MODULE 2C QUESTIONNAIRE TO INDEPENDENT SAGE MEMBERS

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1.	**Please provide some information as to:** **a. Your professional background and expertise; and** **b. A brief explanation as to:** **i. Any roles which you held during the pandemic;** **ii. How you came to be part of Independent SAGE; and** **iii. What your involvement with Independent SAGE entailed.**
	Response: a. I am a public health physician and also trained in general medical practice. I have held consultant and director posts in public health within the health service in Northern Ireland and England, and the Department of Health in England, since 1989. During this career, I have been involved in contingency planning for health emergencies and responding to multiple serious incidents and episodes with public health consequences. I am the author of many scientific papers and policy documents, and I've been involved in or conducted, reviews of serious failures within health services. I am a visiting professor in public health at the University of Bristol, researching health and the built environment. b. Sir David King invited me to become a member of Independent SAGE at its inception. In the context of the questions posed, it should also be noted that I was also an active member of the Irish Scientific Advisory Group on Covid (ISAG), which operated on an All-Ireland basis. c. I participated in all the activities associated with Independent SAGE, including its regular weekly planning meetings and public briefings, preparing briefing documents and statements, speaking to other audiences at public meetings, and responding to media requests for interviews and written commentaries.
2.	**The Independent SAGE Report of 12 May 2020 ("Recommendations for government based on an open and transparent examination of the scientific evidence") ("the May 2020 Report") states at page 21:** ***"One of the main criticisms of the response by the UK government so far has been the highly centralised approach that it has taken, in some cases excluding the governments of the devolved administrations from key decisions. The elected administrations in Scotland, Wales and Northern Ireland have the powers to determine their own policies in many aspects of the response to the coronavirus pandemic. While the general position has been to adhere to the decisions made in Whitehall, each administration has the opportunity to determine the distinctive measures needed to safeguard the well-being of the population for which it is***

	responsible. The pattern of infection with the virus appears to vary markedly across the UK and the devolved administrations should take the opportunity, where possible, to engage fully in the introduction of our strongly recommended approach of case finding, testing, tracing, and isolation. This should be a cornerstone of their approach. Northern Ireland is a particular case, having a land border with the Republic of Ireland. We urge the Northern Ireland Assembly Executive to seek to harmonise their policies with those of the Republic of Ireland in keeping with the commendable Memorandum of Understanding that has been agreed between the two jurisdictions in relation to the coronavirus crisis." **Did you have a personal view as to the importance of the devolved administrations developing their own responses to the pandemic?**
	Response: The very reason that health responsibilities are devolved within the UK is to enable the administrations to respond differently to the challenges and opportunities that present themselves to improve the health of their populations. Mobilising popular support for public health measures is always more likely to succeed if those making the decisions and delivering the messages have strong local support and connection. There has been a progressive weakening of the public health system in England and Northern Ireland over the last 15 years. The same degree of deterioration has not taken place in Wales and Scotland. At the beginning of the pandemic, the state of the public health systems in the four parts of the UK varied considerably, being more robust in Wales and Scotland than in England and weakest in Northern Ireland. Northern Ireland was alone in Britain and Ireland in not having locally based Directors of Public Health. A substantial strength in Wales was having a relatively strong public health system and a public health trained and qualified Chief Medical Officer (CMO). The appointment of clinical specialists rather than public health specialists to the CMO posts has only happened recently in the long history of CMO posts in the UK[1]. The ability of different parts of the UK to mount an effective public health response varied substantially, and so did the incidence of COVID-19 at various points in the pandemic. Scotland, Wales and Northern Ireland populations would have been better served by taking approaches that differed from those adopted in Whitehall. Ref:1. Chief medical officers: the need for public health at the heart of government BMJ 2013; 346 doi: https://doi.org/10.1136/bmj.f688
3.	**Why did the authors of the May 2020 Report attach such significance (in particular) to each nation pursuing its own strategy as regards test, trace and isolate? Did you regard that as being of particular importance to Northern Ireland?**
	Response:

	SAGE initially supported an approach of Find, Test, Trace, and Isolate. SAGE rapidly added 'Support' as we recognised the importance of supporting those being asked to isolate. In my view, this is the fundamental and longstanding approach to controlling the spread of infectious diseases. It should also operate alongside the application of quarantine to avoid further importation of infection. As noted in a previous answer, the ability to mount an effective response was greater where the public health systems were more robust. In the early days of the pandemic, the incidence of new cases was not evenly spread within the UK, and opportunities existed to impede the spread that needed to be taken. This was particularly so in Northern Ireland. The highly organised and well-resourced public health approach in the Republic of Ireland contrasted with the abandonment of testing and control in the community on 13th March in Northern Ireland at Whitehall's behest. This was a clear example of a policy that was accepted and applied across the UK without question.
4.	**Did you have a personal view as to the importance of Northern Ireland seeking to harmonise its approach with that of the Republic of Ireland?**
	Response: Geography and population movement are all-important in the control of infectious disease outbreaks. The border in Ireland is the only land border that the UK has. It has some unique characteristics that make it unusual. It is very long and convoluted, with a total length of 310 miles, compared with the English-Scottish border, which is 96 miles. The artificiality of the border is reflected in the enormous amount of daily cross-border movement that takes place along nearly all its length. For example, children from a family may go to different schools on different sides of the border, and their parents may travel to places of work on different sides. For the public to be told that they must stay at home and self-isolate if they have 'shortness of breath or breathing difficulties' symptom in the Republic of Ireland, but this is not included in the shorter list of symptoms requiring action in Northern Ireland, is, in my view, unacceptably confusing for those living in border counties. Similarly, the period for which self-isolation was required after developing symptoms of Covid-19 was 14 days in the Republic of Ireland and seven days in Northern Ireland. Such different approaches reflect the clear lack of 'harmonisation' and were confusing and potentially dangerous.
5.	**Reference has also been made in commentary to the North-South cooperation on agriculture as effectively enabling the island of Ireland to be treated in policy and operational terms as a single epidemiological unit for the purposes of animal health and welfare (in support of an argument that Northern Ireland and the Republic of Ireland ought to have been regarded as a single epidemiological unit for the purposes of Covid - 19). Can you explain whether you considered that the animal health model was an appropriate or sound comparator in this context? It would be helpful if you could explain any reasons for your views.**

	Response: The island of Ireland requires a joint approach to human health in the same way it requires one on animal health. This is particularly true in terms of infectious disease and foodborne disease. This has been recognised in animal health with the agreement in March 2010 of an All-Island Animal Health and Welfare Strategy. The strategy states: *'The island of Ireland presents a distinct epidemiological entity and it is therefore critical that policies continue to be integrated where possible and complementary in nature.'* A key element of disease control, whether in animals or humans, is the importance of having high-quality and comparable surveillance data available in a timely fashion. This has been achieved on an all-island basis for animal health. The 2021 All-island Animal Disease Surveillance Report was the 11th such report prepared in an official inter-governmental collaboration between the Agri-Food and Bioscience Institute (AFBI), Northern Ireland, and Animal Health Ireland (AHI). There is no comparable agreement or compatibility on human health issues. Clear examples of the gap in cooperation in the field of human health arose during the COVID-19 pandemic, from problems in sharing data on international arrivals, to the inability to agree on a common COVID-19 telephone app. Fundamental issues such as death registration were highlighted, with deaths having by law to be registered within five days in Northern Ireland. In contrast, the period is three months in the Republic of Ireland. There is no comparable all-island collaboration on human health surveillance. There is no annual human all-Ireland infectious disease report, and similar gaps exist for non-communicable diseases with, for example, separate cancer registration systems.
6.	**Did you consider that there was a proper or reasonable basis to compare Northern Ireland with other island nations (such as New Zealand) in relation to the pandemic? Can you explain, in epidemiological terms, what advantages Northern Ireland might have had by reason of its geography or physical location (or whether there is an "island advantage" in a pandemic)?**
	Response: Islands have an obvious advantage in limiting the spread of infectious diseases. The centuries-old quarantine approach can be highly effective in reducing the spread of dangerous infectious diseases. The fact that population movement largely now occurs by air and is already subject to a wide range of controls, including existing international infectious disease regulations, is a significant assistance. The appropriate response on the island of Ireland should have been to maximise the 'island advantage' by harmonising and integrating North-South approaches. The opposite happened. Differential approaches to isolation periods and monitoring isolation meant that travelling via Ireland (either Belfast or Dublin, depending on

	which jurisdiction had the slackest controls) became a means of avoiding restrictions. The experience of islands such as Taiwan and Japan, or virtual islands such as Singapore and South Korea, illustrates how modern, populous, and well-connected countries reduced the death toll and the economic consequences of COVID-19. Similarly, Australia and New Zealand came through the pandemic with a much better record than the UK or Ireland. It must be noted that in understanding population dynamics in countries such as Australia, it is essential to consider population concentration rather than nationwide population density.
7.	**If you were in favour of, or advocated for, an approach based upon harmonisation:** **a. Can you explain what you considered might be achieved by it (from an epidemiological perspective)?** **b. What did you envisage might be harmonised?** **c. What benefits (again from an epidemiological perspective) did you consider might accrue from having a commonality of approach (rather than duality of approach)?**
	Response: Had harmonisation as a public health policy been enacted in advance of the COVID-19 pandemic, I would have expected to have had in place effective monitoring and reporting systems that would have found a sound basis for the provision of accurate, timely and meaningful data throughout the pandemic. Harmonisation of public health approaches North and South would have meant that local Directors of Public Health were in place across the whole island with responsibility for leading pandemic response at the local and community level. In contrast, Northern Ireland found itself as the only part of Britain and Ireland that did not have local Directors of Public Health. If COVID-19 had been harmonised, I would have expected, amongst other things, a common approach to Find, Test, Trace, Isolate and Support, a common app, a single agreed list of the key symptoms of COVID-19, a common approach to isolation of incoming travellers, a sharing of vaccine supplies to help protect the most vulnerable across the whole island, and early moves to require the wearing of effective facemasks and the improvement of ventilation and air filtration in public spaces and workplaces. In my view, a harmonised approach in advance would have laid the basis for the reduction of the death toll by anything from 20 to 40%. This, however, would also have depended on politicians' willingness to make decisions that would have been unpopular in the short term.
8.	**The May 2020 Report referred to the Memorandum of Understanding. It recites as part of its preamble:**

	"Everything possible will be done in coordination and cooperation between the Irish government and the Northern Ireland Executive and with the active involvement of the health administrations in both jurisdictions to tackle the outbreak. Protection of the lives and welfare of everyone on the island is paramount, and no effort will be spared in that regard". **Did you do any further work or research after May 2020 as to the extent to which there was co-operation in the fields set out in the Memorandum in response to Covid-19?**
	Response: I have not been involved in any meaningful and significant work in this regard. The issue is not whether there were 'conversations' between officials during the pandemic; it is whether much, much more could and should have been achieved. I was however involved in a cross-border study post-COVID-19, but please note that the findings in the main body of the paper are not as positive as the abstract would suggest [2]. Ref: 2 Obstacles to Public Health that even Pandemics cannot Overcome: The Politics of Covid-19 on the Island of Ireland. https://muse.jhu.edu/article/810177/pdf
9.	**Do you have any opinion as to the following:** **a. Whether Northern Ireland and the Republic of Ireland ought to have pursued opportunities for cooperation set out in the Memorandum (because they may have improved the response to Covid -19 in either or both territories)?** **b. Whether there were particular areas or types of work which lent themselves to co-operation?** **c. The extent to which there was cooperation between Northern Ireland and the Republic of Ireland.** **d. Whether Northern Ireland and the Republic of Ireland took advantage of these opportunities for cooperation (in pursuit of the common aim of tackling Covid - 19)?**
.	**Response:** I have touched on these points in previous responses. It is deplorable that the possibilities for cooperation and harmonisation were not grasped during the pandemic. As I stated above, conversations between certain officials, North and South, are no substitute for concerted and coordinated action. At times, the lack of coordination and essential communication meant that officials in one jurisdiction or the other were blindsided about the steps being taken. I attach two articles from the Irish Times illustrating this point – many more examples are available in the press coverage.

10	**If you are of the view that opportunities for cooperation were missed or not pursued, do you have any views as to what barriers to obtaining cooperation may have existed?**
	Response: There were two main problems. The lack of an all-island approach to health in general, and public health in particular, led to two systems unused to cooperation and integration. Some cross-border initiatives on highly specialised clinical services cannot be called upon to demonstrate anything more than the exceptional, rather than routine, nature of cooperation. Systemic stasis in the high-level administration of the governmental health function in both jurisdictions is the most serious component of the problem. In particular, I would draw attention to the need for more trained and experienced public health leadership in Northern Ireland at the Chief Medical Officer and local levels.