1 **Monday, 18 November 2024**
2 **(10.30 am)**
3 **LADY HALLETT:** Mr Scott.
4 **MR SCOTT:** My Lady, please may I call Robin Swann.
5 **MR ROBIN SWANN (sworn)**
6 **Questions from COUNSEL TO THE INQUIRY**
7 **LADY HALLETT:** Hello again, Mr Swann.
8 **A.** My Lady.
9 **MR SCOTT:** Good morning, Mr Swann.
10 **A.** Morning.
11 **Q.** Would you please give your full name.
12 **A.** Robert Samuel Swann.
13 **Q.** And it's correct that from 11 January 2020 until
14 27 October 2022 and then again from 3 February 2024 to
15 28 May 2024, you were the Minister of Health in
16 Northern Ireland.
17 **A.** That's correct.
18 **Q.** We set out with the Chief Medical Officer the structures
19 of the healthcare system in Northern Ireland so I don't
20 propose to go back over all of that ground. I just want
21 to ask you, when Sir Michael McBride gave evidence he
22 was asked did the population of Northern Ireland have
23 the healthcare service they needed at the start of the
24 pandemic, and he said no. He was also asked whether HSC
25 was actually equipped to meet the needs of the

1 Northern Ireland population at the start of 2020, and he
2 replied:
3 "No, I don't believe it was ..."
4 Do you agree with him?
5 **A.** I would fully agree with both of those statements, yes.
6 **Q.** Why was that?
7 **A.** I think we have -- I think the Inquiry has heard in
8 regard to the status that the health service was in
9 prior to the pandemic. We'd been three years of not
10 having a sitting or functioning Executive. The health
11 service itself had been through single-year budgets from
12 the year 2016 and a lot of the reforms, the investments
13 and the dedication to our health service and the health
14 service staff and the people who relied on it had not
15 been delivered.
16 **Q.** So, is it effectively that capacity was limited by the
17 funding restraints that had been put upon it over the
18 previous years?
19 **A.** It would be a fact that it was constrained by not just
20 the funding constraints that had been put on it but also
21 the lack of political decision-making on political
22 direction that the health service, again, needed to
23 make, that -- the transformation that it had needed to
24 make best use of the funding that it had but also the
25 investment of the additional funding whether it could

1 receive.
2 **Q.** Again, as I set out with Professor McBride, as the chair
3 has set out in the Module 1 report, there is only so far
4 the Inquiry can go to look at funding. So, in terms of
5 answers that you have throughout the course of the day,
6 if funding is a core issue, please do say, but I think
7 the value of repeatedly referring to funding may be
8 relatively limited in terms of what the Inquiry can
9 achieve.
10 But in terms of the funding constraints that you
11 found yourself in, whatever the situation that you
12 found, as health minister, you'd agree that you had to
13 provide the most effective healthcare service that you
14 could with the resources available to you?
15 **A.** That was correct, but what we also find is, my Lady,
16 when I took up post in January 2020, our health service
17 workers -- the nurses were already on strike, they'd
18 taken industrial action, the first time that health
19 service workers across the UK had actually been forced
20 to take that step in regards to what they felt was
21 necessary, not just in regards to the financial package
22 but also the asks that they had around CF staffing. And
23 when the New Decade, New Approach agreement was agreed
24 between the two governments as to what was going to be
25 part of the restoration package for the new Executive

1 come in, actually additional nursing training places was
2 one of those core agreements, because we had -- there
3 was the recognition that the lack of training places
4 across health and social care in Northern Ireland had
5 been cut due to previous budgets as well.
6 **Q.** Let's look at your assessment of the state of the
7 healthcare in the end of January 20. How prepared did
8 you think Health and Social Care would be to respond to
9 a pandemic?
10 **A.** When I first took up the post in regards to that, our
11 biggest challenge, again, was the industrial action but
12 also where Northern Ireland was in the desperate
13 situation in regards to the length of our waiting lists,
14 the worst across the United Kingdom.
15 So the challenges that I faced or the health
16 service faced was also that of additionally in regards
17 to staff but also the challenges of our waiting lists.
18 So as a priority, as a stress on its own,
19 Northern Ireland I think was an outlier in regards to
20 being in a worse position than some of the other health
21 services across the United Kingdom.
22 **Q.** Okay, well, let's look at it a slightly different way.
23 By the end of January 2020, did you believe that Health
24 and Social Care would have a capacity to respond to
25 a pandemic?

1 **A.** Not at that point because I don't think we had the
2 available capacity built within the system to take on
3 the additional strains that a pandemic would actually
4 present because -- I think we're referring to that
5 earlier answer in regards we didn't have the resource
6 nor the capacity of the challenge the waiting list
7 situation that was the immediate impact in
8 Northern Ireland.
9 **Q.** Mr Swann, I just want to make sure we're focusing on
10 capacity to respond to a pandemic. Those are
11 potentially two different things when we're talking
12 about resourcing other areas compared to responding to
13 a pandemic. I mean, you first attended COBR about
14 Coronavirus on 24 January 2020; is that right?
15 **A.** That's correct.
16 **Q.** Around that time did you ask what plans Health and
17 Social Care had to respond in the event of a pandemic
18 rather than necessarily just the Coronavirus pandemic?
19 **A.** I don't recall that specific question but I am aware
20 that there was the pre-pandemic preparedness plans that
21 we covered in Module 1 in regards to what was necessary,
22 what different management systems could actually be
23 brought in in regards to gold, silver bronze commands
24 within the Health and Social Care system.
25 **Q.** Those are more structures as opposed to physically how

1 Health and Social Care would respond, how it would build
2 capacity, how it would surge in the event of additional
3 critical care capacity needs. Do you remember anything
4 on those lines?
5 **A.** I don't remember anything along those lines but I think
6 that's where, you know, those -- preparedness of silver
7 and gold -- gold commands were there.
8 **LADY HALLETT:** Could I ask you to speak more slowly. You're
9 like me, you speak very quickly, so we'll try to
10 encourage each other to speak more slowly.
11 **A.** Apologies, my Lady.
12 **MR SCOTT:** What did you think would be the major factor or
13 factors that would limit Health and Social Care's
14 ability to extend or expand its capacity to respond to
15 the Coronavirus pandemic?
16 **A.** The main factors would be that of available staff but
17 also space and capacity within the healthcare structures
18 that we currently had. Again, I've already stated that
19 we were challenged with the number of healthcare staff
20 that was available but also our structures were --
21 across the healthcare estate, were ageing and needing
22 updating and investment.
23 **Q.** In terms of the staff, you would have been able, in
24 late January, early February 2020, to be able
25 potentially to re-organise your staffing capacity to

1 make sure that the staffing was focused in the areas
2 where it would need to be to respond to the pandemic, is
3 that right?
4 **A.** That would have been something that would have been
5 an operational decision for the trusts, and I think that
6 was part of that planning preparedness that the only
7 ability that we had to do that was to actually step down
8 other services because we didn't have that inbuilt
9 capacity, that spare capacity within Health and Social
10 Care and, again, as I said in a previous answer, that
11 was one of the reasons that our healthcare service had
12 actually -- went and took industrial action prior to the
13 Executive being restored.
14 **Q.** But in terms of -- you say that's an operational
15 decision. Given your understanding of the capacity,
16 given your knowledge of what you were hearing at COBR
17 in January and February, did that make you personally
18 focus on ensuring that there was a maximisation of
19 capacity, particularly staffing, within Health and
20 Social Care, to respond to the pending pandemic?
21 **A.** It was an issue that was already there in regards to we
22 didn't have enough staff actually to deliver the
23 healthcare service that we wanted to, even pre-pandemic,
24 so, as I keep reiterating, that additional leeway, that
25 flexibility, wasn't something that we had available to

1 disperse and actually engage without having to displace
2 other functions.
3 **Q.** Yes, Mr Swann, but that's the point, you're walking in
4 -- that's the baseline that you're saying there isn't
5 sufficient staff. The question is: did you put a focus
6 on making sure that you were maximising the ability to
7 use the staff that you had available to you?
8 **A.** I think what I'm trying to say is yes, there were those
9 plans in place in regards to what we needed to do but
10 the challenge was that there wasn't flexibility there
11 actually to do what we would have wanted to do.
12 **Q.** What direction were you applying to any planning for the
13 pandemic in February 2020?
14 **A.** Sorry, in regards to?
15 **Q.** In regards to whether there were plans, what the
16 response was going to look like, whether there was
17 sufficient capacity being built in, whether there were
18 actually plans in place for how the capacity would be
19 used that could be made available within Health and
20 Social Care?
21 **A.** There was in regards to the activation of the
22 pre-pandemic preparedness plans that, again, engaged and
23 actually stepped up, and gold and silver commands were
24 at operational delivery, was brought in at silver
25 command. We were bringing the trust together, chaired

1 at that stage by the Public Health Agency in regards to
2 what steps would be taken or could be taken.
3 **Q.** Yes, but the question is what you were doing. So silver
4 command, gold command, they were a level below you, is
5 that right?
6 **A.** Yes.
7 **Q.** So were you doing?
8 **A.** I was meeting with the senior officials within the
9 department, we were meeting at an Executive level, as
10 well, to make sure that there was also a response ready
11 for across the Executive as to how we could respond to
12 a pandemic.
13 **Q.** But the Executive weren't directing how the Health and
14 Social Care should respond; that's a matter for you as
15 the health minister, is that right?
16 **A.** That's correct.
17 **Q.** So I just want to look then at the detail of surge
18 planning for the first wave. So it's right, isn't it,
19 that on 17 February the CMO wrote requesting a detailed
20 surge plan? Do you remember what modelling was being
21 relied upon at that point in terms of, firstly, what
22 capacity Health and Social Care would require to meet
23 the first wave and also what the peak of wave 1 would
24 look like in terms of when it would arrive?
25 **A.** I think that module -- that modelling at that point was

1 coming from SAGE in regards to the figures that were
2 coming across.
3 **Q.** Do you remember any of the detail about it?
4 **A.** I don't remember off the top of my head, not in regards
5 to the January figures.
6 **Q.** If I look at the modelling of 9 March.
7 If we could please have on the screen
8 INQ000425604.
9 So, I believe you're familiar with this document?
10 **A.** Yeah.
11 **Q.** And so this is modelling that was commissioned from
12 SPI-M-O; is that correct?
13 **A.** Yes.
14 **Q.** And this is the first Northern Ireland specific
15 modelling of the potential impact of the pandemic; is
16 that right?
17 **A.** It seems to be, yeah.
18 **Q.** We will look at the specific figures in a second, but
19 when you saw this modelling -- I presume you saw this on
20 9 March or around 9 March; is that right?
21 **A.** I don't recall the exact date I saw this specific
22 document, but I am aware of these figures.
23 **Q.** But it probably would have been given to you around the
24 same time it had been received?
25 **A.** Yeah.

1 **Q.** Did you feel that these were the numbers that actually
2 Health and Social Care were working towards in terms of
3 what the impact would be on them in terms of number of
4 cases, deaths, symptomatic cases, or did this present
5 a dramatic change in terms of the numbers that would
6 have to be dealt with?
7 **A.** This -- at that specific point in regards to the 32,000
8 peak daily new symptomatic cases was, I suppose, a stark
9 focus in regards to what Northern Ireland was actually
10 going to be facing in regards to those numbers without
11 any intervention, actually being taken.
12 **Q.** Yes, but the question was more when you received this
13 modelling, did it present a step change to what you were
14 working towards?
15 **A.** Yeah, I think it was also at that point, my Lady, in
16 regards to the 32,000, the daily hospital admissions of
17 4,000 possibly per day, was really that point that
18 really made this whole thing real, both to me and to my
19 Executive colleagues. In regards to that there had been
20 hypothetical assumptions as to what could happen, what
21 would happen, what was happening elsewhere, but it was
22 in regards to those specific figures, and if I recall
23 correctly, around that time, I think in the receipt of
24 those, we actually made a press statement, the First and
25 Deputy First Minister and myself in regards to those

1 figures, that what could actually come about in
2 Northern Ireland if behaviour interventions didn't take
3 place in regards to that.
4 **Q.** You just said that these figures were the point that
5 really made this whole thing real. This is 9 March.
6 You'd been watching what had been happening across the
7 world. Did it not feel real well before that point in
8 terms of what was likely to happen in Northern Ireland?
9 **A.** It did feel real as to what was going to happen in
10 Northern Ireland, but I think, my Lady, in regards to
11 when you see that level of a population, a population of
12 1.9 million people in Northern Ireland, where they could
13 be facing, 32,000 cases per day, 4,000 hospital
14 admissions in regards to what our system, what the
15 population was able to compete with, and again, those
16 figures were without, as the paper says, without
17 behavioural intervention. So I think that was the crux,
18 as I say, that made it real for us, made it real for me
19 as an individual in Northern Ireland.
20 **Q.** Did that making it real, then, provide a different
21 impetus to the level of planning or the pace of planning
22 that was going on at that point?
23 **A.** I think it made quite a different inference in regards
24 to how the rest of my Executive colleagues reacted as to
25 what was actually coming, as I said in Module 2C, up

1 until that pointed and part of the challenge that we had
2 was that up until then, the Covid pandemic was going to
3 be treated very much as a health issue rather than
4 a whole society issue, but when you look at those sort
5 of numbers when we had the intervention that those sort
6 of numbers were possibly -- what was going to happen to
7 Northern Ireland without the behavioural interventions,
8 that's what focused a lot of minds.
9 **Q.** As you were just talking about Module 2C there, the
10 other minister's responses was dealt with in Module 2C.
11 I'm focused on the response of the healthcare system and
12 the response of you as the health minister, are you
13 satisfied, then, that prior to this modelling, prior to
14 this starting to feel real, that there was sufficient
15 pace of planning, sufficient depth of planning to ensure
16 that Health and Social Care could respond to the
17 pandemic?
18 **A.** I don't think that the surge plans in their totality
19 were preparing for the numbers that we were going to see
20 or we were potentially going to see without the
21 behavioural interventions because, as it states there,
22 average daily beds available in Northern Ireland were
23 actually less than what was being expected as the Covid
24 peak daily new hospital admissions (unclear) that model
25 and so would have crippled our system completely,

1 my Lady, in regards to that, if we hadn't took those
2 behavioural interventions that we did.
3 **Q.** Well, even taking those behavioural interventions, when
4 you look at this modelling, so daily -- peak daily
5 hospitalised caseload of 10,000 when the average daily
6 beds available is 3.8 thousand, peak daily invasive
7 ventilation of 1,000, an average -- so total level 3 ICU
8 beds, so that is those that can deal with ventilation
9 was 100, so a tenth of the peak daily invasive
10 ventilation, did you think that HSC had any possibility
11 of coping with those modelled numbers even with the
12 interventions?
13 **A.** No, and I think that's where the surge plans that were
14 put in place at that stage looked in the beginning of
15 the first wave but dramatically related, and actually
16 stepping down a lot of the core issues and the core
17 services that Health and Social Care were delivering so
18 that we could best prepare for what was in front of us.
19 **Q.** Because four days -- so on 19 March, the department
20 published what was called the summary plan for mid-March
21 to mid-April. So that's about 10 days after this
22 modelling had been received and it's four days after the
23 first Covid-19 related admission to critical care in
24 Northern Ireland; that's right?
25 **A.** That's correct, yeah.

1 **Q.** So there had been ten days before that plan was
2 published to respond to that modelling; that's right?
3 **A.** That's correct, yeah.
4 **Q.** And the purpose of that summary plan was, as it says, to
5 ensure that there's sufficient capacity within the
6 system to meet the expected increase in demand. That
7 was the point of that plan at that time?
8 **A.** That's correct.
9 **Q.** So by the time that summary plan was published, why
10 wasn't there a defined surge plan for critical care?
11 **A.** For critical care specifically, that was something that
12 Critical Care Network for Northern Ireland had been
13 asked to organise. Our bed -- critical care ICU
14 capacity was 88 beds at that point in time from my
15 recollection, so the surge plan in regards to intensive
16 care specifically was something that was built up
17 looking across those networks, how we actually maximised
18 the trust but, again, the limiting factor in regards to
19 be able to supply ICU beds, that critical care capacity,
20 was actually the availability of trained workforce who
21 could actually staff and manage critical care beds.
22 **Q.** Yes, but that's not an answer to the question about why
23 there wasn't a defined surge plan for critical care
24 alongside the summary plan that was published on
25 19 March?

1 **A.** There wasn't one developed at that stage that I am aware
2 of. My Lady, I do know that the Chief Medical Officer
3 had asked the Health and Social Care Board to prepare
4 a surge plan and he had some concerns about that and it
5 had actually been returned before that one was actually
6 published was delivered to the department.
7 **Q.** Yes, and this comes back to the fact that the CMO had
8 requested that on 17 February. So it was over a month
9 since the initial request to when the summary plan was
10 then published and the summary plan didn't include
11 a surge plan. And the question is, why did it not have
12 a surge plan if the point of the summary plan was to
13 make sure you had sufficient capacity within the system?
14 **A.** I'm unsure, my Lady, has to why that surge plan at that
15 point didn't include a specific in regards to critical
16 care. There was a later plan developed in regards to
17 how we managed our critical care beds across
18 Northern Ireland, looking at all trusts coming together
19 but also how we actually, at a later date, instigated
20 a Nightingale facility with the Belfast tower blocks
21 specifically around critical care beds.
22 **Q.** Did you see the summary plan before it was published?
23 **A.** I would assume I did, yes, from recollection.
24 **Q.** Did you ask: where is the surge plan?
25 **A.** For critical care beds, no. If it's not in the

1 submission, my Lady, at that point I mustn't have.
2 **Q.** No, but as the health minister, you're there to
3 critically assess the submissions that you were getting?
4 **A.** That's correct, yes.
5 **Q.** Did you look at this and say: actually, how are we going
6 to scale up critical care here? Do we have a plan in
7 place?
8 **A.** If that's not in that submission, at that point
9 I didn't.
10 **Q.** On reflection, do you think that's a question that you
11 should have asked?
12 **A.** In reflection, yes, my Lady, pointing out that I was
13 newly into the position in regards to that, in regards
14 to there had been no health minister previously, in
15 regards to the specific questions of the surge plan that
16 I could have been asking. On reflection, and what
17 I know now is very different from what I knew then, but
18 I can get back to the work that was taken under the
19 Critical Care Network for Northern Ireland in regards to
20 how they were able to flex up critical care beds where
21 they looked at at later dates.
22 **Q.** I am just going to push that one stage further. You say
23 that you were new in the role. It's not a matter of how
24 long you were in the role to assess whether there was
25 actually a plan in place for how you were going to scale

1 up critical care. That doesn't require experience as
2 a health minister, does it?
3 **A.** No, it's that ability to be able to ask the right
4 questions, at the right time, my Lady, in regards -- in
5 hindsight, knowing what I know now compared to what
6 I know then, I would have asked that question, would
7 have insisted on it.
8 **Q.** So do you think, then, that, whatever the reason, that
9 you weren't providing a sufficient level of direction as
10 the health minister that you believe you probably should
11 have provided?
12 **A.** Yes.
13 **Q.** I see you've also mentioned the Nightingale plan, it was
14 also a fact that the Nightingale wasn't included in that
15 summary plan of mid-March; that's correct?
16 **A.** No, Nightingale was at a later date.
17 **Q.** The surge plan eventually was published on 16 April,
18 that's right?
19 **A.** Correct, yeah.
20 **Q.** You'd received modelling on 1 April that set out --
21 sorry, let me start that again.
22 You had received modelling on 1 April from the
23 Northern Ireland regional modelling group; correct?
24 **A.** Correct, that's right.
25 **Q.** And that modelling set out when it was anticipated that

1 the peak would arrive in Northern Ireland; that's
2 correct?
3 **A.** That's correct, yeah.
4 **Q.** And I think it was anticipated it would be between 6 and
5 20 April; is that correct?
6 **A.** As far as I recollect, yes.
7 **Q.** So do you know why the surge plan was only being
8 published at the very end of the peak period?
9 **A.** It was in preparation of what was available and, as
10 I said earlier on, my recollection was that the CMO had
11 asked the Health and Social Care Board to develop
12 a surge plan and he had queries and questions in regards
13 to that, that it was returned for the second publication
14 and iteration. But it wasn't to say, my Lady, just
15 because the plan wasn't there it didn't mean that action
16 wasn't already being taken.
17 **Q.** No, but the action wasn't complete. If you're talking
18 about a plan, you need to make sure that your plan is
19 complete to know how you're going to respond to the peak
20 of the pandemic; isn't that right?
21 **A.** That's correct, yes, but there was actions being taken.
22 **Q.** Do you know why -- again, maybe this is repeating
23 itself, but do you know why it had taken a month from
24 the publication of the summary plan on 19 March to the
25 publication of the surge plan on 16 April 2020? What

1 was the reason for that length of --
2 **A.** I don't know why that delay was from -- from my
3 recollection of those.
4 **Q.** Can we move on and look at the actual surge plan from
5 16 April.
6 Can we please have INQ000377154. Thank you very
7 much.
8 So we can see at the top there:
9 "Overall planning assumptions: Modelling on
10 7th April ..."
11 So, 9 days before this was published.
12 "... indicates [reasonable worst-case scenario] of
13 140 COVID beds needed at peak, in addition to 35
14 NON-COVID ... This ... [requires] 175, this Plan will
15 reach that target at high surge with a margin for
16 delivery of higher volumes."
17 So, at the time that this surge plan was
18 published, it was anticipated, based on the modelling,
19 that Health and Social Care would be able to deal with
20 the first wave of the pandemic; that's correct?
21 **A.** That would be the assumption -- for critical care beds,
22 yeah.
23 **Q.** Yes. I want to look on the left-hand side, please, and
24 it's a section called "Key points", and it says:
25 "Triggering points identified for each phase by

1 CCaNNI."
2 That is Critical Care Network for
3 Northern Ireland?
4 A. That's correct.
5 Q. What was the role of the department in terms of when the
6 various levels under this surge plan would be escalated
7 through?
8 A. From a departmental point of view it was up to the
9 CCaNNI to actually instigate and move between each
10 module, each stage, each step.
11 Q. Why wasn't the department exercising effectively the
12 final decision that could be informed by the advice of
13 the CCaNNI? Why wasn't that a departmental
14 responsibility?
15 A. Because in regards to how the Critical Care Network had
16 actually been setting up, it was agreed it was their
17 established practice that they would trigger the
18 additional points rather than the department stepping in
19 to make decisions which were operational at that point.
20 Q. Is there not a loss of this central element of control
21 if it's not being taken by the department, given the
22 department's oversight of all aspects of health and
23 social care in Northern Ireland?
24 A. I think in this specific instance, I -- it was that the
25 Critical Care Network for Northern Ireland is made up of

1 those senior officials within each trust working with
2 the representation, as far as I can recall, from Health
3 and Social Care Board, so it is for them to make the
4 operational decision as to what they need.
5 The surge plan itself looks at different hospitals
6 and different trusts escalating different numbers of
7 beds at different times, so it's how they deploy their
8 staff and their resource. I personally think it was
9 best left in the hands of those professionals to make
10 those decisions at those points.
11 Q. And there wasn't a regional command structure for
12 managing the surge plan prior to January 2021; is that
13 right?
14 A. That's correct, yes. In regards to critical care?
15 Q. Yes.
16 A. Yes.
17 Q. Sorry, when I say "the surge plan", we're talking about
18 the critical care services' surge plan.
19 There was an assessment done by a military
20 assessment team in December 2020 that suggested that
21 that regional command and control structure should have
22 been brought in. Did you think that there was a loss in
23 terms of the way that Northern Ireland responded by the
24 department not having that central control in 2020?
25 A. I'm not sure that there was anything lost, my Lady, in

1 regards to how we actually responded, and that's -- we
2 wanted to make sure that that Critical Care Network and
3 how it actually functioned was as robust as possible
4 coming into the second wave, and that's why we actually
5 commissioned that military assessment through -- through
6 a MACA request in regards to making sure everything we
7 were doing was right. They recommended that central
8 control and command structure, which was more robust
9 than what CCaNNI, I believe, had previously through
10 that.
11 Q. So I want to know, did you have any specific knowledge,
12 as the pandemic progressed, about how far each ICU had
13 surged over the baseline figure, so ie, compared to
14 what's on the screen, the number of beds above what's
15 set out in the steady state for each hospital?
16 A. There was regular updates on our Covid NI dashboard in
17 regards to how many patients were actually in ICU at any
18 one time, and those reports would have been coming in --
19 every time we surged I would have received an update.
20 Q. Is there a slightly different matter when you're talking
21 about how many beds there are in ICU across
22 Northern Ireland as a whole as opposed to how many beds
23 there are available in each individual hospital? Was
24 it -- that hospital-level information that you had or
25 did you not have that?

1 A. I believe I had hospital information, but not on a daily
2 basis, in regards to the number of ICU beds that were
3 occupied both by Covid and non-Covid patients that were
4 available on the -- actually on a public-facing
5 dashboard as well. When it come down to that level in
6 each hospital, I don't recall if I was receiving that
7 level of data.
8 Q. But you're satisfied the department did have that
9 knowledge?
10 A. I would be satisfied they did and that also that's been
11 managed through CCaNNI.
12 Q. Okay. The Department of Health data statement sets out
13 at paragraph 6 that between 20 March 2020 and
14 20 May 2022 there were 651 dates wherein at least one
15 hospital in Northern Ireland all ICU level 1, 2 and 3
16 beds were occupied. Did you know how critical care
17 admissions would be managed when all the critical care
18 beds in any given hospital in Northern Ireland were
19 full?
20 A. Well, that was the rationale for the Critical Care
21 Network, that anybody requiring that critical care could
22 then be supported through another hospital somewhere
23 else, and, my Lady, at one stage, I think through the --
24 the CNO had developed a memorandum of understanding with
25 the Republic of Ireland, where if such a situation in

1 Northern Ireland actually arose that we didn't have
2 available ICU bed capacity that we could use
3 cross-border function as well. And I'm not aware we
4 ever actually had to trigger that but it was something
5 that we had prepared.
6 **Q.** When would this have been escalated to you? I say this,
7 when would a decision about escalation of surge states,
8 whether local escalation, regional escalation, whether
9 one hospital is full, is there any time when that would
10 have been information passed to you?
11 **A.** It would have been after the fact. It wouldn't have
12 been -- they wouldn't have been coming to me to seek
13 authorisation or clearance to move from one surge level
14 to another.
15 **Q.** I want to talk now about your understanding of staffing
16 ratios once these surge plans had been produced, because
17 if we can look at key point 10, please -- again on the
18 left-hand side, thank you very much.
19 "Staffing levels per patient will reduce as surge
20 levels progress, staffing ratios across units to remain
21 stand constant."
22 And then, on the right-hand side, but I don't
23 think we need to go to this, there's an explanation
24 about how staffing would operate for each of those
25 individual levels.

1 So, for example, if we go down to "Step three --
2 High Surge":
3 "Patients to staff ratios diluted further in line
4 with CCaNNI plan."
5 Were you told what were the anticipated staffing
6 ratio for critical care for each of those surge levels?
7 **A.** I remember having the conversation with the Chief
8 Nursing Officer, my Lady, because I know it was
9 something that distressed her greatly, that the dilution
10 of critical care beds would be less than one critical
11 care trained nurse per patient across each of the
12 sections. So it wasn't something that was taken
13 lightly.
14 Not every occasion when we escalated actually
15 reduced or caused that dilution to occur, from my
16 recollection. It was necessary in some instances. But
17 that wasn't to say that those patients weren't being
18 supported. It meant the ratio of critical care nurses
19 weren't to the desired level that either I or the CNO
20 would actually have wished have happened, and has come
21 back to an earlier answer in regards to our ICU beds,
22 that our limiting factor at the beginning of the
23 pandemic was those nurses who were actually trained to
24 deliver that ICU critical care capacity.
25 **Q.** Why was it that the Chief Nursing Officer felt the need

1 to raise it with you?
2 **A.** Because it was -- I suppose it was a step away from what
3 was normal. And again the Chief Nursing and I had
4 a working relationship where those sort of concerns that
5 she had she could come to me and have those
6 conversations in regards to being one of my professional
7 officers in regards to that. It was a step that was
8 necessary but it was a step that she wanted to make sure
9 I was aware of was actually something that was going to
10 be necessary to deliver the level of care that we didn't
11 envisage that we would ever have to but was necessary
12 due to stepping through the different levels of surge
13 for critical care.
14 **Q.** Does that not reflect the fact that you should have had
15 more involvement in understanding what the surge plan
16 was going to look like and how triggers were for moving
17 between the various surges and also what happened as the
18 pandemic developed?
19 **A.** And I think in regards to an earlier answer, knowing
20 what I do now, yes in regards to that. But as the
21 pandemic developed and we stepped through these surge
22 plans, that's why when we developed the Nightingale for
23 critical care and the Ulster tower block, that's when it
24 was specifically target toward that critical care
25 capacity.

1 **Q.** One question before we come to the creation of the first
2 Nightingale. This surge plan, did you actually know
3 where the staff would come from to be able to staff up
4 the increased beds across all of the various surge
5 levels?
6 **A.** In regards to these in a specific level that would have
7 been an operational model for each of the trusts, but it
8 was by taking staff from other parts of the hospital
9 delivering other parts of care that we had to step down
10 to make sure these beds were managed and supported.
11 **Q.** Given your concern about staffing and capacity of
12 staffing when you first took on the role of health
13 minister, when you first saw this surge plan did you
14 think to ask: do you have -- I say "you" -- do the trust
15 have plans in place about how you're actually going to
16 make sure that you have the staff to meet the numbers
17 that you've set out in this plan?
18 **A.** And that was -- although the surge plan was not
19 specifically in critical care, actually looked about
20 what services unfortunately we'd have to step down so we
21 could deliver the staff to meet the demand at that we
22 had through Covid and critical care beds.
23 **Q.** That's the generality. Did you know the specifics about
24 where they were going to come from?
25 **A.** No, I wouldn't have had that level of knowledge coming

1 from each hospital nor each trust.
2 **Q.** Were you told that there would be sufficient staffing to
3 meet those numbers?
4 **A.** By displacing other services, yes.
5 **Q.** I want to look now at the creation of the first
6 Nightingale.
7 The Department of Health statement says that it
8 was:
9 "Informed by [the] reasonable worst-case scenario
10 modelling ..."
11 That would have been 1 April, from the regional
12 group.
13 "... the Department initiated a rapid assessment
14 of potential sites ... on which to locate a Nightingale
15 Hospital facility to provide additional critical
16 care ..."
17 The CMO statement says that the site visits were
18 on 28 March. Are you able to remember precisely when
19 planning for the first Nightingale actually commenced?
20 **A.** I don't remember when the planning actually commenced.
21 I remembered the options in regards to a number of
22 non-hospital sites that were explored. I actually was
23 part of the site visit to the Eikon centre in regards as
24 to what a facility could actually be for the first
25 Nightingale. At that stage, and following various

1 assessments both internally but also in regards to
2 engaging military support again, there was -- none of
3 those sites were actually deemed feasible in regard to
4 the amount of physical work that would actually be
5 needed. So that's why the decision was taken to
6 actually step up the first Nightingale within the tower
7 block within the Ulster Hospital.
8 **Q.** Can we look at a briefing paper, please.
9 It's INQ000276382. And if you just go back
10 a page.
11 This is actually the briefing paper that was sent
12 on 18 April, so it's not the first facility, but this
13 provides an overview of some of the lessons that had
14 been learnt as parted of the planning and process, so
15 I think it's a helpful document.
16 If we can please go to just to raise the point
17 that you were just discussing, page 4. And then
18 there's, as you say, first wave site visits, there's
19 a couple of visits, and then paragraph 18:
20 "Of these three sites, the Eikon was considered
21 the most suitable due to the location ..."
22 However, due to the second visit:
23 "... a decision was taken not to progress the
24 project ... due to the amount of work that would have
25 needed to be carried out in a short time scale in

1 order to make the site suitable."
2 That's what you were just saying there about --
3 **A.** That's correct.
4 **Q.** And that's the reason why the Nightingale ended up in
5 the Belfast City Hospital Tower, and it's fundamentally
6 because the preferred option couldn't be made ready in
7 time?
8 **A.** That's correct, yes.
9 **Q.** Is that a reflection, do you think, of the fact there
10 had been a lack of planning for a Nightingale at
11 an earlier stage?
12 **A.** I don't think Nightingales across the United Kingdom --
13 and specifically, my Lady, in regards to the Nightingale
14 facility in Northern Ireland, it was a critical care
15 facility that we were looking at in regards to where we
16 were seeing the most need of beds. The work that would
17 have been done to make oxygen available, to make all the
18 proper medical necessities available for a critical care
19 bed, the Eikon centre would have taken an inordinate
20 amount of work to bring it up to status, because it is
21 actually a large exhibition centre, it's a large
22 warehouse, rather than the facilities that would
23 actually become available by the adaptations of the
24 tower block and the city hospital.
25 **Q.** Yes, those are the practical difficulties that were

1 faced. The reason why it didn't end up in that centre.
2 But I'm asking, should there have been planning at
3 an earlier stage which would have allowed you to then
4 use what would have been the preferred site, apart from
5 logistical issues, as the Nightingale?
6 **A.** I think it was the physical work. It wasn't the ability
7 to assess or actually see what site would have been more
8 suitable; it was the timescale that we had to put the
9 actual physical mechanics, the oxygen lines, the oxygen
10 generators, on to site. As I say, the Eikon is a large
11 centre that's used for conferences and -- or an
12 agriculture show more so than being a medical
13 facilities, so the level of works to bring it up to spec
14 would have been -- would have taken more time than
15 actually just the planning phase.
16 **Q.** Yes, so if you'd started planning earlier you'd have had
17 more time to put all those physical specs in; is that
18 true?
19 **A.** In a roundabout way I could agree but I think what --
20 there's a difference between planning to make these
21 changes and actually putting physical site works in
22 place that would have allowed to us put ICU beds into
23 that facility rather than what actually came about with
24 the physical works that we were able to step up at the
25 tower block and the Ulster Hospital.

1 Q. But effectively the Belfast City Hospital Tower was not
2 the preferred option, all things being equal. You would
3 have preferred it to be elsewhere?
4 A. All things being equal, the recommendation was that the
5 Eikon would have been a preferred site. But as it
6 wasn't -- as we weren't able to make it physically ready
7 in the short timescale that we had, the Ulster -- the
8 tower block at the Ulster Hospital then was the
9 preferred side for actually being able to deliver that
10 large-scale critical care that we would have needed.
11 Q. Because I think, as this briefing papers sets out at
12 paragraph 5, back on page 2, that the layout of the
13 Belfast hospital actually wasn't ideal because the
14 layout meant the maximum group of patients that can be
15 safely managed is 24, but with the same staffing
16 complement, the Nightingale in London is able to deliver
17 care to 42?
18 A. That's correct.
19 Q. So the location of the hospital rather than being in
20 a big site was actually then limiting the ability for
21 you to take in more patients.
22 Now, as it turns out, the full capacity was never
23 required?
24 A. But can I -- maybe just to clarify and take a step back
25 in regards to the Nightingale in London, if I recall,

1 my Lady, it wasn't critical care beds that was actually
2 deployed in the Nightingale in London, whereas we were
3 into critical care beds --
4 LADY HALLETT: I think it may be that it was Wales and
5 Scotland -- I'm not sure it was London that wasn't
6 critical. I thought London was critical --
7 A. It was -- I apologise.
8 LADY HALLETT: But you are certainly right that one of the
9 nations wasn't critical care.
10 A. Wales wasn't. Apologies, sorry.
11 Again, we were fitting something into the physical
12 space that we had to be able to make the changes, the
13 physical changes that we actually need, whereas the
14 Eikon would have been the preferred site if we'd have
15 had time to do that.
16 MR SCOTT: Wasn't there another disadvantage about putting
17 the Nightingale in the BCH Tower, that you were putting
18 the Nightingale in the middle of the regional cancer
19 centre?
20 A. That's correct.
21 Q. What were the consequences for infection prevention for
22 those people who were suffering from cancer who were
23 visiting the BCH by having the Nightingale in the middle
24 of the tower?
25 A. It was on specifically different floors so there was

1 that segregation between the provision of further -- or
2 additional and continual services that were in the
3 tower, as well as being able to adapt those floors that
4 were used for the Nightingale.
5 Q. Was there another difficulty caused by BCH being in the
6 Nightingale that it had a consequential impact on the
7 ability to actually provide cancer care because you
8 didn't have the same level of facilities, you didn't
9 have the same level of staff to be able to offer that
10 cancer care because they were going to be required for
11 the Nightingale?
12 A. It wasn't -- it wasn't that those staff were being
13 simply redeployed to the tower block. Again, we had to
14 step down certain specialities, certain provisions, that
15 we wished we hadn't to have done so, my Lady, but in
16 regards to be able to complement the additionality in
17 regards to critical care, and I'm again referring back
18 to the point with regards to availability and the
19 service of staff was something we did not have in
20 Northern Ireland at that point.
21 Q. I'm asking about a choice that did fall to you,
22 effectively, about the location of the first
23 Nightingale. If you hadn't put the Nightingale in the
24 middle of the BCH tower, you could, had you chosen to do
25 so, have continued to use those facilities to provide

1 cancer care; is that not right?
2 A. It wasn't that we had to stop cancer treatments in
3 regards to the placement of -- to supply the additional
4 critical care beds. It was the fact that some of those
5 treatments and supports were displaced elsewhere in
6 regards to what we did, but again, going back to the
7 operational decision of the trusts in regards to do
8 that. My Lady, we had to step down services that we
9 didn't wish we had to in regards to what we had to do to
10 support the Covid delivery of supporting patients and,
11 again, I think it was something that, again, was more
12 impacted in Northern Ireland due to the status and the
13 state that the health service went into prior to Covid.
14 Q. Let me ask one final question in relation to the first
15 wave Nightingale. Do you remember how much it cost?
16 A. I don't.
17 Q. I'm going to turn now to testing of patients in
18 healthcare workers.
19 At paragraph 301 of your statement you say:
20 "It was brought to my attention that there was not
21 sufficient testing capacity, particularly at the start
22 of the pandemic. To address this, in April 2020,
23 I established and an Expert Advisory Group."
24 Do you think on reflection that you sought to
25 increase testing capacity early enough?

1 **A.** Testing in regards to where we finished up in the
2 pandemic in regards to the availability, the easy use
3 test that we had compared to where we actually were at
4 the beginning, I think there was a rapid change in the
5 science which was beneficial in regards to that. We had
6 access to a number of not only in-house delivery
7 mechanisms but also public sector and private sector in
8 Northern Ireland that we sought to make use of. In
9 regards to were tests developed at a rapid pace, the
10 testing facility in Northern Ireland, if we could have
11 had more tests earlier, I think everyone would have been
12 welcome of those.
13 **Q.** But did you put a focus on ensuring that you ramped up
14 all available sources of testing in Northern Ireland
15 early enough?
16 **A.** There was a request across -- because, if I do recall,
17 my Lady, we did make appeals and actually utilised some
18 of the Department the Agriculture labs in regards to
19 testing platforms and testing specifics were actually
20 identified as to what was necessary, and we were using
21 APHA facilities, we were using private care facilities,
22 and even private providers in regards to that.
23 **Q.** Yes, I think the question is not what you did but at the
24 time that you started doing it. Do you think that you
25 could have started securing that additional testing

1 capacity at an earlier stage?
2 **A.** We could always have done something earlier if we'd have
3 been able to facilitate and look at it, in regards to
4 where we were, in regards to what was needed to actually
5 produce the tests and actually deliver the tests and
6 actually produce the results reliably from them.
7 I think we moved at pace in Northern Ireland in regards
8 to how we were bringing together those different
9 providers and different delivery avenues that we were
10 able to bring together.
11 **Q.** I want to move now away from the first wave and start to
12 look at learning from the first wave ahead of the
13 second.
14 Staffing during the first wave. Were there any
15 specific staffing shortages in terms of location,
16 whether it be geographical, speciality, that were
17 identified in the first wave?
18 **A.** In regards, and I think it falls back to your earlier
19 line of questioning in regards to the specifics around
20 specific ICU care capacity, in regards to what was
21 necessary as we stepped up through those in regards to
22 that. And I think that was the main one that I can
23 recall, my Lady.
24 **Q.** So what steps did you take to improve staffing levels
25 particularly in critical care capacity?

1 **A.** Well, it was about that additional ability to bring in
2 the different resources, also different ratios as well,
3 but again, we were looking at a point where, as I said,
4 New Decade, New Approach was actually about providing
5 additional nursing training places. Nurses can't be
6 trained in a matter of months nor weeks and that's why
7 we were looking to increase the nursing numbers but also
8 looking to see where those weaknesses were in regards
9 to -- I don't remember any specific additional training
10 courses that were identified or delivered in preparation
11 for the second wave.
12 **Q.** Yes, but at this point in time, after the first wave,
13 you've experienced the first wave, you have seen how
14 Health and Social Care has responded to it. You have
15 an understanding of your capacity and your staffing.
16 You had to work with the resources you had available to
17 you. I think the department set out that it wasn't
18 possible to train new nurses in that time. So what
19 focus did you put on making sure that there was
20 an increase in staffing, as much as you possibly could,
21 to be able to respond in the event of a second wave?
22 **A.** We did put out a number of workforce appeals but they
23 were at the start more generic in regards to bringing in
24 additional resource towards bringing in those staff who
25 had either just retired or were working elsewhere to see

1 if they could actually support Health and Social Care.
2 But, my Lady, moving from the first wave into the second
3 wave, we also had to be aware of the strain and the
4 stress that was actually on an already overstretched
5 workforce who had been on industrial action, come off
6 industrial action, and then went head long into
7 a pandemic facing something that healthcare workers, we
8 would never have expected them to be facing at that pace
9 and time. So there was a need, as well, to give them
10 time to actually step back and recharge their batteries
11 as well, as we prepared for that second wave as well.
12 **Q.** Did you do that?
13 **A.** Yes, we did -- as much as possible, I remember, in
14 regards to regarding engaging with trusts and the Chief
15 Nursing Officer in regards to make sure that if there
16 was leave available that could be taken, was taken. But
17 again, that put additional strains on our ability to
18 quickly re-step up other services as well, always
19 cognisant of the critical nature of what we wanted to do
20 against the resources that we actually had.
21 **Q.** And was that with an eye on a potential for a second
22 wave or is that just to allow, effectively, staff to
23 recover from the exertions of the first wave?
24 **A.** In fact it was a reflection of both, because I think
25 moving into the second wave -- sorry, in the first wave,

1 we'd relied extensively on the goodwill and resilience
2 of our healthcare staff and without giving them time to
3 have time to, as I say, to recharge their batteries,
4 actually to get their heads around what they had just
5 been through prior to moving into a second wave, I think
6 it was only fair and right to do that.
7 **Q.** Because you mentioned about the workforce appeal. So
8 was the workforce appeal the main route by which you
9 were trying to bring in additional members into the
10 workforce?
11 **A.** There was, at that point, in regards to that workforce
12 appeal, as to how we re-engaged additional resource into
13 Health and Social Care.
14 **Q.** In your statement at paragraph 151 you say:
15 "From April 2020, and throughout the second
16 wave ..."
17 Do you remember when the first workforce appeal
18 went out?
19 **A.** I don't off the top of my head.
20 **Q.** "... the Workforce Appeal handled almost 60,000
21 Expressions of Interest, and generated over 35,000
22 formal applications. This level of interest delivered
23 a total 5,949 new temporary appointments ... of which
24 2,800 were health and social care ... The other
25 appointments were non-medical, covered support

1 services ..."
2 How was the workforce appeal meant to function in
3 terms of how quickly were you meant to be getting
4 workers in?
5 **A.** It was meant to be -- it was actually subcontracted to
6 a specialist in recruitment in healthcare, as I recall,
7 in regards to that we could turn around some of those
8 appointments as quickly as possible. I was disappointed
9 in regards to the high numbers of people who expressed
10 an interest as to the numbers that actually were
11 employed but I think there was a number of legitimate
12 reasons that we were given in regards to those people
13 who were coming forward, maybe not having the specific
14 requirements, the specific training, or the ability to
15 fix into slots where they were actually needed.
16 I think one of my recommendations, if there is the
17 further need for a workforce appeal that they were
18 actually targeted in regards to what we actually were
19 needing and what we were requiring and where we wanted
20 to put that workforce in. Because it worked when we
21 went looking for social care workers, for GPs, and
22 actually for vaccination teams. When there was
23 a targeted workforce appeal we were able to get a more
24 focused requirement, I think. In regards to the general
25 workforce appeal, people had applied looking for

1 full-time positions rather than the temporary positions
2 that the workforce appeal was offering.
3 There was also people who, I think, were coming
4 forward as an expression, what can I do, how can I help,
5 rather than following through as to what the job may
6 actually entail.
7 **Q.** It's that targeted point that I want to pick up, because
8 you also said earlier on, that "put in a number of
9 workforce but they were at the start more generic", and
10 you said there was a benefit when they were more
11 targeted. Why wasn't the workforce appeal more targeted
12 at the beginning?
13 **A.** I think the more targeted appeal was a learning from the
14 first workforce appeal in regards to that, but it was
15 just a generic, you know, how can you come and help,
16 that's what the workforce appeal was. And as I say,
17 there were later examples I actually just gave, when it
18 was more targeted, it was more beneficial.
19 **Q.** Was the reason why it was generic because it wasn't
20 actually known exactly how these staff would be used?
21 **A.** Well, I think it was an ask for staff to come and help
22 without, again, that targeted focus and I think, you
23 know, your statement, it's not just as how they would be
24 used but it's also where they would be used and what
25 they would be used for so at that point, so it was more

1 a generic ask than that focused ask which the later
2 appeals actually were.
3 **Q.** And is that a consequence of the lack of planing to
4 understand how many staff you would have available,
5 where they needed to be, what specialities there need to
6 be, so you then couldn't provide a targeted workforce
7 appeal in order to plug those gaps?
8 **A.** I think that's a fair assumption, yes, in regards to
9 what that workforce appeal could have been rather than
10 what it actually was.
11 **Q.** And the logic of what you're saying in terms of if you
12 think it would be more targeted, it would be even more
13 successful --
14 **A.** Yes.
15 **Q.** Do you think it would have been more successful?
16 **A.** I think it could have been more successful if we had
17 knew at that point in time, again, my Lady, as to how
18 the generic workforce -- it was something, again, you
19 know, something our health and social care in
20 Northern Ireland had never went out in that state or
21 form before, so it was something new, it was a novel
22 approach for us and we learned from it in regards to how
23 a future one, if necessary, should be targeted and
24 focused.
25 **Q.** As far as you're aware, in the event of a future

1 pandemic, is there a plan within the department for how
2 you would conduct a future workforce appeal?
3 **A.** From my point, when I left the first time, I wasn't
4 aware of any further work being done. That's not to say
5 it hasn't been, but it's not something that I can answer
6 from my position at this time nor when I came back in
7 the second time was it brought to my attention that one
8 was being developed.
9 **Q.** Did you ask when you went back in the second time about
10 what learning there had been from between when you were
11 first health minister and after the hiatus when you
12 started again?
13 **A.** Unfortunately, when I went back in the second time I was
14 faced with the same difficulties as I did the first time
15 with staff once again being on industrial action and in
16 regards to how it had been another two years without
17 a health minister in post and there were a number of
18 specific decisions and requests that needed to be
19 handled and, again, we were faced with an even worse
20 situation in regards to waiting lists across all
21 specialities and all disciplines in regards to that, so
22 it wasn't specifically that I asked in regards to had we
23 updated our workforce appeal and how it could actually
24 be utilised.
25 **Q.** Could you not have asked for a briefing paper from the

1 department to say: this is what we've learned?
2 **A.** I could have asked and I think maybe if I'd been there
3 longer, my Lady, it would have been something we could
4 have got around to in regards to what was the normal
5 working and day-to-day running of the Department of
6 Health rather than being back the first day after
7 another two-year hiatus without a minister in place.
8 **Q.** You say if you'd been there longer. Was it a matter of
9 time to review this or a matter of interest to review
10 the learning?
11 **A.** It definitely wasn't due to a lack of interest. I can
12 assure you I went into that post the second time with my
13 eyes wide open in regards to the difficulties that were
14 in Health and Social Care and again in regards to one of
15 the few parties who actually stepped up and took the
16 health portfolio. I went back in to see what I could do
17 because I knew what pressures and strains the health
18 service had been under the first time, and knew the
19 difficulties coming back in after not having a minister
20 in place. But I willingly went into that post the
21 second time.
22 **Q.** Can we come back to planning for the second wave with
23 the learnings from the first wave.
24 In July 2020, the Critical Care Network asked
25 trusts to provide an updated local surge plan.

1 The second wave surge plan was produced in October 2020.
2 Again, do you know why it took three months for that
3 plan to be developed?
4 **A.** Well, I think in regards to taking the learnings from
5 the first surge plan, making sure it was robustly
6 communicated. I don't know why it took three months but
7 I think the three-month space from actually assessing
8 the first one and the development of the second one
9 would be timely.
10 **Q.** By October 2020 you were aware that there was
11 a possibility of a second wave, if Northern Ireland
12 wasn't already in the middle of a second wave. So did
13 you ask, based on your experiences from the first wave,
14 where is our plan, where is our surge plan, how are we
15 going to respond to escalating critical care?
16 **A.** In regard there were continual surge plans and,
17 actually, we rebuilt plans in regards to how we were
18 trying to get the health service back on its feet as
19 well. We already had the surge plans from the first
20 wave as well to build on and the specifics of the ask,
21 I don't recall, my Lady.
22 **Q.** Is it you don't recall or you don't recall whether you
23 did ask?
24 **A.** I don't recall whether or not I did ask.
25 **Q.** And can we just, please, display the two surge plans

1 next to each other with -- the 16 April surge plan,
2 which is INQ000377154, and then the October surge plan,
3 which is INQ000377221, I believe the one on the right is
4 the one that you'd expected to your statement.
5 Not a huge amount of difference between the two.
6 If anything, the surge plan in October, the one on the
7 right-hand side of our screen is a scaled-down version
8 of the initial surge plan. For example, we can see the
9 extreme surge is equivalent to the high surge in the
10 first plan, high surge is equivalent to medium surge but
11 the bed numbers are slightly less. Do you know why the
12 surge plan for the second wave was a scaled-down version
13 of the first wave?
14 **A.** I would assume at this point it's in regards to actually
15 the learnings from the first wave, in regards to the
16 number of beds that were actually needed at each surge
17 level or actually at maximum capacity when we were using
18 those critical care beds at the height of each wave.
19 **Q.** And so is this a reflection of the capacity of health
20 and social care to scale up or you're saying that this
21 is actually all that was required of Health and Social
22 Care?
23 **A.** This is what was required. This is from the learnings
24 of what was actually there and it moved from local to
25 regional escalation.

1 Q. So were you satisfied, then, by October 2020 that there
2 was this surge plan in place to be able to respond to
3 the second wave?
4 A. Yes.
5 Q. I want to ask then about the briefing that you gave to
6 the Executive on 8 October. You said:
7 "All of our hospitals are currently under
8 significant pressure. Most hospitals are running at
9 more than 85% capacity, with some over 90%. There are
10 already trolley waits in EDs and ambulances queueing
11 outside. This level of pressure does not usually
12 manifest until later in the year. There is therefore
13 a concern about how the system will deal with rising
14 pressures over the winter period alongside increasing
15 numbers of Covid-positive patients."
16 That was 8 October. What did you actually do
17 about those rising pressures in light of what you've
18 considered to be an impending second wave?
19 A. And that was where we actually moved to the surge
20 planning in regards to what was there, in regards to how
21 we actually began to step down other services, and
22 again, as had been actually, unfortunately, normal,
23 my Lady, during winter pressures in Northern Ireland
24 when it came to those challenges as well.
25 Q. Right, and in terms of the normal winter pressures, so

1 your statement says in the period since 21 October --
2 sorry, this is a statement that you made, I believe, to
3 the Assembly in December 2020 in which you said:
4 "In the period since 21 October, regional bed
5 capacity has not dropped below 92%. There are only
6 5 days on which it has been lower than 95%. Some
7 hospital sites have consistently been operating above
8 100% capacity for this period."
9 If I can just show you that graphically at your
10 statement, INQ000492281, page 50, thank you very much.
11 This is the reflection, in pictorial form, of what
12 you were telling the Executive and the Assembly
13 in October and then in December 2020. What steps had
14 you taken, between October 2020 and December 2020, in
15 order to try and prevent these levels of occupation
16 arising?
17 A. That was -- between those levels was actually the
18 introduction of the non-pharmaceutical interventions
19 that had been taken by the Executive that we talked
20 through in M2C in regards to the steps we took as
21 a society, as an Executive, actually to break those
22 chains of infection so we could cut down the number of
23 beds that were actually Covid occupied, as can be seen
24 from that graph, and the number of Covid beds actually
25 increase is when those additional beds in over capacity

1 actually put pressure on our system as well, so that's
2 why we as a Department of Health were asking for those
3 additional interventions, especially in October and
4 November and coming into the Christmas period, that
5 we've covered in M2C to -- or even just to reduce the
6 number of Covid-occupied bed in regards to how we
7 actually implemented non-pharmaceutical interventions
8 but also increased the uptake of vaccination and other
9 methods at that point in time so we could break the
10 reliance on the number of beds that were actually being
11 utilised by Covid patients.
12 Q. Yes, that's stopping people coming into hospital, but if
13 in October hospitals are running at more than 85%
14 capacity and then that didn't drop below 92% from
15 21 October, what steps had you taken to try and make
16 sure there was going to be capacity for the second wave?
17 I don't just mean critical care capacity, just
18 generally, given the pressures that you were telling the
19 Executive?
20 A. Well, the decisions that we were taking and it's
21 actually in that statement in regards to how we reduce
22 the pressures on our health and social care and on our
23 hospitals and our bed capacity was actually to reduce
24 the number of Covid patients who were coming into
25 hospital and we did that through the non-pharmaceutical

1 interventions, because Health was already at its peak,
2 at the major stress of what it could actually deliver.
3 Q. So we'll look at how you were looking to prioritise
4 services and rebuild services a little later on, so
5 I'll come back to this point then.
6 I just want to ask one questions about your
7 statement. If we can go to paragraph 144 of your
8 statement, just on this same page, thank you.
9 "I cannot recall the date on which regional
10 critical care capacity fell below 90% for a period of
11 7 days in a row ..."
12 When you were preparing this statement, did you
13 check with the department whether they actually held
14 that information or not?
15 A. Not that I can recall. If it's in my statement that's
16 what I would have considered to be factually correct.
17 Q. Okay. If we can move then to the military assessment
18 that was conducted of the surge plan.
19 If we can please go to page INQ000276389_0002.
20 So this is a briefing that was provided to you, if
21 we just go back a page so we can see the cover sheet.
22 This is a briefing that was provided to you on
23 18 December 2020, talking about the regional ICU surge
24 plan. We've looked at the levels of the surge plan and
25 if we can just go down to paragraph 3, please. It says:

1 "As you are aware, critical care surge plans
2 were assessed by medical colleagues from ... 9 to
3 11 December 2020 ..."
4 Do you know why it had taken two months for there
5 to be this assessment of the surge plan that had been
6 published in October?
7 **A.** I'm not aware as to why it would have taken two months
8 but it may be because of the availability of the
9 military assessment team and the response to a MACA
10 request coming in as well, and actually being supplied
11 to have been able to link up that assessment.
12 **Q.** Well, there had been a delay in planning for the first
13 wave in terms of how long it had taken the surge plan to
14 be produced. Did you take any steps to make sure there
15 was no delay in planning for the second wave?
16 **A.** In regards to the preparations that was already being
17 made throughout the department, I think we were
18 preparing for the second wave in regards to the
19 specific, as I say, bringing in the military assessment
20 team. It wouldn't be dependent on their availability
21 and the approval of the MACA request as well.
22 **Q.** So following completion of their assessment, they made a
23 number of recommendations. What was your reaction when
24 you read the recommendations that had been provided by
25 the military assessment team?

1 **A.** I was fully supportive that all the recommendations
2 should be implemented as quickly as possible. I don't
3 recall anything that was overtly challenging in regards
4 to that. The stuff you've presented there as well,
5 I also -- well, I also say there was nothing for me to
6 decide, it was all to note, so in regards it was to the
7 officials within the department informing me of what was
8 happening.
9 **Q.** Did you think those recommendations reflected structural
10 issues within Health and Social Care?
11 **A.** I think they highlighted, my Lady, something that we
12 probably knew and were aware of and that's why we asked
13 for that, I suppose, set of outside eyes to actually
14 come in and reinforce and bring to focus what we needed
15 to do.
16 **Q.** Could you specify what it was that you probably knew and
17 were aware of?
18 **A.** In regards to the recommendations I think it was --
19 I come back the earlier point about that need for that
20 central control.
21 **Q.** So did the department know that there was a lack of
22 central control prior to this assessment and had done
23 nothing about it or did they not think that there was
24 much that needed to be done from central control?
25 **A.** I think there was a reliance that the CCaNNI was

1 providing that level of central control but that the
2 military assessment highlighted they needed to go a step
3 further.
4 **Q.** Because if we can go down to page 9. We'll look at some
5 of these individual recommendations.
6 So the way this briefing is structured is that you
7 have got the briefing paper to you. There's then
8 a summary of what the recommendations are and the
9 department's response, and then behind that there are,
10 effectively, the report or the summary of the military
11 assessment team. And I just want to look, first, at
12 recommendations 5 and 6. So, recommendation 5:
13 "Very limited use," made of a number of
14 categories of staffing.
15 That was something that could have been resolved
16 at an earlier stage, would you agree?
17 **A.** Yes. And that's what I was saying, it was agreed by
18 Health and Social Care Board and CCaNNI.
19 **Q.** But it shouldn't have taken the military assessment team
20 to tell you that you were under-using categories of
21 people who could help provide extra capacity; would you
22 agree with that?
23 **A.** I would agree with that but I think some of that
24 additional capacity had been utilised elsewhere.
25 **Q.** And then at recommendation 6:

1 "Trusts appeared to hold little flexibility or
2 willingness to share redeployed staff to other trusts."
3 Again, is that not a matter that if there had been
4 that level of departmental control rather than leaving
5 it to the trusts, that would have been identified and
6 potentially ironed out at a much earlier stage?
7 **A.** It also comes back to, and I say it was agreed by the
8 Health and Social Care Board and CCaNNI to consider the
9 issue of small deployable teams, and the department was
10 asked to consider the issue of incentives. I think that
11 goes back, my Lady, unfortunately, to the employment
12 structures that we have in Northern Ireland within
13 Health and Social Care where staff are actually employed
14 by the individual trust rather than an overall
15 employment contract where they can be easily and readily
16 deployed across a Health and Social Care estate which
17 I think would be of benefit in future, future incidences
18 again.
19 **MR SCOTT:** My Lady, I wonder if that might be a convenient
20 point?
21 **LADY HALLETT:** Yes, certainly. I shall return at 11.55.
22 You remember our breaks, Mr Swann.
23 **(11.38 am)**
24 **(A short break)**
25 **(11.55 am)**

1 **LADY HALLETT:** Mr Scott.
2 **MR SCOTT:** Thank you, my Lady.
3 Mr Swann, if I could turn now to inequalities
4 data, please.
5 So, Aidan Dawson, who gave evidence on behalf of
6 the Public Health Agency, said, when he was asked about
7 surveillance of Covid-19 in the community by way of
8 primary care data, that:
9 "I don't think we had that sort of level primary
10 care data that we would require."
11 This was in relation to his statement that said:
12 "For primary care ... PHA had existing access to
13 ... surveillance as a result of reporting of
14 influenza-like illness for in- and out-of-hours primary
15 care. This system was established during the
16 2009 influenza pandemic. This information was initially
17 considered to be potentially relevant and useful, but
18 upon discussion with HSCB, it was established that there
19 were no permissions from the primary care data owners
20 [GPs] to use this source for COVID-19 monitoring, and it
21 was not subsequently used."
22 So, it therefore appears there was a lack of
23 surveillance of Covid-19 at primary care, and therefore
24 surveillance of the community, due to data protection
25 issues. Were you aware of that?

1 **A.** I wasn't aware of that, and actually when I heard
2 Mr Dawson's evidence, I -- trying to recall what --
3 was I actually there and what was I -- because I do know
4 that, my Lady, we had what was called sentinel GP
5 practices that actually reported back a number of
6 influenza cases in regards to that, and I know they were
7 stepped up early on in the pandemic to actually report
8 back in Covid cases. I'm not sure what Mr Dawson was
9 actually talking about in regards to that data transfer,
10 whether things were automatic or whether actually they
11 had to be asked for in a manual input, that --
12 especially as data had been delivered through
13 spreadsheets or written documentation rather than having
14 access to online systems or automatic data dumps, for
15 want of a better explanation. I'm not sure where
16 Mr Dawson was going with that.
17 But the surveillance of Covid-19 within primary
18 care was something that we were alive to because we
19 actually took a step in Northern Ireland where we opened
20 Covid centres, working with our primary care colleagues
21 in Northern Ireland, community GPs and BMA in regards to
22 where our primary care, our GPs actually set up specific
23 Covid centres, working among our GP federations, so that
24 if anybody was identifying with Covid symptoms they were
25 actually sent to those specific facilities rather than

1 going into a GP practice as well.
2 So I'm not sure in regards to exactly where
3 Mr Dawson was going to in that statement. It wasn't
4 something that was raised with me as minister in regards
5 to those difficulties with that transfer of data between
6 primary care and the PHA.
7 **Q.** I think he was talking about something a bit more
8 fundamental than just transfer of data. I think what
9 he's saying is the PHA didn't have access to the
10 surveillance data that that it was needing, and he said
11 it took until August 2023 for that to be resolved.
12 But is your evidence that actually you were never
13 aware that there was any issues with any access to --
14 **A.** I wasn't aware of any issue in regards to that because,
15 my Lady, we had other concerns that were actually raised
16 in regards to that transfer of data, and we covered it
17 in M2C, between ourselves and the Republic of Ireland
18 that we worked on and worked on actually intensively.
19 If something like that was actually in fact there and
20 had been brought to my attention, we'd have worked on it
21 as well.
22 **Q.** Okay. But you wouldn't dispute the fact that Mr Dawson
23 had raised it as an issue, said it was issue and said it
24 took a long time to be fixed?
25 **A.** Well, look, if he has raised it to the Inquiry, I'm not

1 disputing what Mr Dawson has told the Inquiry and his
2 evidence. I'm conscious that he wasn't in the position
3 he is now in regards to when we were during that as
4 well, but if it's something he has raised, my Lady, I'm
5 sure there will be further questions from the Inquiry to
6 the department.
7 **Q.** Well, if it's not something you're aware of then
8 I'll move on to -- in terms how deaths were actually
9 counted.
10 You set out in your statement that the Health and
11 Social Care response was mainly driven by community
12 transmission, case numbers and HSC pressures, that the
13 manner in which Covid-19 deaths were recorded did not
14 have significant impact on the way HSC responded to the
15 pandemic. That's at paragraph 86.
16 At paragraph 87 you say that you agreed to the CMO
17 commissioning the PHA to provide the relevant clinical
18 data. You talk about the established system for
19 monitoring and reporting deaths in Northern Ireland was
20 through the General Register Office, and that system
21 continued to operate throughout the pandemic and
22 remained the definitive source of reporting on deaths in
23 Northern Ireland.
24 It appears from your statement that you're saying
25 that actually there was sufficient surveillance of

1 deaths through the General Register Office. So why was
2 it necessary for PHA to be asked to provide data about
3 deaths?
4 A. And I think that, my Lady, was in regards to the
5 frequency of reporting as well. And NISRA were at that
6 stage, as the official collection statistics agency,
7 reporting once a week. Elsewhere across the
8 United Kingdom there was an acknowledgement of the
9 number of people who were losing their lives to Covid on
10 a daily basis. I'd asked that Northern Ireland move to
11 be in keeping with that, so PHA through -- well, the CMO
12 had asked PHA to start to gather that data so that we
13 could make sure that we were contributing the same data
14 at the same level as other parts of the United Kingdom
15 as well.
16 Q. So did you consider that there was a data gap, where it
17 was actually just trying to make sure there was
18 comparison across?
19 A. I think it was making sure there was a comparable
20 measure of number of cases, number of hospitalisations
21 and number of deaths due to Covid, and that was the same
22 measure and the same criteria across the United Kingdom,
23 whereas NISRA were the official keepers of the GRO data.
24 Q. So you're satisfied that if Northern Ireland had simply
25 relied on the NISRA data that you would have had all the

1 information that you needed?
2 A. We would have, but it wouldn't have been common at the
3 frequency that was being asked for, that was actually
4 being sought from other parts of health and social care,
5 but also what was actually being reported elsewhere
6 actually on a daily basis.
7 Q. Why did you not ask NISRA to increase frequency rather
8 than asking the PHA to create a system?
9 A. I did. I wrote to NISRA. I asked them to increase that
10 frequency. I think they moved to twice-weekly reporting
11 as well, because NISRA take -- and again, my Lady, this
12 is from my understanding -- NISRA take their official
13 statistics from returned death certificates, so there
14 always was the delay in regards to those coming back and
15 to them as a central reporting agency. That was my
16 understanding at the time.
17 Q. I move on to monitoring deaths of healthcare workers.
18 So a letter sent from the CMO to trusts on
19 12 May 2020 conveyed your request for all trusts to
20 advise the department on a daily basis as the number of
21 health and social care workers died from Covid.
22 For reference, that's INQ000490088.
23 Why did you want that data?
24 A. I -- it was also something that was being asked for at
25 a UK-wide basis level as well. I wanted to ensure that

1 we were getting the appropriate data in regards to our
2 healthcare workers -- my healthcare workers, my Lady,
3 also, not just in regards to the number of healthcare
4 workers who were losing their lives due to Covid but
5 also I asked for the further -- as to how many were
6 being hospitalised, how many were in ICU, in regards to
7 the effect that Covid was actually having on our
8 workforce.
9 Q. Was that driver for that you or seeking to have an
10 equivalence to the UK-wide basis?
11 A. It started off there was a request at a UK-wide basis.
12 I actually at that point felt our system hadn't
13 responded and that's why I asked for it to be done.
14 Q. What did you do with that information?
15 A. I was aware of it and I think something that has been
16 brought to my attention through earlier
17 evidence/statements was that the department wasn't
18 collating that centrally. It was being reported through
19 silver and gold command reports, but I don't think there
20 was actually a central correlation as to that data.
21 Q. So when you asked for that information, did you think
22 that there had been a gap in the mechanism by which that
23 information had been gathered?
24 A. It wasn't something that had previously been gathered
25 before, through any of the other pandemics, so I think

1 it was a different request that had actually came.
2 Q. Okay. And in terms of the request, didn't you also want
3 to know the role that the healthcare worker was working
4 at the time?
5 A. Yes, I wanted to know where.
6 Q. Did you get that information?
7 A. Not that -- I think that was being reported through --
8 again, through silver to gold in regards to where they
9 were and who they were, actually in that regard, and
10 I think looking through previous evidence, one was
11 I think Chris Hagan from the Belfast Trust had actually
12 provided that in his evidence report.
13 Q. It looks like a slightly disjointed picture. Weren't
14 you looking for the information that you wanted to get
15 as a whole in one easy-to-access piece of information?
16 A. Yes, that's what I'd requested. But, as I say, I don't
17 recall that ever being formally tabulated through the
18 department.
19 Q. If that's what you'd requested, why isn't that what you
20 got?
21 A. I was -- I suppose I was getting that data through
22 silver and gold reports as well, rather than just
23 a regular update coming from the department to myself.
24 Q. Did you not also want to know what the ethnicity was of
25 healthcare workers?

1 **A.** Not at that point in time. It wasn't a question that we
2 were asking unfortunately. It's not something that was
3 generally recorded actually in Northern Ireland systems,
4 my Lady. I know it's something that you have taken
5 an interest in and has been raised in previously
6 evidence sessions as well.
7 **Q.** You say "not at that point in time". So the letter
8 conveying your request is dated 12 May. Chief Medical
9 Officer, when he gave evidence -- it's page 22 of his
10 transcript -- says it was in April 2020 that he became
11 aware that those from an ethnic minority background may
12 suffer disproportionate impact.
13 So by the time that you made the request it was
14 known that there was a disproportionate impact upon
15 ethnic minorities. So why did you say "not at that
16 point in time"?
17 **A.** Well, sorry, in response to the answer, I don't think
18 there was the linkage of the request of data between the
19 ethnic identification of our healthcare workers and
20 those who were losing their lives and those who were
21 hospitalised.
22 **Q.** Was it not a link that you were making in your head,
23 about if there seems to be a disproportionate impact
24 upon healthcare workers that you wanted to know what the
25 impact was on healthcare workers? Your healthcare

1 workers, you used the phrase earlier on.
2 **A.** It wasn't a linkage that I made at that point in time,
3 because I was -- I think I was caring about my
4 healthcare workers irrespective of ethnicity.
5 **Q.** But you're talking about those who may be potentially
6 the most at risk?
7 **A.** As were all our healthcare workers, and I think that's
8 the lack -- the lack of our data and I think it was the
9 data systems that we have in Northern Ireland that
10 doesn't actually record -- at that point record that
11 level of detail of individuals.
12 **Q.** Let's look at this in a different way. So every March
13 there's a Health and Social Care Workforce Census; is
14 that correct?
15 **A.** That's correct.
16 **Q.** And that census doesn't record the ethnicity of the
17 healthcare workers, does it?
18 **A.** Not that I'm aware of.
19 **Q.** Why is that?
20 **A.** I don't know, but I think one of the learnings coming
21 out of this Inquiry, my Lady, is that it should in
22 regards to that, because I know there has been a general
23 weakness in Northern Ireland in regards to the recording
24 of ethnicity of workforce across Northern Ireland, not
25 just in Health and Social Care but also in

1 Northern Ireland Civil Service as well.
2 **Q.** Was that important information? Because if you don't
3 know how many of your healthcare workers are minority
4 ethnic, how can you work out questions such as how to
5 risk assess them, how many staff you might lose to
6 illness, any additional measures that may be required?
7 **A.** I would agree, my Lady, it's an apparent weakness in
8 regards to that data collection in Northern Ireland that
9 needs to be addressed.
10 **Q.** Who is responsible for collecting that data?
11 **A.** I'm not sure who actually carries that.
12 **Q.** Okay. Who do you think should be?
13 **A.** Well, the department should within its workforce
14 directorate.
15 **Q.** Okay. Well, if the department should be, then why isn't
16 it?
17 **A.** I think, as -- as the previous health minister, as
18 I said here, I think it should, and I think going
19 forward it would be a recommendation that could be made
20 in regards to that. Why it's not been done, I can't
21 answer that.
22 **Q.** But as the health minister, aren't you responsible
23 essentially in making sure that there is sufficient
24 understanding of your workforce?
25 **A.** Yes. And that goes back to the understanding of knowing

1 what to ask and when to ask it, and I think one of the
2 weaknesses that has been brought to fore in regards to
3 the outworkings of this Inquiry is that fact, my Lady.
4 **Q.** Well even in non-pandemic times, wouldn't you want to
5 know the ethnicity of your workforce?
6 **A.** It hasn't been something that was previously asked for
7 in regards to those annual workforce returns, but in
8 regards to what -- and as I've said, what has been
9 brought to fore in regards to this evidence session and
10 previous evidence sessions, I think it is something that
11 should be done.
12 **Q.** One final question on that. Health and Social Care is
13 under a duty, under the Northern Ireland Act, to promote
14 equality; correct?
15 **A.** Correct.
16 **Q.** How could it do that if it doesn't know the ethnicity of
17 its workforce?
18 **A.** In regard to, I suppose, section 75 requirements in
19 Northern Ireland, there's a number of different strands
20 across the workforce and across the department that are
21 undertaken, and it gets -- goes back to the witness and
22 data collection and it's not something that that
23 I can -- I can say that I'm proud of, that we weren't
24 doing it, but it's something, my Lady, that
25 I acknowledge is something that we should be doing.

1 **Q.** Professor Bamrah, on behalf of FEMHO, gave evidence to
2 Module 3. He says:
3 "It's about retention and recruitment as well,
4 isn't it? If everybody feels valued then they will give
5 the best in their job that they can and if they are just
6 a statistic or even a non-statistic then how are they
7 going to do their best for the NHS."
8 So isn't it also, in a sense, self-sabotaging for
9 the department not to know about the ethnicity of its
10 workforce?
11 **A.** It is, yes, but it's -- also, I think, my Lady, goes
12 further in regards to that, in regards to the
13 Professor's statement, in regards to how you treat your
14 workforce. And again, I don't think Northern Ireland
15 has been good at treating its health service workforce
16 at all, or we wouldn't be now looking, even with the
17 restoration of an Executive, of the potential, again, of
18 industrial action in Northern Ireland. So that's
19 a collective responsibility that the Executive and the
20 Assembly need to address and should be addressing in
21 regards to that.
22 **Q.** Yes, but those are completely two unrelated points about
23 those issues in terms of the restoration of the
24 Executive and the industrial action and whether the
25 Health and Social Care knows the ethnicity of its

1 workforce?
2 **A.** I think it goes back to the point being made and the
3 question been asked in regard to how do you respect,
4 value and maintain staff within health and social care.
5 And not just Northern Ireland, but actually across the
6 patient regards the -- give everybody that equal respect
7 and give them the value that they deserve.
8 If the point is we haven't been collecting that
9 data, I've admitted that I think we should in regards to
10 that and I think it's a weakness that the Inquiry has
11 brought to the fore that I think needs to be addressed.
12 **Q.** And presumably all the points you're making
13 about ethnicity are not just about healthcare workers,
14 it also applies to understanding the ethnicity of your
15 patients; is that correct?
16 **A.** That's correct, yes.
17 **Q.** Is there also sufficient collection of disability data
18 about the population of Northern Ireland and how it
19 interacts with health and social care?
20 **A.** I don't think there is in regards to the generic
21 definition of disability, and I hope that is actually
22 corrected and addressed with the introduction of
23 encompass in regards to what data is actually held and
24 held central, really, in one system.
25 My Lady, when we were looking at the introduction

1 of -- or the issue of letters to those who were
2 clinically extremely vulnerable, I know at the start of
3 the pandemic it took significant trawling of various
4 databases actually to identify who was to get a letter
5 and who should have got a letter, whereas I hope that
6 the introduction and from what I've been told the
7 introduction of encompass should make that a more
8 efficient and easier system to use because of that data
9 and it actually being held centrally.
10 **Q.** Okay. I'm going to move on and look at visiting
11 restrictions. Do you consider the visiting restrictions
12 throughout the course of the pandemic struck the right
13 balance between the benefits of visits to patients and
14 their families and reducing the risk of visits bringing
15 in infection?
16 **A.** I do, but I also acknowledge and respect that they were
17 difficult. They were difficult for people who had
18 people in hospitals and that included at one point,
19 my Lady, my own family as well in regards to members of
20 my family who were in hospital during the pandemic as
21 well. But those balances that were brought and those
22 guidelines that were actually introduced were done so
23 I think in the balance of protections in regards to what
24 was known about the pandemic and the virus at that -- at
25 any individual time, and I think that's why the CMO was

1 always keen to provide those refreshments and those
2 updates as and when they were able to do that.
3 **Q.** You say in your statement that you were advised of any
4 changes to the level of applicable restrictions and my
5 endorsements sought at every stage; that's the advice
6 you were being provided by the CNO?
7 **A.** That's correct.
8 **Q.** Was that an area where you felt competent to challenge
9 the advice, if you sought to challenge it, of the CNO?
10 **A.** It was on occasion. I do believe there was a couple of
11 occasions that I did challenge the specifics. I don't
12 recall at this moment in time but there were a number of
13 occasions -- maybe not challenged but questioned in
14 regards to the advice that was being given.
15 **Q.** But you don't remember those specifics?
16 **A.** I don't remember the specifics not at this moment.
17 **Q.** There is one in your statement at paragraph 241:
18 "On 16 April 2020, I asked Critical Care Network
19 ... to undertake a rapid review of the situation with
20 respect to visiting within Northern Ireland Intensive
21 Care Units at the end of life as I was keen to
22 facilitate visiting in such circumstances."
23 Could you provide a little bit more detail, if you
24 remember it, about the reason why you asked that on
25 16 April?

1 **A.** I do, my Lady, in regards to that because the initial
2 visiting guidance was that there should be --
3 end-of-life visiting should be permitted but I think the
4 initial guidance actually said with the exception of
5 ICU, so it wasn't advised, that the guidelines were
6 against end-of-life visiting within ICU and I felt that
7 there should be opportunity for people to visit with
8 a loved one at the end of life even if they were in ICU,
9 so I did ask the CNO to have a look at that again to see
10 if it was possible and my recollection was there were
11 provisions then made to enable that.
12 **Q.** There was a discussion on 17 April at the executive
13 committee meeting about the balance of visiting and
14 whether it was struck correctly. Why did you take that
15 topic to the Executive?
16 **A.** Because those updates at the Executive were
17 generic -- well, not generic, they were all-encompassing
18 conversations that were being had around the Executive
19 table, all Executive ministers at that point were
20 interested in what was happening, I felt it was
21 important that all my Executive colleagues were updated
22 in regards to what was happening, especially in regards
23 to visiting. I'm not sure it's something that
24 an individual minister had raised with me in regards to
25 that specific point.

1 **Q.** Because it could be seen that because a minister takes
2 a matter to the Executive that it's seen as a political
3 issue. Did you consider visiting as a political
4 issue or more of a clinical issue?
5 **A.** No, it was more of a clinical and humane issue in
6 regards to what we needed to do and I think -- I hope,
7 my Lady, during my tenure as health minister, especially
8 during the pandemic, politics didn't enter into any of
9 the decisions that I made.
10 **Q.** The Inquiry received a report about Every Story Matters
11 in terms of a lot of extensive work that's been done to
12 gather accounts from all across the United Kingdom.
13 Some of those are included in your evidence proposal.
14 Do you recognise the stories about the pain that was
15 caused by lack of people to visit their loved ones in
16 hospital?
17 **A.** I do, my Lady. Having watched the video in regards
18 to -- and again, in regards to opening of this model
19 just last night in preparation of today, those stories
20 are heartfelt. They too -- they are reflective of the
21 experiences of many people across Northern Ireland. Our
22 Health and Social Care workers, departmental workers and
23 even in regards, as I said, my Lady, in regards to even
24 my own family in times.
25 **Q.** When John's Campaign gave evidence their view is there

1 should be a "Find a way to say yes" approach to
2 visiting. Do you think that was an approach that was
3 adopted in Northern Ireland?
4 **A.** I do and I think not just in regards to the doctors but
5 I think in regards to the nurses on the wards as well,
6 in regards to that ability to look for those individual
7 matters as well. But I also think it was reflective,
8 my Lady, and again, I'll go back to that engagement,
9 I think it was reflective of the work that the Chief
10 Nursing Officer led because of her understanding and
11 compassionate role she brought as a profession,
12 actually, to the guidance that she was developing. So
13 it wasn't just a specific policy guideline being created
14 by a civil service. She actually brought that empathy
15 and understanding, I think, as a professional nurse as
16 well. And I believe that was reflected in our guidance.
17 **Q.** Module 2C heard a lot of evidence about the importance
18 and focus that Northern Ireland puts on death and the
19 circumstances of death. Is that something that played
20 into the consideration of balance to be drawn,
21 particularly for end-of-life visiting?
22 **A.** It was and, again, I think there is -- that value of end
23 of life and of death in Northern Ireland, my Lady,
24 I know it's something that was particularly challenging
25 in regards to guidance and guidelines specifically

1 around funerals in Northern Ireland and Wales --
2 **Q.** I don't want to take it outside, just in terms of the
3 visiting restrictions.
4 **A.** But in regards to that overall, not just end of life
5 because I think that -- how Northern Ireland looks to
6 death and the celebration of life is more ingrained in
7 Northern Ireland society, so it's not just that
8 end-of-life visiting within the hospital. There was
9 a wider package around that. But I think I can come
10 back to that change that was asked about the end of life
11 and ICU, that was something that we asked for.
12 Unfortunately, my Lady, it wasn't always something
13 that was possible. And on every occasion and I think
14 the Every Story Matters video and evidence that has been
15 presented by different individuals across the
16 United Kingdom, and Northern Ireland specifically,
17 reflects that level of challenge and empathy. It's not
18 a situation I would like to put any family in or any
19 individual in, but in regards to where we were at
20 certain points in time, what we knew, what guidance was
21 there, unfortunately it was necessary at times.
22 **Q.** I want to ask you about care partners and specifically
23 about care partners in hospital, so nothing to do with
24 the care sector. So it's right that care partners are
25 introduced on 23 September 2020 in relation to visiting

1 care homes, correct?
2 A. That's correct.
3 Q. Were they introduced at the same time for visiting into
4 hospital or not?
5 A. They were introduced at a later stage.
6 Q. Why were they not introduced in hospital visiting at the
7 same time?
8 A. I'm unaware as to the specifics but in regards they were
9 brought in to meet the specific needs within care homes
10 and social care settings, as well, in regards to how
11 they could be supported for those people who were in
12 care homes and social care settings were actually there
13 for a longer term and a longer duration. I'm unsure as
14 to why it took that additional period of time before
15 they were actually introduced into hospital settings but
16 I'm aware that the care partner relationship was
17 actually something that was provided again by the CNO in
18 regards to how we supported visiting within care homes.
19 **LADY HALLETT:** You're speeding up.
20 **THE WITNESS:** Apologies, my Lady. Sorry.
21 **MR SCOTT:** So the Department of Health statement defines
22 care partners as:
23 "... specific individuals allowed the introduction
24 of individualised and tailored arrangements to assist in
25 meeting the needs of the patient."

1 Based on what you were saying that that wasn't the
2 same specific need arising in hospitals as it was in
3 care homes; is that correct?
4 A. There was, I don't want to misrepresent what I was
5 saying in regards to that, but there was those specific
6 needs within the hospitals but the care partner
7 arrangement wasn't introduced into hospitals until
8 a later date.
9 Q. On reflection, do you think that the care partner scheme
10 should have been introduced into hospitals earlier?
11 A. On reflection, and again, my Lady, it goes back to what
12 I know now compared to what I know then, what I knew
13 then. In regards to the introduction of care partners,
14 on reflection, I wish we'd have brought it in earlier in
15 the care home and other care settings, in regards to
16 what we're doing, and in reflection, take that to the
17 next step is yes, I do think we could have brought it in
18 earlier within hospital settings as well, but again,
19 that's knowing what we know now to where we were then.
20 Q. Because one of the main problems that was caused by
21 visiting restrictions was that people didn't have the
22 same level or ability to communicate with their family
23 members who were in hospital. You remember people
24 expressing their views that they weren't able to
25 actually understand what was happening to their loved

1 ones?
2 A. Yeah.
3 Q. Do you think there was enough done within Health and
4 Social Care to help families have a current up-to-date
5 understanding of how their loved one was getting on in
6 hospital?
7 A. I do, but I'm also aware of the weaknesses where the
8 communication systems that we hoped and envisaged to
9 being in place across different hospitals, different
10 trusts, let patients down, let families down at specific
11 points. But I know also the dedication and delivery of
12 our healthcare workers who were with individuals at that
13 very challenging point within their time as well was
14 also a challenge to them, something that they weren't
15 expected to do when they first took up their posts as
16 well in regards to that, just the additional asks and
17 strains that we were putting on our staff as well,
18 but -- could we have done more? Could we do more? Yes,
19 knowing what we know now in regards to additional PPEs,
20 testing, all the rest of it, as to how we could actually
21 facilitate that, and I think as visiting guidance and
22 guidelines progressed, I think that was something that
23 was taken into account.
24 Q. You say that the communications systems that we hoped
25 and envisaged being in place let patients down, let

1 families down. How did those failures occur?
2 A. Well, I think it was always at that point in time on the
3 workload in regards to the staff that were actually
4 working on wards and being able to provide that
5 up-to-date information and data in regards to how
6 a loved one was being actually updated of their care on
7 a ward wasn't always possible in the time they needed,
8 and I do know in the occasions where that does cause
9 stress, I apologise, you know, that we weren't able to
10 get it right every time, but there were many wards, many
11 healthcare workers, who were providing that care, that
12 information, where we were able to meet those needs and
13 the needs where we failed.
14 I want to apologise, my Lady, because it's not
15 something that we would -- sorry, it's not something the
16 healthcare service or even those working on those wards
17 would have wanted to happen.
18 Q. Could more use have been made of non-clinical staff to
19 be able to do that uploading onto the systems or to
20 provide an extra resource to do those tasks to help
21 provide that communication?
22 A. There could have been opportunities to do that as well
23 but always taking into consideration of the infection
24 control and the ability of healthcare staff to do that.
25 I know it's something some trusts and some wards did

1 actually do but I'm not aware that it was something that
2 was actually promoted across all hospital sites.
3 **Q.** Has there been a review done of the department about how
4 that system could be improved in future?
5 **A.** I'm not sure, at this point, having left office in
6 regards to that and, again, it's not something that I'd
7 ask for an update on.
8 **Q.** I'm going to move on to PPE and RPE. It's correct that
9 you didn't have any involvement in creating or
10 overseeing the guidance about what PPE should be used in
11 different circumstances in the healthcare settings?
12 **A.** That's correct.
13 **Q.** Did you have any understanding, and maybe the answer is
14 "no" based on what you've previously said -- did you
15 have any understanding whether FFP3 masks were more
16 protective than FRSM, so the fluid-resistant masks?
17 **A.** No.
18 **Q.** You didn't have any understanding or you didn't think
19 there was any difference?
20 **A.** I didn't have any understanding.
21 **Q.** I just want to ask you about a meeting that you had on
22 24 March 2020 with the First Minister and the deputy
23 First Minister and a number of officials.
24 If we can have on screen INQ000289853, thank you
25 very much.

1 So you can see there it says, on the health side
2 of things there's yourself, CMO, CNO, Chief
3 Pharmaceutical Officer, and then the senior official
4 from the Department of Health; correct?
5 **A.** That's correct, yeah.
6 **Q.** And then just under PPE we have:
7 "DoH noted that there is a misperception that
8 PPE is a major problem."
9 Was PPE access from healthcare workers within
10 hospitals a problem within Northern Ireland over the
11 pandemic?
12 **A.** It was a problem at the start but as the note goes on to
13 describe and as we worked out, our PPE supply mechanisms
14 across Health and Social Care wasn't as robust as it
15 could have been and it wasn't in a position
16 where -- well, sorry, it was reliant on PPE being
17 something that was always there, always available and
18 just-in-time development and deployment and I think
19 that's something that was reflective across health and
20 social care and not just in Northern Ireland but the UK
21 and even worldwide in regards to that.
22 **Q.** Because I'm acutely conscious there's another module
23 coming up dealing with procurement. So are you saying
24 these issues in terms of access were more procurement
25 issues and for BSO --

1 **A.** There was a mixture of both from procurement and
2 delivery and management of PPE across all our sites
3 where it was always that, and my understanding at the
4 start was individual wards were able to order what PPE
5 they needed and always had that supply whereas through
6 the pandemic in the early stages it was something that
7 was more of a controlled management system, at trust
8 level and BSO level.
9 **Q.** So that kind of trust level, how quickly was that
10 situation resolved in terms of delivery and storage?
11 **A.** It was quickly resourced in regards to BSO and PALS
12 working in conjunction.
13 **Q.** So by the date of this meeting, 24 March 2020, the local
14 level, the trust level issues of access to PPE had been
15 resolved?
16 **A.** I wouldn't say it had been resolved but it had been
17 noticed there's some issues of management with PPE with
18 trusts and healthcare professionals. "Need to avoid the
19 use where it's not needed", in regards to that, so there
20 was though challenges as well. And again, going down
21 through the document, more videos in development, but
22 who used them and where it was, and again, about how we
23 went about actually introducing measures to calm fears
24 in regards to the clear need and message around PPE that
25 it should be used. At that point in time we were also

1 looking, as the final bullet points to, the release of
2 the pandemic stock which was being held at a UK level.
3 **Q.** So the calming fears, it's the point above I wanted to
4 ask you about. It says:
5 "DOH have introduced additional measures to calm
6 fears."
7 Did you hear concerns from healthcare workers that
8 they didn't feel safe with the PPE that they had been
9 given?
10 **A.** Yes. And, again, that was I think work that again --
11 and, my Lady, I'm conscious about continually referring
12 to the CNO but it's going back to, I think, her evidence
13 as well in regards to the very detailed work that she
14 did along with her colleagues in regards to the
15 explanation videos, in regards to what PPE was used and
16 specific issues and specific situations as well and
17 I know she put a lot of work and dedication into
18 actually developing videos that were distributed
19 throughout the system as well, as to what to wear, when
20 to wear, and how to wear it.
21 **Q.** So did those concerns about healthcare workers not
22 feeling safe, did they disappear throughout the course
23 of the pandemic?
24 **A.** No, there was always that general concern and I think
25 one of the steps that we actually took was the creation

1 of a specific email address.
2 **Q.** PPE inbox?
3 **A.** PPE inbox, yes, where it was advertised and widely
4 spread across that if anybody had those specific
5 concerns they could email that inbox directly and their
6 query, their concern would be dealt with anonymously.
7 **Q.** And you set out the details, or the department set out
8 the details of that inbox in the statement, so I'm not
9 going to ask you about that.
10 But from your perspective, hearing those concerns
11 of healthcare workers, did you feel that the CNO was
12 doing enough to address those concerns?
13 **A.** Yes. And as I say, my Lady, I'm conscious that I'm
14 speaking here in her absence on her behalf but I think
15 that the level of dedication that the CNO put in to
16 addressing those specific issues I think were to be
17 commended.
18 **Q.** I want to ask you about in your statement which,
19 paragraph 289, it appears to relate to fit testing but
20 I wonder if you can expand upon this. You say:
21 "I regret, however, I cannot recall being made
22 aware of issues specifically in relation to age, race,
23 disability or pregnancy and so I did not take any
24 steps to address them."
25 Could you expand upon what you mean by that

1 paragraph?
2 **A.** And I think in regards to the flow of the statement,
3 I think it was, as I think you've indicated, it was
4 around fit testing, and I don't think there was any of
5 those specific issues were brought to my attention as to
6 why we were seeing at that point, was actually the
7 number of failures in regards to staff coming forward
8 for their fit testing.
9 **Q.** You so recognise that there were failures?
10 **A.** There were, yes, there was quite an extensive piece of
11 work in regards around that because we did see, I think
12 it was one of the contractors who were actually brought
13 in by the trusts to conduct the fit testing, that there
14 were a high degree -- or a high number of staff who
15 failed those or passed those when they shouldn't, and
16 the contractor was then challenged in regards to that.
17 **Q.** Do you think that those failures, particularly in
18 relation to age, race, disability, or pregnancy, should
19 have been brought to your attention?
20 **A.** If that was one of the reasons why those tests were
21 being failed, yes.
22 **Q.** Just moving to the PPE review. So on 15 April 2020 you
23 commissioned a Rapid Review that was led by the
24 department's internal audit team of PPE to assess the
25 appropriate receipt, storage, distribution. Was that in

1 response to concerns raised by healthcare workers in the
2 first wave or was that planning for the second wave?
3 **A.** I think it was a mixture of both. It was an issue that
4 had been raised and that PPE was an issue, I think, that
5 was live across all parts of Health and Social Care and
6 not just in regards to the supply, the distribution, the
7 utilisation. My Lady, again, I think in
8 Northern Ireland we kept that within BSO, within PALS,
9 and we were able to make sure that supply and purchasing
10 systems were, I believe, quite robust.
11 **Q.** The terms of reference review didn't include any
12 equalities issues; do you know why not?
13 **A.** In regards to that point I think it was specifically to
14 look at the supply and distribution in purchasing of
15 PPE.
16 **Q.** As far as you're aware, had there been issues raised
17 about inequalities with PPE in terms of difficulties fit
18 testing?
19 **A.** At that point I was aware we had -- there were some
20 issues again, brought to me in regards to masks not
21 maybe being specifically accessible or utilisation with
22 women's smaller faces in regards to that, so there was
23 work done in regards to that.
24 **Q.** Should that not have been included in the review? If
25 you're reviewing PPE as a whole, should you not want to

1 include equalities issues?
2 **A.** On reflection, it could have been and it wasn't at that
3 stage. My Lady, I'm unsure why it wasn't included at
4 that point.
5 **Q.** It seems there's a number of instances where there's
6 a failure of the department to consider what seemed to
7 be fairly fundamental questions of equalities. Does the
8 department actually hold equalities at the centre of all
9 the decisions that it takes?
10 **A.** Again, my Lady, for -- from responding now in my
11 position and not being able to speak on behalf of the
12 department, I would hope that it did but coming out from
13 even this morning's evidence sessions and from previous
14 evidence sessions, there may be a query that it needs to
15 do more.
16 **Q.** So a query it needs to do more, or would you go further
17 than that?
18 **A.** I would go -- well, speaking in a personal capacity,
19 my Lady, I think it should go further. I said that in
20 an earlier session in regards to previous answers as
21 well.
22 **Q.** I'm going to move now to the support that was provided
23 to healthcare workers. You talked earlier on about
24 after the first wave there was a need for rest and
25 recuperation for healthcare workers. Do you think

1 throughout the course of the pandemic, whether first
2 wave, second wave or subsequently, that there was
3 sufficient support given to healthcare workers?
4 **A.** I think at the beginning there wasn't but I think as we
5 moved through the pandemic, the additional supports,
6 again, identified through the Chief Nursing Officer and
7 chief professionals, Chief Medical Officer, there was
8 additional number of pieces of work actually brought in
9 to how we engaged and how we supported our workers
10 as well. I'm aware that the Chief Nursing Officer
11 actually worked with our Regional Trauma Network,
12 my Lady, in regards to the pressures that were on Health
13 and Social Care staff, Regional Trauma Network being
14 a specific body in Northern Ireland that looks to help
15 and support victims and survivors of the troubles in
16 regards to the psychological pressures that they're
17 under. So I do know that she reached into them as to
18 what supports could be given to our healthcare workers.
19 There was a development of, I think, the Thrive
20 project as well. I'm aware that the Chief Scientific
21 Adviser actually commissioned work through the Ulster
22 University in regards to the pressures that had came on
23 on our healthcare workers in response to that, and
24 I think Thrive actually engendered or engaged
25 psychological supports.

1 **Q.** Psychological support is one of the areas I am
2 particularly interested in, because your statement has
3 talked about a number of areas of psychological support
4 that's been provided. Was there actually 24-hour
5 psychological support available to healthcare workers?
6 **A.** I'm not aware and I don't have the detail of that
7 specific contract and support that was actually
8 delivered.
9 **Q.** I think we've seen documentation which shows it was 9-5,
10 Monday to Friday. Do you think there should have been
11 24-hour --
12 **A.** In reflection, yes, in regards to what should have been
13 available, what could have been available, it would have
14 made a better use.
15 **Q.** You say "on reflection". Is that not a reflection that
16 should have been made ahead of at least the second wave?
17 **A.** Yes.
18 **Q.** I want to ask two other points about additional support.
19 So the Department of Health emergency response strategy
20 from March 2020 talks about providing free travel for
21 Health and Social Care workers on public transport and
22 making car parking free for staff, and car parking and
23 free public transport was provided from April
24 to June 2020 and then it wasn't provided after that; is
25 that correct?

1 **A.** I think it was provided at later dates, as well, in
2 regards to the ability to do that. I know it was
3 actually as a result of a private members bill in
4 regards to the Assembly as to making car parking free at
5 all hospital sites both for staff and visitors alike.
6 We also provided not just free car parking, but all free
7 travel, we were working with the Department of
8 Infrastructure, supports to child care, we provided
9 a £500 payment to all Health and Social Care staff
10 without tax or National Insurance being taken from it,
11 as well, in regards to that.
12 **Q.** The reason I'm asking this question is that the military
13 assessment team from December 2020 that we looked at
14 earlier on say that:
15 "Simple incentives (beverages, food, free parking,
16 laundry, et cetera) should not be underestimated and
17 should be equitable and transparent across all trusts."
18 That was the assessment in December 2020. Does
19 that not indicate that those basic necessities hadn't
20 been provided for all healthcare workers prior to that
21 date?
22 **A.** They had been provided but not just on -- I think what
23 the military assessment is actually saying is that we
24 shouldn't underestimate the value of those things rather
25 than the fact that we haven't been providing them, if

1 I'm correct, because we had been providing childcare
2 support, as I say, and the free car parking as well.
3 And, again, one of the steps that I took, my Lady, was
4 I actually put £15 million across our five geographical
5 trusts, putting £3 million into each charitable -- each
6 trust's charitable status so they could actually utilise
7 that into how they would support their staff over and
8 above what was, I suppose, general costs that were
9 available to them.
10 **Q.** I'm going to move on to DNACPRs and advance care
11 planning. At any stage of the pandemic were you made
12 aware of concerns that blanket or inappropriate DNACPRs
13 were being imposed upon patients?
14 **A.** Not that they were being imposed upon patients but I am
15 aware that there were a number of written questions from
16 Assembly members and correspondence and my replies to
17 those is one that I believe that they were unethical and
18 not necessary to actually be deployed be it on age or
19 disability.
20 **Q.** I just want to tease that out. You set out in your
21 statement at paragraph 307, where you say:
22 "I received a number of written questions from
23 my fellow MLAs asking about the application of
24 DNACPRs. In my response I made it clear that orders
25 based on age or disability were discriminatory and

1 unethical. In terms of the policy in Northern Ireland
2 media reports were ill-founded."
3 It's that last sentence that I just want to focus
4 on. In response to those MLAs, were you saying that
5 complaints of any inappropriate use were ill-founded or
6 that it was ill-founded to suggest that there was
7 a blanket DNACPR as to policy in Northern Ireland?
8 **A.** It was ill-founded that there was a blanket response.
9 **Q.** On what basis were you saying that it was ill-founded
10 that there was a blanket response? How did you know
11 that?
12 **A.** On from feedback from officials in regards to that,
13 my Lady, in regards to if that was a response that
14 I'd have had to either an MLA question or a member's
15 correspondence, not just in response but there would
16 have been back-up documentation supplied with that
17 statement well.
18 **Q.** So you're satisfied that there was a response provided
19 to the department from, presumably, the trusts?
20 **A.** Yeah.
21 **Q.** That were provided documentation setting out
22 an assessment of whether the DNACPRs had been applied
23 inappropriately?
24 **A.** That they were being applied appropriately and there
25 wasn't a blanket response.

1 **Q.** You were aware of the concerns of families that there
2 was an increased number of DNACPRs being applied to
3 patients being admitted to hospital; is that right?
4 **A.** I was aware there was concerns being raised, yes.
5 **Q.** And what did you do in response to the concerns about
6 an increase in numbers rather than inappropriate usage?
7 **A.** Well, again those DNACPRs were medical assessments in
8 regards and they should have been, on all occasions,
9 from my understanding, and negotiated, are discussed in
10 regards to the individual and the family as well.
11 **Q.** Because this was an area, would you agree, that requires
12 maximum transparency in order to dispel family concerns
13 about the use of DNACPRs?
14 **A.** Yes.
15 **Q.** So there was a review done by CQC in England. Why
16 wasn't there an equivalent in Northern Ireland?
17 **A.** I believe the CQC investigation actually covered
18 Northern Ireland as well in regards to some of their
19 responses.
20 **Q.** But there wasn't an in-depth assessment done of DNACPRs
21 that had been imposed in Northern Ireland.
22 **A.** No.
23 **Q.** Do you think that there should have been in order to
24 provide that level of transparency that might have
25 assisted families?

1 **A.** Well, I think, taken from what I'm aware of, there was
2 a reliance on the work that had been done by CQC.
3 **Q.** It's true that the DNACPR forms weren't available on the
4 Northern Ireland Electronic Care Record; is that right?
5 **A.** I'm not aware of that, my Lady.
6 **Q.** Okay. That is from the statement of the witness on
7 behalf of the Western Trust who gave evidence as to the
8 spotlight hospital. As far as you were aware, did
9 inability to collate DNACPR forms play any role in not
10 ordering a review that could then be published?
11 **A.** Not that I'm aware of.
12 **Q.** You were involved in what's called in your statement
13 a single integrated process for advance care planning to
14 support DNACPRs that was approved for publication
15 in October 2020. Is that the ReSPECT forms that you're
16 talking about?
17 **A.** Yes, it takes into -- the advance care planning looks at
18 -- is proposed planning for all aspects, should it be
19 financial, inheritance, and engaging with families in an
20 early occasion.
21 **Q.** Yes, because it's right, isn't it, that actually there
22 is no power in Northern Ireland to provide a lasting
23 power of attorney that covers Health and Social Care
24 decisions?
25 **A.** That's correct.

1 **Q.** Because those powers do exist under the Mental Capacity
2 Act Northern Ireland 2016 but they've never actually
3 been brought into force?
4 **A.** That's correct.
5 **Q.** Do you think that during a pandemic it's beneficial for
6 there to be an option for people to put in place
7 a lasting power of attorney?
8 **A.** There should be the option in regards to that and
9 I think coming out of this Inquiry, and in today's
10 session, I think it will be a recommendation that
11 I would bring forward or even ask my Executive
12 colleagues to look at in the regards to the legislative
13 basis for that because I do believe, my Lady, that
14 across (*unclear*) and the Department of Health there is
15 a Department of Justice requirement for input too.
16 **Q.** Why wasn't that something that was looked at in the
17 middle of 2020, for example, about bringing those
18 provisions into --
19 **A.** I'm not aware why it wasn't raised at that point. It's
20 definitely something that wasn't brought to my
21 attention, nor was it something that I contemplated.
22 **Q.** It's difficult to ask why you didn't contemplate
23 something but I'll try anyway. Is that not something
24 that you should have thought about, about using the
25 powers that were available to the department for health

1 to actually plug a gap that would have been beneficial
2 for the pandemic?
3 A. It actually wasn't until preparing for this evidence
4 session that I was made aware that that lasting power of
5 attorney wasn't available in Northern Ireland under
6 those occasions.
7 Q. So you didn't know that until 2024?
8 A. That's correct.
9 **MR SCOTT:** My Lady, I'll be moving on to another topic. Is
10 that be a convenient moment to break for lunch?
11 **LADY HALLETT:** If you're moving to another topic, certainly.
12 Very well. We shall return at 1.45. And I promise we
13 will finish your evidence today, Mr Swann.
14 **THE WITNESS:** Thank you, my Lady.
15 **(12.45 pm)**
16 **(The short adjournment)**
17 **(1.45 pm)**
18 **LADY HALLETT:** Mr Scott.
19 **MR SCOTT:** Mr Swann, I'm going to move on to look at
20 services during the pandemic and I'm going to start with
21 NHS 111, please.
22 Prior the pandemic Northern Ireland didn't have
23 access to 111; is that correct?
24 A. That's correct.
25 Q. Why was the decision taken to join NHS 111 as part of

1 the response to the pandemic?
2 A. I think so we were able to provide that telephone
3 response in regards to telecommunications as to people
4 who were concerned they had symptoms of Covid, or other
5 queries.
6 Q. So I think access was from 28 February; is that correct?
7 A. That's correct.
8 Q. And how did the department actually go about joining as
9 part of the NHS 111?
10 A. I think that was an engagement that was actually had by
11 PHA in regards to how that engagement was actually taken
12 about, but then with the creation of our own Covid
13 centres as a direct point of contact, we think was a
14 more beneficial route for Northern Ireland patients.
15 Q. Yes, I'm going to come next to the Covid centres.
16 But do you know how NHS 111 from Northern Ireland
17 perspective was staffed?
18 A. There was supposed to be a specific section if you rung
19 111 and asked or indicated you were from
20 Northern Ireland it took you down a specific path as
21 well because of the peculiarities and the differences
22 within our healthcare service and structure in
23 Northern Ireland.
24 Q. You said "supposed to be". Was there not?
25 A. I think there were difficulties that were indicated at

1 the beginning of the pandemic and I think that's -- the
2 utilisation of that service in regards to that, that it
3 wasn't as seamless or efficient as we hoped it would be.
4 Q. And were those difficulties ironed out?
5 A. Not to the extent that we thought that the Covid centres
6 and our own "telephone first" services were actually
7 a better solution to the problem.
8 Q. So from 28 February Northern Ireland joined NHS 111 but
9 then, due to difficulties in the service, was it almost
10 put into abeyance because the preference was to go to
11 Covid centres?
12 A. Yes.
13 Q. On reflection, would there have been a better way to
14 handle joining NHS 111 or would you just not join it
15 at all in the event of a future pandemic?
16 A. I think on reflection we wouldn't probably join it
17 at all but actually go down our "telephone first"
18 service, which is part our "no more silos" strategy
19 that's been directed as to -- actually had a 111
20 alternative specifically for Northern Ireland, my Lady.
21 Q. I'm going to look now at general practice. There was
22 a perception that the population of Northern Ireland
23 couldn't get an appointment to see their GP. Do you
24 think that perception was true?
25 A. I don't think it was accurate on all occasions, as well.

1 We did put out a number of messages not just from the
2 department but also from the GP committee and the BMA in
3 regards to making sure that people who did need to
4 access healthcare could. There was also an introduction
5 in regards to telemedicine and into, again, additional
6 financial supports that the department provided to GP
7 practices as well.
8 Q. Yes, I think it is right, as the strategic framework
9 from June 2020 sets out at paragraph 2.3, "GP
10 appointments have reduced by 19.4% compared to last
11 year." Is that a statistic that you recognise?
12 A. It's not a specific, but I do know there was concerns
13 but, again, that was also offset in regards to those
14 telephone and visual appointments as well.
15 Q. Right. So any reduction in appointments was met by
16 an increase in remote telephone appointments; is that
17 right?
18 A. That was the intention, yes.
19 Q. It may have been the intention but was it the result?
20 A. I believe it was.
21 Q. Does the department keep detailed statistics about how
22 many GP appointments there are?
23 A. It didn't prior to the introduction of Covid but they do
24 now.
25 Q. At what point in time did it come in?

1 **A.** I can't remember the exact date but I'm sure, my Lady,
2 it was in the evidence bundles in regards to when that
3 was actually introduced because it was, again, one of
4 those measures that we found, I think, necessary and
5 useful as well.
6 **Q.** While we're dealing with telemedicine then, that was the
7 "telephone first" consultation process you were talking
8 about?
9 **A.** Yes, and also at GP level.
10 **Q.** Yes. That wasn't a new concept, was it? That was
11 a concept that had been considered in 2017; is that
12 correct?
13 **A.** I think it was initially looked at then, yes, as well,
14 but I think, due to the challenges of the pandemic, that
15 I think it was something that was actually -- additional
16 monies were put in to show that GPs -- GPs could
17 actually put further resource into it as well.
18 **Q.** Okay, because I want to compare the before and after, so
19 the Royal College of GP's statement at paragraph 14
20 says:
21 "The Department of Health in 2017 had encouraged
22 practices in Northern Ireland to consider adopting
23 a telephone first based triage system ... as a way to
24 manage increasing demand, but only a small number of
25 practices had taken this up. There were few practices

1 using digital telephony and no digitally enabled
2 triage systems in place. There was also no
3 e-prescribing capacity in Northern Ireland and this
4 remains the status quo."
5 So when "telephone first" was brought in, were you
6 actually starting -- well, not "you" -- was
7 Northern Ireland actually starting from a position where
8 there was sufficient capacity to carry out telemedicine?
9 **A.** No, and that's the way the department actually put the
10 additional resource in to that point. I think the
11 initial was in the region of £1.7 million in regards to
12 that additional support specifically for that issue.
13 **Q.** And at what point in time did you consider that there
14 was sufficient capacity across primary care generally?
15 **A.** I would still be at an opinion, my Lady, in regards that
16 we don't have sufficient capacity still within general
17 practice. And again, even when I returned as minister
18 in February 2024, I did work to put additional supports
19 into general practice to make sure that we had the
20 ability to make sure that what we wanted general
21 practice to do was actually -- they were able to deliver
22 it as well, because we still have challenges within our
23 primary care in general practice.
24 **Q.** Do you consider that telemedicine or the "telephone
25 first" consultation process is one of the success

1 stories of the pandemic?
2 **A.** It is something that was actually -- well, as you've
3 indicated, it was initially identified as 2017. It was
4 disappointing it took until the additional investments
5 that were made in 2021, due to the pandemic, that that
6 was actually the enabler to bring about that
7 transformation.
8 **Q.** And can I please have your statement on screen.
9 It's INQ000492281. It's at page 38,
10 paragraph 103.
11 Because it may have been a success story in terms
12 of the roll-out of telemedicine to enable people to have
13 telemedicine, do you think that there was sufficient
14 consideration of equalities about the impact that moving
15 to remote appointments in primary care would have?
16 **A.** I don't think there was the ability during the pandemic
17 to take all that into consideration. I do think there
18 is more work needs to be done in regards to that. The
19 messaging at the time was if you still needed to see
20 your GP, you should be able to get an in-person
21 appointment as well.
22 In regards to the additional supports to
23 telemedicine, I do know that we provided additional
24 resource to make sure that there was accessibility
25 through British Sign Language and Irish Sign Language to

1 anybody utilising the service.
2 **Q.** Your statement says it wasn't possible to carry out
3 equality impact assessments. I think we've seen in
4 statements they tend to take about 12 weeks, is that
5 right, and tend to involve consultations?
6 **A.** Yes.
7 **Q.** But it's right that there is a slightly lower level in
8 terms of equality screening that can be carried about in
9 terms of policy that might be put in place; is that
10 right?
11 **A.** That's correct, yes.
12 **Q.** And the equality screening doesn't have to take anywhere
13 near 12 weeks, it's done on a form, generally by an
14 official within the department, and then reviewed and
15 countersigned?
16 **A.** Yes.
17 **Q.** If we can please go to paragraph 105, where you say:
18 "I cannot recall any specific mitigations for
19 older patients, disabled patients particularly those
20 with sensory impairments, patients whose first language
21 was not English, those with literacy issues, patients in
22 areas with poor internet connectivity, patients who were
23 homeless, patients from lower socioeconomic groups."
24 Are you saying that the Department of Health
25 didn't consider the impact of a change in the mode of

1 access to primary care for all those groups?
2 A. I am, yes, in regards to the specific introduction to
3 the telemedicines in regards to that. As I say,
4 I referred earlier to the enabling of the sign language,
5 which was already something that was available through
6 Health and Social Care --
7 Q. Yes.
8 A. -- and the department, so it is regrettable, but
9 unfortunately, my Lady, that was the reality that we
10 were facing.
11 Q. You say it's a reality that you were facing. It's not
12 a reality that you can't carry out equality screening on
13 bringing in a policy such as "telephone first"?
14 A. In regards to the work that had been done in 2017 and
15 the introduction to telemedicine, as I said, I think in
16 a previous statement, there is more could have been done
17 and more still could be done to make sure that we gain
18 the full advantage of what is there.
19 Q. In terms of more that could be done, has an assessment
20 of the impact upon those groups been carried out since?
21 A. Not to my knowledge at this point and from the position
22 I'm coming from.
23 Q. Why not?
24 A. I don't know, my Lady, and I'm not in a position to. To
25 answer that, whether the department can, would be maybe

1 appropriate.
2 Q. Is this another example of the department not looking at
3 decisions with an equalities lens?
4 A. And from the evidence that's been put today and from the
5 number of incidents that has been mentioned, my Lady,
6 I think, yes, that can be another issue that can be
7 asked and, as I've said in previous answers, I think
8 it's something the department could pick up on.
9 Q. I'm going to move now to the primary care Covid-19
10 centres. So those were intended to provide services for
11 those suspected of Covid-19, and the intention was
12 people with Covid-19 would go to those centres and that
13 would keep GPs free for non-Covid patients; is that
14 correct?
15 A. That's correct, yes.
16 Q. Where did the idea come from?
17 A. It came from, I think, discussions with the department
18 with GPs, through the BMA and Royal College of GPs in
19 Northern Ireland, and it was something we were able to
20 deliver actually at pace. I think we were able to open
21 the first centre towards the end of March 2020.
22 Q. Did it work?
23 A. It did, yes -- well, sorry, in my interpretation and my
24 take from -- my Lady, yes, I think it did. I think we'd
25 seen up to 65,000 patients or people went directly to

1 Covid centres rather than approaching GPs.
2 Q. So that was the aim, wasn't it, to keep people out of GP
3 surgeries and also to provide a pathway to hospitals,
4 emergency departments; is that correct?
5 A. That's correct, yes.
6 Q. And so the department considers that that system
7 achieved its aims?
8 A. Well, I'm not sure if the department does, but I do,
9 my Lady. I think it was one of those successes where
10 I actually saw primary care department and trust coming
11 together to deliver those at pace.
12 Q. Going to move now to ambulances. So we've seen in some
13 of the department's reviews of access to emergency care
14 that it's actually not possible to compare -- or it is
15 possible but it's not appropriate to compare ambulance
16 response data before 12 November 2019 with any data
17 after that because there was a change in the clinical
18 response model; is that correct?
19 A. That's correct, from my understanding, yes.
20 Q. And then there was another change actually in
21 18 October 2021 due to a slightly different way that the
22 statistics had been recorded; is that right?
23 A. As far as I'm aware, yes.
24 Q. So the statistic that effectively people are left with
25 is the percentage compliance of how Northern Ireland

1 Ambulance Service (NIAS) met the targets that had been
2 set for response times; that's a fair comparison?
3 A. Yes.
4 Q. And the department statement sets out at
5 paragraphs 429-430 that:
6 "Between April 2020 and March 2022, the mean and
7 95th percentile targets for Category 1 (Immediately life
8 threatening for a response to arrive at the scene) and
9 Category 2 (Emergency calls which are potentially
10 serious) ..."
11 So the mean and 95th percentile targets for both
12 of those.
13 "... were not met during any month."
14 A. That would be my recollection as well, but I think the
15 T1 responses were actually -- where a vehicle is
16 required to be in attendance, were met.
17 My Lady, the pressures on our ambulance service in
18 Northern Ireland are not specific due to the Covid
19 Inquiry. In fact, there's still a challenge in regards
20 to what we're able to deliver and, again, against what
21 we want to deliver.
22 Q. You say that you approved significant additional funding
23 over the period of the pandemic for NIAS, and then,
24 paragraph 94, you say:
25 "[You've] asked officials in the Department of

1 Health as to whether there is information pertaining
2 to ... whether these funds resulted in the expansion of
3 999 capacity but I understand these figures are not held
4 by the Department."
5 Is there a difficulty here that if the department
6 is providing additional funding to an organisation such
7 as NIAS in order to improve its services if it then
8 doesn't actually track whether that funding has achieved
9 the aim?
10 **A.** Well, as the sponsoring authority, on their value for
11 money I believe it should in regards to those. I think
12 at the time of the writing of the statement I wasn't
13 provided with that detail as to whether that had been
14 applied.
15 **Q.** So it may be that the department does have other
16 information but you weren't aware when you were writing
17 your statement?
18 **A.** As far as I'm aware.
19 **Q.** So when you were asked, for example, to provide funding
20 for NIAS to improve its services, would you ever find
21 out whether that funding had been considered to be
22 effective?
23 **A.** Well, in regards to, I think all -- I think actually the
24 majority of the bids that come into NIAS were met during
25 the Covid pandemic. Again, it was for additional hours,

1 it was for PPE, it was for turnaround times, additional
2 cleaning of ambulances to -- sure -- I'm not sure what
3 metric was then applied to make sure that money was
4 actually utilised to the extent that it was meant to,
5 and that's, I think, from that previous answer.
6 **Q.** Okay. One sub-topic for ambulances. At the Executive
7 meeting on 8 April 2020 there's a question about
8 "Air ambulance suspended", and you replied "helicopter
9 suspended air ambulance plane available OK".
10 I appreciate those notes are not notes you took, they're
11 not formal minutes. Was the air ambulance helicopter,
12 as opposed to the plane, suspended at any point during
13 the pandemic?
14 **A.** Not that I am aware of in regards to that specific --
15 but, again, you're referring to handwritten notes that
16 only became evident and presented during the Inquiry.
17 **Q.** Because given the geography of Northern Ireland, it is
18 a critically important service to maintain; is that
19 right?
20 **A.** It's a very valuable service and I think has saved many
21 lives in the past, yes.
22 **Q.** Given you don't remember that, I'm going to move on to
23 a different topic, to look at emergency departments.
24 Why are the waits so long, emergency departments
25 in Northern Ireland?

1 **A.** My Lady, this isn't specifically due to Covid.
2 Unfortunately, it's a challenge that has faced the
3 Health and Social Care in Northern Ireland through quite
4 some period of time.
5 I think why they are so long is actually due to
6 the flow of patients through our entire hospital system.
7 So it's not just moving patients from the emergency
8 departments and to available bed capacity within wards
9 but it's also the onward movement of people who are in
10 the wards, actually moving them back into community
11 settings as well. So when I came back in as minister in
12 February 2024, I put in money into social care to
13 improve that flow through and actually that support of
14 getting people out of hospital, so we can get people --
15 if you can get them out of hospital, you can get them
16 from ED and to wards, and that improves the flow
17 throughout the entire system. Because no part of our
18 system in Northern Ireland, or indeed across Health and
19 Social Care, can be looked at in isolation in regards to
20 the challenges.
21 **LADY HALLETT:** Same problems we have in England, isn't it?
22 **A.** Yes, it would be, my Lady.
23 **MR SCOTT:** But to indicate the scale of the problem, I think
24 it's right that the Northern Ireland hospital statistics
25 emergency care from 2022-2024 recorded that between

1 2018-2019 and then 2022-2023, the number of patients
2 spending longer than 12 hours in emergency department
3 increased from 25,326 to 106,990. So that's a fourfold
4 increase.
5 **A.** Yeah.
6 **Q.** Why aren't the times getting any better?
7 **A.** Because we haven't been able to sustain that investment
8 in the transformation in health that we've wanted to
9 throughout that entire period of time. And again,
10 my Lady, it's down to the topics we've covered
11 previously, in regards to not having
12 a functioning Executive for five out of the last
13 eight years, having single non-recurring budgets year on
14 year since 2016, so the investment in health and social
15 care and domiciliary care hasn't been as robust as
16 I think it should be. It's several steps I took when
17 I was there as minister, and again, my Lady, the
18 difference being is the domiciliary care in
19 Northern Ireland is part and responsibility of Health
20 and Social Care and not devolved to the local authority.
21 **Q.** Did Covid-19 break emergency care or just exacerbate
22 an existing weakness?
23 **A.** I think it exacerbated the weakness that was already
24 there, but it added additional numbers as well. The
25 intention is well-being, that our Covid centres would

1 have diverted some of that pressure away as well. So in
2 regards to the numbers of people who may have been
3 presented to ED with Covid symptoms could -- actually
4 went to Covid centre instead. But definitely the Covid
5 pandemic highlighted and exacerbated the weaknesses we
6 have in health and social care across Northern Ireland,
7 not just in ED but across the entirety of our system, by
8 the additional pressures that were put on our health and
9 social care staff as well.
10 **Q.** I understand that you say that the primary way, maybe
11 the only way, to fix it is investment, but what steps
12 had you taken within the resources available to you, so
13 absent any additional funding, in 2020, 20201, 2022 to
14 try ton improve the waiting times within emergency
15 departments?
16 **A.** Well, it is about the additional monies. As I said,
17 my Lady, the additional monies that were put into
18 domiciliary care, so we could provide actually more
19 packages, more -- more hours to get the flow through
20 hospital actually better, so we get more people out of
21 wards and off beds so that we could get them from ED
22 in -- that's the additional investments that were made
23 in GPs as well, so that people could actually be seen at
24 a GP rather than the need to go to the emergency
25 departments as well.

1 **Q.** Because it's right that two urgent care services, so
2 phone first, which I think is where you call an
3 emergency department -- or, slightly lower, minor
4 injuries unit, is the word I was groping for, and then
5 urgent care centres, that were introduced in late 2020,
6 were aimed to assess patients needs before arrival and
7 ensure they received the right care at the right time
8 and in the right place, outside emergency departments if
9 appropriate.
10 Has either service actually worked?
11 **A.** Well, they're beginning to work. There's also the
12 introduction of ambulatory units as well, where people
13 could actually be taken to a specific speciality in
14 regards to when they do present in EDs as well. It's
15 about the whole package. It's not just simply about
16 looking at EDs, as I keep on referring to. We need to
17 improve our domiciliary care packages and support, we
18 need to improve our flow through hospital, we need to
19 get people actually seen quicker at the right point and
20 the right time. And I think some of steps that have
21 been made -- and our transformation from our elective
22 care strategy, through the introduction of day care
23 procedures unit, elective overnight centres, you know,
24 these are all things that, my Lady -- and, honestly, if
25 they had been introduced as part of Bengoa, post 2017,

1 would actually have made the introduction of red and
2 green sites or the flow through our hospital systems in
3 Northern Ireland actually in a better place coming into
4 the pandemic rather than where we are now.
5 **Q.** You're talking about this being part of the piece, it's
6 about the whole system working, so I just want to ask
7 you about non-emergency departments, about what the
8 department has done to effectively restart services in
9 the pandemic.
10 I think it's right there is a headline comment
11 from the Elective Care Framework that was produced by
12 the department in July 2021 which reports that in
13 March 2019 it was reported that a person in
14 Northern Ireland is at least 48 times as likely as
15 a person in Wales to wait more than a year for care.
16 This is despite Wales being the worst performer
17 otherwise in the UK. That's something you recognise?
18 **A.** I think it's actually part of my opening statement for
19 the elective care strategy. It was produced at that
20 stage. My Lady, can I say that was flowing on from
21 an elective care strategy that was actually published
22 in 2017 that was never built on or never enacted due to
23 the fall of the Executive.
24 **Q.** And I think the 2020 regional service delivery model for
25 day case selective talks about how that the reasons, the

1 fundamental reason why the current levels of waiting
2 lists is because demand is increasing due to demographic
3 change and its demand for care is steadily outstripping
4 the ability of the system to meet it.
5 Prior to the pandemic, for how long had demand
6 been outstripping the ability of the system to meet it?
7 **A.** I think for a number of years in regards to that,
8 possibly from 2016, 2017, if I recall the figures from
9 my time in the department. As I say, when I went into
10 the department and took on the role in January 2020 the
11 biggest challenges or the two challenges were industrial
12 action and the state of our health service in regards to
13 ever-increasing waiting lists.
14 **Q.** I think it's fair to say that the fundamental problem of
15 demand outstripping and lack of investment wasn't
16 something that was fixed during your time as health
17 minister?
18 **A.** Not during the pandemic years, as well, between
19 January 2020 through to when the -- the Executive
20 actually fell, my Lady, in February 2022, ministers were
21 then retained in post up until October 2022, without
22 Executive meetings, without access to being able to
23 formalise or actually having a political decision in
24 regards to budget, that was something that was brought
25 in by direct rule. So did waiting lists get better

1 during any tenure? No, but we were faced by a pandemic
2 through that time as well and then at that point the
3 Executive fell again in October 2022.
4 Q. It wasn't intended to be critical that question, it's
5 a factual statement that it hasn't resolved in your time
6 as health minister.
7 A. No.
8 Q. Is there anything more that you think that you could
9 have done as health minister to improve the situation?
10 A. During the two periods that I was in the first, as
11 I say, the intention was about how we actually developed
12 and delivered the recommendations from Bengoa, my Lady,
13 in regards to the transformation that we could have
14 delivered and we should have actually been pre-delivered
15 prior to 2020. The pandemic then set us off course in
16 regards to how we reacted, how we were firefighting
17 against a global pandemic but also working with a system
18 that was already under pressure. I wasn't able to do
19 that during that time, but I think coming towards the
20 end, when we looked to the development, as I say, the
21 day case procedure units, the elective overnight
22 centres, post-anaesthetic care units as well. There
23 were those measures that were being taken, were being
24 introduced, but again -- and I know it was something
25 that was said in the witness statements -- do require

1 that commitment of sustained recurrent funding to enable
2 those transformation projects actually to continue.
3 Q. The Inquiry's looking at four non-Covid conditions,
4 ischaemic heart disease, hip replacement surgery,
5 colorectal cancer, and inpatient mental health services
6 for children and young people. Just putting aside the
7 mental health services for one minute, in relation to
8 ischaemic heart disease, hip replacement surgery and
9 colorectal cancer, are the challenges faced in restoring
10 those services to what you think you would consider
11 an acceptable waiting list, do all of them have exactly
12 the same answer?
13 A. They do, and I think it refers to about how we bring
14 about that transformation, just as how we look to those
15 specialised centres across Northern Ireland that
16 currently is happening, or is something that my
17 successor is currently looking at, at how we look to
18 specialised centres that can do high-number volumes of
19 those specific procedures, surgeries, diagnostic tests,
20 rather than looking to each trust possibly doing a few
21 so we can actually bring that about and, again, come
22 back to elective overnight centres or day case procedure
23 units, that's what those are all intended to do.
24 Q. I am very shortly going to look at some of those
25 responses in 2020 and 2021. Just one point I want to

1 ask you about is targets. We see throughout a number of
2 the departmental statements and frameworks that have
3 been produced, discussion about targets, so waiting
4 lists for no longer than 9 weeks and no patient waiting
5 longer than 52 weeks. What's the point of those
6 targets?
7 A. It's to set that challenge to those who deliver, those
8 who support, those who call for investment in health and
9 social care, actually, to see what can be achieved, what
10 we want to achieve, and I don't think by moving or
11 removing those targets would actually improve the
12 service because I do believe anybody working in health
13 and social care in Northern Ireland has a genuine desire
14 to meet those targets.
15 Q. So were they actually more to inform people outside the
16 health service about the state of the health service
17 rather than people inside it?
18 A. No, there's balance for both in regards to people
19 outside the service actually knowing what the health
20 service targets are and in regards to the supply of that
21 information, it is something I believe is now available
22 on a central website or a central database across all
23 the trusts, so it's available to the general public as
24 to what state or where the waiting list is in each
25 specific specialisation in each trust area as well. One

1 of the steps that my successor has taken is people are
2 able to move across trusts as well should there be
3 available ability to do that.
4 And we were looking at that in regards to how we
5 actually utilise the whole of the health estate across
6 Northern Ireland and that patients aren't simply
7 restricted to the geographical trust that they live in.
8 Q. And that comes about through an overarching strategy
9 that's imposed by the department rather than leaving it
10 to the individual trusts; is that right?
11 A. That's correct.
12 Q. And is that not something that could have been brought
13 in at a much earlier stage rather than your successor
14 looking at in now?
15 A. Well, no, there is the Elective Care Strategy, I think
16 we actually quoted in their section as well, there's a
17 cancer strategy, there's a mental health strategy in
18 regards to how you set about all those specific pieces
19 of transformation. We also, I suppose -- I'm sorry, the
20 department also employed GIRFT, getting it right first
21 time, assessments in regards to our orthopaedics, in
22 regards to EDs, you know, in regards to how we actually
23 bring about those changes.
24 Q. I want to look briefly at CAHMS. The Department of
25 Health's statement on data at paragraph 53, says:

1 "During the relevant period, the Department did
2 not routinely collect data that in relation to the
3 number of people referred for inpatient mental health
4 services ..."
5 How can there be an effective commission of
6 services if you don't know how many people need them?
7 **A.** It's a weakness that was in the system and I know it's
8 something that I and my special adviser have actually
9 raised within the department on a number of times as
10 well. You mentioned, I think a moment or two ago, the
11 mental health strategy. There actually is a target
12 within the mental health strategy in regards to
13 additional investment in regards to CAHMS, because it
14 was something that was identified by us as needing work
15 done on it, it was something that was discussed at the
16 Assembly level through the health committee as well.
17 **Q.** But isn't it simpler than making sure there is a mental
18 health strategy, isn't it simply, doesn't the department
19 need to know how many --
20 **A.** It does, yes. That data wasn't -- no, I do recall it
21 was a specific that we did challenge.
22 **Q.** It says:
23 "... the department has overseen the introduction
24 of the ... Acute Managed Care Network ... which became
25 operational in February 2022. Work is currently being

1 taken forward by [that network] which will, when
2 complete, enable the department to undertake routine
3 monitoring with the number of inpatient CAHMS
4 referrals ..."
5 That suggests that the department still doesn't
6 hold that data even though the network has been in place
7 two years?
8 **A.** That would be my reading from that statement as well,
9 but as I say, not -- when the Executive and the First
10 Minister resigned in February 2022 there was additional
11 pressures that we were putting on it. Again, it was
12 something that we were specifically asking for within
13 the department was that additional investment and
14 recognition of CAHMS because I knew it was an area we
15 were lacking in.
16 **Q.** Is there a fundamental difficulty with the department
17 being able to access the data that it needs and it's
18 taking multiple years in order to get that data?
19 **A.** I think there has been a general recognition that the
20 number of databases and points of collection have been
21 outstripped by the need of what is accessible and what
22 is concurrent and what is needed by the department to
23 formulate those responses. And I think, my Lady,
24 I hope, my Lady, in regards to that is why the
25 department invested so heavily and the introduction of

1 encompass so that we could have a single point or a
2 single data system that would cover eventually all five
3 trusts.
4 **Q.** I want to look then briefly at the independent sector.
5 You say in your statement that you expected 120 to 135
6 procedures would be carried out per week across a range
7 of red flag and urgent cases. Could you define red flag
8 cases for us, please?
9 **A.** Red flag is cancer or specific medical cases that the GP
10 has indicated that need urgent and timely assessment.
11 **Q.** And you say that was a reduced number of procedures but
12 the best possible in the circumstances. So are you
13 satisfied that no greater use could have been made of
14 the independent sector to either provide additional
15 capacity to carry out treatments or to support HSC in
16 the actual provision of staff or beds to treat Covid?
17 **A.** From the questions that were made by, I think, between
18 the trusts and the Health and Social Care Board
19 contracting and contacting the independent providers in
20 Northern Ireland, which we have a very small independent
21 sector in Northern Ireland, I think it was in the region
22 of 130 beds across the three providers, so it's not
23 comparable to what was here in England or Wales or,
24 indeed, Scotland. But from the feedback that I was
25 getting from those department officials and from the

1 Health and Social Care Board, I was being assured we
2 were making best use of what was available.
3 **Q.** When you say best use, do you mean maximum use?
4 **A.** Yes, maximum use, yes, and I think there's also the
5 concern -- sorry, there's also the added challenge at
6 that stage our independent sector in Northern Ireland
7 didn't have critical care capacity either.
8 **Q.** But, again, it's about using the tools available to you
9 as the health minister even though they are the
10 independent sector but making sure you're using the
11 maximum capacity across all sources of capacity; is that
12 right?
13 **A.** That's correct, and my understanding is that's what the
14 Health and Social Care Board and the trusts were doing.
15 **Q.** I want to look now, just briefly, at three frameworks
16 about rebuilding services. The first is June 2020 which
17 was called the Rebuilding HSC Services to Treat it
18 Framework. What was that framework meant to achieve?
19 **A.** It was meant to show how the system was preparing to get
20 back to the level of delivery that we had prior to the
21 first wave.
22 **Q.** And what was the role of the department in restarting
23 services?
24 **A.** Produce that framework, produce the overarching policy,
25 and then to challenge the Health and Social Care Board

1 and the trusts to deliver.
2 Q. So in this instance isn't the policy: we need to be
3 rebuilding our services, and then it was over to trusts
4 to decide how to implement that?
5 A. Yeah, but there was also that co-production and
6 co-working with the Health and Social Care Board and the
7 trusts to actually do that.
8 Q. Did the department take a firm enough grip about making
9 sure there was a regional response to rebuilding
10 services?
11 A. I think in regards to the challenge of the Health and
12 Social Care Board whose remit it would have been to
13 challenge the trust, I think we were being that
14 challenge function, the establishment of the regional
15 prioritisation organisation group in regards to --
16 Q. The prioritisation group came in in January 2021; this
17 is June 2020.
18 A. Yes. And again, there was that challenge there in
19 regards to what each trust was delivering again, because
20 those documents were public facing and publicly
21 available.
22 Q. Did that framework actually achieve its aims?
23 A. I think that framework was actually probably superseded
24 by the second wave.
25 Q. I want to look at one specific example under it. At

1 paragraph 2.31, so page 14 of that framework, it says:
2 "The downturn in red flag demand through April
3 and into May means that all Trusts outside of Belfast
4 currently report that all parties who are suitable to
5 be listed for surgery have a scheduled date, either
6 locally, or within the Independent Sector facilities
7 secured by HSC."
8 That was probably the best position that
9 Northern Ireland had been in for years, is that correct,
10 about people having dates for cancer treatments?
11 A. It wasn't the best position in regards to the number of
12 people who were probably coming forward for treatment or
13 who had been identified for red flag in regards to that.
14 The fact that at that point we were able to meet need
15 didn't mean to say we were delivering the service we
16 should have been.
17 Q. Yes, because that's what I want to go on to next. So
18 the paper to the Executive and the Department of Health
19 on 17 December sets out there's been an increase in the
20 number of patients on the 62-day cancer pathway and then
21 it sets out that at 1 October 2020, 3,500 patients are
22 waiting longer than 62 days compared to 1500 or so on
23 11 March 2020, an increase of 125%.
24 So, is it the position that even though you'd
25 managed to reach a point where need had been met,

1 I think to use your words, the demand completely
2 outweighed the ability of the service to provide?
3 A. To look at those -- I suppose maybe not to challenge
4 looking at those two specific points in time as being
5 absolutes, it was, I think, the overall demand prior
6 to -- what was presenting prior to the pandemic and when
7 we saw the realistic demand of full presentations coming
8 through GPs and EDs.
9 Q. And again, I'm probably going to get the same answer but
10 was the way to actually address that, the restructuring,
11 the funding, the investment?
12 A. It is, and then I think, my Lady, there's -- quite
13 a number of the questions I could answer today is about
14 funding and investment and recurrent budgets in regards
15 to the health service and what it actually needs in
16 Northern Ireland but I was taking the direction by
17 counsel at the start that that shouldn't be the answer
18 to everything today.
19 Q. And again, is this the same position in relation to the
20 regional service delivery model for day case elective
21 in July 2020, that you put out in place --
22 A. No problem.
23 Q. That you put in place those centres to deliver. You
24 handed them over to the South Eastern Trust or the
25 Belfast Trust but actually there hasn't been the

1 breakthrough in terms of waiting list reduction that
2 you'd look for?
3 A. Well, there hasn't been the large-scale breakthrough in
4 regards to overall reductions to a significant level but
5 it's also about the plateauing of the level of demand
6 against what we can actually supply before the health
7 service as it currently starts to meet the need and
8 actually start to eat into those waiting lists. But
9 again, my Lady, in respect to where the service
10 currently is, I think it's something the department
11 could probably address those issues.
12 Q. Was sufficient use made of elective hubs to ensure that
13 diagnosis and/or treatment for non-pandemic conditions
14 could continue uninterrupted in a future pandemic?
15 A. I think the establishment and, again, it was the call
16 even from Royal College of Surgeons as well about the
17 establishment of red and green surgical hubs were of
18 a benefit. I think prior to the pandemic that work
19 hadn't been completed in Northern Ireland but with the
20 establishment of our day case procedures units or
21 elective overnight centres, there is an ability now to
22 designate those, should there be another pandemic, as
23 those green pathways to service.
24 Q. And then finally and briefly, the elective care
25 framework of July 2021. The experts instructed to look

1 at hip replacements gave evidence and they said that:
2 "... the blueprint ... which recommended elective
3 care ... the recommendations were fairly non-specific
4 and I don't think were well adhered to. There certainly
5 wasn't a financial incentive."
6 There was:
7 "... a review in February 2022 by GIRFT programme
8 which was initially an NHS England initiative that went
9 to visit Northern Ireland and made a series of
10 recommendations which were much more about having more
11 focused central organisation of care for orthopaedic
12 waiting patients."
13 Do you agree with that assessment?
14 A. Actually GIRFT was commissioned by the department to
15 come in and look at orthopaedics in regards to that
16 robust challenge as to what was actually needed in
17 regards to that and I think one of the recommendations
18 actually wasn't even down to the management of who
19 managed Musgrave Park in regards to what trust it should
20 actually be held in and it was managed by Belfast Trust,
21 and I think one of the GIRFT recommendations was that if
22 the Musgrave Park facility didn't get up to the required
23 number of procedures by a certain date, that the
24 management of that site should be taken over by another
25 entity or trust.

1 So the GIRFT report, I think, was much more
2 detailed and forensic in regards to what it was actually
3 saying.
4 Q. But was the outcome of that effectively about having
5 a more focused central organisation of care?
6 A. Yes, in regards to the GIRFT report recommendations.
7 Q. That seems to be a recurring theme, that's from GIRFT,
8 that's from the military assessment about critical care,
9 that there needs to be a greater grip taken to ensure
10 that there's a regional approach; do you accept that?
11 A. I do and I think part of the, I suppose, the
12 restructuring and the moving of Health and Social
13 Care -- the closure of the Health and Social Care Board
14 into SPPG within the department should bring about that
15 focus because it's now in the house in regards from
16 a departmental point of view in regards to where that
17 challenge actually sits.
18 Q. I am going to move on to a different topic, and it's
19 about paediatric pathology.
20 Did you hear the evidence of Catherine Todd about
21 the experiences with her son Ziggy when he was sent for
22 the post mortem?
23 A. I have. And, my Lady, in regards to that I think it's
24 not just in regards to the evidence that was given, my
25 son was in Birmingham hospital at 8 months old for his

1 first open heart surgery, we actually met a couple from
2 Lisburn in regards to a child who was over there for
3 medical treatment, they passed away, and regards were
4 actually left, and a similar situation in regards to
5 being able to bring the child home at that point as
6 well. So again, my Lady, I don't think I can
7 underestimate the evidence that has been given from
8 individuals in regards to what can be done, what should
9 be done.
10 In regards to the paediatric pathology, I think
11 there is an opportunity, actually, that we can develop
12 an all-Ireland solution in regards to paediatric
13 pathology, it's something we've actually been able to do
14 through paediatric cardiology and something that has
15 worked very well. So there are solutions that are there
16 but the challenges that we currently face with not
17 having a commissioned service in Northern Ireland,
18 I think are the outworkings of stories like Ziggy's.
19 Q. Isn't it right that effectively that's been the
20 situation since January 2019 when the paediatric
21 pathologist retired?
22 A. That is correct and we've been able to -- unable to
23 recruit a paediatric pathologist for Northern Ireland
24 and, unfortunately, some of those workstreams, my Lady,
25 fall, when there's no Executive in place or push to do

1 that because the establishment of an all-Ireland
2 approach would be something that would require
3 a ministerial decision, something I can assure you,
4 my Lady, that I was fully supportive of, I would be
5 fully supportive of and I know my successor is.
6 Q. Can I move on to shielding.
7 The department statement says:
8 "By 25 March 2020 letters were being issued to the
9 Clinically Extremely Vulnerable population by
10 a combination of General Practitioners and Health and
11 Social Care Trusts. In practical terms it required
12 a number of weeks for all these letters to be issued."
13 I believe when Ms Hargey gave evidence to
14 Module 2C, she talked about it taking a couple
15 of months, two months, and additional, because of
16 seeking to access 500 databases for each of the general
17 practice surgeries and that took the additional period
18 of time. Could it have been shortened, when I say "it",
19 could the period of time to communicate to those who
20 should shield that they needed to shield have been
21 shortened?
22 A. Not with the functionality that we actually had at that
23 point in time and I think the exact figure was in the
24 region of 370, different databases, that actually had to
25 be sometimes manually trawled across Northern Ireland

1 actually to identify those who met the criteria that was
2 necessary for shielding as well. And again, I think
3 that's why the investment in encompass is worthwhile at
4 this point. But also rather than just stopping the
5 development of it, the access to it by the five trusts
6 that decide to look at it, but going further into
7 general practice or even community pharmacies.
8 **Q.** Has anybody run a test on encompass to see whether it
9 would be able to actually deal with an issue such as
10 notifying people who should shield?
11 **A.** Not that I am aware of.
12 **LADY HALLETT:** Sorry, I failed to catch the first part of
13 your question, as did the stenographer.
14 **MR SCOTT:** Has a test been run to see whether encompass can
15 deal with an issue such as notifying people?
16 **A.** I'm not sure but I know that was one of the selling
17 points that was presented to me that we would have
18 a single system across Northern Ireland that would be
19 accessible, but it does involve it being across all five
20 trusts and accessible to a point of where that
21 functionality can be actually introduced.
22 **Q.** Do you know how many people in Northern Ireland were
23 shielding?
24 **A.** I don't have a figure, no.
25 **Q.** Do you think the department knew?

1 **A.** I do, in regards to the cumulative number of letters
2 that they were asking to be issued.
3 **Q.** Because the briefing paper on 18 June 2020 says there
4 are more than 95,000 people who have been advised to
5 shield but the notes of the Executive meeting on
6 5 January 2021 talks about up to 200,000. Does that jog
7 your memory about how many people there may have been?
8 **A.** If those figures were reported to the Executive, yes.
9 **Q.** Was there clarity about what support should be provided
10 to people in Northern Ireland who were shielding?
11 **A.** Again, that was the intention of the letters going out
12 rather than the reliance on electronic or access to
13 websites, or anything with regards so those specific
14 individuals who required notification would receive it
15 and I think there were a number of letters sent out
16 during the pandemic.
17 **Q.** But that support wasn't actually provided by the
18 Department of Health was it?
19 **A.** No --
20 **Q.** It was provided by the Department for Communities.
21 **A.** Well, there was cross-Executive response in regards to
22 that and I know there was cross-wording across a number
23 of departments in regards to how that would be
24 supported.
25 **Q.** And then I believe it was on 18 June a briefing paper

1 was put to you about pausing the shielding advice from
2 31 July; is that correct?
3 **A.** That's correct.
4 **Q.** Are you able to explain why the view was taken on
5 18 June that people should no longer shield from
6 31 July?
7 **A.** I think it was due to the number of falling cases that
8 we had. I also think it was around that time that we
9 had 14 consecutive days with no deaths due to Covid and
10 it was also in response and to keep in step with the
11 rest of the United Kingdom who were taking the same
12 action at the same time.
13 **Q.** Because I think you were publicly saying that you didn't
14 want anyone to shield for one minute longer than was
15 necessary?
16 **A.** That's right.
17 **Q.** Are you satisfied that's what happened?
18 **A.** I am but, again, and I think that's why we issued the
19 letters with that lead-in time as well in regards to
20 what was actually necessary. We had, my Lady,
21 commissioned through the Chief Medical Officer
22 commissioned the Patient and Client Council in regards
23 to doing an assessment of those who were shielding and
24 the impact and the effect that it was actually having on
25 them and did they find it useful in regards to that and

1 I think there were concerns that were raised by that
2 cohort of people in regards to what it actually meant to
3 them both physically but also mentally as well.
4 **Q.** After 31 July, did you hear concerns from people who had
5 been shielding that they didn't have sufficient support
6 after that point?
7 **A.** There was concerns in regards to the supports that were
8 then available but, as I indicated, and this isn't meant
9 as a derogation of anything we were doing, but it was
10 the support mechanisms that were there through the
11 Department of Communities and through the Department of
12 Finance, as financial supports, letters to employers,
13 and things like that as well.
14 **Q.** I'm going to move to Long Covid. It was known at the
15 start of the pandemic that it was likely that there
16 would be long-term effects caused by the virus. At the
17 start of the pandemic were you made aware of that
18 potential impact?
19 **A.** It wasn't something that was brought to my attention at
20 the beginning of the pandemic. We were very much
21 focused on those who were suffering from Covid rather
22 than there actually being a further condition in regards
23 to Long Covid or indeed some of the other --
24 **Q.** Because in summer 2020 you asked the CMO to established
25 a clinical working group to review the needs of those

1 recovering from Covid-19 specifically following
2 a hospital admission. What took you to make that
3 request to the CMO?
4 **A.** It was actually through conversations being had at the
5 Executive but also other indications from conversations,
6 I think. We met, the four health ministers met
7 regularly for conversations just in regards to what was
8 happening across but there was a need there and I think
9 it was actually something that was brought up at
10 an Executive meeting as well in regards to what we could
11 do, but also from correspondence and presentations that
12 were being made to me as health minister.
13 **Q.** So it wasn't as a result of there being any tracking
14 from the department or the trusts about ...
15 As a result of that review, by the clinical
16 working group, the report recommended that disciplines
17 working on post-Covid recovery should be incorporated
18 into a one-stop clinic and at that point in time there
19 was such a clinic within the Belfast Trust?
20 **A.** That's correct, yes.
21 **Q.** And then I just want to look at the timeline. Because
22 in December 2020, you agreed that HSCB should be asked
23 to develop plans for a multidisciplinary clinic as part
24 of the management?
25 **A.** Yeah.

1 **Q.** On 9 June, approved proposals and the HSCB directed to
2 commission the service and then the service was actually
3 launched on 1 November 2021. How did it take from when
4 the report came back, presumably in around autumn 2020,
5 until 1 November 2021 to actually put in place these
6 services that you believe should be in place?
7 **A.** Well, that was the request I made to the Health and
8 Social Care Board who were the commissioning service in
9 regards to that, as to how quickly and what they
10 actually looked like as well and that was in their remit
11 to do that.
12 **Q.** Is there anything more that you think that you could
13 have done to bring those on stream earlier?
14 **A.** Well, I could have put additional pressures onto the
15 Health and Social Care Board but I think there's
16 a functionality across the department, as well, to doing
17 that.
18 **Q.** I just want to look, finally, then, at lessons learned.
19 So you were health minister from 11 January 2020 to
20 27 October 2022 and, then again, February to May 2024.
21 As far as you're concerned, has Health and Social Care,
22 the Department of Health, and yourself sought to learn
23 all the lessons from the pandemic that occurred?
24 **A.** I think we have, my Lady, and I think that is part of
25 the functionality of this area in regards to the

1 engagement that we're having both CMO, CNO and myself,
2 in regards to that, as being asked have I learned all.
3 There's personal reflections, in regards to the
4 decisions I took when I was health minister weigh
5 heavily on me, my Lady. In regards to the challenges
6 that I face and still think about in regards to even
7 lines of not even the questions that were being raised
8 today but some of the questions that I raised myself in
9 regards to, you know, what could have been done, whether
10 they were the right decisions, were they timely, in
11 regards to what we knew then compared to what we know
12 now.
13 In regards to the responses from the department
14 itself, I think that is one the department would be best
15 placed to answer, my Lady, as I stepped out as has been
16 indicated and put out of post on October 2022 and then
17 didn't get the opportunity to return until
18 February 2024.
19 **MR SCOTT:** Thank you, Mr Swann.
20 My Lady, no further questions.
21 **LADY HALLETT:** Thank you very much.
22 Ms Campbell, would you like to take us to the
23 break.
24 **Questions from MS CAMPBELL KC**
25 **MS CAMPBELL:** Mr Swann, good afternoon. I have topics --

1 five topics and about 20 minutes in which to ask you
2 questions on behalf of the Northern Ireland Covid
3 Bereaved Families for Justice.
4 Can we start, please, by revisiting a topic that
5 you were asked about very briefly before lunch, and that
6 is the issue of PPE. And you'll remember that Mr Scott
7 took you to a readout of a meeting on 24 March with the
8 First Minister, deputy First Minister and, I think, the
9 CMO and others, and that readout suggests that there had
10 been something of a misperception about the problem with
11 the PPE and perhaps all was not as bad as it seemed.
12 You recall that document?
13 **A.** I recall that document, yes.
14 **Q.** I want to then move forward in time by about ten
15 working days, to 3 April 2020.
16 And can we look at a document, please, which
17 is INQ000065719. And it's underscore page 10. There we
18 are.
19 These will be familiar to you not least from
20 Module 2C, Mr Swann. They're handwritten notes of
21 Executive meetings, and this one is on 3 April.
22 I wonder if we can look at the passage in the middle of
23 the page that starts "DfE", which I think is Department
24 for the Economy, and perhaps Mrs Dodds; you can confirm
25 if I'm right about that, and perhaps you don't know --

1 **A.** I honestly don't know. It could be the Department for
2 Education.
3 **Q.** I did wonder. In any event, the query you can see is in
4 relation to:
5 "PPE -- how [is it] distributed in
6 [Northern Ireland] -- not available when nurses need.
7 How do we get to frontline staff."
8 And the Department of Health seems to respond:
9 "[there is] enough for now, but [it] needs to get
10 to [the] frontline ..."
11 And if we can scroll down the page, please, to the
12 next section where Mr Pengelly is noted -- and
13 Mr Pengelly at that stage was the permanent secretary to
14 the Department of Health; isn't that right?
15 **A.** That's correct, yes.
16 **Q.** It is an "Issue of concern", it notes.
17 "[The] Paper circulated today -- details of stock.
18 "Tend to focus on central stock -- [but] asking
19 them to check supplies with Trusts.
20 "Issue for Trusts -- [it's a] low level
21 operational issue ..."
22 And you can see at the very bottom of the page
23 that chief executives are being asked to address.
24 Can we go to the next page, please. Because the
25 question that I'm interested in comes in again from the

1 DfE, and it seems to be -- top of the page, the first
2 two entries from DfE and RP, please, if we can highlight
3 those.
4 The question seems to be is there a:
5 "Mechanism for Trusts to report back to [the
6 Department of Health]? Re [the] level of PPE [and]
7 distribution to facilities."
8 And Mr Pengelly replies:
9 "No specific mechanism for report to us -- ask CEO
10 to fill in Returns. Every location has [its] own supply
11 control system."
12 So, the question really that we have, and focusing
13 on the issue of that central element of control that
14 you've been asked about on the part of the Department of
15 Health, is it really the case that on 3 April 2020 there
16 was no specific mechanisms for trusts to communicate
17 with the department in relation to the availability of
18 PPE on the front line?
19 **A.** I think that is -- that specific point is in regards to
20 the management of stock levels.
21 **Q.** Yes.
22 **A.** If I take this document in regards to my understanding
23 and my recall of that meeting was actually in regards to
24 not the concerns of the front line but what stocks were
25 being held in regards to either each ward or each trust.

1 That's my reading and my recollection of that actual
2 engagement. It wasn't the fact that concerns weren't
3 being raised.
4 As I mentioned in regards to -- the evidence
5 I gave to Mr Scott was in regards to how I asked the CNO
6 to establish that PPE hotline so that any concerns that
7 were raised or could be raised were actually coming
8 directly into the department.
9 **Q.** Of course you've got the PPE hotline which allows
10 an opportunity for frontline staff to email the trust --
11 the department if there are problems. But how does the
12 department ensure that there aren't problems if it
13 didn't have sight of what the stock levels are at trust
14 level?
15 **A.** And I think that's why Mr Pengelly there has asked the
16 CEOs to fill in actual returns so that that
17 documentation was coming back.
18 And again I think in regards to that answer that
19 I gave to Mr Scott, was that Health and Social Care were
20 so used of PPE being that item that was always there, in
21 regards to when it was -- when it was needed, in regards
22 to, then, the change and challenge as to, I've said,
23 distribution, supply chain, the just-in-time supply
24 chains that actually presented the challenges to the
25 distribution in the central management.

1 **Q.** But can we focus for a moment, Mr Swann, on what control
2 that your department had over this. The Chief Medical
3 Officer has told her Ladyship in the course of this
4 module that as of 27 January -- and you'll, I suspect,
5 be familiar with this -- health gold had been
6 established, and then you had the gold, silver and
7 bronze command, the purpose of which was to ensure
8 effective oversight and engagement from top-level
9 Department of Health to frontline staff. And PPE, as
10 we've already seen, is an issue that has been of
11 increasing concern throughout March 2020. So why is it
12 that by 3 April 2020 you were asking CEOs to simply fill
13 in returns without a direct mechanism of communication
14 to the Department of Health?
15 **A.** And, again, that's the statement of Mr Pengelly at that
16 point in regards that no direct mechanism had been
17 established, and that's how the interim measure was
18 being put in place, through the CEO of each trust to
19 fill in those returns, and then that was superseded by
20 the establishment and responsibility of what BSO was
21 actually doing in regards to the overall management of
22 PPE.
23 **Q.** Putting BSO to one side, did the trust chief executives
24 then, in April 2020, get to the point of filling in
25 returns for them to be analysed by the department?

1 **A.** I assume they must have, because it wasn't then, you
2 know, followed up in regards to that, whether they were
3 actually filling it in or somebody on their behalf was
4 filling it in and returning it to the department,
5 because that's when that more centralised control in
6 regards to the work that BSO was doing was actually
7 started.
8 **Q.** What did you learn -- if we focus on the issue that
9 Mr Pengelly was raising at this Executive meeting, one
10 of the things that he said was that there was
11 essentially no -- every location has its own supply
12 control system.
13 So, firstly, do you know what he means by every
14 location? Was it every hospital, was it every trust --
15 **A.** From my understanding, and actually every location
16 actually went down to -- as I said in a previous answer,
17 actually down to ward level in regards to how PPE was
18 actually being managed or distributed at each location.
19 **Q.** And did that change, so far as you know?
20 **A.** Yes.
21 **Q.** And when did it change?
22 **A.** I'm not sure of an exact date but that was the
23 outworkings of the mechanisms that were then later put
24 in place in regards to how stock was managed, stock was
25 delivered, and it was actually ordered via BSO through

1 that central organisation system.
2 **Q.** Would you accept that there seems to have been a problem
3 certainly in March and April 2020 in terms of
4 preparedness to understand what level of stock was
5 available to frontline staff?
6 **A.** Yes.
7 **Q.** And really the email address that you set up, and
8 I think you had something in the region of 100 responses
9 or emails, was of little comfort to staff if in fact
10 they couldn't be assured that the stock was reaching the
11 front lines?
12 **A.** But it was of comfort in regards to they had an ability
13 to directly contact the department and the Chief Nursing
14 Officer in regards to issues in regards to supply, fit
15 and best use, because I think when we looked at the
16 breakdown of the responses that you speak to, there were
17 a number of critical issues that were -- been able to be
18 addressed and again fed back to either the ward or the
19 trust in regards to those queries that were asked.
20 **Q.** I'll move on and my next topic is the topic of DNACPR.
21 Again, you had been asked some questions about that by
22 Mr Scott.
23 I want to revisit that paragraph in your
24 statement, it's 307, in which you refer to questions
25 coming in from MLAs and your response making it clear

1 that orders based on age or disability were
2 discriminatory and unethical and in which you state that
3 the policy -- sorry, media reports about a policy in
4 Northern Ireland around DNACPR were ill-founded.
5 You understand, and I suspect you understood at
6 the time, that you were responding to those MLA
7 questions that there were increasing concerns amongst
8 the bereaved and those who were yet to be bereaved at
9 that point, that there had been a misuse of DNACPR
10 orders in Northern Ireland. You knew that, didn't you?
11 **A.** Not that there had been a misuse in regards to the
12 specific -- any specific instances, I don't think --
13 **Q.** My question was you knew that there were concerns --
14 **A.** Oh, yes, there were --
15 **Q.** -- about the use?
16 **A.** I know there were concerns, yes.
17 **Q.** And you agree, don't you, that from your position as the
18 Minister for Health, it's important not only to consider
19 what a policy might be but how that policy is in fact
20 being implemented within a healthcare setting?
21 **A.** That's correct.
22 **Q.** And you told us in your evidence that you were aware of
23 the CQC report that emanated from England?
24 **A.** Yes.
25 **Q.** And are we right that your understanding of that CQC

1 report was that it also applied in the North?
2 **A.** Well, that they had looked at what had happened in
3 Northern Ireland was my understanding as well.
4 **Q.** Do you recall what gave you that understanding?
5 **A.** I think it was through the reading of preparation for
6 this session.
7 **Q.** Do you recall being aware of the CQC report and
8 recommendations at the time when these issues were being
9 raised with you?
10 **A.** I don't recall those specifics at that point in time,
11 no.
12 **Q.** You see, the CQC report had an interim report in
13 autumn 2020 and a final report I think in March 2021,
14 contemporaneous in fact to the MLA questions that you
15 refer to in your statement. Is your evidence that you
16 weren't aware or you can't recall being aware of the
17 report at that time?
18 **A.** I can't recall it being brought to my attention in
19 regards to that. As I said in referral to -- an earlier
20 answer in regards to those written statements or those
21 written responses to MLAs, there would have been
22 a subsequent information pack that would have been
23 provided. But I don't recall the full content of that
24 additional --
25 **Q.** Let's leave the CQC report to one side if you weren't

1 aware of it when responding to those MLA questions.
2 What assurances, in real practical terms, did your
3 answer that orders based on age or disability would have
4 been or were discriminatory and unethical -- in what way
5 was that meant to assure the population of
6 Northern Ireland that their concerns about the misuse of
7 DNACPR were misplaced or needn't be as grave as they
8 were?
9 **A.** Well, I think that was the intention of those -- those
10 answers in regards to the statements that were being
11 made.
12 **Q.** But how can you answer that, Mr Swann, without having
13 carried out an investigation into what was happening at
14 the ground level, at the front line?
15 **A.** Well, again, come back to, again, the additional
16 information that would have been in the back of those
17 written questions and written responses, my Lady.
18 I think I also -- and I can't be specific in regards to
19 the conversations that I had, around the issue with the
20 Chief Nursing Officer again in regards to the issue of
21 that concern.
22 **Q.** Well, given that those were concerns and that we are at
23 this point into 2021 and that the concerns were
24 persisting, did your department consider that there
25 should be an investigation carried out into those

1 concerns about the inappropriate use of DNACPRs?
2 **A.** I'm not sure if the department considered that or
3 conducted that.
4 **Q.** Do you think it should have?
5 **A.** I think now there is an opportunity actually to
6 retrospectively do that in regards to the
7 recommendations in the work of this Inquiry.
8 **Q.** Going back to the CQC report. Do you think you should
9 have been aware of the recommendations and the
10 conclusions of that report when it came out in
11 March 2021?
12 **A.** Yes, I -- of the final report, yes. But as I say, I'm
13 not sure that it wasn't in -- mentioned in the briefing
14 pack in regards to those written responses. I don't
15 recall nor have I seen them in the evidence bundle, nor,
16 my Lady, unfortunately, did I ask them.
17 **Q.** The CQC report has a number of recommendations, I think
18 something in the region of 11 under three broad
19 headings, including ensuring that health and care
20 professionals have not only the knowledge to make
21 ethical decisions but the skills necessary to have those
22 sensitive and difficult conversations with patients and
23 their loved ones. And particularly significantly for
24 the Northern Ireland Covid Bereaved, they recommend
25 ensuring improved oversight and assurance of the use

1 of DNACPRs.
2 Do you remember any work under your tenure as
3 minister of health that sought to implement those
4 recommendations in Northern Ireland?
5 **A.** I think, my Lady, in regards to that, it was the start
6 of the work in regards to advance care planning
7 documentation and engagement piece that was conducted.
8 I think I commissioned that towards October,
9 possibly October 2022 in regards to work -- I don't
10 remember the specific date but, again, it was the wider
11 piece around advanced care planning that also would have
12 covered and touched upon DNACPRs.
13 **Q.** And that was October 2022, so I'm focusing in particular
14 on the period throughout 2021 when these concerns were
15 being raised directly with you. And the report was
16 available to you from the CQC?
17 **A.** Well, the rules were being completed, I think, by the
18 ethics forum as well.
19 **Q.** Moving on to my third topic, and it's end-of-life care,
20 and it's related because I suspect you will be aware,
21 Mr Swann, that, in addition to the concerns about the
22 use of DNACPR notices, there were similar concerns
23 raised about decisions around end-of-life care,
24 including concerns about the discredited Liverpool
25 pathway, which I'm sure will be familiar to you,

1 concerns about syringe drivers or particular drugs that
2 were used that were believed -- or that there were
3 worries that they hastened death.
4 The same questions really apply. Looking at
5 policies that were in place in relation to that
6 end-of-life care is insufficient if there is not
7 knowledge of what in fact is happening in practice; do
8 you agree with that?
9 **A.** It would be if that was what was happening in
10 Northern Ireland. Again, there is reassurances I think
11 given by CMO and CNO in regards to that wasn't either
12 the policy or practice in Northern Ireland.
13 **Q.** But in terms of investigation, is it right that no
14 investigation was ordered or conducted during your
15 tenure in relation to the concerns that had reached the
16 Department of Health?
17 **A.** Not that I'm aware of.
18 **Q.** And do you agree there was, and indeed probably still
19 is, an opportunity to have that level of investigation?
20 **A.** I would agree with that line of questioning, I think as
21 I said to the earlier question as well.
22 **Q.** My penultimate topic is the issue of aerosol infection,
23 and you'll have followed, I'm sure, how the evidence in
24 this module has unfolded before her Ladyship.
25 Do you recall when you first became aware that

1 there was a -- we can put it, a disagreement between
2 scientists about the route of transmission, be it
3 primarily droplet or aerosol?
4 **A.** From recollection, I think it was around May.
5 **Q.** May which year?
6 **A.** 2020.
7 **Q.** May 2020?
8 **A.** Yeah, from recollection. As I say, it's not something
9 I have any documented evidence from, but if it is, from
10 a conversation in regards to ...
11 **Q.** And do you recall who that conversation may have been
12 with?
13 **A.** It may have been with the CMO and the CSA.
14 **Q.** The CMO's evidence to this Inquiry was that there was
15 nobody in Northern Ireland providing, if you like, any
16 separate advice about routes of transmission and that he
17 was, to a significant extent, reliant on advice taken
18 from the UKHSA, and he accepted that advice and sought
19 to implement it.
20 Was that your understanding of the position?
21 **A.** Yes.
22 **Q.** Well, coming back to this conversation, if it is
23 around May 2020, do you recall raising any concerns
24 about the acceptance of that advice given the
25 disagreement between the scientists?

1 **A.** It was in regards to -- I don't recall the specifics of
2 the conversation but there was a general conversations
3 that were had with CMO and CSA in regards to different
4 aspects of the pandemic.
5 **Q.** And were those concerns -- or that conversation, was it
6 revisited?
7 **A.** It's not that I -- that I -- I don't recall in detail of
8 that, or when those conversations were had, but I do
9 know there was discussions around that.
10 **Q.** Well, we know that there was a representative from the
11 Public Health Agency in Northern Ireland on the UK IPC
12 Cell, and we know about -- we now know, certainly, about
13 the concerns about the length of time the UK IPC Cell
14 took to acknowledge the risk from aerosol transmission
15 and to change advice.
16 Would you have expected that the individual from
17 the PHA in Northern Ireland would have reported those
18 concerns to you?
19 **A.** I would have expected -- not maybe directly to me but
20 I would have expected them to have been reporting that
21 conversation either through the PHA to CMO or CSA, yes.
22 **Q.** And do you recall that happening?
23 **A.** I don't.
24 **Q.** You see, one issue for those we represent is that the
25 answer from the CMO in relation to being heavily reliant

1 on advice coming from sources in England suggests that
2 in a future pandemic Northern Ireland would be
3 effectively powerless to prevent something like this
4 happening again because we don't have the capacity,
5 domestically to replicate what the UKHSA can do or
6 does -- and you're nodding in agreement with that.
7 But one outworking of that is that, from
8 a Northern Irish perspective, there's a limited number
9 of lessons that be learned or changes that can be
10 properly implemented to ensure that doesn't happen
11 again?
12 **A.** And I also -- you know, and I think looking -- I think
13 it was M2C, in regards to Northern Ireland actually
14 having that position at the table, should it be through
15 that body or SAGE or anything else, we don't have, in
16 regards to the size of the population, the size of the
17 department or the size of Public Health Agency, the
18 ability to replicate all those bodies, and I think
19 that's -- it's also part of the benefit that I see of
20 being part of those wider discussions as well, but also
21 the ability, then, to be able to challenge within those
22 bodies as well.
23 **Q.** So, reflecting on lessons learned from your position or
24 from the position of the department, what can be done to
25 ensure a greater level of scrutiny from a Northern Irish

1 perspective rather than acceptance of advice that's
2 coming our way?
3 **A.** Well, in regards to that, I think it is that operational
4 functionality of CMO and CSA in regards to the
5 involvement in how those decisions are being made and
6 the question about -- of what can be done.
7 I'm also aware, my Lady, that The Executive
8 Office, within what is now the -- used to be the Office
9 of the First and Deputy First Minster have now employed
10 their own CSA as well, so that they're not solely
11 reliant on the CSA within the Department of Health for
12 advice as well. So there is, I suppose, a second good.
13 I don't know the full remit of that position, whether it
14 can look across Health or not, because, again,
15 unfortunately, I'm no longer in that position.
16 **Q.** Final topic and it's the topic of nosocomial infection.
17 In your statement -- it's at paragraph 233 -- you
18 identify the creation of a nosocomial support cell to
19 address challenges arising from Covid infections in
20 healthcare settings. And you refer to a report of that
21 cell in relation to Craigavon Area Hospital. And one of
22 the positives, if you like, that you take out of -- from
23 your statement is that the reports from the nosocomial
24 support cell were a timely source of feedback for our
25 trusts on their approach in relation to mitigating the

1 impact of Covid-19 within the acute hospital sector.
2 You're aware, are you, of the content of the
3 Craigavon Area Hospital report from the nosocomial cell?
4 **A.** Yes, so -- from what limited recall I have and access to
5 bundles.
6 **Q.** Would you have known about it at the time?
7 **A.** I do recall having engagements with both the trust
8 chief executive and the board chair in regards to the
9 challenges that were being specifically faced there as
10 well. There was also an SAI instigated at -- level 3
11 SAI at that stage, and I asked that the findings of that
12 SAI be made public, something which isn't normal,
13 my Lady, in regards to that, but such, I think, was the
14 concerns in regards to the workings of what had happened
15 and what had occurred.
16 **Q.** Well, one of the issues that the report found in
17 relation to Craigavon Hospital was that effectively,
18 although staff were doing their best, the problems were
19 so significant due to the lack of ventilation on the
20 site that they were -- almost feel like insolvable.
21 So they found there was no mechanical ventilation
22 in the wards. They relied totally on natural
23 ventilation from opening windows. They raised the
24 problems with that approach during the winter months.
25 They refer to the recommended air change rate of being

1 unachievable. They talk about the proximity of beds,
2 a lack of sanitary facilities combined with poor
3 ventilation mechanisms. And they say it is difficult to
4 see what more the trust can do with the physical
5 environment given the constraints of the existing layout
6 and fabric of that hospital.
7 In essence, their recommendation was that the
8 department should consider the trust master plan for
9 redevelopment, which was apparently a programme that was
10 going to take "several decades".
11 Firstly, from the perspective of patients and
12 visitors concerned about the risks of going to hospital
13 and contracting Covid, would they or should they have
14 felt safe attending that hospital had they known those
15 findings?
16 **A.** Well, again, those findings came as a result of the
17 investigation that was commissioned in regards to the
18 concerns that were being raised and, unfortunately, the
19 incidents that had occurred.
20 **Q.** But do you accept patients and their visitors
21 essentially were not safe in that environment, or
22 certainly didn't have any reason to feel safe?
23 **A.** Well, in regards to the mechanisms and the supports that
24 were being put in place in regards to provision of PPE
25 and other measures that were in place, I think the trust

1 and the staff involved were doing all that they could
2 within the resource that they had.
3 In regards to the investment of the site and
4 specifically around Craigavon, my Lady, that is one of
5 the sites that has been indicated for quite a long term
6 in regards to capital investment.
7 **LADY HALLETT:** Keep your voice up.
8 **A.** Sorry -- capital investment and redevelopment, and
9 I think that's the key finding of those recommendations.
10 **Q.** Well, it very much was, and therefore my question was,
11 do you know if the Department of Health has approved
12 that master plan of redevelopment and, if so, how soon
13 it's going to be implemented?
14 **A.** I haven't been in possession now for a number of months
15 in regards to the financial constraints that are
16 currently on both revenue and capital. I'm unsure as to
17 where that is. But I'm sure, my Lady, it's something
18 the department could respond to the Inquiry on.
19 **Q.** In your dealing with that report and the nosocomial cell
20 you talk about it being never too early to learn
21 lessons. And your statement, at the end of your
22 statement, does set out what lessons that you have
23 identified with the benefit of hindsight.
24 Your statement mentions two broad lessons.
25 Firstly, issues around staffing, including insufficient

1 staffing and the need for an agile workforce. And,
2 secondly, that the CMO at the time had too many roles.
3 Those are the two issues that you identify in your
4 statement.
5 Is that all?
6 **A.** No, there's a number of other recommendations, my Lady,
7 in regards to the completion of that report that
8 I've thought on in regards to -- some of them have
9 already been touched in the question, about how we can
10 look across the borders or across the island in regards
11 to health and social care, something that we've been
12 able to do with paediatric cardiology, in regards to the
13 issue that was raised, paediatric pathology, or indeed
14 ECMO, which was looked at -- or hasn't been touched in
15 regards to today's procedure, again, an all-Ireland
16 response could be something that could be explored, the
17 further development of our health and social care
18 transformation projects, those elective overnight
19 centres, the day case procedure centres, the further
20 steps that we need to implement in regards to Bengoa,
21 but, again, that is, my Lady, depending on long-term
22 recurrent financing in regards to what we need to do, in
23 regards to that as well --
24 **Q.** The list is clearly long and a lot longer than the two
25 lessons learned that you identified in your statement.

1 From the perspective of the Northern Ireland bereaved,
2 can you see why they may have expected more from you in
3 terms of lessons learned?
4 **A.** In regards to this specific module -- you know, there
5 are more modules to come where I'd be able to make
6 further recommendations in the outworkings of what is
7 actually there in regards to what's actually in the
8 statement as to -- in reflection and preparation for
9 today, my Lady, there are others.
10 **LADY HALLETT:** Thank you, Ms Campbell.
11 We'll take the break now, I'll return at 3.20, and
12 then there is just under half an hour of questions left
13 for you, Mr Swann.
14 **THE WITNESS:** Thank you.
15 **(3.05 pm)**
16 **(A short break)**
17 **(3.20 pm)**
18 **LADY HALLETT:** Mr Wagner.
19 Over that way, Mr Swann.
20 **Questions from MR WAGNER**
21 **MR WAGNER:** Thank you. Good afternoon. My name is
22 Adam Wagner and I ask questions on behalf of the
23 Clinically Vulnerable Families group.
24 In December 2020 there was a report published by
25 the Patient and Client Council which reported the

1 findings of a survey and one of the things that it
2 concluded was that those who had been advised to shield,
3 prioritised being kept informed with clear advice and
4 guidance along with being given the scientific rationale
5 for that advice. Do you recall that report?
6 **A.** I do, yes.
7 **Q.** So once that report came out in December 2020 and it was
8 known what those who were being advised to shield were
9 saying, by that point it was obviously clear that the
10 virus was continuing to circulate in the community and
11 for the long term, you were in the middle of the second
12 wave.
13 Do you think at that stage more could have been
14 done to equip people who were at higher risk with that
15 information they needed to empower them to understand
16 the steps they could take to protect themselves and also
17 what support the government was giving them to do so?
18 **A.** And I do think when shielding was re-introduced in
19 England in January of the following year we wrote out
20 again to those who had been indicated to shield in
21 regards to the additional advice and guidance that we
22 were able to provide them at that stage, because coming
23 out of that PCC report, taken from what you've said
24 that's what they asked for, rather than the
25 reintroduction of shielding so that -- I suppose that

1 additional communication that was given in January was
2 I think what you're referring to.
3 **Q.** Was it enough? Do you think people were given enough
4 information to empower themselves?
5 **A.** I believe at that stage, as in regards to what were
6 known, and I think that, my Lady, is one of the steps
7 that by asking PCC to engage with those groups, I think
8 we in Northern Ireland were maybe better engaged with
9 the cohort than perhaps other parts of the
10 United Kingdom.
11 **Q.** I want to ask you about pausing shielding in 2020
12 in June. When the plan was announced to pause shielding
13 you gave an announcement and you said -- one of the
14 things you said was that the difficulty shielding has
15 presented would not just vanish because the need to
16 shield has ended. Do you think that the transitional
17 support which was offered at that stage was enough to
18 meet the scale of the challenge?
19 **A.** In retrospect of -- and, again, this is working across
20 different departments, could we have done more? There's
21 always more that could have been done in regards to,
22 I suppose, allowing people to come back into society in
23 regards after being through a very challenging time
24 where they were shielding as well. My Lady, I'm
25 remembering some of the conversations we had with

1 community pharmacy who we supported to actually deliver
2 medicines directly to those who were shielding, the
3 feedback that they got from community pharmacy when
4 those drivers were delivering those medicines, it wasn't
5 just a matter of: here is your prescription, here is
6 your medication, that they were actually being engaged
7 in conversations because of the challenges they were
8 facing, because of isolation and loneliness, as well.
9 So we looked into those additional supports as well, but
10 again, if the question is could we have done more,
11 there's always more we could have done.
12 **Q.** What about mental health support? There were, I think,
13 mental health support resources were made available
14 online. Do you think those were sufficiently tailored
15 to the particular needs of those who had formerly
16 shielded?
17 **A.** Well, the additional online ones and, again, my Lady,
18 there were also additionality and additional supports
19 provided by community groups and other organisations,
20 and as I say, we put 10 million into the mental health
21 support fund which again supported communities and
22 individuals across Northern Ireland, not only those who
23 were specifically shielding as well but also those who
24 had received -- succumbed to those mental challenges due
25 to the pandemic.

1 Q. When the shielding programme was paused what was also
2 ended was the automatic eligibility to Statutory Sick
3 Pay that people who had been shielding were receiving.
4 And the practical effect was that some clinically
5 extremely vulnerable people had no choice but to return
6 to work because they couldn't afford to stay at home.
7 You said in your announcement in June 2020 that
8 shielding people could decide to do -- decide what to do
9 at their own pace. Do you agree that because of the
10 removal of the -- the, sort of, sudden removal of
11 Statutory Sick Pay the reality was for some shielding
12 people they couldn't return at their own pace, they had
13 to return, effectively, straight away?
14 A. I do agree with that statement although Statutory Sick
15 Pay was not within the remit of myself at that point, or
16 even the Department of Health, in response as to how
17 long they paid for. I do recall engagements as well and
18 I think, and I can be corrected in regards to this, but
19 there were opportunities for those individuals to engage
20 directly either with their GP or their medical
21 consultant in regards to receiving that letter of
22 support which would allow them to continue working from
23 home.
24 Q. Given at the time, June 2020, there was no vaccine yet
25 and also wider, sort of, society-wide mitigations such

1 as better ventilation were still not in place, not
2 really even in place today, do you accept, looking back,
3 that the effect of the pause was to expose some
4 clinically extremely vulnerable people to high levels of
5 risk, effectively a cliff edge from one day to the next?
6 A. In regards to, I think, the pausing of shielding, there
7 was that, I think, a three-week lead-in, from my
8 recollection, from the announcement being made until the
9 actual date being brought about. But, again, going back
10 to, I suppose, the original point that we were taking
11 into cognisance the recommendations or the failings that
12 had been brought about by the PCC reporting engagement.
13 Q. Do you accept that after the shielding advice was
14 paused, the shielding programme was paused, it would
15 have been valuable to continue to engage with those who
16 had been formally advised to shield just to, for
17 example, more ongoing PCC surveys or similar that would
18 help you understand the impacts that the pause, the
19 sudden pause of the shielding programme, even with that
20 three-week buffer, was causing, and also what support
21 they would continue to need going forward?
22 A. My Lady, I do think there would have been value in
23 further engagement via PCC because their initial
24 engagement basically allowed to us make the decisions
25 that we did and I think, as has already been intimated

1 in the line of questioning, one of the strong
2 recommendations was in regards to keeping those who were
3 shielding better informed with reliable and up-to-date
4 information.
5 Q. But do you know why that wasn't done?
6 A. I don't, no.
7 Q. Should it have been done?
8 A. It could have been done, yes.
9 Q. And do you think that might have fed into other concerns
10 that the PCC report had identified that the clinically
11 vulnerable were forgotten or ignored as changes to
12 guidance and restrictions for the wider population were
13 announced?
14 A. I think that ongoing engagement would certainly have
15 addressed those issues as well. And again, my Lady,
16 I think that was the rationale for us actually engaging
17 PCC at that stage to have that direct interaction with
18 that specific group of individuals, and I know it's
19 something that didn't occur to the same extent or the
20 same depth elsewhere across the United Kingdom.
21 Q. Something else that you said when the shielding was
22 paused was, you asked for everyone to be as
23 considerate -- sorry -- everyone to be considerate as
24 people end their periods of shielding and you said, "We
25 should all continue to social distance but in the coming

1 weeks I want you to be particularly understanding of the
2 fact that you might be encountering someone who has had
3 to stay at home for many months. Please be aware of
4 this, show respect and kindness to all and keep your
5 distance."
6 Now, at the time shielding was paused and after
7 that, this is coming from a different direction because
8 it's not about information given to the shielded, or
9 former shielded, it's about information given to the
10 rest of the public. Do you think enough was done to
11 educate the general public about the ongoing risks posed
12 by Covid-19 to the clinically extremely vulnerable and
13 the clinically vulnerable?
14 A. I think that was the basis of that statement in regards
15 to showing that additional respect without identifying
16 those who had been clinically extremely vulnerable and
17 making them actually step outside society, it was about
18 integrating them back into society after what been
19 a challenging period during that period of time.
20 Q. But aside from just saying that during that -- in that
21 statement, was anything else done to educate the public
22 about how to be respectful of and considerate towards
23 clinically extremely vulnerable?
24 A. It wasn't in regards to specifically the clinically
25 extremely vulnerable. We did produce a "keep your

1 distance" badge which was a small yellow badge that we
2 circulated around the general public in regards to that
3 just so people could identify. There was the lanyards
4 as well, so that some people could identify -- it
5 allowed them to identify themselves as clinically
6 extremely vulnerable to encourage people to be that bit
7 more respectful.
8 **Q.** Was anything else done apart from those badges and
9 lanyards?
10 **A.** Not that I can think of at this point.
11 **Q.** Do you accept that responsibility for educating the
12 public falls ultimately on the government and that there
13 is a possible problem in placing the responsibility for
14 explaining why ongoing mitigations are required, so for
15 example wearing a mask, without experiencing kickback
16 and abuse from the public, do you accept that if that
17 is, that burden of education is placed solely on or
18 predominantly on the clinically vulnerable themselves
19 that can become unmanageable?
20 **A.** No, I would agree there is a job for government
21 collectively in regards to how that communication is
22 actually given out to the wider general public without
23 making people uncomfortable in regards to them having to
24 explain their condition continually.
25 **Q.** I want to ask you about DNACPRs. You have been asked

1 quite a lot about this so I'll just ask you one
2 question. And it relates to do not attempt
3 resuscitation orders being placed on clinically
4 vulnerable people. Is there any basis that you could
5 reassure this Inquiry that the clinically extremely
6 vulnerable were not more likely to be the subject of
7 a blanket DNACPR on account of their underlying health
8 conditions?
9 **A.** I'm unaware of it being a blanket approach in
10 Northern Ireland and I think I've given that previous
11 answer in regards to the same line of questioning.
12 **Q.** Would you support a recommendation by the Inquiry for
13 there to be a systematic review of all DNACPRs, notices
14 put in place from 2020 to date so -- to get to the
15 bottom of how many inappropriate notices there were, and
16 also to make sure that clinically vulnerable people are
17 not wrongly refused medical treatment in the future?
18 **A.** In answer to, I think, Ms Campbell's questions from the
19 Northern Ireland families, I think I have indicated that
20 it would be something I would be supportive of although
21 I'm not in the position, my Lady, to actually take that
22 directly back to the department.
23 **MR WAGNER:** Thank you.
24 Thank you, my Lady.
25 **LADY HALLETT:** Thank you.

1 Ms Sivakumaran.
2 Over at the back there. Could you make sure that
3 your voice, because it does drop, you are softly spoken
4 -- think of shouting in the House of Commons.
5 **THE WITNESS:** Thank you, my Lady.
6 **Questions from MS SIVAKUMARAN**
7 **MS SIVAKUMARAN:** Good afternoon. I ask questions on behalf
8 of the Long Covid groups. My first topic is on pandemic
9 planning and long-term sequelae. You said earlier that
10 the risk of long-term sequelae was not something brought
11 to your attention at the start of the pandemic.
12 Professor Sir Michael McBride, the CMO of
13 Northern Ireland, has said in evidence to this Inquiry
14 that he was aware of that risk. Just so we are clear,
15 did he not advise you of that risk?
16 **A.** Not that I can recollect, as a specific issue at that
17 stage in the earlier stages of the pandemic.
18 **Q.** Are you saying that you became aware at a later stage?
19 **A.** Yes.
20 **Q.** What stage is that, can you assist?
21 **A.** I can't think give a specific date but in regards to the
22 answers to Mr Scott, it was in regards -- I think it was
23 around June, July, at that stage, that I asked for the
24 Health and Social Care Board to take forward the
25 delivery of support.

1 **Q.** Professor Sir Michael McBride's evidence was that the
2 long-term impacts of Covid-19 were not tracked from
3 an early stage in the pandemic and he's added, "At
4 present, there is still no system to monitor long-term
5 effects in a future pandemic", but he recommended there
6 should be.
7 Would you also recommend that pandemic planning
8 include provision for monitoring the long-term effects
9 of a novel virus?
10 **A.** I would, yes. And, again, my Lady, I hope that, again,
11 not building up the promises of what encompass can or
12 will deliver, I hope that that's something it can
13 actually do as well and doesn't resolve or resort to the
14 Department of Health or Health and Social Care having to
15 resort to the various databases that we had to
16 previously.
17 **Q.** My next topic is about Long Covid clinics. You were
18 asked about the 18-month delay between your
19 commissioning or working group on the long-term effects
20 of Covid-19 and the establishment of a Long Covid clinic
21 in November 2021. The working group recommendations
22 made clear that there was a need for specialist services
23 which was not being met; do you agree?
24 **A.** I agree, yes.
25 **Q.** And it follows, doesn't it, that the delay in providing

1 dedicated Long Covid clinics in Northern Ireland left
2 adults and children without access to the specialist
3 care and support that they needed? Do you agree?
4 **A.** There was, I think as Mr Scott pointed out, there was
5 clinics already established in the Belfast Trust,
6 although not commissioned centrally across the rest of
7 the region as well, and that's why I had asked Health
8 and Social Care Board to go forward and develop that as
9 a commissioned model.
10 **Q.** Indeed. So there was only one trust that had it.
11 Across Northern Ireland, there wasn't provision of the
12 services that were needed for people with Long Covid?
13 **A.** That's correct.
14 **Q.** You were asked what more you could have done to progress
15 work on the clinic and you said you could have put
16 additional pressure. Why didn't you put that additional
17 pressure? Was there a lack of urgency in your mind in
18 addressing the needs of people with Long Covid?
19 **A.** I don't think it was a lack of urgency, I think it was
20 in regards to what else was going on. I assumed, and
21 whether rightly or wrongly, that that work was being
22 progressed and, again, what I know now compared to what
23 I knew then and what I was asking for then, you know,
24 there is recollections and reflections. As I said
25 earlier, would I do things differently now? Yes.

1 **Q.** You were provided updates and advice, you were told
2 exactly when the clinics were going to be established.
3 Do you now accept that you knew then the delays in the
4 provision of that service?
5 **A.** I don't recall those specific updates or dates in
6 regards to a timeline.
7 **Q.** But can you see why for people with Long Covid who are
8 struggling to get referrals to services or who have been
9 bounced around from services, this delay was
10 inexcusable?
11 **A.** Yes, and I've already said that in regards to how
12 I wanted or should have now, in retrospect, been more
13 vociferous in the delivery of those clinics across all
14 trusts.
15 **Q.** And can you provide any recommendations to the Inquiry
16 on how such an extreme delay in establishing necessary
17 services could be avoided in future?
18 **A.** I think it is in regards to the changes possibly in
19 regards, as I said, my Lady, the Health and Social Care
20 Board was first indicated for closure in 2015. It
21 wasn't until the legislation actually come about,
22 I think in 2022, that it was closed. So the
23 functionality of the Health and Social Care Board is now
24 subsumed them in part of the Department of Health within
25 the SPPG, so there should be a greater focus and

1 attention in regards to what that stream and streams of
2 work are actually being commissioned and delivered.
3 **Q.** Okay. My final topic is about children and young people
4 with Long Covid. There are no dedicated Long Covid
5 clinics for children and young people in Northern
6 Ireland. Professor Sir Michael McBride's evidence was
7 he thought there was much merit to the suggestion by
8 Professor Brightling and Professor Evans that
9 a Long-Covid hub for children and young people could
10 deliver care through virtual multidisciplinary teams.
11 Would you agree with Professor Sir Michael McBride
12 that there is merit to the suggestion?
13 **A.** I would, yes.
14 **Q.** And would you agree that the failure to create
15 a dedicated Long Covid service for children and young
16 people in Northern Ireland has left them without access
17 to that specialist care that they need?
18 **A.** I do, but I also, in, I suppose, reflection of what
19 Sir Michael said in regards to following the NICE
20 guidance at that point in time was what many clinicians
21 in Northern Ireland actually did. I think that was
22 where we were and where we took that advice and guidance
23 from was from NICE, but in regards to the
24 recommendations coming from Sir Michael as Chief Medical
25 Officer, I would be supportive of his approach.

1 **Q.** I just want to pick up this point about the NICE
2 guidance. The NICE guidelines actually make clear,
3 I believe at page 5 under the overview, that the
4 guidelines apply to make recommendations about the care
5 in all healthcare settings for adults, children and
6 young people. They also go on to provide advice, at
7 paragraph 5.8, that a practitioner should consider
8 referral for 4 weeks for specialist advice for children
9 with ongoing symptomatic Covid-19.
10 So the NICE guidelines actually do recognise the
11 need for specialist care for children and young people.
12 Would you agree with that? There's nothing in the NICE
13 guidelines to say there should not be specialist care?
14 **A.** That's why I would be supportive of Sir Michael's
15 recommendation in regards to that, also working, I
16 suppose, in conjunction with the Royal College of
17 Paediatrics.
18 **Q.** So you accept the NICE guidelines do actually make
19 provision for specialist services?
20 **A.** Yes, but not -- I suppose it's how they are accessed and
21 available in regards to what we deliver -- or sorry,
22 what the Department of Health delivers in
23 Northern Ireland and that's why I say I would be
24 supportive of Sir Michael's recommendations.
25 **Q.** Just on that final point, when you say how they are

1 accessed and available, then you agree that they're not
2 accessible -- specialist services are not accessible and
3 available for children and young people in
4 Northern Ireland because there is no specialist
5 provision?
6 **A.** There is no specialist provision, yes. But, as again,
7 my Lady, unfortunately as I'm no longer in post as
8 Minister of Health, it's not a lever I have direct
9 access to, but if the Chief Medical Officer is coming
10 forward in regards to those recommendations I would be
11 supportive, as an individual and as a previous health
12 minister.
13 **MS SIVAKUMARAN:** Thank you, my Lady. Those are my
14 questions.
15 **LADY HALLETT:** Thank you.
16 Ms Polaschek.
17 Thank you.
18 **Questions from MS POLASCHEK**
19 **MS POLASCHEK:** Thank you. Good afternoon. I ask questions
20 on behalf of 13 Pregnancy, Baby and Parent
21 Organisations. You've already answered some questions
22 about the visiting restrictions in general and the
23 difficulties these caused patients and families, and
24 a specific area of concern for women, pregnant people
25 and their families were visiting restrictions in respect

1 of pregnancy care in particular.
2 Was the Northern Irish Government made aware of
3 specific concerns raised by maternity staff in
4 Northern Ireland about the availability and adequacy of
5 appropriate PPE?
6 **A.** Yes, in regards to across the work that was being led by
7 the Chief Nursing Officer who had a chief midwifery
8 officer within part of her team as well and, I suppose,
9 in cognisance, my Lady, of the geographical and size and
10 nature of health and social care in Northern Ireland.
11 **Q.** And would you agree that alternative mitigations such as
12 PPE and testing would have been reasonable steps to
13 investigate which might have avoided the particular
14 harms which women, pregnant people and their families
15 experienced from those visiting restrictions?
16 **A.** I think when -- I think, due to earlier comments in
17 regards to reflections as to the availability of
18 testing, if we had the ability to test at the beginning
19 of the pandemic the way we had towards the end of the
20 pandemic I think we'd have been able to do things a lot
21 more different.
22 **Q.** Thank you. And just finally, were you also aware that
23 some women and pregnant people delayed or avoided
24 attending hospital due to concerns about catching or
25 exposing their unborn baby to Covid-19 and the

1 requirement to attend hospital alone and, if so, what
2 steps did you or the government take to respond?
3 **A.** I wasn't aware of that being raised as a direct issue,
4 my Lady, but I do know midwives in Northern Ireland were
5 using telephones to be in direct contact with those
6 expectant mothers that were in their care as well. It's
7 not an issue was raised specifically with me.
8 **MS POLASCHEK:** Thank you, my Lady, those are my questions.
9 **LADY HALLETT:** Thank you, Ms Polaschek, very grateful.
10 I think that completes the questions for you,
11 Mr Swann.
12 Thank you very much for your help today. It must
13 have been a very long day for you, I'm sure.
14 I'm not sure if I can say we won't be calling on
15 you again, but I promise you we'll try to limit any
16 burdens that we place upon witnesses like you that we
17 keep coming back to.
18 So thank you for your help.
19 **THE WITNESS:** Thank you, my Lady.
20 **LADY HALLETT:** Thank you, Mr Scott.
21 Tomorrow at 10 o'clock.
22 **(The witness withdrew)**
23 **(3.45 pm)**
24 **(The hearing adjourned until 10.00 am**
25 **on Tuesday, 19 November 2024)**

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