**IN THE UK COVID-19 PUBLIC INQUIRY**

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**On behalf of NI Covid-19 Bereaved Families for Justice**

**MODULE 2C CLOSING SUBMISSIONS**

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**Introduction**

1. **T**hese written submissions do not repeat our oral submissions, nor can they reflect every point of concern to NICBFFJ. The evidence heard in M2C laid bare a system of Government that can and must do better on behalf of all residents of NI. The mistakes and missed opportunities were too plentiful to mention. The political dysfunction so flagrant that it needs no emphasis. We take it as read that the Inquiry will accept that the tradition of Departments working in silos can and should provide no cover for failings to implement a speedy and effective cross governmental response to a global health pandemic. We take it as read that the Inquiry will accept that the culture of leaking of sensitive political discussions must be rooted out with clear, public consequences for those who engage in whipping up division and controversy in that manner. We take it as read that the Inquiry will condemn public briefing against Executive decisions and gesture driven politics as immature and unprofessional. We take it as read that the Inquiry will strongly disapprove of actions by Ministers that undermine public trust in governance – be they in public or at Executive level meetings. We take it as read that the Inquiry will accept that government cuts and single year budgets left NI government departments, our health and social care system and the civil service weakened and operating with skeleton staff. Given the evidence the tribunal has heard during this Inquiry about uncertain process and inappropriate deletions of digital data, by individuals who should have known that their actions would necessarily deprive the Inquiry and the public of relevant evidence, we take it as read that the Inquiry will make criticisms where warranted and recommend clear policies for the retention of all governmental records and decision making, including digital data, including, of course, Whatsapps.

2. Any lack of focus on those issues in these submissions does not reflect a lack of importance; on the contrary, the evidence was so stark that, we hope, the Inquiry will need no persuasion. Instead, we address other aspects of the evidence below.

**The lost month of February**

3. Clear evidence was available from late January 2020 that immediate action was required to prepare for a forthcoming pandemic. The Inquiry is very familiar with this evidence.

4. The likelihood that a pandemic would hit these shores had been identified by Prof Sir Chris Whitty in correspondence to Downing Street on 28 Jan 2020 **[M2, 21/11/23, 135-136, 12-8]**, suggesting that the only realistic scenarios were that Covid was largely contained by China, or that it would sweep the world. Strikingly this advice coincided with a visit to NI of a busload of tourists from Wuhan, providing a vivid demonstration that, in our global world, containment was the least likely option. By 5 Feb 2020, the two scenarios identified by Sir Chris Whitty were well understood in NI and there was an acknowledged need for them to be integrated into NI planning (see e.g. **[07/05/24, 32-34, 23-4]**. By that stage the developments in the virus worldwide suggested that containment was no longer a realistic option. In short, the arrival of the pandemic should no longer have been anticipated as the reasonable worst case scenario. The logic of Prof Whitty's reasoning was that this was the only realistic scenario.

5. There was also sufficient evidence to model the likely consequences of the pandemic arriving without adequate preparations. The WHO's figures for the reproduction number (R0=2) and the case fatality rate (4%) demonstrated what this meant in practice, as identified by Prof Woolhouse in his email of 25th January, provided among others to the CMO.

6. There was sufficient evidence to act on the assumption that asymptomatic transmission was occurring. This was the advice from Prof Whitty in the UK CMO whatsapp group which included the NI CMO.

7. There was sufficient evidence to know that the most vulnerable to the virus would be those who were elderly or had pre-existing conditions. This was identified in Prof. Whitty's response to the Woolhouse email on 25 January 2020, it was accepted in evidence by the Minister for Health, and in any event was evident from the messages between Sir David Sterling and Mr Pengelly.

8. There was also sufficient information available to identify the most effective way to react by preparing for the virus at this stage. On 30 January 2020, the WHO COVID-19 IHR Emergency Committee stated its view that it was "*still possible to interrupt virus spread, provided that countries put in place strong measures to detect disease early, isolate and treat cases, trace contacts and promote social distancing commensurate with the risk. Most countries did not seem to get that message...*"[1]

9. It is impossible to conclude that this information was acted on in an appropriate and timely manner once the NI response is considered. Moreover, that there the failures in response continued up to mid-March 2020 is evident from:
   (i) The lack of staff for civil contingencies only begins to dawn on the Executive Office on or around 2 March **[14/05/24, 58, 1-11]**)
   (ii) Thereafter, there was a further delay until 16 March before Karen Pearson was tasked to head up civil contingencies **[14/05/24, 58, 11-19]**
   (iii) The decision that schools should stay open on 16 March, with advice two days later on 18 March that schools should close **[10/05/24, 147, 15-17]**,
   (iv) Test trace and isolate measures were stood down on 12 March, without the Executive being informed until 16 March, and without any substantive analysis underpinning the decision;
   (v) NICCMA being suddenly stood up without adequate preparation, despite this step being under consideration from 6 Feb;
   (vi) Press briefings by the dFM on 13th March opposing the policies agreed on by the Executive in 12th March.
   (vii) The introduction of a number of NPIs at the last minute, including work from home advice, and the 2-metre rule, on an unprepared public, conveying the appearance that political leaders had failed to prepare and were simply reacting in desperation.

10. NICBFFJ consider that the flaws in the NI response failed their relatives and the people of NI and that these failings should be identified. However a linked issue, and an imperative for those we represent, is to ensure that such failings do not reoccur. That requires a full examination of what went wrong, in order to ensure they are not repeated. Such an exercise must be assisted by informed reflection on the part of key decision-makers. There are therefore two significant concerns with aspects of the evidence before the inquiry:
   (i) The self-justifying approach of a number of witnesses who sought to avoid responsibility or blame.

[1] INQ000183545/28 §2

(ii) The lack of self-reflection on the part of those in key positions, who appear not to acknowledge or accept those errors which did occur.

**The lead department under the Civil Contingencies Protocol**

11. The 2016 Civil Contingencies Protocol established the concept of a lead government department. It states: "*The lead Government Department has a key role in NICCMA. It has expert knowledge of the cause of the emergency which it can apply to inform the response by formulating a prognosis, so allowing other emergency responders to understand the implications for their sectors and areas of responsibility. Under NICCMA it is possible that there may be multiple lead departments in a multi-faceted emergency.*" **[INQ000092739/15]**

12. The CMO did not appear to be in doubt that the DOH was the lead department for the response to the pandemic. On being asked this directly, his evidence was to the effect that there was no doubt, certainly in Jan, Feb and into March 2020 that that was the position. **[10/05/24, 84, 17-22]** Any other response would have been surprising. The CMO's correspondence to Ms Rooney in the TEO on 29th January 2020 specifically cited the DOH role as lead department to justify his clearing executive papers, an incident we will return to below **[10/05/24, 79, 17-20]**.

13. Despite this clear evidence, both Minister Swann, and Mr Pengelly refused to accept that they were anything but the "*lead department only insofar as this related to the health response to the pandemic.*" **[07/05/24, 40, 2-6]**; [**13/05/24, 39-43, 7-23]**

14. Mr Pengelly went so far as to argue that "*TEO were the lead for civil contingencies*" and so suggested activating NICCMA was the TEO's decision to make **[07/05/24, 45, 8-10]**. This was despite correspondence from the DOH in early February stating explicitly: "*I do not consider it necessary to activate NICCMA at this time, unless or until the infection appears in [Northern Ireland] and impacts are experienced here*" **[INQ000218470]**

15. The debate over whether the DOH was the lead department for the 2016 protocol (and was the only lead department) may be unedifying, however it is not unimportant. The 2016 Protocol concludes by emphasising that "*it is essential that the response to emergencies has an appropriate level of strategic direction and oversight. It is also essential that all the elements at NI and UK level are coordinated to ensure a seamless response*." **[INQ000092739/17]**

16. There does not appear to have been any doubt among any other witness that the DOH was the lead department for the purposes of the 2016 Protocol. No other department was suggested to have been in the lead. When the lead department is unaware of or otherwise not fulfilling their role, that undermines the necessary level of strategic direction and the prospects of coordination at an NI level let alone NI-UK level.

17. On one view this evidence on the part of the DOH suggests that they did not understand the role they were playing, in real time, under the civil contingencies protocol, and therefore did not discharge the functions of the lead department as stated in that protocol. This could only be considered detrimental to the pandemic response. Alternatively, and we suggest preferably, the evidence demonstrates that they did understand and indeed were possessive over their role as the lead department for pandemic response, but in the fullness of time, they now seek to share the blame for their own departmental failings. That reality is perhaps clearest in the debate over when NICCMA should have been activated.

**The activation of NICCMA**

18. One feature of the apparent failure to fully appreciate DOH role was the lead government department was the decision-making in relation to the activation of NICCMA. The plain language of the DOH's assessment on 5 February was that would not be necessary to activate NICCMA until Covid was detected in the jurisdiction.

19. Mr Pengelly's evidence in relation to this was that "*we in the Department of Health are not calling for the activation, the decision about whether or not to activate it is an issue for TEO. So I don't think I would interpret this as us saying "Don't activate NICCMA", as opposed to "We are not placing a request.*" **[07/05/24, 34-35, 20-1]**

20. That evidence contrasts with the evidence of the CMO, who did not disown the decision around 5 Feb not to activate NICCMA, but emphasised his view that it had been the right decision. **[10/05/24, 88, 6-22]** He observed "*don't forget, at this stage -- you know, the global pandemic wasn't declared by WHO until 11 March, so we're in, you know, very, very early weeks here*." **[10/05/24, 91, 12-15]**

21. It is also striking that although Covid was detected in the jurisdiction on 27 February there was no move by the DOH to recommend the activation of NICCMA for more than 2 weeks, until 16 March 2020 **[INQ000048447/2§7(i)]**. This delay was notwithstanding an indication from the MOH and CMO to Bernie Rooney following the COBR meeting on 4 March 2020 that they intended to request the 'ramping up of the NI Hub' to support the Executive

because, according to the CMO, things were escalating rapidly **[INQ000317435]**. Yet, according to Sir David Sterling, no request was made to activate NICCMA until around 14 or 15 March 2020 and, perhaps surprisingly, when that recommendation ultimately came, it was from the CMO **[01/05/24, 116-117, 18-2]**.

22. While the decision not to activate NICCMA on or around 5 Feb 2020 may have been justifiable given the need to prepare for such activation, the evidence suggests that no such preparation was undertaken either by the CCPB(NI) (see for e.g. **[INQ000205712]**, recommending a review leading to a report by July 2020) or by other government departments. Moreover, even on the DOH's own analysis, that initial decision not to activate NICCMA can no longer be justified by, *at the very latest,* 27 February 2020 when COVID was detected here. In his evidence Minister Swann accepted that one benefit of activating NICCMA earlier would have been that it would have raised alarm bells for other departments **[13/05/20, 119, 3-7]**. The corollary of that acceptance is firstly, that other Departments & TEO should have been forewarned by DOH as the lead department of the need for a truly cross governmental response long before NICCMA was activated, and secondly, that NICCMA should have been activated by, at the latest, the end of Feb 2020.

**Failure of the DOH to sound the alarm**

23. Given the acceptance that the activation of NICCMA would have sent a message to all Departments of the seriousness of the situation that was fast approaching, and therefore the need to undertake extensive preparations, including on cross-cutting issues, there is a stark absence of other effective efforts to sound an alarm that a pandemic was coming and an unprecedented cross government response would be required. There also does not appear to be an understanding, even at this stage, that this was something that should have occurred. By way of example, in response to the suggestion that there was an absence in late January of the sort of alarm that might be expected given that the second scenario identified by Chris Whitty was playing out, particularly when the Department had just dealt with a group of tourists from Wuhan, Mr Pengelly observed that "the travel bit is outside the devolved space." **[07/05/20, 29-31, 22-6 ]** That response misses the point. The Department was aware that it had no control over international travel. This should have caused an appreciation that the second scenario was inevitable. The difficulties this would have posed for preventing the virus arriving in the jurisdiction should have been self-evident. Ensuring the Executive as a whole was aware of this was an integral part of the role of the lead Department.

24. The CMO disputed that the alarm had not been sounded; his evidence was that he would be surprised if the risk was not understood **[10/05/24, 120, 1-14]**. Examples given by the CMO of raising the alarm and putting departments on alert included raising the threat level to "moderate" and writing to other Departments to say "*it would be helpful if you would consider convening a multi-agency meeting in order to ensure/inform an assessment of sectoral resilience, preparedness, capacity and capabilities across Northern Ireland departments*". **[10/05/24, 89, 11-15]** and **[10/05/24, 90, 12-24]**.

25. With respect, this was far from sufficient to identify the seriousness of the situation at that time, including: the likelihood that the pandemic would hit; the likely R number and doubling time; the likelihood of asymptomatic transmission; the risk to the elderly and vulnerable; and the likelihood of the need for an extensive programme of test, trace and isolation. The CMO's suggestion that, around 6 Feb, warnings given merely had to reflect the "potential" that a pandemic was on the way entirely fails to grapple with the reality that it was (or should have been) obvious that the pandemic would not be contained.

26. The CMO defended the lack of alarm in the language used in briefings for the Executive in mid-Feb by suggesting that they were already aware of the situation through earlier briefings **[10/05/24, 106, 14-18]**. However it is also clear that he himself had not updated the Executive, having not been invited to do so **[10/05/24, 121, 23-25]**. With respect, if the concern was that the Executive were insufficiently aware of the risk and scale of what was coming, it is not clear why they would unilaterally invite the CMO to address them.

27. It was also notable that the then dFM had asserted in her statement that the first substantial discussion of Covid by the Executive took place on 2 March. Although in her oral evidence she sought to row back from that and suggested that there had been substantive discussions in February, she accepted that the records of those meetings in fact supported the account provided in her statement **[14/05/24, 53, 1-19]**.

28. That suggests a collective failure, by those in the DOH for failing to sound the alarm, and those in the Executive Committee by failing to exercise adequate oversight despite the fact that the risks and the inevitable cross cutting response required must have been clear to all by that stage.

**Failure of the TEO to step up**

29. Notwithstanding these criticisms of the DOH, it cannot be said that the TEO were entirely unaware of the oncoming risk, or their ability to take proactive action rather than leave matters to the DOH.

30. When offered the opportunity to attend Exercise Nimbus the FM and dFM declined, leaving attendance to the MOH (see e.g. **[15/05/24, 134-136, 4-18]**). This was an express decision to leave the DOH in the lead, notwithstanding the terms of the invitation to NICCMA and notwithstanding that the FM/dFM well understood the risks of a silo approach by the DOH. The evidence strongly suggests that they were content to consider Covid a health issue until it was considerably too late.

31. It is also clear, from the terms of the 2016 Protocol, and from the witness evidence before the Inquiry (see e.g. **[15/05/24, 18, 1-25]**), that TEO had the power to activate NICCMA notwithstanding that the DOH was the lead Department. In these circumstances it is not a proper answer to simply respond, as the then dFM initially did in her oral evidence, that this was a matter simply delegated to the lead Department **[14/05/24, 25, 13-17]**.

32. It was tolerably clear by early February that there was no longer any prospect of containment in China, meaning that the pandemic would inevitably reach this jurisdiction, and would require a whole of government response. Should there have been any doubt about this, world events such as the lockdown imposed in Northern Italy made this very clear. Even if NICCMA was not stood up at that point, steps should have been taken by TEO to ensure a whole of government response, and to ensure all departments were ready in preparation for the point at which NICCMA was stood up. This did not happen.

33. What did happen was a single meeting of the Civil Contingencies group on 20 February, which considered matters at only a very high level. That was manifestly inadequate as a response. The TEO therefore bear their share of criticism for failing to act in the absence of action by the DOH.

**Limited Personnel**

34. The fact that there are limited personnel available in a small jurisdiction was repeatedly identified as a feature of the limits of the devolved pandemic response. Nothing appears to demonstrate this more than the roles of the Chief Science Adviser and the Chief Medical Officer during the pandemic.

**THE DOH CSA**

35. The CSA was on leave from 12 February until 23rd March 2020. There are two points to note in relation to this. Firstly he was not at all involved in the response to Covid prior to going on leave: his expertise was neither sought nor volunteered **[07/05/24, 125, 16-19]**. This raises significant questions as to the role of the CSA in the face of a health pandemic. It also reinforces the concern that Covid was not being treated with the seriousness it deserved by the second week of February within the DOH.

36. Secondly his role was a part-time one with no deputy **[07/05/24, 129, 8-10]**, that simply remained unfilled for the period of his absence. Indeed, no one appears to have noticed or raised concern about the absence of an NI CSA at any point during his absence.

37. It was only after his return that he initiated steps to implement modelling for the jurisdiction, **[07/05/24, 129-130, 21-4]**. The stark reality being that no one had attempted the type of basic modelling on behalf of NI that we know had carried for Scotland by Prof. Woolhouse at the end of January 2020. Even after his return, no one sought nor did he volunteer his advice on the impact of discharging hospital residents to care homes.

38. Perhaps more significantly for the pandemic response, in his absence there was no NI member on SAGE, and whilst observers from NI attended (including the CMO), there were real practical benefits of full membership including taking part in debates and putting forward an NI perspective in such debates. There was also no-one synthesising information coming from SAGE for devolved actors until the CSA began attendance at SAGE on his return **[07/05/24, 132, 3-16]**.

39. These examples serve to demonstrate the apparent limits of the available manpower even at that late stage of preparation/response to the initial wave, and the extent to which this may have hindered the devolved response.

**The DOH CMO**

40. The Inquiry may recall the criticism of the CMO, CSA and others on SAGE in Module 2 evidence, on the basis that, as government scientists, they could not properly be regarded as giving independent advice **[M2 16/10/23, 82-84, 23-16]**. The role of the CMO in NI ensured that this criticism is strengthened in this jurisdiction.

41. Rather than being an "independent adviser" the CMO is part of the management structure of the DOH in NI **[07/05/24, 23, 14-23**]. The CMO also held a policy remit **[07/05/24, 24, 5-7]**, and had input into policy areas that other colleagues were working on **[07/05/24, 24,**

**22-24]**, as well as oversight of the RQIA **[10/05/24, 8, 1-2]**. The extent of his role was apparent from his or evidence, in which identified he had: "*policy responsibility for all aspects of public health, so that would have included health protection, health improvement. I also had policy responsibility for quality and safety and policy, so as that pertained to, for instance, serious adverse incidences, investigation processes and policy, complaints policy. I also had policy responsibility for research within health and social care… I also had a number of other roles within that, including sponsorship responsibilities on behalf of the department which I exercised in relation to the Public Health Agency…*" **[10/05/24, 7-8, 19-11]**

42. The CMO's evidence was that he was not independent in terms of policy responsibility, but simultaneously he was akin to the UK CMO insofar as he provided independent advice as CMO to the Minister and Permanent Secretary **[10/05/24, 4-5, 22-10]**. He accepted he had no separate office and was not functionally independent of the Department, and was a member of the Senior Management team and member of the Departmental Board **[10/05/24, 5, 10-25]**. "*I'm conscious it almost seems like I'm trying to wear two hats, you know, both at the same time*". **[10/05/24, 6, 24-25]** The CMO was at pains to emphasise that he "*was very clear in his own mind*" of the difference in his policy responsibilities and his professional responsibilities as CMO **[10/05/24, 11, 15-18]** and believed that other Ministers also understood and respected his independence when giving advice **[10/05/24, 14, 5-7]**. Despite the CMO's confidence in his own ability to manage the inherent contradiction of a civil servant with policy responsibility for public health giving "independent scientific advice on public health, this all necessarily ensured that his advice was not in fact functionally independent.

43. The power of the CMO in this pandemic response however went beyond what was apparent from his job description. In January 2020 he contacted Ms Rooney of the TEO by phone, whose undisputed account, was that he requested amendments to be made and advised her that all such submissions to the FM/dFM should be cleared by him personally and that this should not happen again. The suggestion that his role extended to clearing TEO submissions, even where this is limited to technical advice, discloses a belief that the role of CMO had significant reach beyond any description on paper.

44. Indeed, such was his reach that it was apparent from the exchange between David Sterling and Chris Stewart on 7 March 2020, about whether to respond to requests for information from the Cabinet Office that, given a choice of whether to annoy the Cabinet Officer or the CMO, the HoCS considered it would preferable to upset the Cabinet Office

**[INQ000325137/9-10]**. This is an extraordinary exchange. The idea that the NI CMO could dictate the timing or terms of a NI cross-governmental response to Cabinet Office queries about pandemic preparedness speaks volumes about the power wielded by the CMO and should be of significant concern to this Inquiry. Moreover, it is notable from the text exchange between Chris Stewart and Bernie Rooney on 9 March 2020 that the efforts made not to annoy the CMO had not been successful **[INQ000325143/4]**.

45. It appears from the evidence that the CMO made the request to NICS to activate NICCMA on or about 15 March 2020, notwithstanding that the 2016 Protocol identifies a variety of individuals and entities who may activate NICCMA, none of which include the CMO **[INQ000065756]**, **[INQ000092739]**. It further appears from the evidence that the answer to the decision as to whether mass events should be permitted and if so, under what terms, would also lie with the CMO.

46. There are accordingly a number of concerns about the nature and extent of the position of the CMO in NI, none of which are intended to be personally critical of the efforts made by the CMO in response to the pandemic.

47. Firstly, it is essential that the CMO role should be properly independent. Whether or not the current CMO was able to maintain the independence of his advice (and it strongly appears that in a number of respects he was not), the absence of an effective safeguard to ensure that advice is demonstrably independent undermines the role in practice.

48. Secondly, as a purely practical matter, the role apparently involved too much work for one person. That is apparent from the fact that NI appears to have been unrepresented at SAGE meetings on a number of occasions due to the fact the CSA was on leave, but the CMO himself was too busy to attend. That is concerning, as the CMO made clear that NI was particularly reliant on SAGE: "*So as part of the UK we are critically dependent and plug into SAGE, its subgroups, including NERVTAG, for expert professional advice, and, as I say, we would not be able to replicate that in Northern Ireland*." **[10/05/24, 19, 20-23]**

49. Thirdly, this meant that, where the CMO may have erred in his approach, there was no real challenge to his assessments. This is a matter of concern, given some of his evidence:
    (i) His view that he apparently did not agree that the UK CMO's advice on asymptomatic transmission, that they should "now assume it may be happening" was properly interpreted as "we should be alert to the possibility", and await definitive evidence and advice from NERVTAG **[10/05/24, 64-65, 19-6]**;

(ii) He appeared to downplay the significance of cancelling mass events [10/05/24, 139, 8-15], which is inconsistent with Prof Hale's evidence in Module 2, which suggested that "*a single day of delaying a mass gathering ban… had an impact of perhaps a 7% increase in the cumulative death toll during that wave"* (M2: [**11/10/23, 80, 18-24]**).

(iii) He suggested in his oral evidence that it was not until mid-March that there was evidence that older people and those with pre-existing conditions should be prioritised as vulnerable **[10/05/24, 198-199, 9-1]**. However even before the COBR meeting of 5th February, the UK CMO's advice was that emerging evidence from international cases suggested the two most high risk groups appeared to be the elderly and those with pre-existing illnesses [**INQ000056215/5, §2]**.

50. As the CMO himself said in evidence: "*I think that in all small jurisdictions, one of the problems is you have too many single critical points of failure potentially … that is something that needs to be considered in terms of learning for the future*." **[10/05/24, 30, 15-19]**

**Failings in Test Trace and Isolation**

51. By 30 Jan WHO advised that it was: *"still possible to interrupt virus spread, provided that countries put in place strong measures to detect disease early, isolate and treat cases, trace contacts and promote social distancing commensurate with the risk."*

52. NI, together with the UK, was in a privileged position to follow such advice. The CMO in his evidence identified that the genetic makeup of the virus was known by 10th January: "*on 10 January, we had -- at that stage knew what the genetic make-up of the virus was, and on 10 February, we were one of 12 centres across the UK who began testing for Covid-19, although we only had 40 tests a day capacity*." **[10/05/24, 73, 5-9]** despite this there was inadequate focus on ramping up TTI capacity. By 19 March (at which point TTI had been suspended) testing capacity was only 200 tests per day **[10/05/24, 190, 18-20]**.

53. Evidence of this comes from the lack of focus on testing in the materials before the Inquiry from this period. Whilst we made the point in M2 that SAGE minutes themselves failed to focus sufficiently on TTI, they did in fact consider in mid-Feb what testing capacity was and how soon it would be reached. SAGE 8 (18 Feb 2020) **[INQ000106114]** had identified PHE test and trace capacity, which could have allowed the reader to understand that capacity would be reached within 2-4 weeks. That statement of capacity was apparently based on a 12 Feb PHE document entitled "*Recommendations on the continuing use of*

*case-identification/contact-tracing/case and contact isolation (CCI) management to mitigate the impact of imported cases of Covid-19."***[(INQ000119729]**. This was an issue that reinforced the anglo-centric approach of SAGE, as the equivalent capacity for NI was not considered at all. However this information was also not sought or provided to the NI Executive, including the FM/dFM, at any stage in Feb, or even at any point before TTI was suspended on 12 March.

54. The evidence now confirms that, unlike England and Wales, NI still had excess capacity for testing on 12 March. It was also suggested that the decision to suspend test and trace was not a decision taken by any NI actor with the power to make that decision, rather it was said to have been "*an issue that flowed from the COBR decision to move nationally from the contain to the delay phase.*" [**07/05/24, 89-90, 19-5]**

55. When pushed on this Mr Pengelly's evidence was that it had been "explained" to him that *"there was an understanding at the COBR discussion, at which both central government and the devolved administrations were present, that this was a UK-wide decision that was being taken, and all the devolved administrations were part of that decision."* **[07/05/24, 90, 10-15]** It is not clear what justification there was in practice for this decision, however Mr Pengelly's evidence was also clear that there was consequently no substantive or qualitive analysis of this decision in NI as to whether there was any merit in continuing to test and trace, as this was simply "swept up" in the broader COBR decision. **[07/05/24, 91, 2-11]**

56. This evidence is relatively consistent with the CMO's written evidence, which suggested that the DOH Wave 1 Corporate statement **[INQ000411550§195]** set out the rationale for the decision to stop contact tracing on 12 March. That DOH statement also provides no justification for the decision, suggesting the: "*decision was underpinned by the UK-wide agreed Protocol for Moving from Contain to Delay... This was followed shortly afterwards on 23 March by the introduction of the first UK-wide lockdown. The decision to pause contact tracing was integrally linked to the decisions to move the delay phase and to introduce population wide lockdown measures*."

57. It is not clear why the move from contain to delay meant contact tracing was suspended, particularly when NI had not yet reached capacity for test and trace, and had by that stage dealt with only 13 positive tests. The question is also not answered by the UK-wide agreed Protocol for Moving from Contain to Delay **[INQ000346695**]. It does not contain any requirement, or even a suggestion, that the result of moving from Contain to Delay will be

that testing and contact tracing are stopped. Nor does it suggest that the move to delay will necessarily coincide with behavioural interventions. In fact it explicitly makes clear these may not be simultaneous (Heading 4 "Interaction with Behavioural and social Interventions"). The move from contain to delay cannot properly explain this decision.

58. It seems however, from Mr Pengelly's evidence, that there is no substantive answer to why test and trace was stopped, precisely because there was no analysis of the decision in this jurisdiction. That reinforces the conclusion that there was a complete failure to appreciate the importance of test and trace as part of the devolved pandemic response.

59. This conclusion is reinforced by the comment of Minister Swann, who when challenged about the decision. The Minister apparently gave a different explanation for suspension when the executive eventually was informed, on 16th March, with handwritten notes recording him as saying he would prefer to "*focus resources on combatting Covid 19 rather than counting*" [**INQ000226010/2]**.

60. This all appears to show a misunderstanding of the importance of TTI both for combating the virus and for avoiding the need for prolonged lockdown measures. The PHE paper (§53 above) considered contact tracing and isolation was "probably preventing at least 30% of potential transmission from these cases..." **[M2, INQ000119729]**. It is concerning that this misunderstanding appears to have been held on the part of the Minister for Health in late March, particularly as the WHO had repeatedly identified the importance of test trace and isolation from an early stage.

61. The failure to appreciate the importance of test and trace at the outset of the pandemic was a significant error. Its potential for managing the virus was emphasised by the UK CSA in his Module 2 statement: *"Ideally the virus would have been contained through a combination of extensive testing, contact tracing and isolation of infected persons. However in February and March 2020 the UK was unable to scale up testing and contact tracing to deal with a virus that had already become widely seeded. ...*" **[INQ000238828/76§240]**

62. In his evidence, the CMO also recognised the importance of having the ability to test: "*…if there's anything that needs to come out of the Inquiry, it's the importance of actually having diagnostic capacity and the ability to ramp that up very quickly once you've identified what the next novel virus is and how we're going to test for that*" **[10/05/24, 191, 2-6]**

63. It therefore appears that this error has been acknowledged by those who were in positions of authority during the pandemic. That reinforces the conclusion that it is both important to formally identify that there was a failure to adequately focus of ramping up TTI capacity from late January which was an error, and that recommendations are made to prevent similar errors from occurring in any future pandemic.

**Hospital Discharge to Care Homes**

64. The series of factors identified at the outset demonstrate that from an early stage, there was sufficient information to identify that the elderly and those with pre-existing conditions were particularly vulnerable to the virus. Evidence of this was identified at COBR on 5th February. Mr Pengelly appeared to agree that by 6th February the Department "*recognised at that point in time that the problem would be when it hit care homes and hospitals*" noting: "*Certainly in terms of our planning work and surge work, we were commissioning work from colleagues across the sector in terms of surge plans for both hospitals and care homes*." **[07/05/24, 31, 15-22]** There was also sufficient evidence of asymptomatic transmission to lead the UK CMO to write in the UK CMO whatsapp group that they should now assume that asymptomatic transmission was happening.

65. Despite this, and despite the move from contain to delay signifying the extent to which the virus was in the community, throughout March 2020, the DOH and Mr Pengelly in particular wrote to those with management of care homes and repeated the point that "*Trusts should …work to maximise and utilise all spare capacity in residential, nursing and domiciliary care*", and that Trusts were to work to fill up vacant spaces in the care sector as quickly as possible. **[07/05/24, 104, 3-23]** This step was taken despite the inherent risks of this policy, given what was known about the virus, the risks to the elderly and those with pre-existing illnesses. It was not until 19th April that individuals being discharged from hospitals into care homes were to be tested for Covid **[07/05/24, 106-107, 19-17]** and even then there was no need to await a result. An individual could also move to a care home where they tested positive, if there were arrangements for isolation. Indeed, on 25th April, Mr Pengelly authored correspondence along similar lines, which ended by saying "*this testing requirement must not hold up a timely discharge*."

66. Mr Pengelly suggested that discharge in the absence of testing was potentially dangerous "*if unmitigated*" but sought to defend this correspondence by the possibility that "*other mitigating measures may be in place*." **[07/05/24, 117, 7-12]** That falls significantly short of a direction not to discharge unless those mitigating measures were followed; a possibility that there may be mitigating measures is insufficient to assuage concerns.

67. It is accepted that there were significant pressures on health and social care in this time period, and hospitals in particular. That does not excuse exposing some of the most vulnerable in society to an unnecessary risk to their health and life. A significant number of those we represent have expressed concerns that they feel their relatives were given up on, or effectively abandoned at the expense of saving others. Many others report a belief that their relatives were effectively given Covid in hospitals or care homes, institutions to which they had entrusted their relative's health and life. Reckless policies such as these reinforce those concerns. It is plain that insufficient consideration was given and insufficient care was taken to protect older people and those who were medically vulnerable. The inevitable consequence must have been at the cost of peoples' lives.

68. Mr Pengelly cited a single and limited study to support the conclusion that, among a limited set over a sample 2 weeks, only 1.1% of those discharged tested positive within 2 weeks. This was cited as though to demonstrate the policy had not caused a significant number of outbreaks. Given the limits of that study we do not propose to engage in a detailed analysis of it or discussion of its conclusions. We would say that the concern with this policy is that, rather than acting in the information available to protect those most vulnerable to the virus, this policy positively (and recklessly) risked the health and lives of the most vulnerable. That remains the case whether or not other factors ultimately caused a greater number of outbreaks in care homes. That said, even the limited study cited does suggest it resulted in a statistically significant level of infection, which in environments such as care homes may have resulted in more significant outbreaks. The study's finding should not have allayed concerns at the approach, as opposed to demonstrating the inherent risk to health and life of an unknown number of vulnerable individuals in care homes.

**The Bobby Storey Funeral**

69. Mr Storey's funeral took place on the 30 June 2020. The dFM, and other senior members of Sinn Fein, were part of an apparently 30 strong funeral cortege. Large numbers of people, in their thousands, lined the route. It is abundantly clear (and now appears to be accepted) that the dFM's actions undermined the restrictions then in place, by giving the impression that there was one rule for political leaders and one for everyone else. Whether or not it was a crime, it was clearly a grave and damaging mistake. It was cruel and wrong and has caused significant hurt to those we represent – a reality that should have been apparent at the time.

70. This incident also led to a halt to joint press conferences with the FM and dFM, and an apparent deterioration in the relationships between the parties. This outcome in practice hindered the pandemic response in practice and plainly continued to impact on political tensions which would arise for the second wave.

**The Second Wave**

71. The second wave of the pandemic was greater in size than the first. This is particularly tragic as this wave overlapped with the initial roll-out of the vaccines which many believe lead to the end of the pandemic. There are a number of aspects of the response to this wave which cause concern.

**Delayed reaction**

72. On 21 Sept 2020 SAGE recommended consideration of a package of measures in response to a surge in the pandemic. In NI the R rate had been consistently above 1. On 24 Sept SAGE's advice was conveyed to the Executive, but without any recommendation to implement significant restrictions. Whilst some limited measures were imposed, it was not until 8 Oct that the CMO / CSA advised the Executive that significant measures should be adopted in response. The meeting notes show the CMO had bever been so concerned as he was at that point **[INQ000421704/195§420]**. Despite this, it was not until 16 Oct that the Executive agreed to implement a circuit breaker - almost four weeks from the initial SAGE warnings and advice.

73. As the CSA summarised in his oral evidence: *"the general concept that the earlier the intervention, the more stringent the intervention and the longer it lasts is better in terms of the short to medium-term impacts of virus transmission. That's absolutely true, and it was true then, as it was true at other parts of the epidemic."* **[07/05/24, 208, 11-16]**

74. Whilst there are other concerns with the second wave, one concern here is that the delay from the SAGE meeting of 21st September until the advice to impose significant restrictions on 8th October, and the restrictions taking effect on 16th October, failed to respect this concept. This delay may have led to a larger wave than would have been seen if earlier measures had been taken. Moreover, if such measures had been imposed sooner the CMO and CSA may not have felt the need to recommend that they should be renewed for a further two weeks. The fact that renewal was recommended resulted in the difficult meeting in mid-November.

**The Meeting on 9, 10, 11, 12 November**

75. The meeting of the 9, 10, 11 and 12 Nov marks a low point of the devolved response. The meeting on 9 Nov was convened to consider whether to extend restrictions which were due to expire on the 12 Nov. The advice from the CMO and CSA was clear: an extension was needed as health services in NI were already under very considerable pressure. **[15/05/24, 121, 3-7]** Despite this, DUP Ministers opposed the extension of restrictions, and so agreement was not reached on 9 Nov. The former FM's evidence was that, on 10 Nov, as the dFM as the Chair could call for a vote "*as opposed to trying to find consensus*." In response, the DUP Ministers insisted on a cross-community vote on the issue, effectively operating a veto over the proposal agreed by all other parties to the Executive.

76. The use of such a mechanism, in order to depart from the advice of the CMO, was in stark contrast to the approach taken by the former FM in correspondence to the HoCS on 29 March, where she had stated: "*we must follow medical and scientific advice at all times, and that politics should play no part in the decisions made*." **[INQ000317455/1]**

77. Naomi Long's evidence about the use of this mechanism identifies succinctly what is particularly objectionable about this decision: "*I felt it was an egregious abuse of a process that was there in order -- conceived in order to protect minorities around issues of particular sensitivity in Northern Ireland. So, for example, constitutional issues, issues to do with language and culture, and issues to do with the Good Friday Agreement itself. Instead, it was being deployed, first of all, on an issue that had no differential bearing on either community, so anyone in society could get Covid and be affected by Covid. It did not recognise people's constitutional aspirations. And therefore the cross-community, if you like, demand seemed to be irrelevant in that context. … The other issue, if I may, which I think is important to say in this, that this was not about a protection of a minority. The DUP were the largest party on the Executive. They were also deploying it against a minister who was of the same designation, so also a Unionist, which to me shows starkly how egregious that breach of and abuse of the mechanism was."* **[09/05/24, 5-6, 16-3]; [09/05/20, 7, 1-7]**

78. In summary, absent some narrow circumstances (which were plainly not present in Nov 2020), the use of the cross-community voting mechanism is an undemocratic and unjustified mechanism to veto a public health response. Its use in this context was abusive. That it was particularly unjustifiable is clear in light of the number of lives lost in the second wave and given how close the rollout of the vaccines were at that stage.

**NPIs and Failure to Protect the most Vulnerable**

79. Another significant feature of concern for those we represent is the extent to which, by the second wave, there were still inadequate measures to mitigate the consequences of NPIs for the elderly and vulnerable. This issue has been eloquently identified in the evidence of Ms Reynolds for NICBFFJ **[30/04/24, 138-154, 19-12]**, who described in clear terms the death of her aunt. Her case served to demonstrate the issues including the failure to implement effective safeguards to protect the most vulnerable from circumstances of isolation, and the failure to ensure that care homes (and others) implemented care partner guidance in practice. These twin failings appeared to operate with particularly tragic consequences for Ms Reynolds, as when she was finally able to visit her aunt, she described believing she was close to death.

80. A recurring feature of such criticisms relates to the failure to ensure that Care Partner Guidance was implemented properly, including that relevant individuals were made aware of how it operated. Ms Reynolds ultimately discovered this guidance and was able to gain entry to her aunt's home. The evidence of Minister Swann was that the introduction of Care Partners was "*a frustration for me in regards to the delivery.*" This was because it was "*not as uniform as we wanted it to be*" and there were also challenges from providers who were being "*precautious in the delivery … in regards to how it could be utilised.*" **[13/05/20, 187, 17-23]** He emphasised that he had put additional monies towards the scheme, but also accepted that "*whatever was done wasn't enough*".

81. The Minister asserted that steps have been taken since leaving office, however it is not clear how effective those are in practice. It is respectfully suggested that the Inquiry should identify that the failure to effectively roll-out Care Partner Guidance, and to ensure that care homes were following and implementing such guidance, was a flaw in the devolved pandemic response.

**Recommendations**

82. Given the significance of the recommendations which will be made by the Inquiry, it is important to note two proposed recommendations in particular which were made by the NI CMO in the course of his evidence and which we strongly endorse.

83. Firstly he re-emphasised that point that in any future such scenario, "*what we need is a two-island, five-nation approach*," explaining: "*…I think for the future You know, this sense that somehow or other that a border between Northern Ireland and the Republic of Ireland insulates approaches to how you respond to a pandemic is not based on any*

*epidemiological basis." [10/05/24, 180, 12-17] Trying to control the pandemic in the UK, in Northern Ireland or in the Republic of Ireland, does not work; you know, it has to be a global response. And it needs to be, certainly within our gift, in my view, co-ordinated across the Common Travel Area*. [10/05/24, 181, 14-18]

84. Such coordination appears likely to be ineffective if it commences only once the next pandemic reaches these shores. That suggests that steps must now be taken, and maintained, to ensure those on all these islands are prepared for that future threat.

85. Secondly, despite of, or perhaps because of, the failure of the response in respect of test trace and isolate, the CMO saw fit to emphasise the importance of testing: "*I think if there's anything that needs to come out of the Inquiry, it's the importance of actually having diagnostic capacity and the ability to ramp that up very quickly once you've identified what the next novel virus is and how we're going to test for that*" [10/05/24, 191, 2-6].

**Conclusion**[2]

86. The Inquiry has now heard evidence of the response at the UK and devolved level. It is clear that there were flaws in the response of both, however one feature that is striking (and which makes the task of the Inquiry more difficult) is that the responses were flawed for different reasons. As Tolstoy wrote, "*Happy families are all alike; every unhappy family is unhappy in its own way.*" That resonates when considering some of the uniquely dysfunctional features of the NI response. Many of these flaws can be resolved by practical measures, and we have annexed a set of recommendations which we hope may assist the Inquiry in identifying solutions to ensure such errors never again recur.

87. There are also some flaws which affected both central government and devolved responses. This is unsurprising given the reliance NI placed on UK entities such as SAGE and COBR for the direction of the response in the early stages. At times this resulted in inexplicable and unjustifiable decision-making in the devolved context, most notably the suspension of test and trace in NI, despite NI testing not having reached capacity, at the same time as this was suspended in GB, where it had. The most obvious criticism is that both were too slow to act on the knowledge and warning available, and to the extent that they acted they did so in an incorrect and ineffective way. Again we urge the inquiry to make meaningful recommendations to ensure such mistakes are never repeated.

[2] See further suggested recommendations on the part of NICBFFJ which are provided as an annex to these submissions.

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**6 June 2024**