by the Department on such a harmonisation approach, and I understand no such papers were developed by the Executive Office.

3. Obstacles

233. Structures existed which should have allowed the sharing of information at a political level, but, as was stated by the Minister of Finance, these were bureaucratic. However, they were countered by working relationships and cross-border bodies that allowed engagement at an operational level. As a newly formed Executive and with the Republic of Ireland and the United Kingdom governments all dealing with the onset of a pandemic, I do not believe there was the capacity or bandwidth to carry out a significant realignment of these structures. This could also have been affected by the disharmony that Brexit had caused between the United Kingdom and the Republic of Ireland governments at that time.

234. Attempts were made carry out research aimed at understanding the impact of Covid-19 along the Irish border, but I understand it proved impossible due to the differing access to testing and reporting of deaths in either jurisdiction. It was not due to the analyses being "'actively discouraged' between administrations, north and south" as contended by Deirdre Heenan and referenced in [Exhibit RS/137 INQ000137387], but I do agree that the development of data sets that allow direct comparisons should be developed across these islands and not just North and South.

235. The lack of comparable data was a limiting factor during the pandemic and means that it is difficult to assess whether the Republic of Ireland had better outcomes and reduced deaths from Covid-19. Such a comparison was attempted at one point but proved impossible. Since leaving office I am not aware of any work done to examine whether greater harmonisation or co-operation with the Republic of Ireland might have produced better outcomes in Northern Ireland. Equally, although aligned to the United Kingdom, the Northern Ireland Executive made its own decisions based on the advice it was given, and comparable data as to how Northern Ireland performed in relation to Covid-19 is still available at coronavirus.data.gov.uk. [Exhibit RS/138 INQ000257925, paragraph 62].

4. Ministerial relations

236. It was suggested in a record of a Quad meeting on the 9 June 2020 that there were issues about the timing of Republic of Ireland announcements and the ability of the Northern Ireland Ministers to respond [Exhibit RS/139 INQ000091381]. I felt there was more of a tension and lack of trust between the Republic of Ireland and the Northern

Ireland Executive in the sharing of information and advance notice of announcements at a political level, but this was balanced by good working relationships at Chief Medical Officer/Public Health Agency/Arm's Length Bodies level, as described above. The issue at the political level was one which was ongoing and at the meeting was acknowledged by the Tánaiste. I believe it was based around decisions being made in the Republic of Ireland Cabinet and that they were concerned that, when shared with the Northern Ireland Executive, they could also be used to inform Sinn Féin who were the official opposition in the Republic of Ireland.

237. I also believe the interaction between the United Kingdom and the European Union may have adversely affected United Kingdom and the Republic of Ireland governmental relations by ongoing challenges based around Brexit. However, the only direct example that I can point to is the European Union's triggering of Article 16, which could have delayed Northern Ireland from receiving Covid vaccines. [Exhibit RS/140 INQ000400110].

238. Article 16 is a provision in the Northern Ireland Protocol which allows the European Union or the United Kingdom government to take individual safeguard measures where the application of the Protocol causes serious difficulties. The safeguard measures used by either party must be strictly necessary to remedy the situation and prioritise measures which will least disturb the functioning of the Protocol. It is intended to be used as a last resort if the European Union and the United Kingdom are unable to reach an acceptable solution after consultation. On 29 January 2021, the temporary triggering of Article 16 by the European Union created an immediate risk to the movement of medicines and vaccines moving from or through the Republic of Ireland to Northern Ireland. In the event the trigger was temporary and short lived and there was no adverse impact on supplies. The temporary triggering of Article 16 on 29 January 2021 heightened concerns about the Northern Ireland Protocol which the United Kingdom Government raised with the European Union.

239. From the outset of the pandemic, I had a good and open working relationship with Simon Harris TD but, following the change in Government in the Republic of Ireland after their election in February 2020, this unfortunately did not continue with Steven Donnelly TD where engagements were more structured and intergovernmental with the formation of their coalition government in June 2020. At one point Minister Donnelly declined to meet me over cross border outbreaks for a number of weeks, stating that officials should meet instead. There was also a tension between the

Republic of Ireland and all parties in the Executive in regard to the Republic of Ireland sharing international passenger details and this became a running point of contention. The lack of sharing of this data would also have had an adverse effect in the approach to treating the island as a Single Epidemiological Unit.

240. There was very close liaison with the United Kingdom Government, other Devolved Administrations and the Republic of Ireland. Decisions made in any of these jurisdictions inevitably had an impact on the other jurisdictions given travel within Common Travel Area and that international travellers often arrived in one jurisdiction on their way to another jurisdiction. Discussions took place in multiple fora, such as the Border Health Measures Board meetings, chaired by Cabinet Office, which looked at all aspects of International Travel and the future of border controls; and the United Kingdom Government/Devolved Administration International Travel Programme Board meetings chaired by the Department for Transport.

241. A scheme for proof of vaccination status for the purposes of International Travel for Northern Ireland residents was launched in Northern Ireland on 17 July 2021 enabling those travelling from 20 -25 July 2021 to apply for a downloadable certificate and QR code. The COVIDCert Northern Ireland app was launched shortly afterwards and it enabled those travelling after 25 July 2021 to get their vaccination certificates on their phones. The European Union Digital Covid Certificate launched on 19 July 2021 and it enabled Republic of Ireland passengers to apply for proof of vaccination status for the purposes of international travel.

Q. LEGISLATION AND REGULATIONS: THEIR PROPORTIONALITY AND ENFORCEMENT

242. The Regulations in Northern Ireland contained criminal sanctions; these were considered necessary as it was recognised that, unfortunately, there would be a small minority who would not adhere to guidance and who would therefore set a challenge to those who would. Financial Penalty Notices were considered as an option at one point but the Justice Minister informed the Executive that specific Covid Financial Penalty Notice for the Police Service of Northern Ireland would take 12-16 weeks and therefore was not a viable option.

243. Adherence to, and enforcement of, the Regulations was not straightforward. I noted on 20 August 2020, along with the First Minister and the Chief Medical Officer, that we had not been enforcing the Covid Regulations and that the fines in place were too

small. Concerns were raised in the Executive but, at that point, no Minister or Department had assumed 'ownership' of enforcement of the Regulations: as the Department of Justice does not have operational control over the Police Service of Northern Ireland the Justice Minister did not feel that it was a function of her department [Exhibit RS/141 INQ000065769, page 15].

244. I believe the non-adherence had to be compensated for by stronger messaging at press conferences regarding the number of cases and pressure on our National Health Service. I do recall that the Chief Constable took part in a number of Covid press Conferences with the First and deputy First Minster to strengthen the messaging.

245. At an Executive Meeting on 10 September 2020 it was then noted that "a working group on compliance and enforcement of the regulations [will] be established" [Exhibit RS/142 INQ000048488] – it had been hoped that no such body was necessary. This was led by the Junior Ministers within TEO; however, while their role was beneficial regarding engagement and encouragement, it still did not address the issue of enforcement, and this was something which I continued to raise with the First and deputy First Minister [Exhibit RS/143 INQ000400111 and Exhibit RS/32 INQ000103694]. There was also consideration given by the Executive to local councils deploying Covid Marshals to support engagement and encourage adherence to the Regulations but I do not believe this produced the results that it potentially could have.

246. The Chief Medical Officer and I had, at times, direct contact with an Assistant Chief Constable in the Police Service in relation to enforcement. I believed that engagement was positive but the Minister of Justice subsequently reported to the Executive, from the Chief Constable, that there were difficulties.

247. I do not recall information being received by the Executive as to the number, or detail, of criminal sanctions that had been deployed or other actions that had been taken.

R. SCRUTINY BY THE ASSEMBLY

248. I believe the format and approach of the Northern Ireland Assembly in how it managed regulations brought under the Coronavirus Act could have been more agile at times, as on a number of occasions the regulations that were being debated in the Assembly had been superseded by further amendments, although these were mainly on the easing or lifting of restrictions. However, by the time the Assembly came to debate

covid regulations they had already been scrutinised and accepted by the Assembly's Health Committee and had also been through the office of the "Examiner of Statutory Rule".[9]

249. Debates in the Assembly were detailed and robust, although mostly only attended by members of the Health Committee and a small number of other Members who took an active interest. This was in contrast to the Ad-Hoc Committee on the Covid-19 Response which drew more attention; I believe this was a creative approach by The Speaker to widening the debate in the Executive's response, rather than restricting it to the specific detail of legislation, which was able to engage a wider interest by MLAs.

250. The main scrutiny of the decision and actions taken by my Department and I was undertaken by the Assembly's Health Committee. The Committee was established to advise and assist the Minister on matters within his responsibility. The Committee undertook a scrutiny, policy development and consultation role with respect to the Department for Health and played a key role in the consideration and development of legislation. During my remit the Chairperson was Colm Gildernew, Sinn Féin, and deputy Chairperson Pam Cameron, Democratic Unionist Party with members drawn from the Alliance Party (1), Democratic Unionist Party (2, including the deputy Chairperson), Sinn Féin (3, including the Chairperson), People Before Profit Alliance (1), Ulster Unionist Party (1) and the Social Democratic and Labour Party (1).

251. I appeared in front of the Committee 16 times, usually accompanied by the Chief Medical Officer and occasionally with the Chief Scientific Adviser.

252. At the early onset of the pandemic when the Assembly ceased to function there was a noticeable increase in the number of Assembly Questions for Written answer. This naturally had an impact on Departmental officials, who along with progressing urgent policy and legislation in relation to Covid-19, also had to answer an increasing number of questions. The Executive wrote to the speaker raising concerns about the number of questions and seeking a reduction in the number that members were encouraged to ask. I also wrote with similar concerns and seeking the same reduction, which was subsequently allowed, although it was voluntary.

[9] The Examiner assists the Assembly and the appropriate Statutory Committees in the technical scrutiny of statutory rules and draft statutory rules which are subject to procedures before the Assembly (that is, affirmative resolution, negative resolution, confirmatory procedure or laying in draft for approval).

S. FUNDING THE RESPONSE TO THE PANDEMIC

253. Funding and financial support for the majority of the Covid-19 response came from Her Majesty's Government by way of Barnett Consequentials of decisions made in Westminster. However, there were instances in Health where the Department received supports outside direct monetary supports, for example testing and vaccine programmes were provided by way of population breakdowns.

254. While the Executive received financial support it was heavily reliant on decisions of Her Majesty's Government, I do recall discussion at a 4 Nations meeting where the devolved administrations requested the ability to draw down financial support for specific Non-Pharmaceutical Interventions which were not reliant on a decision of Her Majesty's Government; however, this never materialised.

255. The funding of specific sectors on a few occasions, for example taxis and taxi drivers, were problematic for the Executive as to which Department would take the lead and act as a conduit for funding, with a blurring of direct responsibility meaning support was not disseminated as quickly or seamlessly as it could have been; I recall instances like this between the Departments of Finance, Economy and Infrastructure.

256. The Executive wanted to introduce additional Non-Pharmaceutical Interventions in December 2020, but felt that this would present too great an economic risk without providing financial support to affected businesses alongside such measures. There was a risk that if the UK Government did not move to similar measures (and therefore provide financial support to English businesses) that there would be no funding flowing to NI for such a financial support package via Barnett consequentials. Hence there was a risk that introducing measures here (and providing necessary support to businesses) could lead to an overspend at NI block level. In reality this was more around when, not if, a Barnett Consequential would be released, but, recognising how necessary these Non-Pharmaceutical Interventions were to alleviate pressure on the Health Service, I indicated that I was prepared to surrender £70m in the December 2020 monitoring round to enable a financial package to support those sectors who would need it to survive to be provided without the risk of an overspend. This was based on the understanding that in the early monitoring rounds of 2021 I would be able to claw this back, which we were able to do. Unfortunately, this action was misrepresented which led to media reports that DoH was unable to spend money during a pandemic rather than it being about supporting a wider Executive response, due to cash flow.

257. The timing of the availability of financial support was always something which the Department remained alert to; even as of September 2021 I was being advised that "the current assessment of total forecast expenditure in 2021/22 is £6,991.2 million, resulting in a shortfall of £868.8 million of which £240 million is in respect of Covid-19 and £157 million is in respect of New Decade New Approach Agreement priorities" [Exhibit RS/144 INQ000391422].

T. CONTROLLING NORTHERN IRELAND'S BORDERS

258. Due to only having three airports and five commercial ports, along with the early suspension of international flights, the ability to impose restriction on people entering Northern Ireland was something that should have been easily managed. Unfortunately, this was not the case due to continuation of international flights entering the Republic of Ireland and the freedom of movement under the Common Travel Area.

259. On 23 July 2020 the deputy First Minister advised that she and the First Minister had agreed to request an urgent dedicated British Irish Council meeting to resolve issues relating to the Common Travel Area [Exhibit RS/145 INQ000048482]. I was strongly in favour of the First and deputy First Minister's call for a British Irish Council approach in managing travel across the United Kingdom and the Republic of Ireland. Unfortunately, this was something that Her Majesty's Government did not progress and, like the deputy First Minister, I am unclear as to why [Exhibit RS/132 INQ000183409, paragraphs 20-22]. However, at that time there remained Brexit related tensions between the two Governments and with the Republic of Ireland following the European Union lead on international travel. I did continue to raise these challenges at 4 Nations International Travel meetings where I highlighted that there was a theoretical opportunity where an international traveller could arrive in the Republic of Ireland, travel through Northern Ireland and into Great Britain, especially if different countries were on either restricted list.

260. There was an ongoing issue between the Northern Ireland Executive and Republic of Ireland government in relation to sharing the data of international travellers who arrived in the Republic of Ireland. It took some time to progress the technical solution and the legal framework for the sharing of passenger details of those returning on international flights into the Republic of Ireland and then travelling on to Northern Ireland. This included, for example, the development of a Short Message Servicing (SMS) system by officials in Northern Ireland and the Republic of Ireland that notified those travelling

across the border of the requirement to complete both jurisdictions' passenger locator forms. However, the formal sharing of passenger data was not finalised until 15 October 2021, despite it being raised as a concern, by all sides and via all channels with the Republic of Ireland Government. This was the subject of a significant level of formal engagement. There was also an issue when the United Kingdom restricted movement from Denmark due to the discovery of Covid-19 in Mink in November 2020; this ban was not reciprocated in the Republic of Ireland, despite mink farming being practiced in the Republic of Ireland. I believe a meeting of the British Irish Council would have been useful in determining how a joint approach could have been established across our islands.

U. CARE HOMES

261. Early in the pandemic it was accepted that I gave regular updates as to the health response in certain areas and this included the care home and domiciliary care centre. The document [Exhibit RS/146 INQ000065725] that you refer to, dated 8 April 2020, early in the pandemic, demonstrates that Ministers were aware of testing in care homes and the need to prioritise it. Throughout the pandemic care homes and our response to them continued to be a central theme.

262. Collectively the Executive did not take any decisions on care homes at an operational level; this includes decisions on testing, the supply of Personal Protective Equipment, support from the health and social care sector to independent care home providers, staffing or financial supports. I believe that they viewed this as an operational matter that fell entirely within the remit of the Department of Health. Individual ministers did raise personal and constituency issues around specific care homes, or providers, which were then addressed by the Department of Health. In general, the focus of the Executive seemed to be on the overall general supply of Personal Protective Equipment rather than the specific supply to care homes.

263. In 2020-21 there were numerous financial exercises commissioned by the Department of Finance to assess the financial impact of Covid-19 and secure funding. These exercises did not necessarily align with monitoring rounds. The Department tended to do a lump sum bid (although we may have provided the Department of Finance with estimates of what we would spend it on it would not necessarily have been detailed). Various submissions were subsequently prepared for me on the basis of funding received from the Department of Finance which clearly detailed the funding required

to manage pressures in the care home and domiciliary care sector and how this funding would be allocated against various categories of cost.

V. INEQUALITIES

264. The Executive had to take into consideration, and find a balance between, health, societal and economic consequences when making decisions around the introduction of Non-Pharmaceutical Interventions and I believe discussions on these are evidenced through the notes that were taken during Executive meetings, albeit not in the formal minute issued. Initially I do not believe that there was an informed evidence-based assessment of either the societal or economic consequences of Non-Pharmaceutical Interventions as they had never been introduced before to such an extent. I do believe, however, that there was a wider understanding and these were reflected through the various support programs developed by the Departments of Communities, Finance, Economy, Education and Infrastructure, which were attempts to alleviate and compensate for those challenges. The Department for Communities, for example, 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 to put arrangements in place for priority access to online grocery shopping slots for those who were Clinically Extremely Vulnerable, in place from early May 2020 until shielding paused on 31 July 2020.

265. I have stated above that in some cases the usual equality impact assessments and section 75 were unable to be carried out due to the speed at which events were occurring. However, that is not to say that the Department and Executive ignored the impact on the vulnerable or those with protected characteristics. As I have highlighted earlier departments worked both individually and collectively to alleviate any potential detrimental impact of decisions relating to non-pharmaceutical interventions. I do not recall any particular features of Northern Irish society which made the identification of particular hardship within communities and its alleviation easier to achieve.

W. PUBLIC HEALTH COMMUNICATIONS, BEHAVIOURAL MANAGEMENT AND MAINTAINING PUBLIC CONFIDENCE

266. The Executive Information Service coordinated the Executive messaging, and the Executive received an update as to the feedback and engagement that certain

messages and medium had received on a number of occasions. The Department of Health's press office also kept a similar update in respect of how Department of Health specific messages of PR's were received and disseminated [Exhibit RS/147 INQ000400113, Exhibit RS/148 INQ000400113, Exhibit RS/149 INQ000400118].

1. Tackling Disinformation

267. There was a need to tackle disinformation and this was recognised early in the pandemic when the Chief Medical Officer said, and I paraphrase, that an additional challenge was that Covid-19 would be the first pandemic that we had to combat alongside social media. Throughout the pandemic Northern Ireland was not immune to the disinformation that was being circulated across the United Kingdom, the Republic of Ireland and further afield. To combat a number of these, the Department of Health's press office developed a number of specific 'myth busters' which sought to counter some of the narrative [Exhibit RS/142 INQ000259560].

268. An additional issue that we had to deal with in Northern Ireland related to misinformation was the fact that the people of Northern Ireland had access to media from both Great Britain and the Republic of Ireland. This meant that people could see restrictions being lifted at different rates, not only in the other devolved administrations, but, in some instances, in neighbouring counties. As the virus reached different stages at different times in all the different jurisdictions, a single message at specific times would not have been effective. However, there was a level of consistency in the high-level messages such as social distancing, coughs and transmission; the challenges arose when there were differentials in approach due to the stages of each wave in a specific area.

269. In Northern Ireland the Chief Medical Officer was able to work with his counterpart in the Republic of Ireland in response to a high level of infection in the border area of Donegal and Strabane and Derry City Council area, in effect taking a common epidemiological approach. At the request of both Chief Medical Officers, respective public health agencies worked with local councils, the business community and wider civic society to ensure coordinated action to reduce community transmission. This included joint public messaging on media outlets.

2. Children and Young People

270. On receipt of your Rule 9 I discovered that the Northern Ireland Commissioner for Children and Young People had written to the Education Minister and First and deputy

First Minister on four occasions with the request that they hold press conferences for young people but no such conferences were held. The Northern Ireland Commissioner for Children and Young People states that young people "were very critical about how they felt their voices were not heard during lockdown" [Exhibit RS/151 INQ000221928, paragraph 51]. Given it was among younger people that there was some resistance to, and non-compliance with, protective measures, on reflection, I do believe that other communication channels could have been used to disseminate advice and Covid-19 messaging specifically to younger people. However, as Minister of Health I had 4 meetings with the Northern Ireland Commissioner for Children and Young People in 2020 and 2021 and one of these included the Youth Panel Members on 1 December 2020, where they asked questions around mental health, school and youth club closures, Covid-19 restrictions and living with a hidden disability.

3. Media Briefings

271. I believe the regular media briefings by Ministers/Chief Medical Officer/Chief Scientific Adviser/Chief Constable/Department of Health officials worked well, and also allowed the media a live forum to raise questions. It is my opinion that these worked best and were strongest when they included First Minister/deputy First Minister/Health Minister, on a united platform, as everyone had someone to listen to and identify with. The biggest challenge to this format was after the Bobby Storey funeral, which was attended by the deputy First Minister, and the subsequent political fallout; there was a period where the First Minister and deputy First Minister did not do joint conferences, but to compensate for this, for a time they became solely Department of Health briefings. The public media briefings were supported by British and Irish Sign Language interpreters.

272. At the beginning there was an attempt to include every Minister in the press briefings, but I do not believe every Minister participated.

4. Threats and Abuse

273. During my time as Minister, and during the pandemic, I was in receipt of online threats and abuse, mostly from anonymous accounts; however, there were a few direct threats that did come from identifiable sources which due to their nature led to a range of penalties which included the issuing of a police caution, the use of a restraining order and a suspended prison sentence.

274. During a home visit from the local Police Service of Northern Ireland Crime Prevention officer they suggested due to the level of threats and harassment that I should seek to upgrade my personal security and they provided advice and equipment to myself and family. I was also advised to apply to and was accepted onto the Northern Ireland Office's Home Protection Scheme, on an exceptional basis by the Northern Ireland Office's Secretary of State

275. There was an incident at an event in the Europa Hotel in Belfast, and subsequent media reporting, which is now subject to civil proceedings in relation to which I cannot comment at the present time.

X. EXECUTIVE COMMITTEE DECISION-MAKING

1. Mandatory Coalition

276. The Northern Ireland Executive did face challenges because of the 5-party mandatory coalition where parties identify as Unionist/Nationalist/Other, right/left/centre of economic and social policy and pro or anti Brexit. A further challenge was that the government had only been formed in the weeks immediately preceding the pandemic taking hold, following a 3-year hiatus of there being no government. We were still learning how to work as a cohesive unit when we were faced with a global pandemic.

277. Irrespective of the challenges, Northern Ireland did have an Executive Government which represented nearly everyone during the pandemic. It benefitted Northern Ireland to have a functioning Executive at the outbreak of the pandemic, following the 3-year period of no executive, as I do not think that a direct rule response would have been in the best interests of Northern Ireland nor would it have been politically acceptable to many.

278. I believe the Executive Committee is the most effective structure for the Government of Northern Ireland, at any time, not just during a pandemic. As a devolutionist, I consider it brings, and delivers, local and accountable government.

279. I do not believe that the 5-party mandatory coalition did impede much decision-making in Northern Ireland other than on a small number of challenging decisions in November 2020, as described above; instead, it brought a diverse range of points of view and opinions.

280. From my own point of view, I believe I was able to act as a Minister for Health in Northern Ireland as I was unrestricted by Party Office. In addition, due to how my Pary, the Ulster Unionist Party, functions, I also had a high level of autonomy and independence from it when it came to how I discharged my responsibilities and duties. Politicians, by nature, align and take positions on issues that are informed by, or representative of, their political beliefs and I feel that was no different during the pandemic, but there were, on occasions, especially in the initial period of the pandemic, that it was obvious other Ministers set those aside, after having expressed their views in the Executive, and came to, and supported, the agreed position. The other Ministers would be best placed to comment on their own autonomy.

281. I cannot comment definitively on whether some Ministers came to Executive meetings having either agreed lines or positions with other ministers from their party; however, if they did so, and I would not be surprised if this was the case given how some Northern Ireland Parties operate, it was also obvious that there were occasions when there were tensions between Minister from the same Party.

2. Executive Support

281. In the early stage of the pandemic I do believe that decisions were made collectively and that collective responsibility was adopted, even though the perception prevailed that the pandemic and the associated response was a "health" issue. As time progressed, however, collective responsibility did weaken and, on a few occasions, Ministers did openly criticise and contradict decisions made collectively by the Executive, which did undermine the united approach that was often sought.

281. In [Exhibit RS/153 INQ000065748] the deputy First Minister is noted as saying, "DoH see the Exec as a thorn in the side." I never saw the Executive as an impediment nor was I aware of any ongoing tensions. I was also unaware the deputy First Minister had made this comment as I had not picked up on it at the meeting, nor was it recorded in the official minute, so I am unable to put it in context. This note seems to reflect a meeting at the beginning of the pandemic, where the Head of the Civil Service along with Richard Pengelly, the Permanent Secretary, are presenting how the response needed to be a joint one across all Departments.

282. In the early stages of the pandemic, I did feel that there was support from other Executive colleagues, especially from the First and deputy First Minister, despite the deputy First Minister's initial criticism. As the pandemic progressed, however, there

were other Ministers who publicly criticised the Executives response, by unfortunately using me and the Department of Health as the proxy for that criticism. During the early stages the Junior Ministers took the Covid Regulation debates through the Assembly, which both took time pressure off me but also, I believe, demonstrated that the regulations being brought forward were Executive regulations and not solely those of the Department of Health.

283. Due to the different stakeholders each Department had there were times when Departmental Ministers would have disagreed with each other. Minister Dodds, for example, during her tenure at the Department of the Economy, was a strong advocate for those stakeholders she represented at the Executive, so while both her and I made representations and presentation that could be at odds, especially around Non-Pharmaceutical Interventions, I would not refer to it as a consistent tension and not did it impact the Executive's ability to formulate a collective response.

3. Public Confidence

284. On the occasions where there were public differences between Ministers, I believe it caused a detrimental impact on the overall messaging. It was these differences that were often what the media reported rather than the decisions which had been taken, and the advice and guidance which was being given, based on an agreed collective Executive position. It is regrettable that these public disagreements did take place, but, unfortunately, the nature of a 5-party mandatory coalition with such a diverse make up, and the level of leaks, made it impossible to keep around the Executive table.

285. At one stage a comment was made that the rates of transmission were higher in nationalist area in comparison to unionist areas, allegedly by the Agriculture and Environmental Affairs Minister. This assertion was publicly dispelled by myself and the Chief Medical Officer and I believe it was political commentary and not anything based on health matters. I imagine that those in the nationalist community would have been upset at such an assertion by a minister and potentially viewed it as an opinion shared by all unionists, which it was not nor was it shared my me.

286. I believe the public's confidence in the Executive, and government in general, did diminish in the light of alleged breaches of rules by senior political figures and senior civil servants. In Northern Ireland, there was significant concern following the Bobby Storey funeral in June 2020, which the deputy First Minister attended, and it did have an effect on the relationship between the First Minister and deputy First Minister, and

across the wider political spectrum and society in general. It led to a period where the First Minister and deputy First Minister would not do joint press briefings. As I have stated above, I feel the press briefings were most effective when given by myself, the First Minister and deputy First Minister on the same platform. The incident also called into question the response of both the Police Service of Northern Ireland and Belfast City Council as to their enforcement and delivery of Covid-19 regulations.

287. There were also a number of other incidents both in Great Britain and the Republic of Ireland, which I believe undermined the public health messaging that continued to come from the Department of Health, for example:

- The reporting around a function associated with the Oireachtas Golf Society in Co. Galway, in August 2020, that led to the resignation of the Irish European Union Commissioner Phil Hogan.
- Dominic Cummings' decision to move his family out of London during Lockdown in April 2020.

4. Information Leaks

288. The leaking of documents was a continuing concern and difficulty for the Executive, but unfortunately around either the introduction of or easing of Non-Pharmaceutical Interventions it almost came to be expected. It did cause tension at times, especially when not just Executive papers were being leaked, but, on more than one occasion, it seemed that some in our media were being given a live update as to what was being discussed at Executive meetings. I feel that the leaking of papers prior to the Executive meetings was done in such a way as to try and exert public or stakeholder pressure on certain Ministers or Parties, prior to the meeting, to make certain decisions. As far as I am aware, there was no policy of proposed policies, or their amendments, being leaked in order to test public reaction.

289. The leaks did affect public confidence, as it allowed the Executive to appear divided sometimes even before the meeting had been held. They also created an air of mistrust and frustration among ministers as to where exactly the leak was. Following an unauthorised disclosure of information to BBC Radio Ulster's Nolan Show on the matter of Personal Protective Equipment and China Supply routes, there was an attempt to address these leaks, when the then Permanent Secretary at the Department of Finance held a leak inquiry [Exhibit RS/154 INQ000065486], but I do not recall it presenting any findings.

5. Cross-Community Votes

290. The cross-community vote is a mechanism established under the St. Andrews' Agreement and it was used on five occasions during the pandemic. Three of these took place on 6 April 2020, all related to abortion and a further two on 9 November. Each time it was the Democratic Unionist Party that requested it. Its use on these occasions was in keeping of the mechanisms that determine its use; however, personally I do not believe it should have been used on health-related matters during a pandemic.

291. By its nature, a cross-community vote in the Executive excludes the vote of those Ministers who do not designate as Unionist or Nationalist so its use causes differences to be expressed mostly along party and by political designation.

292. While I am of the opinion that the cross-community vote should not have been used in relation to a health matter during a pandemic, I still believe that it should be available for use by Ministers during a pandemic as it is a legal mechanism within the current structures of governance in Northern Ireland. However, an option that a future Executive could consider is whether to amend the cross-community vote in the same way that the "Petition of Concern" mechanism was amended so as to require more than one Party to deploy it.

6. Chief Medical Officer and Chief Scientific Adviser

293. I had no concerns in relation to the responsibilities held by either the Chief Medical Officer or the Chief Scientific Adviser, and I am thankful that I had them in their respective roles not just to advise me but also to advise and regularly attend and brief the entire Executive.

Y. COMMUNICATIONS WITH MINISTERS, ADVISERS, POLITICAL PARTY OFFICIALS AND CIVIL SERVANTS VIA ELECTRONIC DEVICE(S)

1. Devices issued the Northern Ireland Civil Service

294. I had a laptop and an i-phone issued by the Northern Ireland Civil Service. These were returned to my Private Secretary in the Department of Health on the 27 October 2022, my last day in office, at approximately 20.30. I did not delete anything from the devices prior to returning them. The laptop has not been wiped, cleansed or factory reset. I am uncertain as to whether the mobile phone was wiped or if steps were taken to preserve its content.

2. Personal Devices and Notebooks

295. As I was not supplied with a mobile phone from the Northern Ireland Civil Service initially at the start of my tenure, I had to continue to use the phone paid for by the Assembly as part of my expenses. I made the decision to continue using this after being supplied with an i-phone and informed the Department of Health of my intention to do so. I still have that device.

296. I communicated with the people listed below, in the relevant groupings, via WhatsApp:

Names of individuals	Name of Group	Purpose
Jeanne Freeman Matt Hancock Vaughan Gethin	Health 4 Nations	To provide updates to other Nation Health Ministers as to restrictions Northern Ireland were introducing, so they were not take unaware and to unsure vaccine delivery was consistent across all 4 nations. Not used for decisions
Arlene Foster Michelle O'Neill	Arlene & Michelle	To provide updates on number of Covid-19 cases/deaths/identification of new variants/changes RED/GREEN List countries. Single group used to ensure First and deputy First Minister received the same updates at the same time. Not used for decisions
Michael McBride	RS & CMO	General exchange & updates, not used for decisions.
Ian Young	Ian Young Robin Swann	General exchange & updates, not used for decisions.
Richard Pengelly Michael McBride Ian Young Mark Ovens		General exchange & updates, not used for decisions.
Ian Young	Ian Young	General exchange & updates, not used for decisions.

Richard Pengelly	Richard Pengelly	General exchange & updates, not used for decisions.
Brandon Lewis	Brandon Lewis	General exchange & updates, not used for decisions.
Michelle O'Neill Paul Givan	FMdfM	Single group used to ensure First and deputy First Minister received the same updates at the same time. Not used for decisions
Michelle O'Neill Paul Givan	FMdFM Health Update	Single group used to ensure First and deputy First Minister received the same updates at the same time. Not used for decisions
Simon Harris	Simon Harris	Information exchange with Republic of Ireland Health Minister.
Steven Donnelly	Steven Donnelly	Information exchange with Republic of Ireland Health Minister.

297. I am not aware of the use of WhatsApp or any other informal messaging platform being used as an alternative to formal or minuted meetings. Text-based communications or chat functions were rarely, if ever, used as part of video conferencing during Executive Committee meetings as conversation typically moved at a pace that the 'chat' function was unable to keep up.

298. I did not keep any electronic or paper personal diaries, notebooks, daybooks or planners during my time as Minister. With the exception of Executive meetings I would have been supported at meetings by Departmental officials and I would have expected them to keep a note of proceedings. At Executive meetings any notes I did make would have been on the hard copy of the papers which would have subsequently been shredded shortly after the meeting.

299. In your Rule 9 to me you have queried references to 'chat' in the handwritten notes of Executive Committee meetings (for example, [INQ000065769, page 20]) and asked to what I believe it refers: I believe it to refer to a suggested change to wording in the paper [Exhibit RS/155 INQ000207279] being discussed.

Z. LESSONS LEARNED

300. I consider that the Northern Ireland Executive responded well to the pandemic particularly given that we had only returned to government on 11 January 2020. Without doubt there are areas where we could improve should we ever be faced with a pandemic again and I hope the Inquiry's work will aid in identifying those along with the internal reviews that have taken place. Perhaps the biggest obstacle was the lack of an Executive in the three years preceding the pandemic which meant that Northern Ireland lacked political leadership at a time when Brexit was dominating thoughts and, in turn meant that all the Northern Ireland Executive departments were not fully prepared for a civil contingency [Exhibit RS/23 INQ000092712].

301. As detailed above, I, and the Executive as a whole, received a wide range of scientific, medical and modelling advice from a number of sources, including the Chief Medical Officer, the Chief Scientific Adviser, the Strategic Intelligence Group, the modelling group and the Scientific Advisory Group for Emergencies. This advice was always considered, discussed and used to inform mine and the Executive's decisions.

302. I held regular media briefings, alone, with the Chief Medical Officer and with other Minsters. These allowed open channels of communication with the media and, as I have explained, they worked best when they involved both the First and deputy First Minister. I realise now that different media channels could have been used to direct Covid-19 information and guidance to young people.

303. I have highlighted above some issues we experienced in the early stages of the pandemic with the United Kingdom when the government made 'England only' announcements on international travel and border controls, without any involvement of the devolved administrations. Equally with the Republic of Ireland travel restrictions also initially caused problems in terms of the sharing of data of travellers leaving the Republic and travelling into Northern Ireland. It is important to note, however, that issues were generally resolved through co-ordination with the relevant bodies and groups in the Republic of Ireland and across the United Kingdom.

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