IN THE COVID 19 INQUIRY –
MODULE 4: VACCINES AND THERAPUTICS

OPENING STATEMENT ON BEHALF OF THE NORTHERN IRELAND COVID BEREAVED FAMILIES FOR JUSTICE (NICBFFJ)

INTRODUCTION

1. NICBFFJ exists to ensure that the voices and experiences of the Covid bereaved in Northern Ireland are heard and properly considered throughout this Inquiry. Throughout the preceding Modules, we have sought to highlight a range of systemic and structural failings within the political and health systems of NI that rendered it both ill-prepared and ineffectively run to be able to react to a global health emergency. NICBFFJ members experienced first-hand the impact of a chronically overstretched and ill-equipped health system, run in the context of a political vacuum or repetitive instability. They felt the pain and frustration of such a system in a myriad of ways which, where relevant to this module, we will seek to highlight so as to assist the Inquiry in achieving its purpose of looking beyond the ever changing political analysis of the day and assessing how the four nations really dealt with this pandemic and what that meant for ordinary people within each jurisdiction.

2. Along with identifying failures, a significant part of this Inquiry's task is to consider what was handled well during the pandemic, and if so, why? The evidence in this Module, likely to a far greater degree than others, provides examples of successes which played the ultimate part in bringing the pandemic under control. Chief among them was the development, regulatory approval and procurement of the vaccine(s). Though not without controversy, it is a commonly held belief that this, more than anything else, brought an end to the global health emergency, with the UK, as the first country to launch a mass vaccination programme, right at the forefront. Similarly, the relative speed with which means of deploying the vaccines were devised is testament to what can be achieved when central government has

a whole system focus on the immediate needs of the public and the protection of its health system.

3. However in relation to Northern Ireland, we ask the Inquiry to consider the extent to which existing weaknesses in the health and social care system affected the ability to roll out the vaccine across all sections of the population, including hard to reach groups. One such weakness, the Inquiry might conclude, lies in the collection of (and ability to collect) data on vaccine rollout and uptake and whether this hindered the effectiveness of the programme in Northern Ireland and ability to evaluate that effectiveness. Another might be the failure to anticipate or promptly consider the unique positions of groups of people in Northern Ireland, included but not limited to our migrant workers and our many unpaid carers, in the vaccine roll out.

4. In Northern Ireland, it might be concluded that reliance on the UK government for the development and supply of the vaccines made sense, given the scale of the task and relative research capability and purchasing power of the jurisdiction. It might also be considered that the reliance on and lack of deviation from the advice of the JCVI as to prioritisation was understandable given the novelty of the situation and the speed in which the roll out was required to take place. However, the Inquiry will want to scrutinise whether and to what extent Northern Ireland decision makers, scientists and representatives might have better participated at all stages, not least to ensure timely communication, to improve understanding and, by extension, to ensure that the needs of the residents of Northern Ireland were fully considered at all stages.

5. Within those topics, the Inquiry will want to consider whether lessons had been learned and changes implemented from earlier pandemics? Whether, given, the early recognition across all societies that only a mass vaccination programme was likely to provide a route out of the crisis, NI acted with sufficient speed and impetus to lay the groundwork for it? Once a vaccination programme became a reality, did the NI administration and health sector devise the necessary means to

ensure maximum uptake was achieved or was NI hindered by its inability to assess the needs of often marginalised groups that has been touched upon in other modules? Was vaccine safety adequately discussed with the public and were the needs of the sick and elderly and their relatives properly served by vaccination deployment and (lack of) mandates?

6. We add at this stage that we fully adopt the submissions made on behalf of CBFFJ UK who have dealt in detail with potential issues around the planning and development of vaccines and the crucial issue of the extent to which discrimination played a part in differing uptake rates among ethnic minorities.

NICBFFJ EXPERIENCES

7. As the Inquiry knows, the experiences of our group in relation to the pandemic and ensuing government response are diverse and cover a range of situations, from those working in front line health care roles to those caring for or supporting wives, husbands, mothers and fathers and children who sadly lost their lives as a result of the pandemic. For some of our families, the issue of the speed with which the vaccine was made available is all too raw.

8. Fiona Clarke's 90-year-old mother, Margaret Lusty, was given the first dose of the Astra Zeneca vaccine on 7th January 2021. On 12th January 2021 she was diagnosed with Covid. She was admitted to hospital on 16th January and died on 17th January 2021. Given what is known about the length of time it takes for the vaccine to be effective, it is Fiona's belief that had the vaccine been available to her mother just a few weeks earlier, she may have had sufficient protection to have increased her chances of staying alive. As the Inquiry knows from earlier modules and will explore further in Module 6, there were many more like Fiona's mother. Therefore, whilst it is right to acknowledge the speed of the vaccine development, we look forward to the Inquiry considering if preparedness could have been better to allow for even more rapid deployment.

9. Other members of the group suffered heartbreaking experiences connected to the way in which the vaccine was rolled out. Michelle Reid's father, William Creen, tested positive for Covid on 24th January 2021 and lost his life on 6th February 2021. He was eligible for the vaccine but was immobile and housebound in a rural area, and thus unable to attend his GP to receive the vaccine. Despite the vaccination programme beginning in NI on 8th December 2020, Michelle had been told by the GP at that time that no mandate from the Department of Health existed to allow them to administer vaccines in the home. This is just another example of how crucial weeks or even days can be for the deployment of vaccination in a pandemic and ensuring that the means exist to rapidly get the vaccine to all those that need it most. For Michelle and others like her, the Inquiry will wish to consider whether in a future pandemic reaching those who are unable to leave their homes can be done quickly and without bureaucratic hurdles.

10. Other concerns raised by our group center on consistency and the fairness of the requirement to be vaccinated. Vaccination as a condition of deployment (VCOD) is a controversial policy that, although ultimately not executed in NI or the rest of the UK, generated strong feelings. There are many within our group who are concerned that there was an unfairness in the fact that care homes allowed unvaccinated staff to continuing working there, all the while prohibiting vaccinated relatives from visiting their loved ones and prolonging the social and emotional isolation of residents. This feeling is particularly acute given the enhanced definition of 'fully vaccinated' for visiting purposes in Northern Ireland vis à vis England or the other Devolved Administrations [INQ000486007].

11. There is ongoing concern that in Northern Ireland, the right balance was not struck between the rights of care home workers to not have vaccination mandated upon them, and the rights of residents and their families who were so desperately in need of face-to-face contact. Many of our families question how it was that vulnerable loved ones could be looked after by unvaccinated staff while at the same time being deprived of visits from vaccinated family members. They believe it is no answer to say that those staff were following strict infection prevention and

control measures when family members could also have followed such procedures. The effect of the pandemic on care homes will be explored in detail in Module 6. However, the question of VCOD is important to many of our families and their underlying sense that the importance of contact with loved ones was not given sufficient priority in relation to the elderly and the sick.

12. The NICBBFJ families represent a diverse range of experiences and viewpoints and as a result some of the issues raised may not be shared or have been experienced by all members. It is important in this module that all perspectives are given proper consideration. There are some within our group who are concerned that speed was prioritized over vaccine safety, and that the safety of the vaccines simply could not be guaranteed given how quickly they were developed and deployed. One member of our group, William Wilson, suffered organ failure after receiving the Pfizer vaccine. Others hold deep concerns about the whether the true picture as to the safety of the vaccines was or is being imparted to the public. Professor Prieto Alhambra's report suggests that adverse reactions were very rare, but more prominent in certain subgroups (Professor Prieto Alhambra Expert Report, §3.14). However, our families look forward to the Inquiry investigating the experiences of those within the vaccine injured group and considering whether the evidence on vaccine safety was in fact sufficiently robust and adequately communicated to the public to enable informed choices.

13. Finally, a number of families within the group have concerns regarding the use or misuse of therapeutics. Clearly, the discovery that Dexmethazone could reduce the severity of the virus in many patients was an important achievement. However, some within the group such as Fiona Clarke feel their relatives were treated very poorly through the failure to administer drugs such as morphine or Midazolam whilst suffering from Covid in hospital (INQ000474358_13). Others such as Deborah Braiden and Derek Glagow feel that the use of Midazolam hastened their respective parents' demise and many in the group call on the Inquiry to explore whether appropriate information was given to relatives about the use of therapeutics and options available.

PREPAREDNESS AND A HEALTH SYSTEM UNDER STRAIN

14. The parlous state of the NI health and social care system has been touched upon in Modules 1, 2C and 3. However, as NICBFFJ have repeatedly highlighted in our submissions in those modules, the full extent of those issues have yet to be given the full consideration they deserve, either within this Inquiry or in the form of a devolved Inquiry in NI. The already overwhelmed and ill-equipped Health and Social Care system forms the backdrop to the enormous undertaking that the vaccine rollout represented. As Sir Michael McBride says in his statement for this Module: " *In NI, the Health and Social Care system has been under increasing pressure for a number of years due to an increasing elderly demographic as well as a lack of long term healthcare structural reform and lack of political stability. Therefore, as the system was already under strain, setting up and delivering a mass vaccination programme, at the same time as resuming those services that had been stood down during earlier lockdowns was a difficult balancing act.*" (INQ000474249_89). Given what the Inquiry already knows about the state of the HSC system in NI, that may be considered something of an understatement.

15. Staffing and operational capability were clearly depleted at the start of and during the pandemic. There was no Senior Medical Officer with responsibility for vaccines at the Department of Health in the run up to the vaccine programme (Naresh Chada, INQ000474476_0002) and, despite Dr Chada's eventual role as Senior Responsible Officer for NI, it would appear that significant operational planning and management of an inevitable mass vaccination campaign did not take place until Patricia Donnelly was appointed head of the Covid Vaccination Programme on 5th October 2020. As Dr Donnelly and others acknowledge in their statement, the Public Health Agency would normally be expected to lead on a mass vaccination programme but it simply did not have the capacity (and, we contend, the organisational capabilities) to do so (INQ000474429_005). That was not simply a marker of the unprecedented scale of the public health emergency but indicative of the fact the PHA was and is under resourced and under skilled as earlier evidence has shown.

16. Inevitably, a substantial amount of responsibility for oversight of the vaccine programme fell on the already overburdened CMO. Although day to day running of the programme was headed by Dr Donnelly, it is notable that the CMO sitting within the Department of Health Chaired the Oversight Board and ultimately took responsibility for the implementation of the programme (INQ000474429_005). This, in addition to his many other roles, not least that of having to provide independent medical advice to the Executive, strongly points to a system that did not have the structures or resources it required.

DATA COLLECTION AND EVALUATION

17. This Inquiry has already heard (most vividly in Module 3) that data collection was routinely deficient in NI. In relation to vaccines the Inquiry will wish to explore the ability to collect and analyse data relevant to vaccination deployment and whether any proper evaluative exercise of the vaccination programme and its attempts to reach all parts of the community has ever in fact been undertaken.

18. It is a stark fact that prior to the pandemic NI had no central means of collecting vaccination data. The M4 disclosure contains little insight into why that was the case, particularly in light of lessons that might reasonably have been learned from previous pandemics or as a result of pandemic preparations. Moreover, ascertaining from the disclosure when and by whom this significant systems gap was identified is a challenging task.

19. The Inquiry will want to ask why it was that a VMS system had not been implemented (or even developed) prior to 2021. The 2009 H1N1 pandemic provided recent experience of a pandemic vaccination programme in which rollout was aligned across the UK. Should a better performing government and HSC sector have learned lessons from it that may have foreshadowed the importance of a range of preparations, including a centralised vaccine system?

20. Prior to the full operation of the VMS any such data relied on returns submitted by GPs and HSC Trusts. GP practices, who played the main initial role in vaccinating the second highest priority cohort of the over 80s from January 2021, were each responsible for identification of those eligible as well as generating appointments and communications. Through simultaneous Trust led vaccination exercise, individual HSC Trusts would have been responsible for data collection and feeding it into the DoH, including on care home vaccination. As Dr Donnelly states, the reality of pre-VMS roll outs was that during (for example) annual flu vaccination programme, data only becomes available several months into the exercise (INQ0004744429_0019).

21. We know that between March 2020 and November 2020, Dr Naresh Chada, provided medical input for vaccination related issues, including contributing to the early preparatory work for the Covid-19 vaccination programme [INQ000474476_002]. We know that in October 2020, Dr Patricia Donnelly was asked by the Permanent Secretary and CMO to take on the leadership role for the vaccination programme [INQ00047 4429_0003]. We know also that, from the outset of her role, Dr Donnelly recognized that the absence of a Vaccine Management System, enabling access to timely and reliable uptake data was a "*major drawback*" (INQ0004744429_0019). The Inquiry may wish to ascertain when it was appreciated that a Vaccine Management System ('VMS') was not available but would be required, and what work was undertaken to achieve that in the months between March and December 2020.

22. Plainly, the creation of the VMS by the DoH was a necessary and welcome development. Yet the evidence regarding the collection and use of data prior to the availability of detailed VMS reports, together with clarity on what data was actually collected and retained by the VMS, remains vague. The key DoH witnesses acknowledge that data collection was initially insufficient in NI but do not set out the likely effect of such deficiencies. It is apparent that the VMS was in operation as early as 11th January 2021, as the CMO instructed all those administering the vaccine to use it to book and record vaccine data

(INQ000390121). However, according to Sir Michael McBride, the VMS did not start generating detailed reports until April 2021 (INQ000474249_0117). In their expert report Drs Chantler and Dabush highlight the fact that translation of the VMS data was not possible until June 2021, some 6 months into the vaccine programme (Chantler & Dabush §9.6). In the absence of an SMO for vaccines, it would appear that significant steps to set up a VMS were not taken at speed in the period March to October 2020.

23. It is suggested that the VMS allowed for central collection and generation of a wide range of data on vaccination numbers, age, postcode, vaccine type, local government district, mortality and ethnic background where available (INQ000474476_0039 & INQ000474364_0025). Given the evidence heard in M3, particularly in relation to the stark absence of data in relation to ethnicity in Northern Ireland, the Inquiry may wish to probe whether they VMS really does allow for adequate data collection in relation to protected characteristics – with a focus on ethnicity. What categories or codes were used, what staff training was available in relation to data input and how meaningful was the output (particularly in a region that had few other means to capture data relating marginalized groups)? Ultimately, the question is: is the Vaccine Management System as good as it needs to be for any future pandemic?

24. NICBFFJ is concerned that none of the key NI witnesses in relation to the Vaccine Programme including the CMO, DCMO, Dr Donnelly, PHA or Minister Swann appear able to provide a detailed analysis of how and where data was obtained from in the early part of the pandemic or why no VMS existed. Whilst it is apparent that the VMS began to receive data from a relatively early stage, it is not clear to what extent it was able to be accessed and deployed and quality assurance provided. What is clear is that a VMS had to be created in real time, was not ready when the vaccine was being rolled out and did not produce sophisticated information, particularly in relation to vaccine equity or uptake amongst 'hard to reach groups' for at least 5 months after vaccine roll out had commenced [INQ000477804_0031]. The real time development of such a complex system

undoubtedly will have posed significant difficulties and the question of accuracy and quality assurance becomes all the more acute, as notes from the Vaccine Oversight Board demonstrate (INQ000413825, INQ000413827, INQ000413838).

25. The impact of not having access to clear data in the early stages of the pandemic may be particularly significant for certain categories of individuals. For example, as stated above, members of our client group had relatives who were housebound and thus reliant on the vaccine being administered at home. Unlike those in care homes for whom HSC Trusts deployed mobile teams to carry out vaccination (see for example, INQ000276660), vaccination of these individuals was the duty of GPs and District Nurses. By 21 February 2021, DoH acknowledged that of the remaining 5% of over 80 year olds still to be vaccinated, the majority would likely be housebound and vulnerable (INQ000381469_0003). Yet, there does not appear to have been a means of easily monitoring whether such individuals were being reached and how quickly. It is known for example that a 'Dial a lift' scheme was introduced in January 2021 to arrange transport to vaccine centres, but not any detail as to take up (INQ000411402). For those among our families that experienced the anguish of knowing a vaccination of a loved one just a week or two earlier may have saved a life, this issue is one of real significance.

26. The disadvantages of not having a central VMS with easy access to detailed data of, at the very least, vaccine uptake, age, geographical coverage and ethnicicty are clear. In any mass vaccination programme, success depends on reaching the widest range and number of people. If sections of the community are overlooked, then the potential for the virus to proliferate amongst them is clear. This is before the obvious danger to those individuals who are unvaccinated is considered.

27. It would appear that, when reports and analyses from the VMS became available, efforts were made to increase vaccine uptake amongst groups identified as less likely to come forward. In May 2021, the food company Moy Park, one of NI's largest employers, approached the DoH for assistance to get its workforce vaccinated, many of whom come from ethnic minority and/or migrant

backgrounds. We pause to note that it was Moy Park that approached the DoH with concerns that large numbers of its work force remained unvaccinated – and not the other way round. Nonetheless, in partnership with the PHA, a pilot was developed that involved vaccination across sites in Ballymena, Dungannon and Craigavon resulting in vaccination of 8% of the workforce (INQ000474364_0025). Similar schemes were set up after an approach by the Northern Ireland Meat Exporters Association (NIMEA) at a number of sites across the region.

28. While these schemes were commendable, given that in both cases it was the employer who approached the DoH, questions arise as to how proactive the DoH and the Vaccine Programme leadership were in seeking to reach ethnic minorities and other groups. Dr Chada states that "*deprivation and ethnicity are known to have a recurrent impact on full uptake of all immunisations*" (INQ000474476_0038). Thus, it was acknowledged at the outset that such groups represented a barrier to uptake. Yet the PHA were not approached at all by the DoH to undertake any planning or work in relation to reaching vulnerable or disadvantaged groups in the early stages of the pandemic (INQ000474364_0023). A Low Uptake Group was established by the PHA upon the instruction of Patricia Donnelly, but this did not have its first meeting until April 2021 (INQ000474429_0025).

29. Both Dr Chada and Dr Donnelly set out a number of actions (including those mentioned above) that were taken to reach low uptake groups and stress that the data was carefully monitored in this regard prior to the existence of the low uptake group. However, the Inquiry will wish to consider how and to what extent such efforts were sufficient and can be properly evaluated. Going back to the issues around data collection we have raised above, aside from data in respect of individual vaccine drives it is not clear how data monitoring took place prior to the VMS being fully operational in around April/May 2021. As Drs Kasten and Dabush highlight in their report, academic or government evaluations of the vaccine rollout in NI are limited to non-existent, requiring the experts to rely, almost exclusively, on the self-report of the CMO (INQ000474623_0035).

CARERS

30. Allied to concerns around reaching vulnerable groups is the issue of those who provide unpaid or informal care and thus fall outside of the professional care sector. We ask the Inquiry to consider the particular position in NI in relation to vaccine prioritisation of carers who fell in vaccination priority Group 6. Statistics in relation to unpaid carers in NI are stark. Census statistics from Northern Ireland suggest that, in 2021 some 222k people (or 12% of the NI population) provided some form of unpaid care, including many within NICBFFJ. Approximately 70,000 of those provided 50 hours or more of unpaid care per week and there were an estimated 3,000 children with caring responsibilities.[1] Carers UK and the ESRC Centre for Care estimate that people providing unpaid care for sick or disabled family members and friends are saving Northern Ireland's health service *£5.8 billion* in care costs each year. Yet Northern Ireland has no central register of carers, allowing for the identification of carers and those reliant upon them.

31. The inability to identify carers who might fall into priority Group 6 for vaccination purposes again appears to have been appreciated in 'real-time' for vaccine roll out purposes [INQ000276655_004]. The Inquiry may wish to ask, particularly given the high numbers of carers in Northern Ireland, why that gap in information relating to carers had not been appreciated, and therefore planned for, in advance.

32. The Inquiry will be aware that Minister Swann approved a plan to allow carers to self-certify to allow eligibility for priority vaccination Group 6 on 18 February 2021(INQ000276655, INQ000276656, INQ000474451_0011). While self-certification was inevitable consequence in the absence of any other means of formal certification, and while welcomed by carers, it was not without controversy and confusion. Given the extremely high proportion of individuals providing such unpaid care within NI, the Inquiry should consider what impact the absence of a

[1] https://www.niassembly.gov.uk/globalassets/documents/raise/publications/2022-2027/2024/economy/0824.pdf

central register of carers had. Did it hinder access to priority Group 6 for the 220k potentially eligible individuals? Were members of this priority able to be reached by efforts to increase vaccine uptake? What has been done about creating a register in the years since the vaccination programme concluded?

JCVI AND NI INVOLVEMENT

33. Northern Ireland has no statutory membership of JCVI, although Professor Whitty has confirmed that all four nations have observers on the JCVI. At a Four Nations Health Minister meeting on 5th November 2020, the Ministers agreed to have "*due regard of the JCVI advice in developing its policy position on prioritization and utilization of any successful Covid -19 vaccine(s)*" (INQ000474451_0007). In reality, the CMO and Minister for Health confirmed that all such advice from the MHRA and/or JCVI was implemented "as it became available" (INQ000474249_0033). Minister Swann says in his M4 statement that he has always maintained that approach on the basis that neither his department nor the Health and Social Care sector in NI, have the expertise or capacity to attempt to replicate the work of the JCVI (INQ000474451_0007-8).

34. Whilst it is acknowledged that NI may not have the capacity to replicate the JCVI, the Inquiry may wish to consider whether Northern Irish officials were sufficiently represented on and involved in JCVI decision making. In particular, what is the basis for denying Northern Ireland and the other DAs a formal presence? This may be particularly so in pandemic times where any advice from the JCVI is to be implemented swiftly and uniformly.

35. Moreover, in the context of Northern Ireland, additional considerations arise given that decisions of the Irish Government's National Immunisations Advisory Committee (NIAC) may not align with the decisions of the JCVI. The Inquiry has direct evidence of this when, in April 2021, the Irish Government, accepting the advice of NIAC, took a more cautious approach to the use of the Astra Zeneca vaccine than that recommended by the JCVI (INQ000474476_0045). It would appear that the safety issues in relation to the AZ vaccine were discussed by the

JCVI on 1st April 2021, but the DoH were not advised of the outcome until 7th April 2021 (INQ000474476_0045), coinciding with public announcements and formal advice issued by JCVI on the same day (INQ000390088). Given the potential controversy of such an announcement, the reality that the Irish Government (and indeed other European Governments) might adopt a different or more cautious approach and the consequent effect it would have on rollout in NI and elsewhere, might earlier involvement in the JCVI discussions have enabled better communication to the public from NI's own, accountable, vaccine leads?

36. The Inquiry is well aware that the NI public receive their news from the local press, from the UK press and from the press reports emanating from the South of Ireland. Different approaches on either side of the border, particularly when insufficiently foreshadowed or explained, causes confusion and risks distrust. Northern Irish residents will undoubtedly look to their own administration to explain and/or justify why certain decisions are taken regarding prioritisation, safety and deployment. It cannot be assumed to be sufficient, from an accountability perspective, to simply say the advice comes from the JCVI and NI will follow it regardless. Therefore, the Inquiry may wish to consider whether an alternative approach, ensuring meaningful NI engagement on and with JCVI, could yield greater transparency - up to and including whether NI (and other DAs) involvement in the JCVI should be placed on a formal or statutory footing.

COMMUNCATIONS WITH THE DEVOLVED ADMINISTRATIONS

37. Linked to the issue of greater involvement with JCVI decision making and communications is the recurring issue of poor communication between the UK government and the Devolved Administrations. We anticipate that, once again in this module, the Inquiry will hear evidence of last minute and rushed communications, often coinciding with public announcements from Westminster that failed to adequately consider or reflect the prevailing situation in the Devolved Administrations. The Inquiry will again hear of concerns of tokenism in communications with the DAs, of policies or press announcements being made with little or no effort to consult the DAs within a reasonably time frame, and of

the tensions that ensued as a result. We simply observe, at this juncture, that the Inquiry may want to consider why issues of poor, ill-considered or late communications prevailed in excess of 1 year into the pandemic and what the consequences of that poor communication and consultation was on vaccine roll-out, uptake and public confidence.

CONCLUSIONS AND NEXT STEPS

38. NICBFFJ understand that the terms of reference set for this Inquiry are extremely broad and that every effort is being made to counter the potential for such an Inquiry to continue for years without reaching conclusions. However, it is essential for those we represent that sufficient consideration is given to NI within that streamlined process. In population terms it may be substantially less than that of Greater Manchester but the impact of every aspect of the pandemic from political response to vaccine rollout is of vital importance to NI.

39. The problems relating to the NI health system (both political and operational) have been apparent in every module of this Inquiry and are no less relevant in relation to vaccines and therapeutics. As Sir Michael McBride said, the strain under which the system found itself at the start of the system made implementation of a mass vaccination programme a "difficult balancing act". Yet despite that fact neither he nor the responsible DoH witnesses who have provided statements to this Inquiry seem able to engage in proper critical analysis of problems or failures that fell within their own remit. Virtually identical accounts of successes of the vaccine programme are given applying a collective corporate narrative. Yet, attempts to fully evaluate the veracity of that narrative is undermined by a lack of proper analysis of the programme by the NI government itself or, it would appear, the existence of sufficient data to allow others to consider it.

40. We therefore ask the Inquiry to delve behind platitudes and unsupported assertions to try and ensure that at the very least, in future a more nimble and data driven approach might be pursued in the likely event another pandemic requiring mass vaccination comes along.

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