1 **Wednesday, 26 March 2025**
2 **LADY HALLETT:** Good morning, Ms Gardiner.
3 **MS GARDINER:** Good morning.
4 My Lady, the first witness today is Karen Bailey.
5 **MS KAREN BAILEY (affirmed)**
6 **Questions from COUNSEL TO THE INQUIRY**
7 **MS GARDINER:** Please could you state your full name for the
8 Inquiry.
9 **A.** Alice Karen Bailey.
10 **Q.** Ms Bailey, you've given three witness statements to the
11 Inquiry, two in your capacity as corporate witness for
12 BSO PaLS, and one in your capacity representing
13 the Counter Fraud and Probity Service. Those are dated
14 17 January 2025, 12 February 2025, and 2 December 2025.
15 Are those statements true to the best of your
16 knowledge and belief?
17 **A.** Ms Gardiner, there's one small amendment that I'd like
18 to make in relation to the information that was supplied
19 to the Competition and Markets Authority.
20 **Q.** We'll perhaps get that up. That is from your corporate
21 statement INQ000514103, and paragraph 190.
22 Thank you.
23 Is that the paragraph you're referring to?
24 **A.** That is, Ms Gardiner. And just to confirm that there
25 was a query about the submission of this to the CMA, and

1 that was provided last night and we've done a quick
2 check and found a copy of the details but what we can't
3 establish is if that was submitted to the CMA, and we're
4 currently investigating that at the moment and will
5 follow that up in due course with the Inquiry.
6 **Q.** Thank you. So that will be -- that clarification will
7 be taken into account and any further witness evidence
8 that you want to provide by means of a supplemental
9 statement will also be taken into account.
10 I want to first ask you about your role. You are
11 the chief executive of the Business Services
12 Organisation, and I note that you say in your witness
13 statement that you were appointed to that role in
14 June 2020 but you are willing to speak and familiar with
15 the events prior to that in your capacity as a corporate
16 witness.
17 **A.** That's correct.
18 **Q.** Could you briefly explain what the Business Services
19 Organisation is.
20 **A.** So the Business Services Organisation is an organisation
21 that provides professional and shared services to the
22 wider health and social care community in
23 Northern Ireland. We were established under statute
24 in 2009 to provide those services as an arm's-length
25 body of the Department of Health.

1 **Q.** And you've provided your witness statements in relation
2 to two services within the Business Services
3 Organisation, BSO Procurement and Logistics Services,
4 which we've referred to as BSO PaLS, and BSO Counter
5 Fraud and Probity Services. We're going to discuss
6 primarily BSO PaLS today, and you say in your witness
7 statement that BSO PaLS is a Centre of Procurement
8 Expertise for the health and social care system in
9 Northern Ireland.
10 Can you explain what that is and what BSO PaLS's
11 role is in the health and social care system.
12 **A.** Okay, so Centre of Procurement Expertise, in terms of
13 procurement, that's a devolved matter to
14 Northern Ireland through the Minister of Finance, and
15 there are a number of what we call CoPEs, Centre of
16 Procurement Expertise, that are aligned to the
17 departments in Northern Ireland, and the central one of
18 those would be the construction and procurement
19 directorate, who is responsible for setting procurement
20 policy, and they disseminate out, if you like, the
21 Procurement Policy Notes to all departments and --
22 **Q.** And that's within the Department of Finance?
23 **A.** And that's within the Department of Finance. What then
24 is -- so the seven CoPEs, as I say, and BSO PaLS is one
25 of those Centres of Procurement Expertise. So they

1 would work with all the health and social care
2 organisations in terms of sourcing, in terms of
3 procurement, in terms of warehousing and logistics for
4 the various health and social care organisations that we
5 support, and all the main trusts, for example, would be
6 part of that. We would also support Northern Ireland
7 Fire & Rescue Services through that CoPE.
8 **Q.** And looking first at the sort of service that you're
9 providing, and that direction of things, you've said
10 that you provide Health and Social Care trusts, and are
11 all health and social care organisations in Northern
12 Ireland required to use BSO PaLS for their procurement?
13 **A.** Yes, that would be the direction that they would come
14 through, PaLS, for their advice, for their sourcing and
15 procurement.
16 **Q.** And do any trusts ever carry out any direct procurement
17 as well?
18 **A.** Yes, I think it's my understanding that they may do --
19 occasionally do direct procurements, generally with
20 advice from PaLS.
21 **Q.** And in relation to the lines of accountability, who is
22 BSO PaLS accountable to in terms of departments?
23 **A.** Okay, so I suppose the relationship I've described there
24 through the permanent secretary and the -- if you like,
25 and the CoPE status is very much a professional line,

1 and in terms of policy, procurement policy, coming
2 through. But in -- and I describe that, if you like,
3 then, as two lines. So that's through that line. But
4 they've also then got the organisational line through
5 BSO, which is through myself as accountable officer to
6 the permanent secretary in health, and that's very much
7 around the accountability for service delivery and
8 performance.
9 **Q.** So is it fair to sum it up in this way: in terms of
10 service delivery, and that is providing suitable and
11 sufficient healthcare equipment and supplies for the
12 health and social care system, that line of
13 accountability goes all the way up to the Minister for
14 Health?
15 **A.** Yes.
16 **Q.** And then in terms of application of good procurement
17 policy --
18 **A.** Absolutely.
19 **Q.** -- it goes all the way up to the Minister for Finance?
20 **A.** It would go to the perm sec, and that's operationalised
21 through our sponsor branch arrangements with the
22 Department of Health. So we would be in discussion with
23 them about operationalising policy and delivery.
24 **Q.** Thank you. You've already mentioned that health and
25 social care in Northern Ireland in your statement

1 involved the supply of goods to social care providers.
2 Does that expand to -- prior to the pandemic and outside
3 the pandemic, does that expand to private providers of
4 social care or only those run directly by health and
5 social care trusts?
6 **A.** Yes, under the legislation that established us, we were
7 only able to and we are only able to actually supply to
8 health and social care organisations, and in that
9 context it would be social care that is actually
10 directly provided by those health and social care
11 providers. We would not have had a remit to supply to
12 private sector or independent sector providers.
13 **Q.** And I think we'll get, later on, to the point in the
14 pandemic when that remit was expanded to independent
15 service providers and the effect that that had.
16 First, though, I wanted to bring you to paragraph 33
17 of your witness statement. Here you discuss what you
18 call the electronic materials management system. Sorry,
19 this is at page 14 of your first witness statement.
20 Thank you.
21 What is the purpose of the EMM?
22 **A.** So EMM is this electronic materials management system
23 that effectively works at ward level and at theatre
24 level in the trusts and effectively allows an inventory
25 management approach whereby 24 days of stock is handled

1 through that system and stored at the ward level, and
2 automatically, when the usage gets to a point, there's
3 a trigger of 12 days for an automatic trigger going back
4 to our warehouse management system in our central
5 distribution points to replenish the stock at the acute
6 and the ward and the theatre level.
7 **Q.** So was this system in place throughout the pandemic?
8 **A.** It was initially -- at the start of the pandemic, it was
9 in use. However, at a point in the pandemic it was
10 superseded by the push arrangements out to the trust
11 organisations. So that's very much based on the pull
12 model and being able to automatically replenish but
13 ultimately, that was replaced during the pandemic by
14 push arrangements.
15 **Q.** But regardless of whether the system is pulling items to
16 the hospitals or wards or theatres, or you're pushing
17 them proactively, is it right that this gives you,
18 BSO PaLS, visibility over stock levels in trusts?
19 **A.** No, I think it's important to clarify, so when it did
20 move to the push system that was through a central hub
21 arrangement at the trust levels, so that actually took
22 precedence over individual acute arrangements. There
23 wouldn't have been that automatic, you know, the trust
24 hubs would have been coordinating right across at the
25 PAN(?) level, and not really allowing acute wards just

1 to automatically replenish at that point.
2 **Q.** And what level of visibility does BSO PaLS have today
3 over stock levels in wards and trusts?
4 **A.** Well, it would have reverted back at this point now to
5 the EMM system.
6 **Q.** I want to -- thank you, we can have that off the screen.
7 I want to look next at stockpiles and preparedness.
8 Can you tell us who has responsibility for the PIPP
9 stockpile in Northern Ireland?
10 **A.** So the PIPP stockpile is managed in our warehouses
11 through, you know, it's a service level agreement with
12 the Department of Health, kept separately and procured
13 separately from our main stock in the warehouse, and
14 that's through the lines of the Department of Health
15 Emergency Preparedness Team in the Department of Health.
16 **Q.** And who makes decisions about what sort of things you
17 keep in the PIPP stockpile?
18 **A.** At the start of the pandemic, that's very much
19 a national decision, and pushed out to the devolved
20 nations and so --
21 **Q.** So that would have been DHSC?
22 **A.** So that would have been DHSC at that point, yeah.
23 **Q.** And apart from the PIPP stockpile, which you give
24 further details of in your statement, what sort of
25 preparedness or business continuity plans did BSO PaLS

1 have in place for the type of emergency which it faced
2 in January to March 2020?
3 A. The business continuity plans that would have been in
4 place at that point would have primarily been concerned
5 with loss of facilities, loss of systems, probably over
6 a much reduced period of time. So it would have been
7 more about short, you know, short, sharp shocks to the
8 system rather than what we faced, if you like, over
9 a very long protracted period of time in Covid.
10 They had been updated and refreshed by -- and
11 a lived experience, I suppose, of dealing with the
12 Brexit preparations, as well. So there was definitely
13 experiences with that that had informed the continuity
14 plans, but nothing of the nature, if you like, of what
15 we faced over the Covid period.
16 Q. And those preparations that you mentioned in relation to
17 the EU exit, did they anticipate any form of supply
18 chain disruption?
19 A. They did. Obviously, Northern Ireland was in a very
20 unique position when it came to planning for Brexit, and
21 some of the very important considerations to do with
22 obviously the -- without straying into political
23 territory, but the border situation, and how we might
24 deal with any disruption across borders. And also, you
25 know, certifications, for example, in terms of products

1 coming across -- EU certifications, for example, how
2 those would be treated. So there was probably unique
3 things that Northern Ireland faced in terms of
4 preparing, if you like, for Brexit, and certainly part
5 of that involved building up stocks, if you like, prior
6 to the Brexit situation.
7 We would also have been involved in four nations
8 planning with the Brexit -- on the Brexit situation with
9 the other devolved administrations. So that would have
10 also refreshed into our continuity planning as well.
11 Q. But there was no planning specific to supply chain
12 disruption as part of planning for a future pandemic or
13 health emergency?
14 A. Well, we would have been definitely thinking about how
15 we would have got freight through and those kind of
16 issues.
17 Q. You also mention in your statements the standard
18 contract terms used by BSO PaLS at this point, and you
19 say that there were variation clauses built in so that
20 you could vary quantities that -- of healthcare
21 equipment and supplies that you'd ordered, in line with
22 growth. Usual business-as-usual growth, but these were
23 not suitable for surges in demand such as you had with
24 Covid. You say that BSO PaLS was not commissioned or
25 requested to build in those kind of clauses. Was this

1 something that BSO PaLS could have foreseen, given the
2 preparations that had been put in place for EU Exit,
3 swine flu, or indeed the future pandemic?
4 A. I think the sense was that the variation in clauses
5 provided enough capacity in terms of the Brexit
6 planning. In terms of Covid I think it goes on further
7 to say in the statement that even where we could
8 possibly have had surge clauses in the contracts, it
9 would have been very -- highly unlikely that suppliers
10 could have committed to those surge clauses anyway. So
11 there was a sense of, you know, yes, you could have put
12 it into contracts but the reality was that suppliers may
13 not have been able to meet them.
14 Q. I want to again refer to something that you've said in
15 your witness statement. I don't think we need it up,
16 I'll just read it. But at paragraph 8 you say that:
17 "... prior to Covid, BSO PaLS enjoyed productive,
18 mutually beneficial relationships with three key
19 organisations."
20 And you set out that those organisations are: NHS
21 Supply Chain as a customer, and also with the other
22 devolved administrations, Wales and Scotland, because
23 you had a long-established practice of joint
24 contracting. Presumably that was so you could benefit
25 from economies of scale and a greater degree of contacts

1 and product volumes at that point; is that correct?
2 A. Yes, very close and positive relationships is really the
3 sense, and as I say, we had, actually had a number of
4 joint contracting initiatives such as a radiology
5 framework with Supply Chain, et cetera, that it was
6 about economies of scale in effect, and there would also
7 have been a great sharing of soft market intelligence
8 that went on as well.
9 Q. And how did those relationships change at the outset of
10 the pandemic?
11 A. So in terms of how they changed, the four nations group
12 that would have been dealing with Brexit, if you like,
13 transitioned into what was known as the WN Covid Group
14 and that was chaired by DHSC, and that group then met
15 really from January on for a period of months to discuss
16 the, you know, the collective response to Covid. And it
17 was really at that point, fairly early on, that we
18 realised that Supply Chain was struggling from an early
19 point to actually supply to us. We would have got a lot
20 of our FFP3 masks and cleaning products, if you like,
21 through Supply Chain, so there was a definite sense that
22 that was going to be an area of concern for us.
23 Q. What proportion of your PPE, and particularly you
24 mentioned FFP3 masks, would you have procured from
25 Supply Chain, NHS Supply Chain prior to the pandemic?

1 **A.** My understanding would have been most of the FFP3 masks
2 would have been -- the 3M masks would have been sourced
3 through Supply Chain.
4 **Q.** And what about other forms of PPE that you needed for
5 the pandemic?
6 **A.** Other forms of PPE, we actually had -- that wasn't
7 supplied nationally so we actually had strong local
8 contracting arrangements ourselves. We had set up
9 arrangements primarily with UK and Ireland suppliers.
10 So we had our own contracts for the other areas.
11 **Q.** But almost all FFP3 masks and cleaning products came
12 through NHS Supply Chain?
13 **A.** Came through Supply Chain, yeah.
14 **Q.** And when did it become apparent that that route of
15 supply was going to be insufficient?
16 **A.** My understanding is that became evident fairly early on
17 in the first surge.
18 **Q.** I want to bring up INQ000446232. If you can go to
19 page 2. Thank you.
20 This is a document that you produced, exhibited to
21 your witness statement, and it is dated June 2020,
22 titled "Supply Chain Strategy -- PPE Products" and here
23 you set out a variety of options for dealing with the
24 supply chain disruption that you faced at this point and
25 the pros and cons of doing so.

1 The first is to:
2 "Maintain local stockholding at 4 weeks with 'just
3 in time' weekly deliveries."
4 I understand that is the system you had in place
5 prior to the pandemic; is that right?
6 **A.** That reflected business as usual arrangements, if you
7 like.
8 **Q.** And you set out underneath that that is not going to be
9 a particularly useful option, has already failed to
10 deliver what the health and social care system needed at
11 that point.
12 **A.** That's correct.
13 **Q.** Option 2 that you set out is to:
14 "Outsource PPE supply to Supply Chain Coordination
15 Limited and Clipper Logistics."
16 So that's NHS Supply Chain, and you note, and this
17 further down at page 3, that this was a high risk option
18 due to the lack of control HSE would have over supply of
19 PPE.
20 Is this reflective of a lack of confidence at this
21 point in NHS Supply Chain to deliver quantities of PPE?
22 **A.** I think that's a fair comment.
23 **Q.** And then the final option, and I believe this is the one
24 that was adopted, is to:
25 "Maintain local stockholding at 12 weeks with 'just

1 in time' weekly deliveries ..."
2 And it is noted that this provides stability and
3 resilience but also the disadvantage is cost.
4 **A.** That's correct.
5 **Q.** Is it right to say, however, that at that point that was
6 the only real option available to BSO PaLS for managing
7 the PPE crisis that it found itself in?
8 **A.** I believe so. You know, at this point we had been
9 involved in mutual aid discussions with the other
10 devolved administrations and while there were some small
11 quantities of PPE coming primarily through NHS England
12 and through Wales, it was of small quantities. There
13 was a sense that, I think, we'd had some experiences
14 with the NHS England thing where, you know, the mutual
15 aid just wasn't able to be confirmed or we couldn't
16 rely. It really was that lack of confidence that if we
17 were depending on that, we wouldn't be in a good strong
18 position locally.
19 **Q.** If I can also get up INQ000436300.
20 Thank you. And I think we need to go to the next
21 page. Oh excuse me, I'm sorry, I was wrong we were on
22 the previous page.
23 This is an email from Michael McBride who is the
24 Chief Medical Officer for Northern Ireland and this is
25 sent in April 2020. He has been in conversations with

1 NHS England, Keith Willett, "last night."
2 This conversation is about release from Northern
3 Ireland's PIPP stockpile of, I believe, gowns to, as
4 mutual aid to other devolved nations. However, he also
5 comments on incoming PPE via NHSE and it's that comment
6 I want to ask you about. He says that:
7 "There are concerns that the DHSC stock anticipated
8 may be of variable quality and [the] timeframe for
9 delivery is indicative."
10 Does that reflect your experience with NHSE or
11 BSO PaLS's experience at this time?
12 **A.** Certainly in terms of Supply Chain, yes, that would
13 reflect the fact that we had -- not so much, I think,
14 about variable quality but the fact that we knew Supply
15 Chain was under great pressure.
16 In terms of that PIPP stockpile, I think it's
17 important to point out that we didn't release the PIPP
18 stockpile all at once at the start of the pandemic. It
19 was actually used as a bridge, if you like, to
20 supplement any gaps or where we were getting
21 particularly low, so it was actually used as a kind of
22 reserve. So, you know, that worked very well for us in
23 terms of the pandemic.
24 So in terms of mutual aid, there was a sense that
25 where possible, we should be trying to support, and

1 equally, we got some back. So decisions about the --
2 what was released out of the stockpile would have been
3 very much at the CMO level.
4 **Q.** Thank you. And you say in your witness statement that
5 your relationships in general with other devolved
6 administrations strengthened in this period with
7 information sharing --
8 **A.** It did.
9 **Q.** -- increased contact and also provision of mutual aid.
10 I wanted to ask you something about what a previous
11 witness said in their evidence. Mr Tim Losty, who has
12 already given evidence to this module, he said in his
13 evidence that at times he felt as though the
14 UK Government was disinterested in working with the
15 devolved administrations, or did not take sufficiently
16 seriously the concerns of the devolved administrations.
17 Is that something that was reflected in your
18 experience?
19 **A.** I would be speculating, Ms Gardiner. You know, not
20 having been there firsthand, I would be speculating at
21 that point.
22 **Q.** That's fine. If it's not something you're able to
23 comment on --
24 **A.** I can't comment on that.
25 **Q.** -- we can't take that any further.

1 But to sum up the position in the spring of 2020,
2 you had been relying, for these essential items of PPE,
3 in particular FFP3 masks, very heavily on NHSE. It came
4 to light that that was not going to be a substantial
5 route of procurement any more, and so Northern Ireland
6 was put in a place where it was going to have to do much
7 more direct procurement. And I want to go to the
8 process that was undertaken by BSO PaLS at that point.
9 You say that you had three main approaches, BSO PaLS
10 had three main approaches: one was use of previous
11 contractors and suppliers; one was sourcing proactively
12 those new suppliers, including local manufacturers; and
13 the other was following up contacts and leads that were
14 being referred to you directly or through third parties
15 such as ministers, MLAs, MPs, senior civil servants.
16 How were -- the third category of contacts that were
17 referred to you, how were those dealt with?
18 **A.** So those would have come in in a variety of different
19 ways. We would have had people sending information into
20 the trusts, into a mailbox that the Department set up,
21 a PPE mailbox, directly into PaLS itself. So, you know,
22 there was a real sense of -- and I know others have said
23 that as well -- a real deluge of this information coming
24 into the system. As that came into PaLS, a triage
25 process was set up, and that effectively logged initial

1 contacts, and then there was a more rigorous follow-up
2 process, followed up with them in terms of getting
3 further information, a form that those people had to
4 actually fill out, and giving details.
5 We had structured ourselves at that point into
6 category teams, dealing specifically with the different
7 areas of PPE internally, and because FFP3 was probably
8 our biggest risk area, there was -- that triage process,
9 there was the bit that dealt with the rest and then the
10 bit that dealt with that priority, FFP3 masks, route.
11 And that they would have obviously been the first that
12 we were trying to deal with in terms of sourcing.
13 **Q.** And you mention in your witness statement a call that
14 was published by the Department of Finance Construction
15 and Procurement Delivery organisation for suppliers of,
16 among other things, PPE. And this was advertised on the
17 eTendersNI website and then later on NI Direct.
18 Was BSO PaLS asked whether that call to arms, if
19 I can put it that way, was necessary or useful? Was
20 anyone asked about that from a procurement perspective?
21 **A.** I wouldn't have the detail of that, Ms Gardiner, I'm
22 sorry.
23 **Q.** Very good.
24 I want to bring up INQ000498735. Thank you. If we
25 could have -- yes, this is slide 2.

1 This is a slide deck from early in the pandemic,
2 spring 2020, and this sums up the situation which
3 BSO PaLS finds itself in and it's illustrative of what
4 we've heard from many procurement professionals in this
5 module so far. And particularly, at point 3, it says
6 you were:
7 "Inundated with 'offers' of help"
8 Were those offers useful or were they a distraction
9 to the work of procurement teams at that time?
10 **A.** No, we ended up -- I think we got about 2,000 approaches
11 from different companies. There was a number of
12 duplicates coming in to different people, so once those
13 were weeded out I think we had about 1,200
14 approximately. And having gone through the triage
15 process, we actually got about 45 really useful leads
16 out of that.
17 **Q.** Thank you.
18 Thank you, we can have that off the screen.
19 And you mention that some of those offers and
20 referrals came through senior politicians, perhaps
21 senior civil servants, and that they were all inputted
22 into this contact log.
23 **A.** Yes.
24 **Q.** This module has heard at length from other witnesses
25 involved in procurement in UK central government about

1 the operation of a High Priority Lane or what has
2 sometimes been called a "VIP Lane", where offers were
3 referred in by senior politicians and repeatedly chased
4 by either those politicians or the potential supplier.
5 Was there an equivalent situation in Northern Ireland?
6 **A.** No, I can confirm that we would have logged -- all --
7 all offers of help went through that triage process and
8 I think our logs would demonstrate that, and it was
9 quite a rigorous process that was applied equally to
10 everyone.
11 **Q.** And did you have instances of senior politicians or
12 other VIPs, if I can put it that way, chasing up
13 referrals or offers of PPE, or other equipment?
14 **A.** Well, we would have had instances where politicians
15 certainly would have alerted us to particular companies
16 of interest and -- you know, but in effect, those went
17 onto the log and would have been subject to the same
18 checks and balances as any other. And not all of them
19 would have been successful.
20 **Q.** How were those offers in the contact log prioritised?
21 How would you decide which to deal with first?
22 **A.** Well, it came in as a sequential basis, as I said, bar
23 anything that was FFP3 related. And we had a separate
24 triage stream which prioritised the offers of help for
25 FFP3 in particular.

1 **Q.** So it was otherwise first in, first served?
2 **A.** Otherwise first in, first served.
3 **Q.** Yes, thank you.
4 You have said in your witness statement that there
5 were two main differences in terms of procurement during
6 the pandemic. The first is that price was not always as
7 important as availability, and the second was the lack
8 of open competition. We're going to come to deal with
9 that at a later stage.
10 But you also say that if an offer was considered to
11 have potential in respect of availability, there was
12 then a process that it went through in terms of testing
13 and quality assurance. Can you explain what that was.
14 **A.** So in the early stages that process of testing and
15 quality assurance would have -- so it was a multi-agency
16 approach. So, very early on, there was a process
17 established with the Medicines Optimisation Innovation
18 Centre which would have looked at the testing and
19 certification of products that were offered to us and
20 confirmed that they met CE standards, et cetera. So
21 that process happened. And then, later on, following
22 a rapid review that the minister had initiated and some
23 early problems with a contract with NHS Wales where we
24 had issues about user preference and acceptance, the
25 silver command structures. So we had a sort of

1 structure of gold, silver, and bronze command, gold
2 being at departmental level, silver being at the various
3 organisations level.
4 So the Health and Social Care Board established
5 a silver cell through -- with, really, infection and --
6 prevention and control people to look at acceptability
7 and usability, et cetera, as well. So those kind of
8 triage processes were very useful in terms of -- because
9 they were done prior to contract being awarded, and that
10 was definitely a real learning point for us, because
11 they weeded out a lot of the offers that were unsuitable
12 and then once we had placed orders we knew that that
13 level of acceptability, both at a technical level and
14 user level, was in place.
15 **Q.** So you mentioned a couple of things that I want to
16 clarify there. The first is the rapid review of PPE.
17 I believe that was in April 2020; is that right?
18 **A.** It was, yes.
19 **Q.** And that was commissioned by the Minister for Health?
20 **A.** The minister.
21 **Q.** And this led to what you have set out, and other
22 witnesses have set out, as the product review protocol,
23 and is that what you've described as this multi-agency
24 approach involving, on the one side, the technical
25 assurance from the Medicines Optimisation Innovation

1 Centre?
2 **A.** Correct.
3 **Q.** And on the other side, user acceptability?
4 **A.** Yes, so this was a specific cell established at the
5 silver command level independent of PaLS, who in effect
6 took samples. So samples would have been provided and
7 they would have gone through quality and user
8 acceptance, and that was really influenced by some of
9 the experiences we'd had with the NHS Wales contract
10 where we had sourced a face mask that met all the
11 technical standards, but the user preference -- and
12 I think I have to put this into context -- users were
13 very frightened at this point in the pandemic. They had
14 been used to specific types of product, and we'd
15 standardised, for example, on 3M masks for the FFP3.
16 You know, anything that was new, and it was inevitable
17 some things were new because we were having to source
18 such a wide variety of different suppliers. So anything
19 that was new was very, you know, they were unused to it,
20 there was a lot of fear about whether or not they would
21 be protected accordingly.
22 So really that came off the back of that experience
23 with Wales, this strengthening of the protocol. And
24 I euphemistically refer to it as the three-legged stool,
25 and it really meant that products had had that very,

1 very rigorous assessment prior to any orders being
2 placed.
3 Q. And if we can just go into that procurement, that
4 specific procurement you mention from NHS Wales, we
5 heard a little bit about this from the Welsh perspective
6 yesterday in the witness evidence of Jonathan Irvine
7 from NWSSP, the NHS Wales Shared Services Partnership.
8 And what he described and what you also describe in your
9 witness statement is that NHS Wales or NWSSP had secured
10 a volume of type 2R masks, which is the blue surgical
11 masks, I believe, yes?
12 A. Yes.
13 Q. Which -- some of which they could offer to BSO PaLS for
14 Northern Ireland. And I understand from your witness
15 statement, and also from his evidence that the problem
16 when those masks arrived in Northern Ireland was not
17 that they failed any technical specification, but
18 instead it was a matter of user preference.
19 A. Yes.
20 Q. Is that correct?
21 A. Yes. So as I say, our staff had been very used to
22 a metal strip, and this had a plastic strip, and was
23 felt not to be as malleable, if that's the word.
24 Q. So it doesn't create as tight a seal?
25 A. Well, that was the perception from staff. As I say, it

1 had been assessed through, at this point this was prior
2 to the MOIC and the three-legged stool arrangement so it
3 had been assessed by Wales's own laboratories --
4 Q. So it was technically --
5 A. Technically perfect but just did not meet the user
6 preference.
7 Q. And you say that this amounted to 2% of all face masks
8 purchased --
9 A. Yes.
10 Q. -- during the period of the pandemic. And do you recall
11 how much that contract was worth?
12 A. I think it was, from memory -- well, not from memory,
13 I have a figure here and it's an approximation, but
14 roughly about 3.3 million.
15 Q. So that's a very significant procurement?
16 A. Yeah.
17 Q. And what did you end up doing with those face masks?
18 A. In terms of what we did with them, we actually ended up
19 having to donate to charity. The mask was deemed
20 unusable by the trusts and was withdrawn from service.
21 Q. And you've already said that this highlights the
22 importance of that second leg of the stool of the user
23 acceptability assessment. Has there been any other
24 lessons learned from that incident in BSO PaLS?
25 A. Really, the product review protocol was the major lesson

1 learned from that, and, you know, just, I suppose, the
2 sense that on the wider systemic level, the whole
3 systems level, the importance of having that user voice
4 expressed through some mechanism.
5 Q. And one further question on the product review protocol.
6 You've already mentioned that it came out of the rapid
7 review of PPE, which was commissioned in April of 2020,
8 and you say that the product review protocol was applied
9 from about May but not formally approved until July.
10 Why was that?
11 A. I'm not party to what the formal approval processes were
12 at that point, but I know we were very actively, on the
13 basis of the experience with Wales, working on that
14 basis early on.
15 Q. Thank you. I want to consider the issue of fit more
16 widely. We will also turn to look at modelling, but one
17 of the points you raise about modelling is that
18 modelling did not at any stage indicate that there was
19 a need to take into account variation of fit for
20 different ethnic minorities or gender or religious
21 observance by healthcare workers.
22 Did you have any issues about that issue raised with
23 you as BSO PaLS?
24 A. Not to my knowledge.
25 Q. Did you seek any information from, for example, the IPC

1 cell or the Health and Social Care trusts on that?
2 A. No, in respect of the modelling, the modelling, again,
3 was set up as a silver command modelling cell in its own
4 right, and that was led by the Public Health Authority
5 in Northern Ireland. I wouldn't -- I wouldn't be party
6 to the kind of factors, I know there would have been
7 some clinical input looking at activity and gathering
8 intelligence, I suppose, from the trusts. I wouldn't be
9 privy to the methodology that was used to come to that
10 modelling.
11 Q. I also wanted to ask about the point you've already
12 raised about the standardisation of certain products in
13 Northern Ireland.
14 In particular in your witness statement you mention
15 the FFP3 mask. Is it the case that Northern Ireland
16 essentially procured, prior to the pandemic, one type,
17 one brand, of FFP3 mask for the whole of the health and
18 social care organisations?
19 A. Yeah, and I think it's -- again, this is very
20 contextual, so public policy, procurement policy at that
21 point was encouraging a policy of standardisation for
22 value-for-money reasons, and clinicians had been engaged
23 in the selection of that particular mask. It was chosen
24 because it had a very, very high degree of fit testing
25 success. It was a trusted product. And, and, you know,

1 and represented value for money then as well, because of
2 that standardisation approach.
3 Q. So you could procure larger quantities --
4 A. Exactly, yes.
5 Q. -- and deliver on economies of scale. And so is it the
6 case, then, that at the outset of the pandemic there was
7 only one type of FFP3 mask regularly in use in Northern
8 Ireland to the extent that any FFP3
9 mask -- (overspeaking) --
10 A. They were certainly the most widely, yes, used.
11 Q. And that almost everyone who required an FFP3 mask in
12 Northern Ireland would only have been fit tested for
13 that particular mask?
14 A. That's correct, as I understand it.
15 Q. And you then detail that the supply of that mask broke
16 down and it became necessary to source other masks. Was
17 that mask coming through NHS Supply Chain?
18 A. No, so the alternatives would have come from a variety
19 of, you know, based on the sourcing strategy that I've
20 described earlier. So we would have gone to existing
21 suppliers; we would have gone to new suppliers; we would
22 have contacted leads that were given to us for FFP3
23 masks. So, you know, the situation was pretty acute
24 with those particular masks. So all those various
25 sourcing strategies were applied, and a variety, then,

1 of masks came through that route.
2 Q. And that would have necessitated fresh fit testing for
3 each --
4 A. It would have -- for every --
5 Q. -- new type --
6 A. As I understand it, yes, the particular masks have to
7 be, any time there's a change, and I'm not a procurement
8 expert but I am told that was the situation that any
9 time there was a test -- (overspeaking) --
10 Q. And who provided fit testing for trusts?
11 A. So fit testing for trusts during -- there had been
12 a regional, as I understand it, a regional approach was
13 initiated in 2019 but hadn't completed by the time the
14 pandemic hit. There had been some difficulties,
15 I think, in getting engagement for what's called the
16 contract adjudication group and there are four at that
17 point. Going into a full open competitive tendering
18 position through Covid would have been counterproductive
19 given the time that was in it, the need was to have the
20 fit testing done at that point.
21 So customers had to revert to existing arrangements;
22 which were either using the fit testers that they had
23 trained locally, because it's a health and safety issue
24 for the trust organisations or, indeed, going out and
25 awarding direct awards to existing fit test contractors.

1 Q. It might be helpful at this point to look at what one of
2 the trusts says about this.
3 This is INQ000514350 and at page 23 -- 24, excuse
4 me, paragraph 79.
5 This is the witness statement of the South Eastern
6 Health and Social Care Trust. And they're talking about
7 the impact of BSO PaLS, of having to go out and procure
8 their own fit testing contracts as opposed to those
9 being arranged centrally by BSO PaLS.
10 And they set out a number of consequences,
11 including: lack of standardisation and controls testing;
12 the potential impact on service delivery; obviously, the
13 stress and anxiety for the staff in having to be
14 fit tested potentially a number of times; and obviously
15 the increased administrative burden and cost,
16 particularly given that a regional contract might have
17 benefited from reduced price due to it being a larger
18 contract.
19 And if we can also have a look at the Northern
20 Ireland Audit Office report.
21 This is INQ00034882 and at page 15. Thank you.
22 At paragraph 19, we see that the Health and Safety
23 Executive in Northern Ireland expressed the -- sorry,
24 the Royal College of Nursing expressed to the Health and
25 Safety Executive Northern Ireland that local fit testing

1 was not widely available at that point.
2 And it also observes that BSO PaLS did not procure
3 centrally fit testing, and it says that it was more
4 expedient for trusts to award their own direct award
5 contracts for this service.
6 Can you explain why it was considered more expedient
7 at that point?
8 A. Probably referring back to what I said at the outset
9 there. So there had been a process initiated in 2019,
10 prior to the pandemic, to actually try to agree
11 a regional fit testing arrangement. That had not
12 progressed due to lack of engagement in terms of the
13 contract adjudication groups, and that's very important,
14 that they are the people who actually need to be
15 involved in the tender process.
16 So it wasn't -- you know, to have continued that on
17 through the pandemic we would have had to have been
18 getting into standing up a contract adjudication group,
19 inviting tenders, evaluating tenders, open -- you know,
20 that open, competitive normal process. There wasn't --
21 there wasn't the time in it, given the need to have fit
22 testing done with these new masks for staff.
23 Q. What about -- was consideration given to BSO PaLS
24 awarding a direct award contract or another accelerated
25 procurement process for fit testing?

1 **A.** So that's what I'm talking about. It still would have
2 had to have gone through -- you know, sorry, in terms of
3 the testing contract, it was just deemed more expedient
4 given the number of suppliers that were available. The
5 sense from the procurement specialists was if there had
6 been some sort of regional award to one supplier, for
7 example, they would not have had the wherewithal to have
8 coped with the amount of fit testing surge that was in
9 Northern Ireland at the time.
10 **Q.** And it's also noted in the Audit Office report that
11 a regional fit testing framework is currently being
12 developed. How has that progressed to date?
13 **A.** So that has now been put in place.
14 **Q.** Okay. And is the standardisation that you mentioned
15 earlier, is that still occurring in procurement?
16 **A.** There's certainly -- as I understand it, yes, we've gone
17 back to primarily using 3M masks.
18 **Q.** Thank you. We can have that off the screen.
19 I want to turn to look at modelling more generally.
20 You have said in your evidence that the "WN Covid Supply
21 Chain Cell" group, which you've already mentioned as
22 being a four nations group to respond to supply chain
23 issues, it was identified that reasonable worst-case
24 modelling was being worked up by NHS England at that --
25 at that point, at the very end of January 2020. And

1 requests were made, I understand, on a number of
2 occasions throughout February and March from devolved
3 administration members for modelling to enable demand
4 planning to take place. And you note that the group
5 ceased to exist by the end of March and no central
6 modelling was ever forthcoming through that group.
7 Did you ever receive that modelling?
8 **A.** We did not.
9 **Q.** Do you know why?
10 **A.** I have no insight into that.
11 **Q.** And instead, you say that BSO PaLS had to rely on the
12 demand patterns emerging from warehouses, but that was
13 obviously not very indicative --
14 **A.** No.
15 **Q.** -- because it was -- it wasn't predictive of anything.
16 It was just telling you what was happening at the time
17 and that you -- it couldn't create an impression of what
18 demand you would have in the future.
19 However, later, there was modelling that came
20 through the Department of Health and Social Care when
21 you were asked to provide data on PPE demand on
22 27 March 2020. There was then a model that was worked
23 up that set out modelling for hospital-based care in
24 three different scenarios.
25 How much did that delay until late March for any

1 form of modelling hinder BSO PaLS's ability to procure
2 sufficient PPE at that point?
3 **A.** Well, certainly at that point, you know, that led to our
4 first supply and demand type of situation, which was
5 first published in April 4th, so in terms of, again,
6 back to the sort of governance structures, the -- you
7 know, there hadn't been a modelling cell stood up at
8 this point. That particular piece of work done in March
9 was led by the Health and Social Care Board and our
10 public health colleagues coming together to, really,
11 look at kind of the projections across those three
12 scenarios and to understand where we were in terms of
13 supply and to give us some sort of an indication of what
14 we should be buying in terms of the various levels
15 of PPE.
16 Obviously some of the orders had already been placed
17 prior to that, and as you say, Ms Gardiner, that was
18 very much just, you know -- you know, we were working
19 off demand that was coming into the system at that
20 point. So it was adjusted -- that particular one was
21 adjusted fairly quickly as well, following a change of
22 guidance just immediately after that, for the needs of
23 the independent sector and the domiciliary care sectors
24 and -- so community was then added to that, that
25 particular piece of modelling. But it was still a very

1 initial attempt at trying to create that demand
2 modelling.
3 And again, that led to, I suppose, a realisation
4 that there needed to be a more nuanced and sophisticated
5 form of modelling, so a modelling cell was then
6 established in silver command that actually produced
7 a more informed model in June 2020, named "reasonable
8 worst-case scenario".
9 **Q.** I think we'll come to that very soon but I first want to
10 address two issues with that initial set of modelling
11 that you got. You say it was only focused at
12 hospital-based care. To what extent could that be
13 useful for BSO PaLS, given that health and social care
14 in Northern Ireland has and was at that time, and had
15 been for some time, integrated with social care?
16 **A.** It was obviously limited to that.
17 **Q.** And you set out later that subsequent modelling
18 reflected that community settings accounted for about
19 60% of the PPE that was expected, which gives us a sense
20 of the impact of that omission from the first model.
21 **A.** And perhaps, just, you know, just to clarify, so the
22 social care, you know, health and social care, there
23 would have been social care that would have been
24 directly provided by the trusts in Northern Ireland.
25 The addition of the community that we're talking about

1 here then would have also included private sector
2 community care.
3 Q. And the further reasonable worst-case scenario modelling
4 that you mentioned, that was provided in June 2020 and
5 then later again the next summer, in 2021. And it
6 assumed that the health and social care system would
7 function as normal so it used, I believe, the data from
8 the previous year in 2019 --
9 A. Yes.
10 Q. -- as well as dealing with Covid -- with Covid cases,
11 and then it provided a further buffer of 20% on modelled
12 PPE demand.
13 Are two things not obviously problematic from that?
14 The first is that this is a reasonable worst-case
15 scenario, so we're saying this is probably as bad as
16 it's going to get, and then you add an additional 20% on
17 top of that, which is -- also seems quite high. Does
18 this not obviously lead to over-purchasing at this
19 stage?
20 A. Respectfully, you know, BSO were instructed to use the
21 modelling to procure, and I think this is the limits of
22 the various cells. You know, between the first
23 reasonable worst-case scenario and the following one, we
24 would have been indicating actual usage, that would have
25 fed into the second set of modelling figures, but, you

1 know, it did reflect, I suppose, a very conservative and
2 prudent approach to modelling.
3 Q. And coming to the quantity of surplus, you've set out
4 that as of 31 March of 2024, of the total volume of PPE
5 procured, 2.72% of that has expired in storage. And is
6 that that it has expired and it has not been re-lifed or
7 extended?
8 A. Yes.
9 Q. So that has had to be disposed of?
10 A. Yes.
11 Q. And of that PPE there are 362 million individual items
12 still in stock, although you not that 238 million of
13 those are gloves so they're not considered to be surplus
14 stock because presumably the health and social care
15 organisations will use those?
16 A. Yes.
17 Q. They'll get through that stock; is that right?
18 A. Yes, well, they -- I mean, it's a very fluid picture,
19 the whole issue of, you know, there's various attempts
20 to try to work with suppliers to re-life products as
21 much as possible. Some of the PPE, as you rightly point
22 out, will go on indefinitely and -- but there are, as
23 time goes on, obviously there's a situation where some
24 of it reaches end of life, as well. So yes, you know,
25 that's a moving picture.

1 Q. And indeed, you say that since March 2022, BSO has
2 already written off £15.9 million of surplus stock, and
3 you've also made provision for future write-offs.
4 You say that the most significant factor leading to
5 this surplus stock was the accuracy of the demand
6 modelling. What kind of feedback has been delivered to,
7 whether the modelling cell itself or those responsible
8 for the modelling cell, to ensure this doesn't happen in
9 the future?
10 A. That would have been pretty consistent in terms of
11 feedback. So in terms of reflecting, I suppose, the
12 picture of demand versus supply, a report was developed
13 that actually reflected that planned modelling, the
14 actuals, and the situation right across the Province,
15 and what was anticipated to be coming in, and that was
16 actually worked up and provided to all major
17 stakeholders, including trust chief executives, Silver
18 Command, Gold Command, and the strategic supply chain
19 that would have been established at Gold Command.
20 Q. One further point on modelling, we know that since
21 June 2020, Northern Ireland has had a DPS set up in
22 respect of PPE, that's noted in the Northern Ireland
23 Audit Office report, though that report also notes that
24 only two contracts had been awarded up until that point
25 through the DPS. Is that reflective of the quality of

1 PPE that had already been procured at that point?
2 A. Yes, I think that's a fair assessment.
3 Q. And do you know, have any further contracts been awarded
4 for PPE since the publication of that report?
5 A. I don't believe for PPE but the dynamic process/system
6 is still in place.
7 Q. So essentially, you're still working through some of
8 that stock --
9 A. Yes.
10 Q. -- that we procured --
11 A. Yes.
12 Q. -- in that early stage --
13 A. Yes.
14 Q. -- prior to June 2020. Thank you.
15 There are a few other points that I wanted to deal
16 with, before we finish, in terms of lessons learned, and
17 they come -- they also come from the Northern Ireland
18 Audit Office report. One of the points that is observed
19 in that report is that BSO PaLS had not identified any
20 conflicts of interest in contracts awarded during the
21 pandemic, and that's reflected in your evidence, as
22 well.
23 You set out in your statement some reasons as to why
24 conflicts of interest weren't an issue in Northern Irish
25 procurement. Could you elaborate on some of those?

1 A. In terms of -- so yes, we would have had the standard
2 declarations of interest. I think the fact that we had
3 established the product review protocol, while it was
4 primarily aimed at establishing the veracity of
5 products, you know, the benefit of that in terms of, you
6 know, conflicts of interest, the fact that you had three
7 multiple agencies involved before any contract was
8 placed meant that, you know, in terms of conflicts of
9 interest, even if someone had had a particular, you
10 know, interest in something, they wouldn't have been
11 able to have overridden that very independent set of
12 three different organisations, and all of them having to
13 have approved the order before it was placed.
14 Q. So that's the fact that the decision doesn't rest with
15 one person --
16 A. Exactly.
17 Q. -- alone. You also talk about the annual conflicts of
18 interest declarations that officials have to make.
19 Given that we know that there was a decent amount of
20 procurement from local organisations, some of which
21 repurposed facilities in order to make PPE or similar
22 products, were staff reminded of the need to keep up to
23 date those declarations --
24 A. Yes.
25 Q. -- given they might be engaging with organisations,

1 businesses, that they wouldn't have anticipated to
2 engage with in the course of procuring healthcare
3 supplies?
4 A. Yes, there would be a fairly rigorous internal
5 governance process about conflicts of interest, and
6 indeed, that would have extended right up to myself as
7 chief executive. I would have been involved in some of
8 those discussions, as well, at that point.
9 Q. The caveat that's given in the Northern Irish Audit
10 Office report is that while it is correct that no
11 conflicts of interest were identified, the process that
12 BSO PaLS has in place relies on those proactive
13 declarations by officials, and therefore, it's not going
14 looking for any undisclosed conflicts.
15 Have any changes to that process been implemented to
16 ensure a more robust or proactive approach?
17 A. Not at this point. As I say, the fact that there was
18 that multiple whole-systems approach I think prevents
19 that conflicts of interest process arising, to be
20 honest. You know, I mean we are -- our PaLS team are
21 very, very experienced professionals of long standing,
22 you know, and have been -- and are very much seen as
23 a trusted partner. There would be that division, if you
24 like, within the PALS structure itself as to who was
25 placing orders and who was approving orders, et cetera,

1 so it wasn't a case of it was all going through one
2 person and if one person had a conflict of interest they
3 had the ability to actually place an order the whole way
4 through. And in fact, during the Covid period, anything
5 that was deemed to be of high risk or of particular
6 interest had to go through finance and had to go through
7 chief executive, and SMT information as well. So there
8 was a real sense of scrutiny, I suppose.
9 Q. The other point that is made in the NI Audit Office
10 report is that fuller documentary evidence would have
11 provided a more complete record and trail of important
12 procurement decisions taken during the pandemic. You
13 also note in your witness statement that BSO PaLS has
14 accepted in full all of the Northern Ireland Audit
15 Office's recommendations?
16 A. They have.
17 Q. What steps have been taken to implement the
18 recommendation on fuller and more complete
19 recordkeeping?
20 A. So that would have included documenting all our logs,
21 all our processes, documenting flow diagrams and making
22 sure that we had the appropriate evidence, if you like,
23 alongside each step of those, making sure our DACs,
24 direct award processes, were documented and signed off
25 appropriately, particularly at the chief exec level, and

1 the rationales, and making sure things like contract
2 award notices were actually issued in time because some
3 of those had been up to a week late during the pandemic.
4 Q. Finally, in your witness statement you say that you're
5 not aware of any specific lessons learned reviews that
6 have been carried out by BSO PaLS. Given the number of
7 learning points identified in the Audit Office report,
8 and, indeed, the very evident public interest in
9 procurement of healthcare suppliers during the pandemic,
10 what consideration has BSO PaLS given to carrying out
11 a more holistic review of lessons learned during the
12 pandemic?
13 A. Okay. So there would have been a BSO-wide corporate
14 lessons learned report that was actually created through
15 our director of legal services. However, that would
16 have been at a very high level, corporately, right
17 across all of our services. And indeed, there was some
18 work done in terms of the lessons actually being
19 incorporated into PaLS' own processes and continuity
20 plans but we absolutely accept that there's a need to
21 probably collate.
22 I think we still feel that we're not really finished
23 at the point where we could pool all of the lessons
24 learned because some of that will be about disposal and
25 some of the initiatives, for example, we're involved in

1 at the moment in terms of putting them into energy and
2 into waste initiatives.
3 So we want to make sure it's a full picture before
4 we actually do a final lessons learned. But happy to
5 take any recommendations that the Inquiry makes to us in
6 that respect.
7 **MS GARDINER:** Thank you.
8 My Lady, those are all my questions. I believe
9 there are 20 minutes of questions from Core
10 Participants. We usually take a break, but I'm in your
11 hands as to whether you want to proceed.
12 **LADY HALLETT:** Ms Bailey, are you okay to come back at half
13 past for another 20 minutes?
14 **THE WITNESS:** I'm content, my Lady.
15 **LADY HALLETT:** Thank you very much. In which case we'll
16 break until half past.
17 **MS GARDINER:** Thank you.
18 **(11.15 am)**
19 **(A short break)**
20 **(11.30 am)**
21 **LADY HALLETT:** Ms Gardiner, I think it's Ms Banton first.
22 **MS GARDINER:** Yes.
23 **Questions from MS BANTON**
24 **MS BANTON:** Good morning.
25 **A.** Good morning.

1 **Q.** Thank you. I ask questions on behalf of the Federation
2 of Ethnic Minority Healthcare Organisations, FEMHO.
3 During the early stages of the pandemic, the urgency
4 of the situation led to significant challenges in PPE
5 procurement, including periods when purchases were made
6 without formal quality control. This situation presents
7 concerns regarding the potential distribution of
8 substandard or even fraudulent PPE to frontline workers,
9 which FEMHO is particularly concerned about, given the
10 risks to healthcare workers, especially those from
11 ethnic minority backgrounds who were disproportionately
12 affected.
13 I just want to ask two questions. The first
14 question being, the product review protocol was only
15 formally introduced in July 2020, months after
16 large-scale PPE procurement had already taken place.
17 During this time, were substandard or fraudulent PPE
18 items distributed to frontline workers, and what
19 specific risks did this delay create?
20 **A.** Thank you. I think it would be really important to
21 state that while the three-tiered product review
22 protocol didn't formally begin until the period you've
23 talked about, that we had been working with MOIC almost
24 from the very start of the pandemic in respect of
25 technical assessment of products. So I think -- I don't

1 think we would accept that any substandard products --
2 in terms of not meeting the technical assessments set
3 out at policy level by the national, sort of, standards
4 weren't met. Those processes would have been very
5 thoroughly checked by the MOIC staff.
6 Our sense was that anything that we bought met the
7 criteria that was established for technical quality.
8 **Q.** The second question. Prior to May 2020, PPE purchases
9 were made without formal quality control. Given this
10 gap, was any retrospective review conducted to assess
11 whether earlier procurement contained fraudulent or
12 unsafe products? And if not, why not?
13 **A.** So, again, while I say the product review protocol was
14 endorsed formally, really, it -- from the experience
15 with Wales, you know, we had been working with MOIC in
16 terms of technical assessment but very early on started
17 working with the infection prevention cell to
18 actually -- and infection prevention staff at trust
19 level to make sure that -- it was very much around user
20 acceptability and preference rather than the quality
21 assessment against technical standards.
22 **MS BANTON:** Thank you, those are my questions.
23 **LADY HALLETT:** Thank you, Ms Banton.
24 Ms Campbell, I think you're up next.
25 **Questions from MS CAMPBELL KC**

1 **MS CAMPBELL:** Thank you, my Lady.
2 Ms Bailey, I ask questions on behalf of Northern
3 Ireland Bereaved Families for Justice, or Covid Bereaved
4 Families for Justice. Some of my questions have already
5 been touched on, others in fact have been asked, and
6 I'll cut my cloth accordingly. But I wanted to start,
7 please, with asking you questions about the
8 decision-making process in procurement, and to look at
9 one email chain in particular.
10 Can I have, please, INQ000503883. There we are.
11 And can we go to the very bottom of this email chain and
12 perhaps have a look at where it starts, on the 19th.
13 To put it in context for you, Ms Bailey, this was
14 19 March 2020, and of course we will remember this was
15 a really panicked time, a few days before we entered
16 into lockdown and so on, but we can see, at 17.52 on
17 19 March, the Minister for Health, Mr Swann, receives an
18 email from a company that promises to supply -- or
19 a potential to supply 20,000 ventilators over a six-week
20 period, which are approved for the EU and the
21 manufacturer already supplies to the NHS.
22 So, just to put that into context, we're just before
23 6 o'clock in the evening, and if we can just zoom out,
24 please, and scroll up, Mr Swann at the very bottom of
25 the page a few minutes later, ten minutes later I think,

1 forwards the email on to his private office
2 suggesting -- and also to the CMO, suggesting that this
3 may be "Worth a follow up".
4 Then if we can go to the middle of the next page,
5 please. So at the very bottom -- I'm so sorry -- the
6 very bottom of that page.
7 19 March. We're now just 23.04 in the evening, so
8 this is really happening between what's normal close of
9 business and 11 pm.
10 The CMO writes:
11 "Liam
12 "Consider full approval and please proceed with
13 procurement.
14 "Please accept this email as confirmation.
15 "Deborah and I will square away."
16 So we have a period of a matter of hours where this
17 email comes in with a promise of 20,000 ventilators, and
18 by 11 o'clock that evening the CMO is indicating that
19 you should consider full approval -- not you personally,
20 but there should be a consideration of full approval and
21 proceed with procurement.
22 Is it fair to read this email as the CMO giving his
23 full approval for purchase of those ventilators for that
24 source? Is that a fair interpretation?
25 A. Upon investigation of receiving this email chain, what

1 I can confirm is that we checked our logs in terms of
2 this particular referral.
3 Q. Yes.
4 A. It was logged through the normal triage process that we
5 have, and the decision was that we would not be
6 proceeding with the -- the suggested product was not fit
7 for use, didn't proceed.
8 Q. Right.
9 A. Now, the other thing that we have checked and we believe
10 and, my Lady, we're happy to confirm this at a later
11 stage, is we believe the business case, and if you look
12 at the timings, the business case that is referred to
13 here was a business case that was already developed on
14 behalf of the HSCB for purchase of ventilators --
15 Q. Yes.
16 A. -- and had been in track already, that was with the
17 Critical Care Network of Northern Ireland, to procure
18 ventilators. So that business case had already been --
19 that was a completely different business case.
20 I appreciate, reading the email there's confusion
21 because you're not quite clear what business case, but
22 that business case would not -- there's no way
23 a business case would have been developed between
24 6 o'clock and 10 o'clock that night. So when we checked
25 back, there was a business case being developed at that

1 point on behalf of the HSCB for ventilators, and we
2 believe that that's the approval that is being talked
3 about here.
4 Q. Understood. I think the focus of my question is
5 slightly different, Ms Bailey. On the one hand, there
6 was a business case for ventilators, and we can all
7 understand why. On the other hand, this email, although
8 it seems to have attracted the approval of the CMO,
9 ultimately didn't lead to the purchase from that
10 supplier --
11 A. Yeah.
12 Q. -- and in fact open source would suggest that supplier
13 wasn't even incorporated on business -- on government
14 house, or Companies House, at the time the email was
15 sent.
16 A. Yeah, yeah.
17 Q. But in his own statement, the Chief Medical Officer
18 indicates that he had no direct role in procurement and
19 was not a key decision maker in respect of procurement.
20 Okay? But if we look at this email, and perhaps we can
21 just focus in again right in the middle of the page at
22 the email at 5.00 -- I think it's 5.29 in the morning --
23 the title, in fact, of that email at the point at which
24 it is forwarded has changed -- "CMO approval for BSO
25 procurement of ventilators and PPE". So far as you were

1 concerned or are concerned, what role did the CMO have
2 in approving the procurement of ventilators as opposed
3 to the need for ventilators?
4 A. I would need to come back to the Inquiry on that basis.
5 Q. It's important, I think, that I should make clear that
6 I'm not suggesting that the CMO's intentions were
7 anything other than honourable and indeed urgent, but is
8 there some evidence in this email chain that the
9 procurement system was not immune to outside influence,
10 given this CMO approval for the procurement of
11 ventilators?
12 A. Well, it would have been standard, I believe, that if
13 a business case was actually developed and sent through
14 to the Department for approval, it would be the
15 Department who would be approving the business case.
16 So, you know, in that respect I would have no qualms
17 about Departmental Health approval for a business case.
18 I am not familiar with the statement that the CMO had no
19 part in that.
20 Q. Do you have any qualms about an email that seems to
21 develop between 6.00 in the evening and 11.00 in the
22 evening approving procurement as a --
23 A. No, because as I say, I don't that email chain was
24 approving procurement of the particular issue that was
25 being raised, the north -- NWT. I think it was

1 referring to an already-developed business case that had
2 been through the requisite processes in silver, and we
3 were asking for gold approval, I believe, was the
4 intention. And perhaps that could be best explored with
5 the Department of Health.
6 Q. Yes. Thank you. I'll move on to my next topic, and
7 it's been touched on to some extent in terms of the
8 availability and adequacy of PPE. You've addressed in
9 your statement and in your evidence the need to source
10 alternative FFP3 masks, and we understand the reasons
11 why, and the complication then that ensued in terms of
12 not having the standard masks that were ordinarily
13 available throughout the trusts, because staff had to be
14 re-fit-tested for each alternative mask.
15 The Inquiry has statements, as you can imagine,
16 from -- you may well have seen them -- from the trusts,
17 and the Belfast Trust identifies that when less than 1%
18 of staff within the trust had just been incorrectly
19 fit tested so there wasn't -- we're not talking about
20 a need to completely re-fit-test, but just less than 1%
21 having been incorrectly fit tested for an available
22 product, the ripple effect on the number of staff
23 ultimately affected was 1,385 members of staff.
24 Were you, or was BSO PaLS aware of that really
25 significant impact of re-fit-testing or newly

1 fit testing percentages of frontline staff?
2 A. We would have certainly been aware that every time
3 a variation in mask was introduced, that there was
4 a need to re-fit test staff. I certainly wouldn't have
5 been aware of that, that level of detail. And it was an
6 inevitability, if you like, of having to source those
7 variations in product, that the fit testing had to be
8 re-carried out.
9 Q. Might it have been important to know the ripple effect
10 that we're not just talking about the consequences on
11 staff having to go and be re-fit tested, it's the other
12 staff that are also affected, and if you're looking at
13 1,385 members of staff across just one trust in relation
14 to one fit test, surely BSO PaLS should have been aware
15 of that type of figure?
16 A. Well, certainly it comes down to almost, you know,
17 there's something here about risk appetite in terms of
18 where we were at the time in terms of sourcing the FFP3
19 masks. It was a really, really critical situation. You
20 know, the procurement and sourcing staff, I mean, we're
21 talking about a situation where we knew that we had to
22 get these masks, particularly for Covid wards,
23 et cetera, and aerosol-generating procedures, these were
24 our own family and staff that we were trying to protect.
25 So the real priority was to actually try and get the

1 FFP3 mask, and I'm not saying, and I'm, you know, I'm
2 absolutely sympathetic to the fact that that incurred
3 a re-testing implication, absolutely. I think -- but
4 the priority at that point was actually making sure that
5 staff were adequately protected on the wards.
6 Q. Given the very significant impact, has BSO PaLS
7 considered whether it could have done more to mitigate
8 the consequences of changing masks or sourcing
9 alternative masks?
10 A. I really feel, you know, in the situation I was in at
11 the time, there wasn't very much alternative. As I say,
12 the priority was to actually secure the masks to allow
13 the staff to carry out their work. You know, we all
14 would have been very aware, you know, Spotlight
15 programme and the kind of fear and the situations that
16 staff were in, in terms of those aerosol-generating
17 procedures. So the absolute priority from a risk point
18 of view was to secure the masks and allow staff to carry
19 out their work.
20 Q. You've touched on it just in that answer, and indeed in
21 your answers to questions from Ms Gardiner earlier this
22 morning, that these new masks and re-fit-testing were
23 all occurring at a time of really heightened anxiety for
24 staff, and we also know it also happened in combination
25 with regular changes in PPE guidance --

1 A. Guidance.
2 Q. -- which led, according to, really, all the trusts and
3 the Belfast Trust reference to their statement in
4 particular, which led to a reduction in confidence in
5 staff that the PPE they were receiving was really
6 providing them with optimum protection. To what extent
7 was BSO PaLS made directly aware of the impact on
8 confidence at the time of trying to source the
9 alternatives?
10 A. No, we would have had some awareness, for example, you
11 know, the PHA had done their 10,000 Voices report and
12 there was a sense, and actually very interesting, if you
13 read that report, you know, there was a sense of, you
14 know, where the equipment met technical specifications
15 and where it was available, even with that, there was
16 a sense of not quite trusting and not quite being
17 confident. So you could meet as many technical
18 specifications, many quality assurance as you like, the
19 fear that staff had was that -- and so we would have
20 been aware of that, and indeed, that sense of
21 perception, I think, is something that in any lessons
22 learned we'd have to be very mindful of the confidence
23 in perceptions of staff.
24 Q. And bearing in mind the difficulties that you were
25 having with sourcing the consistent, the one consistent

1 mask, did BSO PaLS consider what it might do in terms of
2 communicating with the trusts, and therefore with the
3 staff, why it was that you were having these
4 difficulties, why these masks were suitable alternatives
5 and did offer the protection that was required?
6 **A.** There would have been very regular communication through
7 both the gold, silver, bronze command and control
8 structures, and indeed there was a supply cell,
9 operational cell that would have operated with the
10 trusts on a daily basis, and it is my understanding that
11 the rationale for why we were having to source
12 alternatives was highlighted and discussed at those
13 meetings, and indeed at an operational level with the
14 trust providers.
15 So, you know, as I say, we were really between
16 a rock and a hard place in terms of trying to make sure
17 that we actually got the supply of the very, very
18 critical PP3 (sic) and certainly that was communicated
19 out. It was, as I say, an inevitability that we had to
20 re-fit test and unfortunately that was the consequence.
21 **Q.** And finally, just moving on to my final, if you like,
22 subtopic. Again, you've touched on it in terms of the
23 consequences of different body types, face shapes,
24 ethnicity, religious observance, and so on, of our
25 frontline staff, and the fact that the demand modelling

1 provided didn't -- to you didn't, at any stage, indicate
2 variations of this nature, which is perhaps surprising,
3 given the demographics of those staff on whom the health
4 and social care system relies. Again, using the trusts'
5 statements as a reference, on the whole it would appear
6 that at trust level, there wasn't really any adequate or
7 any analysis of the characteristics of staff members who
8 had been incorrectly fit tested or who were failing
9 fit tests; it was just a simple pass or fail.
10 So if the trusts didn't undertake an analysis of the
11 characteristics of staff who failed a fit test, is it
12 fair to assume that this is one reason why your demand
13 modelling might not have indicated variations of that
14 nature?
15 **A.** Perhaps. I would be speculating, frankly, to say any
16 comment on that. I think that's best directed towards
17 the trusts and to the infection and prevention cell.
18 **Q.** As far as BSO PaLS was concerned, was it the case that
19 throughout the pandemic, the demand modelling and the
20 purchasing didn't take into consideration variations in
21 face types?
22 **A.** What we did do was try to base our buying on historical
23 patterns of usage, and that, you know, in itself would
24 have accounted for some, I suppose, variation. The
25 fit-testing process itself is very specific to facial --

1 you know, to individual faces.
2 The other thing that we did when we onshored
3 production of some of the FFP3 masks was we did actually
4 make an effort with one particular supplier to get
5 a particularly small fit -- or FFP3 mask produced, and
6 that, you know, ensured a very, very high pass rate for
7 smaller faces.
8 **Q.** And looking forward, is the variation in face types, in
9 religious practices and beards and so on, is that
10 something that BSO PaLS is sighted on in order to inform
11 future ordering and modelling?
12 **A.** Again, respectfully, that would be health and safety
13 considerations at the trust level to make sure that
14 staff -- those kind of variations are accounted for.
15 The role of PaLS would be to buy to the specification
16 that would be coming through from our customer
17 organisations.
18 **MS CAMPBELL:** Thank you very much.
19 My Lady, thank you. Those are my questions.
20 **LADY HALLETT:** Thank you very much, Ms Campbell.
21 That concludes the questions that we have for you.
22 Thank you very much for your help. And if you could,
23 perhaps with the assistance of colleagues, answer any of
24 the issues that you said you could back to us on, I'd be
25 really grateful.

1 **THE WITNESS:** I will indeed. Thank you.
2 **LADY HALLETT:** Thank you very much indeed.
3 Ms Gardiner.
4 **MS GARDINER:** My Lady, the next witness is Chris Matthews.
5 **MR CHRISTOPHER MATTHEWS (affirmed)**
6 **Questions from COUNSEL TO THE INQUIRY**
7 **MS GARDINER:** Could you please state your full name for the
8 Inquiry.
9 **A.** Chris Matthews.
10 **Q.** Thank you.
11 Mr Matthews, you've provided a witness statement to
12 the Inquiry already. That is the corporate witness
13 statement on behalf of the Department of Health in
14 Northern Ireland. It runs to 129 pages and it's dated
15 5 February and it is INQ000521964.
16 Is that statement true to the best of your knowledge
17 and belief?
18 **A.** Yes.
19 **Q.** Thank you.
20 Mr Matthews, you are the deputy secretary for
21 resources and corporate management; is that correct?
22 **A.** Corporate governance, yes.
23 **Q.** Corporate governance. Thank you.
24 And that means that you are also the executive board
25 member with sponsorship responsibilities for BSO; is

1 that right?
2 A. Correct, yes.
3 Q. So, for that reason, you've given the corporate
4 statement on behalf of the Department of Health.
5 A. Yes.
6 Q. But I understand that you only began -- you were only
7 posted to that role on 25 April 2022.
8 A. That's right, yes.
9 Q. But you have familiarised yourself with events over the
10 entire period, and you are content to speak to the
11 extent of your knowledge --
12 A. Yes.
13 Q. -- to that period. Thank you.
14 It might be helpful at the outset to address some of
15 the issues pertaining to the structure and the systems
16 of procurement in Northern Ireland and actually, also,
17 of its healthcare system that are particularly unique to
18 or particularly characteristic of Northern Ireland.
19 We have heard in Ms Bailey's evidence and also
20 Mr Losty's evidence so far about Health and Social Care
21 (Northern Ireland). We have heard that you represent
22 the Department of Health, and that Mr Losty represented
23 the Executive Office, and that Ms Bailey represented the
24 Business Services Organisation and specifically Business
25 Services Organisation PaLS.

1 A. Yeah.
2 Q. Could you please, as briefly as possible, explain what
3 some of those acronyms mean and how they relate to one
4 another.
5 A. Okay. So if we start with the Executive Office, that is
6 essentially the, kind of, office that supports the First
7 and the Deputy First Minister. It has a number of
8 administrative functions. Probably most relevant to
9 this discussion is around the civil contingencies
10 function.
11 BSO is the Business Services Organisation, which is
12 an arm's-length body of the Department of Health.
13 And PaLS is a unit within BSO and it's the
14 Procurement and Logistics Service for Northern Ireland,
15 for the Northern Ireland health service.
16 Q. Thank you. And when we speak about Health and Social
17 Care (Northern Ireland), to what extent does that body
18 exist, in what form does it exist, and how does it
19 relate to the Department of Health?
20 A. So the HSC is really a kind of term of art. It doesn't
21 have a kind of a legal or sort of corporate existence.
22 It's made up of primarily five Health and Social Care
23 trusts, and a number of arm's length bodies, the PHA,
24 which I think we've -- the Public Health Agency, which
25 I think has already been talked about today, and the BSO

1 being some examples of that.
2 There are other bodies, Patient and Client Council,
3 for instance, off the top of my head, but the HSC is
4 not -- it's just a term we used to collectively describe
5 the trusts and the -- sort of, ALBs that are in ...
6 Q. But there is a Health and Social Care Board. So what is
7 that --
8 A. There was a Health and Social Care Board, yes.
9 Q. Yes.
10 A. So the Health and Social Care Board, which was in
11 existence at the time of the pandemic, was the
12 commissioner of services. So, in essence, it sort of
13 would set out at the start of every year what services
14 were being purchased on behalf of the Department of
15 Health. Since -- oh, actually, during the pandemic, the
16 Health and Social Care Board was dissolved and was
17 absorbed into the department as the Strategic Planning
18 Group within the department so it's now part of the
19 department.
20 The functions are broadly similar to what they were
21 during the pandemic but the HSCB now no longer exists.
22 Q. And what is the relationship between the Health and
23 Social Care trusts on the one hand and the Department of
24 Health on the other?
25 A. So the social care trusts are the bodies which provide

1 health and social care operationally for Northern
2 Ireland. They are creatures of statute, they are
3 created by the relevant, sort of, legislation for the
4 health service. The Department of Health funds them and
5 also has sponsorship responsibility. So one of my
6 responsibilities in my role is as corporate sponsor for
7 the trusts as well.
8 Q. We heard from Ms Bailey a little bit about this, but
9 could you also explain or elaborate on the relationship
10 between BSO PaLS and the Department of Health
11 particularly as it relates to, kind of, lines of
12 accountability?
13 A. Yes. So, in brief, the -- BSO is accountable through
14 their board to the Department and the accounting
15 officer, who is the permanent secretary, is my direct
16 boss.
17 Q. And what involvement does the Department of Health
18 itself have in procurement or is that all delegated to
19 BSO PaLS?
20 A. Broadly, yes. So occasionally the department will
21 procure, in the event that we're doing something sort of
22 novel or interesting. So, you know, for instance, at
23 the minute we're looking at the use of AI in certain
24 circumstances, and we may do the procurement ourselves
25 on that. But generally speaking, when you're talking

1 about equipment and services for the health service at
2 large, that's done through PaLS.
3 **Q.** And in terms of ministerial accountability for
4 procurement decisions, we heard from Ms Bailey that
5 there are potentially two lines of accountability: one
6 to the Minister for Health and one to the Minister for
7 Finance. Does that reflect your understanding as well?
8 **A.** Yes. So the BSO is accountable to the department on the
9 basis of its performance and its expenditure. The
10 accountability to DoF, as I understand it, is around
11 their status as a CoPE, which -- that's not awarded by
12 the Department of Health, we don't have the competence
13 to do that. That's a separate function of the
14 Department of Finance.
15 **Q.** As you've set out in your statement, the permanent
16 secretary of the Department of Health is also the
17 accounting officer; is that correct?
18 **A.** Yes.
19 **Q.** And you set out the details of a number of different
20 organisations that were set up during the pandemic to
21 assist with procurement of healthcare supplies and
22 equipment. One was the PPE strategic -- cell, excuse
23 me.
24 **A.** Yes.
25 **Q.** And you also stood up the gold command structure. What

1 were those two bodies? What were they intended to do,
2 and what did they end up doing?
3 **A.** Okay, so if we start with the gold command cell, that is
4 just the -- kind of the standard structure as part of
5 a civil contingencies response, and it is essentially
6 the sort of strategic mind coordinating the emergency
7 response to the pandemic.
8 The PPE supply cell was specifically spun off of
9 gold command to focus on the PPE issues that were kind
10 of emerging from the system, particularly from the kind
11 of exponential growth in demand, and then the lack of
12 clarity in those early stages as to, well, how are we,
13 as a system, going to manage this kind of novel and
14 unexpected demand for PPE?
15 **Q.** And you also mention the roles of the CMO, the CNO and
16 the CPO, the Chief Pharmaceutical Officer?
17 **A.** Yeah.
18 **Q.** You mentioned that the Chief Pharmaceutical Officer in
19 particular was the head of the medical supplies cell.
20 **A.** Yes.
21 **Q.** Was that a body that was in existence prior to the
22 pandemic or was it stood up since the --
23 **A.** No, that was part of the pandemic response.
24 **Q.** And what role did it play in pandemic response?
25 **A.** So overall I think its main function was to ensure the

1 continued supply of key pharmaceuticals, in --
2 specifically in this kind of instance it looked at
3 oxygen and it, I think, helped, through the MOIC group,
4 with the quality assurance of PPE, on the technical --
5 on the technical side of PPE.
6 **Q.** So that would have been the involvement in the system of
7 technical and quality assurance
8 that -- (overspeaking) --
9 **A.** Yes, the quality assurance of the technical data that
10 I think, you know, came with any proposal for PPE.
11 **Q.** Thank you.
12 You also say, however, that the Chief Pharmaceutical
13 Officer did not have any direct role in procurement
14 through that, and that that cell didn't have a direct
15 role in procurement --
16 **A.** Yes.
17 **Q.** -- is that correct?
18 **A.** Yes.
19 **Q.** One comment that you have also made, which it might be
20 helpful to expand on as it gives context to the
21 situation which you found yourselves in, in March 2020,
22 is in your witness statement at paragraph 3. You say:
23 "The system here is believed to be too small to
24 support a fully-fledged 'market' and emphasis has been
25 on commissioning as a means of developing and promoting

1 reform and modernisation."
2 **A.** Yes.
3 **Q.** You also notice that -- you note the small size of the
4 private sector in healthcare.
5 **A.** Yes.
6 **Q.** How do you consider that the size of the system has an
7 effect on the healthcare -- (overspeaking) --
8 **A.** Yes, so I think this is in the sense that most people
9 would understand commissioning, and I think certainly in
10 the sort of, in larger jurisdictions, commissioning
11 would often also then take a sort of a more critical
12 role in terms of thinking about decommissioning some
13 services and expanding others.
14 In Northern Ireland, commissioning hasn't tended to
15 be in that space because there aren't that -- there
16 aren't the sort of viable alternatives for services that
17 you would find in other jurisdictions. So what we call
18 commissioning in Northern Ireland would probably not be
19 understood as commissioning in other jurisdictions. It
20 is -- so in terms of service development, and
21 innovation, as we say that's more where commissioning is
22 lying, and sort of developing services and growing
23 services.
24 **Q.** And another point that you make, which is somewhat
25 similar, is in relation to the Department of Health's

1 role as a Lead Government Department.
2 A. Mm-hm.
3 Q. How is that different from what our understanding of the
4 function of a Lead Government Department might be in
5 relation to Westminster, for example?
6 A. Yeah. I suppose there was basically -- we can't sort of
7 direct or instruct across departmental lines. We have
8 direct control over the Department itself, the
9 Department has a sort of statutorily defined set of
10 functions and the Minister has control of those
11 functions, and no others, and therefore, in the sense of
12 leading a cross-departmental or cross-governmental
13 response, that has to be done through cooperation as
14 opposed to any power given to the Department to direct
15 or to direct the use of resources from other
16 departments.
17 Q. And you described in your statement, and indeed other
18 witnesses have, as well, a number of situations where,
19 in particular, the Department of Health and the
20 Department of Finance and the Executive Office have
21 worked together on particular procurements but also
22 issues generally relating to procurement.
23 A. Yeah.
24 Q. So that clarification about the Lead Government
25 Department categorisation is helpful.

1 Mr Losty, in his evidence last week, also noted the
2 need for cooperation between departments and between
3 ministers --
4 A. Yeah.
5 Q. -- and to that end he observed one of the unique
6 features of the Northern Irish system, which is that you
7 have ministers from different, indeed sometimes
8 opposing, parties who have to work together
9 collaboratively over a problem like the pandemic, and
10 his observation was at that time that led to friction or
11 delay that might not have been present in other systems.
12 Does that reflect your understanding of what
13 happened during that time?
14 A. I suppose because I have no contemporaneous knowledge of
15 how things were going from my review of the material,
16 the things that we needed to get done broadly got done.
17 So if there was friction, it's not obvious from the
18 outcomes, if that makes sense.
19 Q. And again, one other aspect which -- of the health
20 system which is peculiar to Northern Ireland, you set
21 out in your witness statement that for a very
22 considerable period of time, between 2 March 2017 and
23 11 January 2020, there was no Minister for Health in
24 Northern Ireland, and just as context, how does the
25 health system work in that scenario?

1 A. So a set of functions are given to a Permanent
2 Secretary, but they are very limited, and have been,
3 because it's quite a novel area of law as well, it's
4 often tested in courts exactly where the boundaries are
5 drawn. Generally speaking, departments are unable to
6 make major changes during a period of suspension and
7 they won't be able to legislate either because there's
8 no legislature. So it, in effect, limits to a degree
9 what departments are able to do.
10 Q. You note in your statement that you haven't identified
11 any particular issues where that lack of an Executive up
12 until 11 January 2020 impinged on decision making --
13 A. Yeah.
14 Q. -- in relation to procurement. But culturally, when
15 a Civil Service is more used than not to functioning
16 without ministerial involvement, what impact does that
17 have on the day-to-day running when you do have
18 a minister, perhaps after a long period of time of not
19 having one?
20 A. From my experience, generally speaking, people welcome
21 the return of ministers. It brings back the sort of
22 purpose of the department. So when ministers returned,
23 it generally just gives you more options for how you
24 approach issues.
25 Q. And finally on the role of the Department of Health,

1 particularly, in relation to procurement, what role does
2 the Department of Health have in relation to approval of
3 direct award contracts?
4 A. So we are required to approve above-threshold contracts
5 for EU tenders. So there are delegated limits and
6 I think the number is 139,000 would have to come to the
7 Permanent Secretary for approval.
8 Q. And in relation to approval of spending limits, was that
9 varied in any terms during the pandemic?
10 A. So I think there was a period where the then Permanent
11 Secretary agreed a set-aside purely for pandemic-related
12 expenditure for a brief period, it's in my statement,
13 I can't quite remember the dates, but for a matter of
14 months, where specifically those things related to Covid
15 spending were delegated to trusts and ALBs.
16 Q. And presumably that was for reasons of expediency and
17 urgency?
18 A. Yes, it was essentially to avoid clogging up the
19 decision-making apparatus inside the Department.
20 Q. And where a decision is referred up from BSO PaLS to the
21 Department for approval, whether that's to do with
22 spending limits or direct award contracts, what sort of
23 scrutiny does that receive and by whom?
24 A. Yeah, so in brief the relevant business area will
25 consider the proposal, will think about the

1 value-for-money sort of implications of it, whatever the
2 operational implications are of not doing it, whether
3 there are any alternatives that the relevant ALB ought
4 to think about, and then they will provide that advice
5 to the Permanent Secretary for their agreement or
6 otherwise.
7 **Q.** And is there any ministerial involvement in those
8 decisions?
9 **A.** I don't think so, no. Not for DACs.
10 **Q.** And finally on that topic, you will be aware of the
11 Northern Ireland Audit Office report into the
12 procurement of PPE during the pandemic?
13 **A.** Yes.
14 **Q.** One of the recommendations which, as I understand it,
15 both BSO PaLS and the Department have accepted in full
16 is to create less reliance on direct award contracts --
17 **A.** Yes.
18 **Q.** -- and urgent emergency procurement in any future
19 pandemic. What plans have been implemented or are going
20 to be implemented by the Department for more flexible
21 procurement routes in any future health emergency?
22 **A.** Sure. So as you know from Karen's evidence, DPS was
23 instituted during the pandemic. So that's one part of
24 any solution. Obviously, it depends on what needs to be
25 procured. There will be novel circumstances that are

1 difficult to predict. The Department will work with
2 BSO. At the moment I chair a sort of regional
3 procurement board where we consider a range of issues in
4 terms of procurement that are both business as usual and
5 any other things that emerge. It's just generally
6 better practice to reduce the number of DACs, so it's
7 kind of a constant thing, and we have an audit and risk
8 committee who is also very keenly paying attention to
9 DACs.
10 So it's a thing that we kind of work on constantly
11 and we are, you know, reluctant to award DACs if we can
12 avoid it. In some cases, unfortunately, it's
13 unavoidable.
14 **Q.** I want to turn to look at the PPE Strategic Supply Cell
15 in a bit more detail.
16 **A.** Sure.
17 **Q.** You've set out that this was established by the Health
18 gold command on 23 March 2020. What organisations had
19 a seat at that table, essentially, and how did they
20 coordinate the various bodies involved in --
21 **A.** So it was primarily officials within the Department. So
22 I think the officials were drawn from what was the
23 transformation of the health service, and their remit
24 really was to kind of carry out the functions of the
25 lead department, that sort of coordination across

1 government, so both into Whitehall with the Department
2 of Finance, with TEO, to kind of synthesise the various
3 signals and communication coming from across the system
4 into a set of recommendations for gold command. And
5 that was, I think, the main kind of relationships and
6 points of communication were between BSO PaLS, DoF and
7 DoH coordinated by the PPE Supply Cell.
8 **Q.** And you say that at around about the time the Strategic
9 Supply Cell was set up, various issues were being
10 escalated within the Department and in particular from
11 trusts and from community care settings --
12 **A.** Yeah.
13 **Q.** -- including settings which would normally source their
14 own PPE --
15 **A.** Yeah.
16 **Q.** -- about availability of PPE?
17 **A.** Yes.
18 **Q.** What level of visibility did the PPE Strategic Supply
19 Cell have of levels of PPE in those settings, or was it
20 just receiving *ad hoc* reports?
21 **A.** I think initially it would probably have been *ad hoc*
22 reports from BSO. Over time, that became much more
23 systematic and I think there are a number of iterations
24 of the sort of supply and demand type situation, and the
25 reporting got much more effective quite quickly.

1 However, absent of that, there was always the sort
2 of silver-gold command route, so it wasn't that the
3 signals didn't come in; it's just that they weren't, you
4 know, at the start, as with many other things, the
5 signals were coming from all over the system, and they
6 were sort of being channelled by silver command to gold.
7 Because the PPE Supply Cell was a gold-level body, there
8 was never any risk, really, that the PPE issues were not
9 going to be visible at the highest levels of decision
10 making.
11 **Q.** One of the matters that was overseen by the PPE
12 Strategic Supply Cell was the implementation of the
13 recommendations published in the rapid review of PPE?
14 **A.** Yes.
15 **Q.** The rapid review, you tell us, was commissioned on
16 15 April by the Minister for Health. Can you say why it
17 was commissioned?
18 **A.** Yes, in essence to try to get a kind of strategic sense
19 of what was happening in the system and what kind of
20 things we ought to do as a system to get better control
21 over the PPE situation.
22 **Q.** Why was it not until mid-April that such a programme was
23 undertaken when we know from your evidence and the
24 evidence of others that there were concerns about PPE
25 supply much earlier in the year than that?

1 A. I would have to speculate on that. I'm not really sure.
2 None of the documents I reviewed really set out why that
3 was done at that time.
4 Q. That's fine. Thank you.
5 You -- we know from that review that there were 19
6 recommendations made for kind of short-term improvement
7 of the PPE position in Northern Ireland and that led to
8 17 actions, 12 of which were critical and five of which
9 were essential, and that informed different periods of
10 time for implementation.
11 A. Sure.
12 Q. I'm not going to take you through each of them, because
13 that would take a very long time, but there were two
14 actions which took longer to resolve than the others.
15 A. Yeah.
16 Q. One was in relation to the appropriateness of the re-use
17 of personal protective equipment and that is something
18 which this module has heard about from other witnesses
19 from other devolved administrations, and from UK central
20 government.
21 A. Yeah.
22 Q. And that was to do with a recommendation about the
23 re-use of otherwise disposable single-use personal
24 protective equipment in a period of critical shortage.
25 A. Mm-hm.

1 Q. And you say that took longer to close, despite being an
2 essential recommendation. What was the reason for that
3 and what was the conclusion?
4 A. So as I understand it, it was the -- the work was done
5 by PHA to examine the sort of risks and so on of
6 re-using PPE. In the event, it was decided that we
7 weren't going to have to use (sic) PPE. I think there
8 was generally a sense that if you could avoid doing
9 that, you should, and then, because we were in
10 a situation where we didn't need to re-use PPE it wasn't
11 taken any further than that.
12 Q. Thank you. The second action which took longer to close
13 than expected was the recommendation that there be
14 a development of systems to enable feedback from end
15 users around the quality of PPE.
16 A. Yeah.
17 Q. And that was across the health and social care system
18 and the independent sector, and the idea of that was
19 that it could inform procurement. And that was
20 classified as a critical, meaning to be completed within
21 two to four weeks, action?
22 A. Mm.
23 Q. Again, why did that take a bit longer to conclude? And
24 when was it concluded, and what was the ultimate
25 conclusion?

1 A. So I think that was one of the recommendations that was
2 also not completed. It's not clear to me in the things
3 that I've read, it was -- the piece of work was led by
4 the PHA. Again, I might speculate that it was
5 considered the existing systems for communicating these
6 things were sufficient, and I'm not sure that that's the
7 case, but --
8 Q. That doesn't seem to follow from the fact that it was --
9 A. Yes.
10 Q. -- a recommendation in --
11 A. It was a recommendation, yes. But it's not clear to me
12 why the PHA never made a recommendation on how that
13 should work, and so other than that we had the PPE
14 mailbox that the CNO side set up, but nothing in
15 addition to that.
16 Q. Yes. I want to look at the analysis of the feedback
17 that was gathered through the PPE mailbox.
18 A. Sure.
19 Q. That is INQ000411115. Thank you.
20 And if we can go to paragraph 3, so this was not
21 a response to that recommendation --
22 A. No.
23 Q. -- because as you've already said, the rapid review was
24 commissioned on 15 April, this PPE mailbox was announced
25 on 17 April. So this was a separate exercise --

1 A. Yes.
2 Q. -- by the Department to receive concerns from health and
3 social care workers about PPE.
4 And if we can go to slide 4, thank you. At
5 paragraph 10, this analysis sets out that there were 95
6 queries received by the mailbox, some of which required
7 no response but the rest of which had been segregated
8 into four themes: offers to supply PPE, concerns
9 regarding access to PPE, concerns regarding the correct
10 use of PPE, and concerns regarding quality and
11 decontamination of some items of PPE.
12 And if we can go to slide 5. Thank you.
13 This is the breakdown or the discussion of some of
14 those queries which were regarding access to PPE. And
15 the summary that's given there at the third bullet point
16 is:
17 "In all cases, suppliers were either found to be
18 available or made available via the relevant Trust
19 contact."
20 And there are a couple of examples given below but
21 it is noted that there were 15 queries so those are just
22 examples.
23 A. Sure.
24 Q. In regard to that third bullet point, the suppliers were
25 either found to be available or made available, there's

1 quite a difference between the two, because it seems to
2 accept that in some cases, those concerns that there
3 wasn't sufficient access to PPE were in fact justified
4 because ultimately, the trust had to -- the Department
5 had to respond and make those supplies available. So is
6 this accepting that there were instances within the
7 health and social care system in Northern Ireland where
8 staff did not have the correct PPE?
9 **A.** So I can't speak to any specific instance. What
10 I understand is that in the early stages, even though
11 there were sufficient supplies of PPE, because of the
12 initial kind of pull system, some of the PPE was in the
13 wrong bits of the system and then had to be kind of
14 moved to other areas.
15 **Q.** So a distribution --
16 **A.** So I think it was a distribution and logistics problem
17 rather than a supply problem, in those kind of early
18 stages where demand was essentially exponential and the
19 system, I think as you've already heard, the
20 business-as-usual system could not cope with the demands
21 being placed on it at that point.
22 **Q.** But from the perspective of a healthcare worker on the
23 ground, they might not have had -- (overspeaking) --
24 **A.** I accept that.
25 **Q.** Yes.

1 **A.** Again, in the things I've seen, no specific instance has
2 been referred to us, but I accept that it's a logical
3 consequence of that situation.
4 **Q.** I also want to look at what some of the Health and
5 Social Care Trust witnesses have told us in their
6 evidence.
7 **A.** Sure.
8 **Q.** If we can go to INQ000514028.
9 This is the witness statement of Peter Watson on
10 behalf of the Belfast Health and Social Care Trust.
11 Thank you.
12 So he sets out that the type of mask which was
13 available frequently changed. There was on occasion
14 little or no notice that that was going to happen. That
15 had an impact on fit testing.
16 He also mentions that some of the masks received had
17 been re-lifed, and we've heard a little bit about how
18 that happened across the country.
19 **A.** Yeah.
20 **Q.** And those expired masks would have been -- been
21 extended. Then he also lists some concerns that the
22 older masks did not afford as good a seal as newer
23 masks, and that correlated with a higher fail rate.
24 This is an issue which is raised in the analysis of
25 the PPE mailbox as well, but the question is, really,

1 this sounds, from the Belfast Health and Social Care
2 Trust statement, like a systemic issue. We are told
3 that the type of mask available frequently changed, that
4 there were multiple instances of fit testing, and we
5 also heard earlier from Ms Bailey that that was almost
6 an inevitability because of the reliance on
7 a standard FFP3 mask prior to the pandemic, which then
8 became unavailable.
9 Is it fair to say that you would have expected to
10 see more of this type of query in the PPE mailbox if it
11 had been -- if it had been used more widely by health
12 and social care workers?
13 **A.** It's difficult to say. I think, on -- sort of
14 reflecting on the decision to set up the mailbox,
15 I think it was anticipated there would be more traffic
16 than, in effect, there was. And I think the other thing
17 about the mailbox is that the traffic dies off quite
18 quickly as well. You know, even the relatively low
19 number of queries drops quite rapidly over a couple of
20 months.
21 So it's difficult to kind of posit a hypothetical
22 situation but I think clearly, you know, from the
23 evidence Karen has given and from just the reality of
24 what it was like at the time, the uncertainty around PPE
25 and the need to source alternatives definitely gave rise

1 to these kind of situations where, whether it's
2 a genuine technical or safety problem or whether it's
3 a perception because it's a piece of equipment that's
4 unfamiliar to people, there was widespread concern
5 about PPE.
6 And I think that's reflected in a number of
7 different places, and is one of the issues that really,
8 sort of, comes out for me, with the, sort of, benefit of
9 retrospectively looking at this stuff, is around sort of
10 the communication issue, and shows the struggles that
11 the system had in communicating messages to staff when
12 they were competing with social media and, sort of, word
13 of mouth, and so on.
14 **Q.** Yes, thank you. That is relevant to the next document
15 that I want to take you to.
16 This is INQ000325799.
17 And if we can go to page 10 initially, just to
18 explain what this document is. This is a document
19 produced by the Public Health Agency that I believe
20 you've seen.
21 **A.** Yes.
22 **Q.** And it collates staff experiences of personal protective
23 equipment over the initial phase of the pandemic,
24 I believe, up until December 2020, and it's called the
25 10,000 More Voices initiative in various places, and it

1 aims to identify some common themes in terms of health
2 and social care workers concerns relating to PPE.
3 **A.** Yeah.
4 **Q.** You can go to page 30, thank you.
5 So, at the very bottom we see some of the concerns
6 that we've just been discussing about communication.
7 So, people saying:
8 "... it took weeks of form filling to convince
9 people above us that PPE wasn't good enough ... [and]
10 this was time we didn't have and we were left feeling
11 like our opinion didn't count ..."
12 Months of complaint sheets about ill-fitting ear
13 loop masks, and also concerns about re-use of PPE,
14 quality of PPE. And throughout that document there's
15 a great deal of information and quotes from the people
16 who participated about concerns which -- which are
17 reflected, but in small quantities, in the PPE mailbox.
18 **A.** Sure, yeah.
19 **Q.** If we can go back to the PPE mailbox analysis, please.
20 That's INQ00041115. Thank you. And if we can go
21 to 6, page 6, or slide 6. Thank you.
22 This, again, is the breakdown, the analysis of
23 queries related to the issues just mentioned. So
24 correct use of PPE and also quality and decontamination.
25 So we see at the bottom there that quality issues and

1 fitness for purpose were identified in 15 separate
2 queries and -- queries -- sorry, in the first paragraph,
3 there were 27 queries seeking information on correct
4 type of PPE, which again goes to the issue of
5 communication that you just raised.
6 **A.** Yeah, yeah.
7 **Q.** So bear in mind that these are quite small numbers.
8 There are only 95 queries in total received into the PPE
9 mailbox. Only 15 of those were in relation to quality
10 issues and fitness for purpose, which we know came up in
11 other forms from the evidence of Health and Social Care
12 trusts, from the evidence of PHA.
13 What action was taken to evaluate the use of the PPE
14 mailbox and whether that was a particularly good way of
15 measuring, at the time, the concerns of healthcare
16 workers in relation to PPE?
17 **A.** I don't think -- beyond the evaluation of the material
18 received through the mailbox, I don't think there was
19 then any follow-up evaluation of the utility of the
20 mailbox itself. I suspect that some comfort was taken
21 in how quickly the use of the mailbox dropped off,
22 although you could argue that's false comfort because
23 you could say, well, people stopped using it because it
24 didn't produce any -- (overspeaking) --
25 **Q.** They didn't know about it --

1 **A.** Or maybe they didn't know about it, or -- I think one of
2 the areas where we can take assurance from is that in
3 the case of those queries around use of PPE and quality
4 and so on, we were able to answer the questions that
5 were being brought forward. And I think also it's
6 probably accurate to say there was nothing new coming
7 out of the mailbox that wasn't already coming into the
8 system through other channels. And particularly through
9 silver command around, you know, quality and the
10 concerns around the usage of PPE.
11 In talking to colleagues who were working in this
12 area at the time, I think one of the issues that, kind
13 of, became prevalent around the guidance was that there
14 was a suspicion, an incorrect suspicion, that the
15 guidance was being tailored around the availability of
16 PPE as opposed to the sort of quality and safety
17 elements of PPE. And that, I think, proved to be quite
18 a difficult perception to shake over time.
19 **Q.** So what action has been taken or is planned to be taken
20 in the event of any future healthcare emergencies in
21 relation to making sure that those lines of
22 communication are strong?
23 **A.** So at the time, I think the trusts themselves had --
24 there's multiple different sort of initiatives that they
25 tried. Departmental guidance was, sort of, refreshed

1 and put out and there were, you know, media messages and
2 so on. I think, for us, in a similar kind of situation,
3 the communications strand I think will need to be
4 strengthened, and I think in particular the thing that
5 I really sort of reflect on in looking at this material
6 now is the kind of power of social media to override the
7 kind of official guidance, because it -- it wasn't that
8 there was no guidance; it was that there was enough kind
9 of confusion in the sort of general environment, and
10 just enough ambient sort of concern that the official
11 guidance wasn't quite having the impact that we would
12 hope.
13 **Q.** Thank you. Briefly, I want to look at modelling.
14 **A.** Okay.
15 **Q.** We -- you -- we've just discussed with Ms Bailey her
16 statement that the overstatement of demand from the
17 reasonable worst-case scenario modelling was, in her
18 view, the biggest factor leading to surplus stock.
19 I just want to briefly look at the quantities of
20 surplus.
21 **A.** Yeah.
22 **Q.** That is INQ000503893.
23 Apologies, that's not quite -- that's the next one.
24 INQ000498841, it's the quantities. Thank you.
25 These are the total quantities of what's considered

1 surplus stock.
2 **A.** Yeah.
3 **Q.** So we can see that that's a significant quantity, at the
4 bottom in "Totals", and we can see the breakdown
5 according to type there --
6 **A.** Yeah.
7 **Q.** -- which is also relevant when we consider the need to
8 be agnostic as to what type of PPE might be required in
9 a future scenario.
10 **A.** Sure, yeah.
11 **Q.** My first question is, does the Department of Health
12 recognise that the factor that led to this large
13 quantity of surplus was overwhelmingly a demand, the
14 inflated demand predicted by the modelling that was
15 provided at the time?
16 **A.** I don't know if I'd say inflated demand; I would say
17 the --
18 **Q.** Overstated, I think is the word that was used, yes.
19 **A.** -- yes, the modelling overstated actual demand, I think
20 that's fair to say, yes.
21 **Q.** Yes. And how will that be prevented or catered for in
22 the next emergency?
23 **A.** Yes, um, so I think there is a piece of work going on at
24 the minute to look at modelling in general, and to look
25 at what lessons can be learned and I think that will be

1 important for us. And I think also we would look to any
2 recommendations made by this Inquiry around modelling
3 because I think it is fiendishly complicated and you are
4 dealing with, you know, as you've seen, some of the
5 details that went into the modelling, there are a lot of
6 variables that are essentially unpredictable at the time
7 you make your projection.
8 And we would certainly be interested in any
9 techniques that would allow us to be more accurate in
10 future.
11 **Q.** And to that end, we heard a little from Ms Bailey about
12 the lack of demand modelling initially that was coming
13 through from UK central government. Is there a need for
14 greater collaboration, in terms of modelling, between
15 the UK central government and the devolved
16 administrations?
17 **A.** I suspect that's probably generically true. I can't
18 point to a specific point here, we -- in terms of our
19 own modelling, we had two goes at it, really. We had an
20 initial attempt and then a more sophisticated sort of
21 dynamic model. It's probably just generically true
22 that, you know, the more expertise you can bring to bear
23 on something like this, the more likely you are to be
24 accurate.
25 **MS GARDINER:** Thank you.

1 My Lady, those are all my questions. I believe the
2 Core Participants have some as well.
3 **LADY HALLETT:** Thank you. I think it's Ms Banton. Is that
4 right?
5 **MS BANTON:** Yes.
6 **Questions from MS BANTON**
7 **MS BANTON:** Thank you, my Lady.
8 If I may just ask you some questions on behalf of
9 FEMHO, which is the Federation of Ethnic Minority
10 Healthcare Organisations.
11 Mr Matthews, your insights into the challenges
12 associated with PPE fit, particularly for ethical
13 minority healthcare workers, are crucial. The failure
14 to incorporate demographic data into PPE demand
15 modelling has raised significant concerns about the
16 adequacy of protective equipment for these high-risk
17 groups. Given the known disparities in PPE suitability,
18 it's essential to understand the rationale behind these
19 modelling decisions and subsequent actions taken to
20 address these critical fit issues.
21 I've got four points, if I may. The first one is,
22 why did the Department not incorporate -- sorry. Why
23 did the Department not incorporate demographic data,
24 particularly ethnicity, into PPE demand modelling, given
25 that certain groups, including ethnic minority

1 healthcare workers, were at a heightened risk of fit
2 testing failures?
3 **A.** In my review of the documents it's not clear to me why
4 that wasn't specifically included. What I would say is
5 that everyone who was going to wear equipment was
6 fit tested to make sure that it was suitable. In the
7 event that a particular piece of equipment wasn't
8 suitable, an alternative was found, or in some cases
9 I think the members of staff were moved to other duties
10 where they wouldn't be exposed to risk. But I think
11 I -- I can accept, and I think there's a general issue
12 in Northern Ireland, and the Executive Office is leading
13 a piece of work on diversity and understanding more
14 about the sort of complexion of Northern Ireland
15 society, I accept that there was a gap that would need
16 to be addressed in the future.
17 **Q.** Right. What steps, if any, did the Department take to
18 ensure that PPE procurement and distribution accounted
19 for the differences in facial structures among frontline
20 staff, particularly those from ethnic minority
21 background?
22 **A.** So really the main, as I understand it, the main action
23 taken was to fit test everybody to make sure that
24 everyone who was using equipment was protected by it.
25 **Q.** Third point. Shortages of FFP3 masks suitable for

1 certain facial features were noted. Was there any
2 correlation on grounds of ethnicity differences?
3 **A.** I have no information on that. I'm sorry.
4 **Q.** All right. And my last point. Given that over 2,800
5 staff required re-testing due to fit testing failures,
6 was there any analysis conducted to determine whether
7 ethnic minority staff were over-represented in this
8 particular group, and if not, why not?
9 **A.** So there was what's called a Serious Adverse Incident
10 Review into the failure of the fit testing in the cases,
11 I think you're referring to. Its conclusion, broadly,
12 was that it was the application of a different protocol
13 that caused the fit testing to fail and not really
14 anything to do with the characteristics of the
15 individuals who were being tested.
16 **MS BANTON:** Right. Thank you very much, those are my
17 questions.
18 **THE WITNESS:** Thank you.
19 **LADY HALLETT:** Thank you very much.
20 Thank you very much for your help, I'm very
21 grateful, Mr Matthews. I hope we haven't kept you from
22 Northern Ireland for too long and your other duties. We
23 shall adjourn now and return at 1.45. Thank you.
24 **THE WITNESS:** Thank you, my Lady.
25 **(12.42 pm)**

1 **(The Short Adjournment)**
2 **(1.45 pm)**
3 **MS GARDINER:** My Lady, the next witness is Conor Murphy.
4 **LADY HALLETT:** Thank you, Ms Gardiner.
5 **MR CONOR MURPHY (affirmed)**
6 **Questions from COUNSEL TO THE INQUIRY**
7 **LADY HALLETT:** I hope you haven't been kept waiting too
8 long, Mr Murphy.
9 **THE WITNESS:** Thank you.
10 **MS GARDINER:** Could you please state your full name for the
11 Inquiry.
12 **A.** Conor Murphy.
13 **Q.** Thank you. Mr Murphy, you've given a witness statement
14 to the Inquiry. That is INQ000534957. It is 35 pages
15 long and it is dated 23 January 2025.
16 Is that statement true to the best of your knowledge
17 and belief.
18 **A.** It is, yes.
19 **Q.** Thank you. And at the time that you gave your
20 statement, you were an elected MLA. I believe that's
21 now not the case and you've recently been elected to the
22 Irish Seanad; is that correct?
23 **A.** Yes, I'm now a senator in the Irish Parliament in
24 Dublin.
25 **Q.** Thank you. This module of the Inquiry is focusing on

1 the period of time when you were Minister for Finance
2 within the Northern Irish Executive.
3 Could you briefly sum up your responsibilities as
4 Minister for Finance in relation to public expenditure
5 and procurement in particular.
6 **A.** Yes.
7 Could I just say art the outset I was unable to give
8 evidence at the scheduled time for -- at the module in
9 Belfast, when the Inquiry sat at Belfast, so I didn't
10 get the opportunity at that stage to offer my
11 condolences and sympathies to those who have been
12 bereaved through the Covid experience. So I'd just like
13 to take that opportunity to do so now.
14 My job as the Minister for Finance, there were
15 a range of jobs and functions there but primarily it was
16 to set the budget for executive, to oversee spending by
17 other departments to allocate funding that became
18 available through the course of the year from
19 Westminster and to liaise with the Treasury in
20 Westminster. There were a number of other functions in
21 the department then in relation to the collection of
22 property taxes and the management of that system and
23 also they had overarching function in relation to
24 procurement for the whole of government, and the
25 Department of Finance did provide a number of services

1 to other departments to assist them with the business
2 that they were carrying out.
3 **Q.** Thank you, and we will touch on some of those services
4 that were provided as we go along, I'm sure.
5 You say that, in general terms, you were responsible
6 for advising the Executive, the Assembly, on control and
7 management of public expenditure. And you also,
8 I believe, had responsibility for the development of
9 procurement policy and legislation within the Assembly;
10 is that correct?
11 **A.** That's correct, yes.
12 **Q.** And during the period that we are discussing, you also
13 chaired the Procurement Board. Was that throughout the
14 period of time of 2020 to 2022 and did it change in any
15 way during that period?
16 **A.** Yes, the Procurement Board had previously been chaired
17 by the permanent secretary, and when I took up office
18 there was a discussion that had already developed in the
19 department in the period of time when there were no
20 ministers in charge about the function and the --
21 I suppose, the attendance at the Procurement Board and
22 how to strengthen the procurement guidance that the
23 Department of Finance would issue.
24 So we took an initiative to, if you like, take out
25 of the Procurement Board some of the permanent

1 secretaries who had sat there, because it was very much
2 an internal government function to bring in other
3 practitioners from outside, to bring in the -- a number
4 of other departments have their own procurement
5 function, Health, Education, and Infrastructure, but the
6 Department of Finance provide the service for the rest
7 of the departments.
8 And also then to ensure -- in terms of procurement's
9 guidance notes, which were the advice that the
10 department produced across a range of areas, to ensure
11 that they had perhaps more of an effect and an
12 imprimatur from the whole Executive, so I would the
13 procurement guidance notes to the Executive for
14 approval, which hadn't previously been the case, to give
15 them more strength in terms of that level of guidance
16 and advice to all of the other departments.
17 **Q.** And you say in your statement that that reflects
18 a desire to get that level of buy-in that having the
19 approval from the whole Executive gives; is that
20 correct?
21 **A.** Yes. I think there was a feeling in the department that
22 the procurement guidance that was issued by the
23 department would have more effect across -- I don't
24 think there was a huge problem, but they certainly felt
25 it would have more effect if the notes were brought

1 through the Executive and secured the support of the
2 Executive, and in that way, they were the property,
3 then, of each individual department rather than just
4 an advice guidance note from the Department of Finance.
5 **Q.** And in terms of the change that you've described in
6 terms of bringing in more procurement expertise,
7 perhaps, from each of the relevant procuring bodies,
8 when was that brought into being?
9 **A.** In the early months of 2020.
10 **Q.** Very good. And was that a change that was influenced in
11 any way by the pandemic or was that planned already?
12 **A.** No, I think that had been planned. I mean, the entirety
13 of the plan was not in place when I came into office,
14 because obviously, as an incoming minister, I had to
15 have some input into that, but the general sense of how
16 we needed bring more people who were actively involved
17 in procurement to make sure that the guidance notes that
18 we produced for all of the departments then had more of
19 an input from people who were at the coalface of
20 procurement rather than simply from a senior level in
21 the Civil Service.
22 **LADY HALLETT:** Mr Murphy, I'm sorry to interrupt. For those
23 of us who speak quickly it is very difficult to change
24 our speech patterns but if you could slow down a bit for
25 the benefit of the stenographer, it would be --

1 **THE WITNESS:** I'm sorry, I get that, thank you.
2 **MS GARDINER:** Am I correct that the -- you became Minister
3 for Finance when the Executive was reformed on
4 11 January 2020, so you had a very limited period of
5 time with which to get to grips with the role and
6 probably the Department to get to grips with you, before
7 you were plunged head first into the crisis, is that --
8 **A.** That's correct.
9 **Q.** Yes. And you have said in your statement that you've
10 not identified any direct result in relation to
11 procurement of the lack of power sharing over the period
12 of 3 years prior to that. But did you find that there
13 were certain policies or there was certain reform that
14 hadn't been introduced in that period of time that then
15 had to be either delayed in terms of implementation
16 because you had to deal with the crisis at hand, or was
17 more difficult to implement as a result of the pandemic?
18 **A.** No, I think that the -- I mean, it's not an ideal
19 situation when the Executive wasn't in place and you
20 hadn't got ministers taking decisions, but the type of
21 procurement guidance and notes that have been developed
22 and the approach to procurement in terms of the board
23 itself were being developed by the Civil Service in that
24 period.
25 None of them would have really directly related to

1 the challenges that we met in terms of what the Covid
2 experience threw up, the challenges of trying to acquire
3 critical medical equipment. Those would not have been
4 anticipated, I think, had ministers been in post in the
5 preceding time. So I don't believe that there was
6 anything in particular that prevented us from responding
7 to the -- as a consequence of a lack of procurement
8 preparation over the preceding period.
9 **Q.** And we'll get to the meat of some of that guidance and
10 reform that was introduced very shortly.
11 I want first to understand some of the structure
12 that existed within the Department of Finance,
13 particularly for you as Minister for Finance, to engage
14 with the work of the procurement professionals who were
15 undertaking this work. You mention in your statement
16 the PPE hub. Was this an organisation or a body that
17 you engaged with regularly?
18 **A.** No, it was a function that was largely carried out by
19 civil servants. The creation of it would have been
20 agreed by myself and by the Executive. It was an
21 immediate and direct response to the challenges that
22 were presenting as a consequence of the pandemic and the
23 need to acquire more material to support health services
24 and, indeed, other services that the government provided
25 who required PPE.

1 So it was a rapidly-moving picture both in terms of
2 the demand but also in terms of trying to, I suppose,
3 assemble a response to that both at an international
4 level in trying to secure some of the materials but also
5 at a local level in trying to encourage the provision of
6 certain materials from local manufacturers, as well.
7 So that meant that there was a lot of traffic coming
8 into the departments through ministers, of people
9 offering services or support, and it was agreed to
10 create a PPE hub, it was almost like a one-stop shop, to
11 make sure that those offers of support and
12 considerations of where materials could be got were
13 brought under one roof, with various agencies
14 interacting with each other to make sure that all offers
15 were properly assessed and all opportunities were
16 properly explored.
17 Q. And through what sort of routes would you engage with
18 any issues that arose around procurement and PPE? How
19 did you become aware of those issues?
20 A. Well, the CPD, which was the procurement function within
21 the Department of Finance, the people that were then
22 engaging with other departments and with the PPE Hub had
23 sat on that but would have reported directly to me in
24 relation to feedback as to what was happening, and
25 consideration and advice in relation to how to bring

1 matters forward. So Sharon Smyth was our direct person
2 in relation to that, but there were other members of CPD
3 directly engaged with procurement.
4 We had, at the start of the pandemic, obviously
5 collectively discussed our approach through the
6 Executive and there was, if you like, a sense of all
7 hands to the pump. And so even though procurement of
8 medical equipment was not the direct responsibility of
9 the Department of Finance, because we had that
10 overarching responsibility, we felt obliged and willing
11 to make an offer to support the Department of Health in
12 its attempts, both to secure locally some PPE supplies
13 but also to assist them in procuring, internationally,
14 supplies if they needed.
15 Q. Thank you. And the Inquiry has just heard in the
16 previous session from Mr Matthews from the Department of
17 Health about some of the aspects of governance in
18 Northern Ireland which are unique to that
19 administration, in particular the concept the Lead
20 Government Department which, in a Westminster context
21 would be DHSC. It's quite different, is it not, in
22 relation to Northern Ireland? Because the Department of
23 Health, during the Covid pandemic, was not able to
24 direct other departments; is that correct?
25 A. Yes, that's correct. We do have a unique system of

1 governance -- government which is, I suppose,
2 a consequence of the Good Friday Agreement and the
3 attempts to ensure that there was genuine power sharing
4 across all communities in Northern Ireland. So we have
5 a system of government which gives a significant degree
6 of autonomy to each individual department and with
7 overarching, if you like, governance from the First and
8 Deputy First Minister's offices, but there is
9 a significant degree of autonomy in the departments, and
10 that was a necessary step in order to get buy-in from
11 all communities to the idea of shower sharing in the
12 Good Friday Agreement.
13 Q. From your perspective as Minister for Finance obviously
14 you collaborated a great deal, and we see that in your
15 written evidence, with Minister Swann, who was Minister
16 for Health at the time, in a situation such as a global
17 health pandemic or other emergency, does that system of
18 power sharing continue to work or does it create
19 friction or delays which could hinder effective decision
20 making?
21 A. No, I think is there was a genuine attempt across the
22 Executive parties to try and collaborate together, to
23 respond collectively to what was a very real, critical
24 health crisis.
25 There was one party in the Executive who disagreed

1 with the direction of travel, the DUP, in terms of some
2 of the health advice we were getting from the Chief
3 Medical Officer or the Chief Scientific Adviser, but the
4 other four parties who were in the Executive were very
5 largely on the same script and prepared to follow that
6 and to collaborate together.
7 So there was a difference, not along the traditional
8 constitutional lines, uniquely, I suppose, for our part
9 of the world but there was a difference that one party
10 was less inclined to agree with the necessity for the
11 measures that were taken during the course of the
12 pandemic, and the other four parties who wanted to
13 follow the advice that we were given.
14 So that did create some tension, but the, I think,
15 there was even with that, there was a strong level of
16 collaboration across all of the parties and a desire to
17 pool our efforts together to make sure that we responded
18 accordingly.
19 Q. Thank you. I also want to discuss your collaboration
20 with UK central government and particularly the
21 Department of Health and Social Care.
22 We heard this morning from Ms Bailey from BSO PaLS
23 that before the pandemic there was a great deal of
24 particularly FFP3 masks, which became very crucial in
25 the response to Covid, that were procured directly from

1 DHSC through NHS Supply Chain, and that there was
2 a realisation in May 2020 that NHS Supply Chain was not
3 going to be able to provide the PPE necessary to fulfil
4 the demand that there was going to be.
5 Was the Department of Finance and in particular were
6 you, as Minister for Finance, kept abreast of those
7 concerns at the time? And if not, when did you become
8 aware of them?
9 A. Well, the interface with the departments in London in
10 relation to health matters were done primarily through
11 the Department of Health, so Finance wouldn't have had
12 any particular role in that regard, in that we
13 interfaced with the Treasury in relation to funding and
14 finances but not in relation to the equipment that was
15 being supplied, the availability of it, the suitability
16 of it. That was all matters for the Department of
17 Health.
18 So, other than hearing general reports at an
19 Executive meeting from the Minister for Health,
20 I wouldn't have been directly involved in any of that.
21 Q. I want to have a look at some of your correspondence
22 with the Chief Secretary for the Treasury during this
23 period.
24 If we could get up INQ000336538. Thank you.
25 This is a joint letter, I believe, dated 12 May 2020

1 to Stephen Barclay MP, who was the Chief Secretary to
2 the Treasury at the time, and this is a joint letter,
3 together with the ministers of finance for Wales and
4 Scotland, where you're expressing what you describe as
5 your "collective concerns in regards to the limited
6 supply of PPE ... being delivered through [what was
7 then] the proposed UK-wide procurement approach".
8 And you say this has resulted in the devolved
9 governments incurring significant costs through your own
10 direct procurements, and we'll discuss some of those
11 direct procurements as well.
12 The proposal at this time, if I'm correct, is for
13 a four nations approach to PPE. And is it right to say
14 that this letter expresses some concerns that the
15 devolved administrations will be able to rely on DHSC to
16 deliver on that PPE?
17 A. Well, I think it recognises that, firstly, PPE was
18 proven extremely difficult to acquire. The bulk of it
19 was made in the Far East, and that presented logistical
20 difficulties, but also the fact that all countries
21 across the world were basically going to similar
22 buyers (sic) to try to secure material meant that the --
23 it had almost become a frenzy in trying to pursue PPE.
24 The NHS in England had undertaken -- and the
25 Treasury had undertaken to buy that for all parts, so

1 for Scotland, for Wales, for ourselves, and for England.
2 But at the same time, given the difficulties that they
3 were having in securing material, were also encouraging
4 us to, for instance, encourage local businesses to
5 repurpose and supply us with material. So -- and then
6 also then, subsequent to that, to explore options
7 ourselves for procuring PPE across the world, wherever
8 we could receive that.
9 I think the issue that the letter and ourselves and
10 Scotland and Wales used to make frequently with the
11 Chief Secretary to the Treasury -- we'd raise various
12 issues in relation to spending generally but, at this
13 period, in relation to Covid spending, I think this was
14 to try to ensure that if we were incurring expenditure
15 on money which had been given to us in a general sense
16 for Covid spend and we were buying PPE with it in --
17 that we wouldn't suffer as a consequence of the central
18 spend on PPE not coming to us because we'd already
19 purchased materials, so that we would get the amount
20 that we were due from that as well.
21 Q. Yes.
22 A. So it was really to recognise that although the four
23 nations approach, as they called it, had taken
24 a responsibility to try to supply everyone, that was
25 facing difficulties and we were being encouraged,

1 in Scotland, Wales and ourselves, to pursue our own
2 options in that regard. So we were trying to make sure
3 that we didn't lose out as a consequence to that.
4 Q. Yes, and we can see that if we just scroll down a little
5 on this letter we can see that concern addressed in --
6 reflected in the first paragraph:
7 "... we need assurance that we will receive funding
8 to meet the costs that we have incurred already," and
9 there are suggestions as to how to do that.
10 There is an email exchange that I also want to look
11 at which reflects some further concerns. That's
12 INQ000377395. If we can look at page 2. Thank you.
13 This is an email from an official within the
14 Scottish Government, and it's looking at this same
15 approach to a proposed four nations approach where DHSC
16 would manage this PPE fund on behalf of all four
17 nations.
18 It notes that:
19 "... [Her Majesty's Treasury] believes it to be the
20 most efficient way to procure PPE."
21 But it also notes a couple of concerns.
22 There is a concern about equitable distribution of
23 expenditure, and if we scroll up to the next email,
24 thank you, we see a response from Sharon Gallagher who
25 I believe is, yes, a Northern Irish official, which

1 reflects her concern, or perhaps Northern Ireland's
2 concern about the challenges of implementing this
3 protocol and the need to retrofit some account of the
4 expenditure which had already been incurred.
5 Were you aware of these concerns at the time, and
6 how were they ultimately concluded?
7 **A.** Well, the exchange there is -- it seems to be within the
8 health departmental systems across Scotland and with
9 ourselves, and London. I think the concern, as I
10 outlined in my previous response, was that while the --
11 I agree -- I think the figure of 7 billion was going to
12 be held centrally to try to secure PPE for all of the
13 regions, that there were difficulties and some
14 challenges in relation to that, and the suggestion was
15 that we moved to what -- the normal distribution of
16 funding is what's known as Barnett consequentials, and
17 as you see a reference to consequentials in this email,
18 the normal consequentials process. So if money has been
19 spent additionally to what was originally outlined in
20 the budget in England, then we get the corresponding
21 amount of money into our coffers following the Barnett
22 formula.
23 **Q.** Thank you.
24 **A.** So I think there was some concern from the Health side
25 in relation to the procurement and the involvement of

1 Scotland, Wales and Northern Ireland in relation to
2 decisions on that procurement and the type of equipment
3 and they thought that it might be an option just to give
4 us the money and try and let us do our own thing.
5 **Q.** And if we can go back to the previous email we were
6 looking at, we can see the proposal that was made within
7 this email chain, and they're describing a situation
8 where each administration is an equal partner in a new
9 four nations PPE procurement group. It would be looking
10 at future PPE expenditure, and implied in that is that
11 there would be a reconciliation of your past
12 expenditure, but where, because obviously PPE
13 requirements overlap, the group could secure better
14 value than each administration on their own.
15 Is that -- is that proposal one that was discussed
16 with Finance or is that contained within the Department
17 of Health?
18 **A.** Well, I think the origins of that discussion were
19 obviously within the Department of Health because they
20 were responsible for deciding the amounts, the quality,
21 the quantity that was needed, where it was to be
22 directed. As you said, we have a different system of
23 government, so Social Services is part of our health
24 system which wasn't necessarily the case in England,
25 Scotland or Wales. We also had other areas of

1 government to supply with PPE, the police, prison
2 officers, other sections. So if there was central
3 procurement through the Health Department in London, it
4 may not necessarily have tailored for all of the
5 specific needs of ourselves or for Scotland for that
6 matter, or Wales, and so there was a sense that it might
7 be better if we got access to the resource, and were
8 able to tailor the demands. And if those overlapped,
9 then there was a rationale for using what they call
10 a four nations approach.
11 **Q.** And therefore you are able to deliver on economies of
12 scale and things like that?
13 **A.** Yes, I think so. I think the sense was that we knew
14 what our own specific needs and requirements were, and,
15 you know, in the kind of, as I say, the intensity of the
16 procurement exercise that we were all trying to acquire
17 material, then there was a concern that the further you
18 are from the centre on that, the less your needs are
19 heard or provided for. And I think that was the same
20 feeling for Scotland or Wales and that was the sense
21 from our health departments that they had some
22 dissatisfaction with how things were being procured and
23 what was being procured and how much was intended for
24 our specific uses, and obviously then that was related
25 to Finance because we were the people who dealt with the

1 money part of it.
2 **Q.** And some of our witnesses to that end, and on that
3 topic, have expressed some doubt that the concerns of
4 devolved administrations were taken into account at four
5 nations meetings in relation to procurement of PPE. Is
6 that what you're describing there?
7 **A.** Yeah, well, I didn't attend the meetings in relation to
8 PPE procurement in particular so I can't and attest to
9 that. As a Finance Minister, and listening to the
10 experience of other ministers in the Executive and other
11 ministers in other devolved governments, generally we
12 had the sense of being politely entertained but not
13 really listened to in most matters that we brought to
14 central government in Whitehall. So I think that kind
15 of sense of how we were treated permeated right across
16 both Scotland, Wales and ourselves in that regard.
17 **Q.** I want to bring up -- or sorry, I don't actually need to
18 bring it up but I do want to briefly touch on the four
19 nations protocol for the PPE procurement which was
20 implemented in March 2021, and I believe that that is
21 the protocol that stayed in place until the end of the
22 pandemic. That protocol set out that each devolved
23 administration would control its own share of the
24 funding envelope, and also would collaborate on
25 information and intelligence, and therefore you would be

1 able to get better value for money by minimising
2 competition but also, perhaps, collaborate on delivering
3 economies of scale and improving resilience.
4 Were you aware of this protocol when it was
5 introduced, and did Finance have any contribution to it?
6 Or again, was that the Department of Health's remit?
7 **A.** We wouldn't have had a contribution in that regard to
8 make to it. But we would have -- because our finance
9 officials worked very directly with the health officials
10 in terms of assisting them in procurement, so they were
11 aware of other developments, it seemed to be a better
12 approach. It seemed to be that there was, at least in
13 that area, some listening had gone on to the devolved
14 regions from central government, but yes, because we
15 would have been assisting the Health Department in its
16 procurement responsibilities then, our officials would
17 have been aware of some of those discussions where we
18 didn't have a direct input into those decisions as to
19 how that shaped up.
20 **Q.** So that protocol was an improvement on the previous
21 situation?
22 **A.** Well, it certainly seems to answer the criticisms that
23 were put forward in that the central procurement of PPE
24 didn't necessarily take account of the particular needs
25 of the regions, and that there was little input in terms

1 of decisions in relation to materials and what type of
2 materials. So I think it did appear to meet some of the
3 criticisms that were made in those discussions between
4 the health departments.
5 **Q.** And is this sort thing a protocol that could be in place
6 and then stood up in times of shortages or supply chain
7 breakdown in future, do you think? Is there sense in
8 having this sort of thing in your back pocket, so to
9 speak?
10 **A.** Well, I think that the -- clearly we were all responding
11 to a very rapidly evolving situation, one which is very
12 critical and which was affecting directly people's
13 lives, people's health. So there was an element of
14 trying to keep ahead of the curve in that regard to try
15 to respond as effectively as we possibly could to do
16 collaborations, where we could, with central government
17 in Britain, and to try and secure our own measures to
18 get supplies necessary.
19 So I do think that if a situation like this arose
20 again, and hopefully it won't, but if it did, then the
21 idea that a centralised response has to be more
22 cognisant of the particular demands of the regions, that
23 I think would be of benefit. We wouldn't go through the
24 early misfiring of this approach to get to the point
25 that we got.

1 **Q.** Before we move on from this idea of collaboration with
2 other governments, were there opportunities for
3 collaboration with the Republic of Ireland in terms of
4 PPE procurement?
5 **A.** Yes, there are collaborations both north to south in
6 Ireland on a range of health matters, and have been for
7 some time, and there are good working relationships
8 obviously between the health departments. There were
9 also good working relationships which are a formal part
10 of the Good Friday Agreement, so we have a North South
11 Ministerial Council where on sectoral level ministers
12 meet on a regular basis and on plenary level twice
13 a year the entire Executive and the cabinet in Dublin
14 will meet. So those relationships were already there
15 and obviously that lent itself to much closer
16 collaboration when we were faced with the challenges of
17 pandemic.
18 **Q.** I want to look at INQ000130078, if we can.
19 This is a letter from yourself to the Irish Minister
20 for Health. It's 3 April. And this is in relation to
21 a particular proposed procurement, which I believe
22 didn't proceed, where the -- it was proposed to
23 collaborate with the Irish government on an order of PPE
24 from China. We understand from your statement and also
25 from this letter that this procurement at this point was

1 not going to proceed. And you say:
2 "... market conditions in China have become
3 increasingly difficult as other countries have increased
4 their demands on this essential equipment.
5 "We understand that IDA has no further capacity to
6 pursue the collaborative order."
7 Can you expand briefly on why that order didn't go
8 ahead. And is there anything that, from the Northern
9 Ireland perspective, could have been done differently to
10 have it come to fruition?
11 **A.** Well, I think all administrations, ours and Dublin's
12 administration were no different, had people on the
13 ground in China trying to secure orders on behalf of
14 their administration. And where there was already
15 collaboration taking place between the two
16 administrations and if we felt that IDA, which is the
17 economic agency in the south of Ireland, was further
18 ahead in perhaps securing, then we had discussed with
19 them the possibility of adding, if you like, an order
20 from Northern Ireland into that and having a joint
21 procurement exercise. This was a very rapidly moving
22 situation, so this was changing not just day by day but
23 hour by hour in relation to what was happening in China,
24 and there were a large number of orders which had been
25 diverted with people that had come in with the larger

1 chequebooks, and it wasn't just ourselves competing in
2 this field, all -- a lot of countries internationally
3 were competing on the ground in China for PPE.
4 So we had tried to develop a joint order with them.
5 We were agreeing that we would do that. The IDA were
6 on -- the lead on the ground in terms of their contacts.
7 They then were, I think, of the impression that they
8 could only get enough to satisfy their own needs, they
9 couldn't get the additional amount of order that we had
10 asked them to include in ours, and so we concluded then
11 that that wasn't going to be the case and that our
12 people on the ground for the Northern Ireland Bureau in
13 Beijing would then pursue their own contacts and try to
14 secure supply for ourselves.
15 So it was, as I say, very rapidly moving. The
16 picture was not just only changing at home in terms of
17 demand but it was changing internationally and
18 particularly in China in terms of who was getting out
19 there and who were securing orders, how much they were
20 paying for them, and how they were shipping that back,
21 back to the -- Western Europe.
22 **Q.** Thank you. Yes, we can have that off the screen now,
23 thank you.
24 You mentioned the procurement from China Resources.
25 That was ultimately successful, and we had Mr Losty in

1 last week describing his role in that. And he was frank
2 in describing his own role in that as one of chance or
3 good fortune, that he happened to be evacuated to
4 Northern Ireland in the early stage of the pandemic and
5 happened to have these business contacts.
6 Ultimately, do you think Northern Ireland has the
7 links that it needs with overseas suppliers to procure
8 in a future healthcare emergency, or indeed any civil
9 emergency, where supply chains become an issue?
10 **A.** Well, I think Mr Losty underplays his role. I think it
11 was very critical in securing supply for us. I mean, we
12 are a very, very small player internationally. We're
13 not a large economy. We're not a large nation, and we
14 were very much, you know, down the queue when it came to
15 people competing for PPE orders in China. Tim Losty
16 used his own personal connections that he had built up
17 as the Northern Ireland Executive's representative in
18 Beijing for a number of years at that point and managed
19 to secure us a contract, which -- I think when you see
20 some of the exchanges from Scotland and Wales, they
21 were, you know -- and indeed from London -- that we had
22 managed to secure that ourselves was a matter that
23 raised some eyebrows, given how small we were in the
24 international stage.
25 So I think that, of course, it does point to the

1 fact that our offices, and there are offices all over
2 the world, even with small entities like ourselves, that
3 we do need to continue to make those local contacts.
4 They're not only beneficial in broader economic terms,
5 in terms of doing business, but in more critical terms
6 then those contacts are very, very important.
7 I think also the lesson from that, and I know that
8 you have touched on this, was to ensure -- and it's part
9 of the advice that I've given to the Executive -- that
10 the supply chains needed to be looked at in terms of the
11 resilience, and that was for me the singular big lesson
12 in terms of procurement from the pandemic. There are
13 a lot of other health lessons to be learned but, in
14 terms of procurement, to make sure that all your eggs
15 weren't essentially in the one basket in terms of
16 getting critical medical supplies.
17 **Q.** Thank you. You've provided details of a PPN,
18 a procurement practice note (sic), on supply chain
19 resilience that you issued during the period of the
20 pandemic on that topic. We won't bring it up, but is it
21 fair to summarise it as emphasising the importance of
22 modelling the supply chain, having sight of the length
23 of the supply chain generally but also the advantage of
24 shorter supply chains, and building in that flexibility
25 and responsiveness so as to weather these types of

1 events?
2 **A.** Yes, I think absolutely. I mean, I think in terms,
3 generally speaking, of supply chains we have to have an
4 account of carbon footprint. So if people just pursue
5 things on the basis of cheapest price, they generally
6 find that they're made in the Far East, not exclusively
7 but generally speaking, where labour costs are cheaper.
8 But that leaves them a long way away from, particularly,
9 critical supplies if you're facing into an emergency.
10 So it was an opportunity not just to make
11 a contribution environmentally but also economically, in
12 a local sense, to make sure that people who could
13 provide some of this equipment, could repurpose their
14 manufacturing to supply some of this equipment, were
15 encouraged to do so, and that was the purpose of the
16 procurement note.
17 That had already happened as a consequence of the
18 kind of call to arms from the Executive during the
19 pandemic, that people did step forward and make material
20 that was critical for our health services, and we wanted
21 to ensure that that lesson was learnt and applied into
22 the future.
23 **Q.** What sort of support did the Department of Finance give
24 those companies in Northern Ireland who wanted to
25 repurpose perhaps existing manufacturing equipment to

1 produce much needed healthcare supplies?
2 A. Well, we couldn't really give them any direct support.
3 I mean, we were supporting companies generally because
4 we had funds to distribute as part of the response to
5 the Covid pandemic for the shutdown of businesses, but
6 in some ways, the encouragement in this area allowed
7 some of these businesses to reopen and to make some, I
8 suppose, business for themselves in terms of responding
9 to the needs of the health service locally for the
10 pandemic.
11 So it wasn't a matter of financial support or
12 inducement. It was to say to people that if you can
13 make this material, that there is a market for it here,
14 there is a health service which needs this material on
15 an ongoing basis and that hopefully beyond this pandemic
16 they will look, given the advice that we had given them
17 in terms of shortening supply chains, that they and
18 others departments will look to the local economy in the
19 first instance for things that can be manufactured
20 locally.
21 Q. You've given us many examples in your witness evidence
22 of companies that did rise to that call to arms, as it
23 were, and provide PPE and other equipment. Can you give
24 us any insight into the current situation or, perhaps,
25 given your recent departure from the Executive, the

1 recent situation in Northern Ireland? Is that
2 manufacturing base still there or is it capable of being
3 scaled up or repurposed if a similar health emergency
4 which might require different equipment in a future
5 event, is that still there, or has that been dismantled?
6 A. Yes, we do have a very strong manufacturing base in
7 Northern Ireland and one which has some international
8 reputation. We don't have natural materials in terms of
9 supplies, so that will always be a challenge for us, but
10 I think that there are companies there who are still
11 supplying perhaps, and I don't have firm evidence,
12 I only have a sense anecdotally, as I went on to become
13 the Economy Minister so I had some interaction with
14 business, perhaps not at the level I would have wanted
15 to see in terms of a continuation of contracts to make
16 sure that we actually encouraged and built up a bank of
17 businesses and manufacturers that could support
18 particularly critical supply for us in response to any
19 future pandemic.
20 So I would hope that in the Northern Ireland
21 Executive those lessons had been learnt and that they
22 are carried on into the future.
23 Q. Thank you. And finally, in the same vein, in terms of
24 increasing supply chain resilience, the Northern Ireland
25 Audit Office report, which I know you've seen, has

1 a recommendation to the whole of the Executive on
2 building supply chain resilience and one aspect of that
3 that it highlights is reducing this reliance on
4 emergency procurement. As you were responsible for
5 procurement policy during this time, what measures do
6 you -- did you implement, or do you think ought to be
7 implemented, to reduce that urgent emergency procurement
8 which is, naturally, less cost effective?
9 A. Well, that, there is always a challenge there because
10 that's a balance between procuring a lot of supply,
11 which then isn't used and becomes waste, and you become
12 subject to some criticism for having bought materials
13 that is, you know, outlives its shelf life, and is not
14 used. So the balance is in ensuring that you're ready
15 for some measure of emergency but not stockpiling to the
16 extent that it becomes a waste of money.
17 So that's always a fine line in which all government
18 departments, I think, will walk.
19 I think the more that we had ensured that at the
20 very least that supply chain was closer to home, then it
21 meant that we weren't running into logistical challenges
22 that there were during a global pandemic of trying to
23 get supply. So I think, I would hope that those lessons
24 are learnt that if there is critical supply that can be
25 manufactured on the island of Ireland, or indeed between

1 Ireland and Britain, that that is a much easier
2 accessible supply of material than would be the case if
3 we are trying to go to the Far East to find it.
4 **MS GARDINER:** Thank you.
5 My Lady, those are all my questions. I believe the
6 Core Participants also have some.
7 **LADY HALLETT:** Thank you very much, Ms Gardiner.
8 I think it's Ms Campbell.
9 **Questions from MS CAMPBELL KC**
10 **MS CAMPBELL:** Mr Murphy, thank you. I ask questions on
11 behalf of the Northern Ireland Covid Bereaved Families
12 for Justice. I have three topics too, which in fact
13 you've touched on so we can deal with them quite
14 briefly.
15 I want to revisit the issue of cross-border
16 co-operation, and we looked at the letter that you had
17 sent to Simon Coveney, and we've discussed briefly the
18 proposal for joint procurement that didn't quite work
19 out.
20 The flip side of that coin, if you like, was that in
21 China Tim Losty, and we heard from him, I think you
22 know, last week, but he told the Inquiry towards the end
23 of March he was in contact with the Irish ambassador in
24 Beijing, so you were in communications, if you like,
25 between north and south and he was in Beijing, really

1 discussing the same opportunity as it arose.
2 But it became quickly apparent that the Irish
3 negotiations were at a stage at which it was too late,
4 essentially, for the Northern Irish requirements to be
5 piggybacked onto that order because they had maxed out
6 their requirements. And that's what you found as well;
7 is that fair?
8 A. Well, I think that was the ultimate end point of it.
9 The fact is that that situation was, as I said in my
10 previous answer, was changing on an hourly basis, not
11 just on a daily basis. So I think it was very, very
12 late in the day when we -- we were very much, I think,
13 confident that the joint order was being made and the
14 material was there, that we learnt very late in the day
15 that that wasn't available and that the joint order
16 couldn't be pursued. So, yes, that's what ultimately
17 happened, but, as I say, it was in a very rapidly
18 changing environment.
19 Q. It was indeed. And we know not only were things
20 changing on the hour and the world was scrambling for
21 PPE and Northern Ireland was a very small fish in a very
22 large ocean at that point in time, so, bearing all of
23 that in mind, we're now at the end of March and
24 beginning of April, is there an argument that those
25 discussions with the Irish Government should have

1 happened at an earlier point in March, to enable you to
2 be participants in that order before it was placed or
3 before discussions commenced?
4 A. Well, I don't have the detail with me as to when that
5 order was placed. So, again, I suppose, all agencies
6 and all representatives, particularly on the ground in
7 Beijing and in China generally from all governments all
8 over the world, were moving very quickly to try to
9 secure their own PPE.
10 I think by the time we became aware that they were
11 more advanced than perhaps we were, and there may be an
12 opportunity through informal dialogue obviously on the
13 ground in Beijing between the officials but also between
14 ourselves and government ministers in the south -- there
15 may have been an opportunity to tack on an order, if you
16 like, to that, and then we tried to develop that. It
17 looked promising, and then, at the last moment, it
18 didn't materialise. So it's hard to make a judgement
19 now as to how soon in that process we could have known
20 that an order was materialising and that -- whether that
21 would have had a material effect in terms of getting our
22 own supply in that. Obviously people like Tim Losty
23 then moved immediately to secure our own order, which we
24 did in the weeks after that.
25 Q. Thank you. You've also touched on the issue of

1 coordination amongst the DAs, and with the London
2 government, and again, before we leave Mr Losty, he
3 indicated in both his evidence and in his statement last
4 week that he felt the UK Government sometimes came
5 across as disinterested in working with or hearing the
6 concerns of the devolved administrations. In fact, in
7 evidence he said that he felt that some of the issues
8 that were being raised by the DAs, particularly in four
9 nations calls, deserved a greater degree of discussion
10 and consideration and debate than they ultimately
11 received.
12 Does that chime with your experience in as much as
13 a Minister of Finance, you had, I think you've told us
14 this morning, a sense of being -- or this afternoon --
15 a sense of being politely entertained but not really
16 listened to?
17 A. Well, I can't speak to the direct experience in terms of
18 Health because I wasn't involved in those discussions,
19 but my general sense of dealings with Whitehall at that
20 time, and subsequently as Economy Minister, were chimed
21 with that -- of getting an audience but not having any
22 impact in terms of decision making. I had many
23 discussions at that time with my counterparts in
24 Scotland and Wales. I think it wasn't just felt by us;
25 it was felt by Scotland and Wales also.

1 Q. Ms Gardiner drew your attention to the four nations
2 protocol on PPE procurement which ultimately, I think,
3 comes into fruition in March 2021, so a good 10 or 11
4 months on from some of the documents that we looked at
5 in mid -- spring 2020. Do you have any sense as to why
6 it took until March 2021 to -- (overspeaking) --
7 A. I don't, because I wasn't involved in the direct
8 discussions on those health matters. It was the Health
9 Department who was dealing specifically with the
10 administration in Whitehall and the other
11 administrations in Scotland and Wales in relation to
12 those matters directly. We were just assisting the
13 Health Department, given the broad experience of
14 procurement in the Finance Department.
15 So I don't know why it took so long, but I make an
16 assumption that everyone was reacting to a pandemic and
17 trying to do the system of government at the same time,
18 but it perhaps is attributable to the fact that it takes
19 a long time, if at all, for Whitehall to listen to what
20 the devolved administrations are saying to them.
21 Q. Finally, then, on the topic of lessons learned you
22 conclude your statement at paragraph 90 with a reference
23 to your former department's production of a lessons
24 learned document, and I just want to look at it very
25 quickly and not in any detail.

1 It's INQ000494732. It's a four-page document. You
2 see the first date is 2 April 2020. We' can then see 8
3 April, a date at the end of May, and can we just very
4 quickly scroll down through the four pages.
5 We will, inevitably, look at the substance or the
6 content of this document in more detail in a different
7 way. First question. The document is not dated. Do
8 you have any sense of when it was issued as a lessons
9 learned document from the Department of Finance?
10 **A.** I think -- I don't recall the exact date. I think, from
11 memory, before the Inquiry started, that there was
12 material sent round various government departments --
13 I would not have been in the Department of Finance at
14 that time -- to ask us for a general sense of how things
15 were done and what lessons might be learnt from that, so
16 it's probably sometime in the period around when the
17 Inquiry was beginning its work.
18 **Q.** So -- and in response to the Inquiry's work?
19 **A.** Yes, I think that's --
20 **Q.** -- (overspeaking) --
21 **A.** Yeah, I think that's what it was, yes.
22 **Q.** The earliest date referred to that we can see there is
23 2 April 2020 and, in fairness, it's not really clear why
24 that date is particularly chosen. But the document
25 itself doesn't seem to engage with the issue of, if you

1 like, pre-pandemic preparedness or what might have
2 happened throughout February and into March in terms of
3 putting the Department in perhaps a more resilient or
4 structured position. Should it?
5 **A.** Well, this relates to the Department of Finance and most
6 of the focus of preparedness really would fall more in
7 a general sense to the Executive and the First and
8 Deputy First Minister's office in terms of civil
9 contingencies or directly to the Department of Health
10 because it was a health crisis, a health pandemic that
11 we were facing. So perhaps it isn't as clear as what
12 lessons might have been learned across the range of
13 other departments.
14 I do think there are, of course, in any of these
15 experiences there are lessons to be learnt and I would
16 hope that the experience of the pandemic is, through the
17 work of the Inquiry, and the analysis that will come
18 from that then, applied to make sure that we are in
19 a better prepared state, should such a situation arise
20 again.
21 I don't think that the administration in Northern
22 Ireland is unique in terms of not being fully prepared
23 for the extent of a pandemic that faced us. But
24 I think, of course, the experience, the analysis that
25 will come through this Inquiry and the kind of,

1 I suppose, self-examination across each of the
2 administrations then hopefully will make people in
3 a better state of preparedness should such a situation
4 arrive again. At the very least, we will have the
5 experience of that to draw on in terms of a response.
6 **MS CAMPBELL:** Thank you. Those are all my questions.
7 Thank you, my Lady.
8 **LADY HALLETT:** Thank you very much indeed, Mr Murphy. Those
9 are all the questions we have for you. I'm sorry we
10 couldn't get to hear from you when we were in Belfast
11 but thank you for the help you've given to the Inquiry.
12 **THE WITNESS:** Thank you very much.
13 **MS GARDINER:** My Lady, I'm going to pass over to Mr Sharma.
14 **LADY HALLETT:** Thank you.
15 **MR SHARMA:** My Lady the next witness is Major General
16 Phillip Prosser.
17 **MAJOR GENERAL PHILLIP PROSSER (sworn)**
18 **Questions from COUNSEL TO THE INQUIRY**
19 **LADY HALLETT:** General Prosser, I hope you were warned that
20 you were the last witness of the day, I hope you haven't
21 been hanging around for too long.
22 **THE WITNESS:** Not at all, my Lady.
23 **MR SHARMA:** Thank you.
24 General Prosser, good afternoon, you have already
25 provided the Inquiry with two witness statements. The

1 references are INQ000560895 and INQ000538647. Would you
2 confirm that they are true to the best of your knowledge
3 and belief?
4 **A.** Yes, they are true.
5 **Q.** You are Major General Phillip Prosser. During the
6 pandemic you held the rank of Brigadier Commander of the
7 101 Logistic Brigade; is that right?
8 **A.** That's correct.
9 **Q.** And between 19 March of 2020 and 23 July of 2020 you
10 were deployed, were you not, to assist the PPE team
11 within the NHS England headquarters at Skipton House?
12 **A.** I was.
13 **Q.** The Inquiry has heard a lot of evidence about the
14 procurement of PPE but less about its distribution, that
15 is getting the kit that was bought to the front line.
16 Could I ask you, please, to begin with your experience
17 in logistics and just an outline of what the
18 101 Logistic Brigade is?
19 **A.** Yeah, of course. So 101 Logistic Brigade is part of the
20 3rd (United Kingdom) Division, which at the time was the
21 UK's warfighting force, the primary warfighting force
22 held at readiness. I had 17 units delivering three
23 basic functions or three important functions.
24 The first was delivering engineering support to
25 frontline vehicles to make sure we could fix them as far

1 forward on the battle space as possible.
2 Second was the delivery of combat supplies, so from
3 ammunition all the way to clothing and rations to the
4 forward line of the battle space.
5 And then the third one is medical support as well,
6 so looking at casualty extraction, and setting up
7 enhanced surgical capability forward on the battle
8 space.
9 So those three capabilities came under my command.
10 **Q.** And it's right, isn't it, that you have served in the
11 armed forces for some 28 years?
12 **A.** At the time, yes.
13 **Q.** You have served in Kosovo, Iraq and Afghanistan.
14 **A.** Yes.
15 **Q.** Could I turn, please, to what is described in your
16 witness statement as a MACA request. Could you just
17 please in very broad terms just outline what a MACA
18 request is.
19 **A.** Yes, so it's military aid to the civil authorities. The
20 Civil Authorities Act says that civil authorities will
21 react to crisis in the homeland, but, in extreme
22 circumstances, if the military or any other government
23 department have a capability that is needed in an
24 emergency, for the military, we place a military -- we
25 put a MACA task in that asks the military for help and

1 then that goes through a scrutiny check to say, if this
2 is a capability that cannot be provided elsewhere, then
3 the military will step in and provide that support.
4 **Q.** And in terms of a MACA request, does it have limits as
5 to what it can ask you to do?
6 **A.** Yes. So it is about delivering something that nobody
7 else can deliver. So the military, I think the MoD in
8 this sort of circumstance should be seen as almost the
9 last resort. And it is something that nobody else can
10 deliver or in the timeframe that they can deliver.
11 And the way we make sure that there isn't mission
12 creep or growth is to try to put some boundaries on it
13 to make sure that we deliver what we're meant to deliver
14 and then we can go back to our core purpose.
15 **Q.** Thank you.
16 I wonder if we can bring up the MACA request or
17 rather the email that leads to the request.
18 It's INQ000534264.
19 These are emails between the Ministry of Defence and
20 NHS England on 19 March 2020, so at the very beginning
21 of what was an emerging crisis in the procurement and
22 distribution of PPE.
23 Could we turn to page 4, please.
24 "Please accept this e-mail as formal notification of
25 a request for military support for NHS [England]."

1 Then if we just scroll down the page, it just
2 outlines in broad terms the scale of the crisis which
3 NHS England and SCCL were experiencing. It says just at
4 the first bullet point:
5 "• NHS [England] lacks the necessary planning and
6 logistic task at this scale in the timeframe available.
7 "• [The] supply chain is under ... pressure ...
8 "• ... [the] NHS Supply Chain is unable to recover
9 sufficiently [within the] next 24-72 hours ..."
10 Then if we can scroll down, please. Just those
11 bullet points in the middle of the page.
12 "Deficiencies to current structure:
13 "• No national planning capability to meet
14 unprecedented national demand.
15 "• No NHS Supply Chain capability to meet
16 unprecedented national demand."
17 Then:
18 "Proposal-Request:
19 "Logistic expertise and support (for the immediate
20 and interim distribution of PPE across the NHS Estate)
21 in order to undertake and complete the following ..."
22 Then it goes on to list a large number of tasks.
23 And perhaps we'll come back to the division as to what
24 the MACA request did and didn't cover during the course
25 of your evidence.

1 Could we go, please, to page 2 of that document
2 before we take it down.
3 This is just to summarise what the position was at
4 and around about that date, at least from the
5 perspective of NHS England.
6 "The NHS supply chain for PPE is falling apart.
7 They urgently need assistance. This is a large scale
8 request ... There is no commercial capability [within
9 the] time frame."
10 And then the final lines:
11 "Please treat this as the first report from the
12 battlefield -- details will change but the base problem
13 of PPE supply chain risk is very real. More to
14 follow ..."
15 Now, in your written evidence you describe the
16 Ministry of Defence and your team being effectively
17 immediately deployed in order to assist with this
18 request; is that broadly right?
19 **A.** That's right, yes.
20 **Q.** Two people were deployed to NHS England on the afternoon
21 of 19 March and then you arrived on 20 March.
22 **A.** That's right.
23 **Q.** Just to provide us with an idea from your vantage point,
24 was what was being described in this email broadly
25 consistent with what you saw?

1 **A.** Yeah, I think -- so I guess there's two aspects to that.
2 First of all, I think this was a description of all the
3 problems rather than what they actually wanted me to do.
4 I think there's a line here, the fourth line down,
5 you know:
6 "... may be as large as 25 trucks ..."
7 So it's quite a bounded problem.
8 And then, you know, in the next line:
9 "... to establish a full end-to-end supply chain."
10 Those are two extremes of a problem.
11 So I think the email first of all described what the
12 big problem was, and I -- you know, I was called on the
13 night of the 19th to say we're going up to the NHS next
14 day. You know, it's about delivering PPE using trucks.
15 But when I arrived in Skipton House I realised that it
16 was much, much more.
17 So this is definitely a description of what the
18 situation was on the ground. But I needed a bit of time
19 to understand exactly what we needed to do.
20 **Q.** When you were deployed and you were working with
21 NHS England, was your role in any ways connected to
22 procurement or was it entirely operational?
23 **A.** It was entirely operational but because -- I think as
24 the situation unfolded, it was first a logistics and
25 distribution challenge, and then became a supply and

1 procurement challenge. And those two things sort of
2 existed at the same time but one was bigger, you know,
3 than the other at certain times of the operation.
4 So I wasn't involved with the actual procurement but
5 of course, as I was focusing on distribution, I needed
6 to know what was coming in. So I worked with the
7 procurement team but didn't do procurement.
8 **Q.** Just some questions, please, you refer in your statement
9 to the PPE distribution network being jammed, that's one
10 of the expressions in your statement. Could you
11 describe to the Inquiry, please, what is it that you
12 mean by "jammed" and what was causing that jam?
13 **A.** Yes, so this is similar to Emily Lawson's evidence.
14 There was -- so Unipart had seven regional distribution
15 centres.
16 **Q.** If I can ask you to pause there. So Unipart were
17 a subcontractor of SCCL?
18 **A.** Yes.
19 **Q.** Someone who we've heard evidence from, and Unipart's
20 task was essentially to be leading on distribution. It
21 was subcontracted by SCCL; is that right?
22 **A.** Yeah, exactly that. Sorry, I should have said that.
23 So SCCL subcontracted to Unipart who then had seven
24 regional distribution centres around the country to
25 serve each of the NHS regions, and then we had the

1 eighth centre which was a storage facility in Haydock,
2 run by Movianto where the PIPP stock was based.
3 So my understanding from the situation on that first
4 weekend was that the distribution centres were just --
5 so in a distribution centre, without going into too much
6 technical detail, you have a large open space where
7 stuff coming from the supplier would be placed as soon
8 as it arrives in the distribution centre.
9 So if you're buying from a glove manufacturer you
10 will get a lorryful of gloves, but of course you're not
11 going to deliver a lorry full of gloves to a hospital,
12 you're going to deliver gloves, masks, et cetera, so you
13 need to break down the gloves. So you need an open area
14 to break down the gloves and then put them on the shelf
15 and then you need another open area where you take 20
16 gloves, you know, masks, custard powder, as I've heard
17 from other people's evidence, put that in a lorry and
18 then deliver that cross-commodity, multi-commodity
19 delivery to the hospital.
20 And as I can understand it, and just looking at some
21 of the evidence, you know, Emily is asked by the chief
22 executive on 10 March to look at trusts not getting
23 their goods. As early as end of January we heard about
24 demand management being put in place because people are
25 starting to order more than they ever have. And as

1 understood it, at these distribution centres, as staff
2 absence was increasing because Covid was going on,
3 people were shielding, people had elderly parents, etc,
4 some people had Covid, people were over-ordering, so
5 these open areas were becoming fuller so you couldn't
6 break down the gloves that had arrived from the
7 supplier, and then you lack this open space. So it was
8 harder to get stuff into the distribution centres and
9 then harder to get it out.
10 And then slowly between, it must have been February
11 and March, my sense was that the network had just become
12 clogged.
13 **Q.** And that clogging was caused not only by the increased
14 demand but also the fact that people who might have been
15 working in those centres were shielding or had caught
16 Covid themselves. Was that one of the other problems?
17 **A.** Yeah, that was my understanding, that was certainly the
18 brief we had on that first weekend.
19 **Q.** A number of personnel were deployed, you refer to 312
20 personnel being deployed over the next two weeks. Was
21 it their job essentially to help unblock that jam?
22 **A.** Yes. So they went in and it was -- I mean, it was like
23 a large Tetris jamming, so you needed to take something
24 out of the open space in order to break the stuff down
25 that has come in, you know, the inbound stock and put it

1 on the shelf in order to then create space for the
2 outbound. So the team went in, I think, you know, it
3 was 312 for between 12 and 20 days, and just worked long
4 hours, put temporary accommodation, you know, temporary
5 warehousing up outside with tents, etc, made some space,
6 and then, you know, did what would have probably taken,
7 you know, four to six weeks. They did that in one to
8 two weeks. So they created that space to allow the flow
9 of goods again.
10 **Q.** So a major operation, essentially, to unblock that
11 problem within 20 days. Would you agree with that?
12 **A.** Yes.
13 **Q.** I'd like to take you forward just a little bit in the
14 chronology to a meeting on 21 March which you had with
15 Jin Sahota, who was the CEO of SCCL. You've referred to
16 the role of Unipart and SCCL. Could you take us through
17 a little bit about what happened at that meeting and
18 what you or the MoD were being asked to do?
19 **A.** Yeah, so the immediate deployment hadn't happened yet,
20 so this is my second day. We arrived on the 20th, so
21 this is my second day, and it was the Saturday morning
22 and Jin and I think his supply chain director was there
23 as well. And they took us through exactly what SCCL was
24 and, you know, I was new to the NHS, so I needed
25 a fairly basic brief on exactly what it was. And we

1 heard -- you know, you've heard from Emily Lawson about
2 the towers, et cetera, and, you know, it's quite
3 a complicated structure.
4 And he talked to us about what SCCL was, you know,
5 how it was set up, all the background to it. Some of
6 the challenges they were facing, some of the increased
7 demands, challenges of supply. And I just remember at
8 the end he said, "Look, and we can't scale any more."
9 And that's backed up by some of the, you know, some of
10 the other evidence I read in preparation for the
11 Inquiry. You know, Emily, the week before, has talked
12 to SCCL about increasing capacity, SCCL and Unipart
13 about increasing capacity.
14 Gareth Rhys Williams has said, "Look, you know, you
15 might have increased capacity now but you might have to
16 do it times eight again."
17 So all these conversations were happening before
18 I arrived. So -- and then, you know, Jin finished and
19 said, "Look, you know, we can't get any bigger so
20 somebody needs to set up another network and it's got to
21 be the MoD." And, you know, having gone from 25 trucks
22 for four days to suddenly running quite a major
23 distribution mission sort of took me back slightly.
24 So we just left it there and I said, "Look, I need
25 to go away and understand a bit more about this, Jin."

1 **Q.** So to go back to your -- the beginning of your evidence,
2 in terms of what you were expecting and your team were
3 expecting to do, was there in your mind a risk of
4 mission creep, of what you were being asked to do to
5 potentially expand further than the initial MACA
6 request?
7 **A.** Yeah, after that conversation I realised that, you know,
8 somebody might have -- and that was a personal view from
9 Jin. I don't think he shared that with certainly
10 anybody in the NHS. But I did get the sense that,
11 actually, this might be much bigger than what I was
12 prepared, you know, and what the army should have
13 been -- what the MoD should have been prepared to do.
14 So at that moment I realised yes, this was, you
15 know, much more serious, much more urgent than I had
16 appreciated before I arrived and that risk of mission
17 creep was significant.
18 **Q.** What, based upon your experience in logistics and your
19 wider experience, what would it have meant if the MoD
20 and your team needed to be expanded in terms of that
21 level of personnel? What numbers of people were you
22 thinking about?
23 **A.** Well, I think it would have been -- and I don't know how
24 many people, you know, were employed by the Clipper --
25 the whole Clipper operation in the end. Perhaps that

1 would have been a good question to ask, but my sense
2 would have been anything between 5,000 to 8,000
3 soldiers, and once we had set that up it would have
4 taken probably 18 months to two years for us to extract
5 from it, depending, you know, depending how much of the
6 set-up we did.
7 So it would have been a significant ask and it would
8 have definitely -- it would have undermined the MoD's
9 ability to deliver against its primary role.
10 **Q.** That primary role, if I can ask some questions about
11 that, please. One of the areas of your written evidence
12 which you are conscious of, and the MoD is conscious of,
13 is being drawn away from that primary role.
14 Could you just describe a little bit, it may be
15 obvious, but as to what that primary role is, because
16 it's not necessarily logistics and distribution during
17 the pandemic.
18 **A.** No, and it's -- so the MoD role is to keep the country
19 safe and help it prosper, which is probably the
20 overarching purpose, but below that, within 3rd (United
21 Kingdom) Division, my role was to deliver logistic
22 support to the warfighting division, and that was about
23 fighting an enemy overseas.
24 **Q.** So in terms of the risk in your mind at the time, and
25 perhaps the risk to your colleagues, was that if this

1 demand on the MoD and on military support continued to
2 expand, it would jeopardise the primary function of the
3 MoD and the military, which is defence of the country?
4 **A.** Yes. And there was a secondary threat. We didn't --
5 you know, this was still early days, so this is
6 the 21st, so two days before lockdown, we also don't
7 know what's going to happen with Covid-19. So if we
8 needed to reinforce other government departments for
9 short periods, we couldn't be fixed on one big task. We
10 needed to remain flexible in order to reinforce other
11 government departments, if need be, for short periods of
12 time. So, one, we didn't want to take away from the
13 primary role, and equally, we didn't want to get fixed
14 on a single task either.
15 **Q.** In terms of the risks, and of course we're talking now
16 about a situation that was -- five years in the past,
17 but were there -- what were the risks, what were the
18 geopolitical risks that were in your mind at the time,
19 in the MoD's mind at the time?
20 **A.** Yeah, so it was a different -- obviously it was
21 two years until -- two years later for the second
22 illegal invasion of Ukraine by Russia, Crimea had
23 happened a few years previously and geopolitical tension
24 was always there. So part of deterrence is being seen
25 to have a credible warfighting force to deploy at any

1 time, so geopolitically it was two years before the
2 Ukraine, it was five to six years after the first
3 illegal invasion of Crimea, so things weren't safe, but,
4 importantly, deterrence is about being seen to have
5 a credible warfighting force, and if that warfighting
6 force is fixed delivering a peacetime or a homeland
7 contingency task, then you're going to undermine that
8 credibility of that deterrence.
9 **MR SHARMA:** Thank you, General Prosser.
10 My Lady, I wonder if that is a convenient moment.
11 I am going to move on to another topic.
12 **LADY HALLETT:** Certainly, Mr Sharma, and also I'll try to
13 get rid to the Northern Lights behind me. I'm sorry
14 about that. I think it's the sun's come round.
15 Very well, I shall return at 3.15.
16 **(2.57 pm)**
17 **(A short break)**
18 **(3.15 pm)**
19 **LADY HALLETT:** Mr Sharma.
20 **MR SHARMA:** General Prosser, Clipper Logistics is the next
21 subject of my questions. You referred earlier to
22 a number of issues with Unipart and they would be solved
23 by the engagement of Clipper Logistics to come and
24 assist with warehousing, logistics and distribution.
25 Could you help us, please, with who Clipper

1 Logistics were and how they came to be involved in the
2 distribution effort during the pandemic.
3 **A.** Yeah, of course. So just to sort of back up and get to
4 that point, in chronology terms, we've that the
5 conversation with Jin on the Saturday morning. I'm
6 looking at the Unipart system being clogged. We've come
7 up with a -- we come up with a plan on Saturday
8 night/Sunday morning to deploy the 312 soldiers, but
9 I know that's only a short-term fix. That's about
10 unlocking what we've got.
11 But going back to the conversations that had
12 happened the week before, we knew we needed more
13 capacity. And SCCL just -- there was something blocking
14 it, and I think, you know, digitally they couldn't do
15 it, their systems couldn't expand. Physically, they
16 weren't presenting options about extra warehousing. And
17 then Jin suggests this is what the MoD can do.
18 So I'm in a position where I'm trying to make sense
19 of, okay, once we've created the flow through the
20 distribution centres, we are going to create -- we need
21 more capacity, and there didn't seem to be a plan.
22 So Neil Ashworth, who was -- I think he was chief
23 commercial officer at the time for Yodel, I can't
24 remember whether he was still in that role or had just
25 finished, and he'd been supply chain director for

1 Woolworths and Tescos, but he had -- he was a member of
2 the organisation called, at the time, the Engineer and
3 Logistic Staff Corps, it's now called the Staff Corps,
4 which is a Group B army reservist unit. And they are
5 recruited from people in specialist organisation --
6 engineer, logistics specific -- back in the day; they do
7 much wider, communications, cyber and digital now.
8 But they are a group of experts -- reservist
9 officers, so they can wear uniform -- who provide us
10 solutions in time of operational challenges.
11 As an example, it might be quite useful just to
12 understand, in Iraq in 2003 we tried to open the port --
13 the army tried to open the port in Umm Qasr but there
14 were some problems with the handling facility at the
15 port, so ferries -- roll-on/roll-off ferries couldn't
16 come alongside and offload. And what -- a member of the
17 Engineering and Logistics Staff Corps worked for a large
18 maritime operation and was able to source one of these
19 pieces of equipment, bring it over from a nearby
20 Middle East country, and solved the solution in
21 24 hours. So that's the sort of capability they bring.
22 Neil Ashworth had been appointed to me about
23 six months earlier as my mentor, so I phoned him up,
24 "I'm faced with this challenge of I need more network
25 capacity, SCCL and Unipart are saying they've reached

1 their capacity and can't expand" --
2 Q. Can I just interrupt you for a moment, what do you mean
3 by network capacity?
4 A. So that's the warehousing and distribution. So we talk
5 about network as the -- the sort of trucks and sheds, so
6 it's where you store your stock and how you distribute
7 it.
8 Q. Right.
9 A. So there seemed to be no facility to increase
10 warehousing, and therefore once you've increased the
11 warehousing you need to increase the distribution
12 because you're delivering from more sites.
13 So I phoned Neil, and I think it was the Sunday
14 morning, and he said, "It sounds as if you need a new
15 partner", and I said "Yeah, it does, but" -- you know,
16 this is isn't something we do in the military -- "how do
17 I do that?"
18 And he said, "I know Clipper are down" -- I didn't
19 realise how many logistics people know each other from
20 across the industry, and he said, "You know, Clipper,
21 a lot of their market is the retail" -- high street was
22 closed -- "they've got a lot of capacity and they're
23 really good at this agile stuff."
24 And he said, "Do you want me to contact them to
25 SCCL?"

1 And he had contacts in SCCL and Unipart.
2 And I said, "Yeah, please, that would be absolutely
3 fantastic. Let's scope the feasibility of this and see
4 what happens."
5 Q. So, just to be clear, you put them in contact with other
6 people, but did you have any role in the structuring of
7 the relationship between SCCL, Unipart and Clipper?
8 A. No, I just -- I was -- I saw the role of the military --
9 you know, I should have said up front, you know, this
10 isn't something the military did on our own. We worked
11 with the NHS as a really high-performance team, and it
12 was a really proud moment to me -- for me to be part of
13 that team. So everything we did was with NHS, with
14 DHSC, with all the consultants that came along with
15 that.
16 And I often saw the military role as being the
17 catalyst or being the oil in the cogs of those teams to
18 just speed things up. And this is a great example of
19 that. So understand the problem, come up with some
20 choices and then try to make it happen as quickly as
21 possible but make others make the decisions for
22 themselves.
23 Q. What you're describing, if I may say so, in terms of
24 Clipper Logistics and those with whom you had contact
25 with, was a mix of military experience and commercial or

1 retail expertise, was what was being brought together;
2 is that right?
3 A. Yeah, it's exactly, it's the blend, you know, it's the
4 blend, and I often talked when I was with the NHS --
5 I think we brought four things from the military: we
6 brought discipline, tempo, a different way of thinking,
7 and then the resilience, because this was long days for
8 long periods of time and the military are used to
9 pushing ourselves quite hard, so we brought that level
10 of resilience into a team, you know, that was having to
11 work really, really hard.
12 So in terms of that discipline and tempo it was, you
13 know, having the discipline to get to the core of what
14 the problem was and then having the tempo to actually
15 come up with some choices and then, you know, get on
16 with the plan as quickly as we can. But again, you
17 know, not making the decisions, just having the --
18 presenting the information as quickly as -- the right
19 information as effectively as possible to make the
20 decisions quickly.
21 Q. In your written evidence you describe instilling
22 a wartime mindset amongst those with whom you were
23 working, and instilling a speed and pace of working
24 which you didn't see was there, at least when you
25 arrived, and that needed to be pushed. Could you help

1 us with that, please. What were the things that were
2 slowing the distribution down? What were the blockers
3 that were in your way?
4 A. So in terms of the blockers, I mean, the distribution
5 centres were the biggest one, right in the early phases.
6 It was the distribution centres --
7 Q. The distribution centres, you mean the infrastructure,
8 the actual warehousing as to where all of this picking
9 and packing was going on?
10 A. Yeah, and they were clogged so it was -- but it wasn't
11 doing anything about it. That's what -- you know, we
12 seemed to be -- and Emily refers to it in her evidence,
13 that there was no forecasting of what needed to be
14 bought, there was no forecasting of how we were going to
15 bring the extra capacity organisational, you know,
16 external agencies were sort of, you know, answering
17 emails in two days' time.
18 And I think at that stage, you know, I had to go
19 through that acceleration myself. I arrived on the 20th
20 and remember, you know, on the Saturday we'd gone
21 through the analysis and then Emily came down and, you
22 know, having read the evidence and what had happened
23 before I arrived, I now realise the pressure that
24 frontline healthcare workers were under and the NHS
25 staff were under in trying to establish this PPE supply

1 chain. And I remember on Saturday night I sort of said
2 to Emily "Hey, look at my analysis" and she said, you
3 know, "You haven't done anything yet."
4 That's the pressure everybody was under and you just
5 needed that moment to realise, actually, we need to
6 switch, and this not about two days now, this about two
7 minutes to respond to your emails.
8 And very slowly as, you know, lockdown happened and
9 the whole situation changed I think, you know, much more
10 of the organisation got put on that war footing, but
11 over that weekend, you know, that was my acceleration,
12 and we watched others go through the same thing.
13 Q. One of the groups that you established was something
14 called the Immediate Replenishment Groups, what were
15 they and why were they necessary?
16 A. So over that first weekend, as I accelerated on to a war
17 footing, we tried to work out what we'd been asked to
18 do. It wasn't just about driving trucks, it was more
19 than that. And one of the tasks I set my team was, you
20 know, what is our binding purpose here? I believe
21 high-performance teams have a purpose, a plan that
22 delivers against the purpose that everybody owns and
23 then the team who truly believe in that purpose, who own
24 the plan and then deliver against it, and we wanted to
25 understand: what is that purpose? And somebody said,

1 "Look, this isn't about delivering masks, this is about
2 instilling confidence in the frontline healthcare
3 workers, this is about making sure they get up in the
4 morning and know they are going to feel safe and be able
5 to go out and do their jobs."
6 So one of the jobs -- so as part of that I needed to
7 make sure that we -- people could see that if they were
8 in crisis we would respond. So we had the NSDR, which
9 was the National Supply Disruption -- it's a phone call
10 service -- Response.
11 Q. Forgive me, that was something that was established
12 during the EU Exit process as part of the contingency
13 planning?
14 A. Yeah, that's right.
15 Q. That was something that was able to be stood up during
16 the pandemic?
17 A. Yeah, that's right. So everybody knew the phone number,
18 if they were facing a challenge in their supply, they
19 had the number, and then I wanted people to respond
20 really quickly, so I established an IRG, Immediate
21 Replenishment Group, in the south and one in the north.
22 So if anybody in the dark of night felt as if they were
23 running out of PPE, some soldiers in a truck would
24 appear and just give them that response to get them
25 through the next day.

1 Q. Sitting where you were, there were two sides to this
2 distribution equation. There was the inbound logistics
3 problem and there was the outbound logistics problem.
4 Could you help us, please, with what were the challenges
5 with the inbound logistics, the items that were arriving
6 from overseas and being procured within the UK?
7 A. Yeah, so what we had was a new supply chain and again,
8 you know, a lot of people have given their evidence
9 about the buy team, Andy Wood, I thought did a great job
10 of describing how he was trying to bring this disparate
11 team together and as part of the, you know, we had a new
12 buy team, we had a new supply base, and distribution had
13 changed as well. So, traditionally, I think SCCL would
14 have bought goods including transport, so when they went
15 on to contract they would have known when it would have
16 been delivered to one of their distribution centres and
17 they could book it in and it was all very stable.
18 But now we're using new suppliers. We don't have an
19 international distribution system that we can just use;
20 we have to create that as a new system. And we've got,
21 you know, new people, new contracts, new suppliers in
22 a shifting supply base.
23 So because contracts were being -- deals were being
24 done very quickly, you weren't getting the certainty
25 that you would have had in peacetime for delivery dates.

1 So they might say, you know, 26 March you're going to
2 get X number, but 26 March will come and it will go and
3 they won't have arrived. Because we haven't got that
4 line of sight, that line of sight or a certain line of
5 sight to that delivery, it makes a distribution
6 operation really challenging. You know, the life as
7 a logistician or a supply chain expert is about
8 balancing demand and supply, and we're learning about
9 the demand signal and, you know, a number of witnesses
10 have talked about that, and the supply chain, looking
11 backwards has now sort of, you know, is falling apart or
12 changing and evolving. So we've got no certainty of
13 what we need to deliver and no certainty of when we're
14 going to get it. So this the worst case.
15 Q. So essentially what's happening is that the buy team are
16 making their purchases with an estimated date of
17 delivery of that equipment from overseas, China in
18 particular, but other markets around the world.
19 A. Yes.
20 Q. But no one really knows precisely as to when that's
21 going to arrive and what the demands are going to be on
22 that distribution system; is that right?
23 A. Yeah, that's right. And that's nobody's fault.
24 Pragmatically, that is a sign of the times, and I know,
25 my Lady, you referred to chaos in Emily Lawson's

1 evidence. It was full on, to quote Emily. And it's
2 entirely pragmatic that, you know, manufacturers in
3 China who were now serving multiple more customers than
4 they've ever served before, are finding it difficult to
5 plan themselves.
6 So this is just a sign of, you know, a sign of the
7 operational pressure that everybody is under across the
8 end-to-end supply chain.
9 **Q.** We'll come back to it perhaps at the end of your
10 evidence. One of the areas which the experts to the
11 Inquiry John Manners-Bell described as an issue was
12 supply chain visibility.
13 **A.** Yeah.
14 **Q.** We'll come perhaps on to that when we deal with
15 recommendations, but if I could turn, please, to another
16 topic which is Daventry, and the operation at Daventry.
17 We know that Clipper established a centralised National
18 Distribution Centre of 260,000 square feet at Daventry
19 and that was the main site for the storage and
20 distribution of PPE during the pandemic. And one of
21 your colleagues, Lieutenant Colonel Dutton was based at
22 Daventry. You, on the other hand, were based at Skipton
23 House.
24 **A.** Yes.
25 **Q.** Could you describe to the Inquiry the nature of that

1 liaison with Lieutenant Colonel Dutton and what his role
2 was in Daventry and how that helped you with your job?
3 **A.** Yeah, so it was just having eyes forward and there were
4 actually two people in Daventry that really helped us
5 run the operation there but run with Clipper as part of
6 the subcontractor Unipart.
7 So there was Eb Mukhtar who was a -- who works for
8 a global supply chain and then Ed Dutton whose works for
9 Amazon, so supply chain experts. They were reservist
10 officers so again, you know, the flexibility of the MoD
11 being able to call on reservist officers with specialist
12 skills was really important in this operation.
13 **Q.** Forgive me for interrupting. That mixture, again, of
14 commercial and military expertise?
15 **A.** Yeah, yeah, exactly, like the staff corp. But these
16 were serving -- they weren't group B type reservists,
17 these were more traditional reserve officers. So they
18 came in and they just helped us do that discipline
19 tempo, diversity of thought, and the resilience forward
20 in Daventry and they allowed really clear pragmatic
21 comms, you know, that discipline and tempo is part of
22 telling your operational commander what they need to
23 know, not everything you want them to hear, and they
24 just brought that ability for us to get a really good
25 picture of what was happening in Daventry.

1 **Q.** If I may turn with you, please, based on your
2 experience, not only of the pandemic but your experience
3 prior to the pandemic, you've described some of the
4 problems that were encountered, about the bringing on
5 board of Clipper Logistics to deal with the issues with
6 Unipart, the combination of military and commercial
7 expertise, but you also refer in your statement to
8 a theme which has occurred throughout much of this
9 Inquiry, which is access to information and data.
10 Could you help us, please, from your point of view
11 and from your vantage point during the pandemic, what
12 were the problems with that for you, and what are the
13 features in the event of a future pandemic that the
14 government and those involved in pandemic planning
15 should be looking for?
16 **A.** So in terms of data, I've already covered the
17 overarching challenge, which is demand and supply.
18 That's the big challenge that any supply chain has to
19 resolve. And as Professor Manners-Bell said, you know,
20 it's about the flow of goods to satisfy both of those.
21 So if you look at demand, you need an understanding of
22 what the demand is, but not just what it is and what
23 it's going to be, what it could be in terms of the
24 pandemic.
25 And as I understand it, some of the exercises prior

1 to the pandemic just hadn't gone far enough in terms of
2 the scale at which the demand signal would go up and the
3 intensity. So, you know, how quickly it would go up.
4 So the scale and intensity of that demand signal.
5 And then looking downstream so looking to the right
6 of Professor Manners-Bell's diagrams, what you'd want to
7 understand is exactly where you've got stock, so
8 you'd -- there would be some held on the ward, there
9 would be some inevitably held, maybe across three or
10 four wards or just at the trust level. Then you've got
11 the regional distribution centres and then, as you go
12 back, you'd want to know what was being -- you know,
13 what was on a train coming across Europe, what was on
14 a ferry coming from China, a ship coming from China, and
15 then you'd want to know what commercial -- what
16 contracts are in place about what you're buying.
17 So once you've got that end-to-end visibility, you
18 can balance your supply and demand. So you can
19 distribute, knowing that you're not going to run out
20 because you have confidence in what's coming in.
21 **Q.** You refer in your written evidence to the logistics
22 systems being neither well integrated nor modernised.
23 Is that what you're referring to or is that something
24 else?
25 **A.** Yeah, that's part of it. So SCCL and Unipart were going

1 to go through a digital transformation in -- later in
2 2000(?) so they were covering it -- I don't know what
3 the system was called, but when I talked Alan Wain, the
4 chief operating officer, he said, "We've currently got
5 a lot of green screen technology, which is common -- you
6 know, still common across a lot of the industry."
7 Q. "Green screen" referring to, I mean, quite literally
8 what is displayed on the screen, older technology.
9 A. Yeah, exactly that. So with that system it's much
10 harder to integrate it with other systems, and you can
11 see with Clipper, they -- you know, they set up their
12 warehouse management system in I think it's the fourth
13 day, something called Blue Yonder, which allows you to
14 integrate because it's much more modern. You can
15 integrate it much quicker.
16 That still wouldn't solve the problem of seeing
17 what's in the hospital. So that was a design -- that's
18 a deliberate design of the NHS Supply Chain that you
19 wouldn't see that at the time -- sorry, at the time, not
20 now I don't think -- but it's a deliberate design choice
21 that you don't need to see what's being held by the
22 trusts. And Emily sort of described why that was.
23 Q. Another observation that you make in your written
24 evidence, and if you'll forgive me I'll just quote it to
25 you so that I can ask you some questions about it. You

1 say this. You say:
2 "I believe that The UK Government must perfect the
3 balance between outsourcing and internal performance.
4 The matters suitable for outsourcing must be defined and
5 managed, and the matters performed in-house must be
6 critical and provide sovereign capability where it is
7 needed most."
8 Could you unpack that a little bit, please. What is
9 it that you mean by that? Is that a reference to the
10 performance of Unipart and the bringing in of Clipper or
11 is it something else?
12 A. I think it's wider. I think it's what
13 Professor Manners-Bell was talking about when he talked
14 about domestic manufacturing capability, stockpiling, or
15 strategic relationships with your partners. So this is
16 about how you design your supply chain.
17 And it's not -- nobody can afford a perfectly
18 resilient supply chain, so it's about risk management
19 and being able to evolve to disruption. And, you know,
20 it is worth saying, when the NHS would have let the
21 SCCL contract, it was 2017(?), 2018 for them to set up
22 in 2019. I think at the time -- it seems a different
23 world but I think at the time we would have believed
24 that we could predict the future that global supply
25 chains wouldn't be disrupted.

1 And here we are, only five to six years later, with
2 global, you know -- the global supply chain being
3 disrupted on quite a large scale, and that disruption
4 changing in nature quite frequently.
5 So, in order to deliver a supply chain, you have to
6 construct it in the way -- the best way possible to be
7 able to take these future disruptions. In 2020 we had
8 Covid. '22 we had the Russian invasion of Ukraine.
9 We've had disruption in the Red Sea and now we've got
10 the -- you know, the tariffs being placed upon various
11 countries. So supply chains now have to adapt.
12 So you have to build it in a way that it can
13 constantly evolve. So creating a sovereign manufacture
14 capability might not be right in five years' time and
15 it's going to be expensive.
16 So how do you manage risk in a whole new way?
17 And it's not so much about looking at the
18 traditional risk and likelihood -- you know, likelihood
19 and impact. This is about understanding where your
20 biggest risk is and where you have the ability to do
21 something about it.
22 And just to make sense of that, just link into
23 Lord Deighton's evidence. When you're going from
24 producing a bin bag to an apron it's quite a simple
25 transition. So we just need to understand where we have

1 similar-to manufacturing capabilities to allow us to
2 scale. But if you're producing a FFP3 in the UK that's
3 a totally different equation. It needs access to raw
4 materials, processing and the skills required to make
5 these.
6 So where do you invest in that capability? Where do
7 you outsource?
8 This a really sophisticated equation but it's
9 something we need to pay much more attention to,
10 I think, since 2020 and the global disruption that's
11 happened since.
12 Q. Just finally, if I may, one of the recommendations or
13 reflections that you make in your witness statement
14 refers to the requirement of logistics excellence and
15 network design, optimised network design.
16 Assuming that in the future, in the event of
17 a future pandemic, that some of this work of logistics
18 and distribution has to be commercially provided,
19 perhaps with the assistance of the military, what is it
20 about those providers of major logistics and
21 distributions that we, the Inquiry, my Lady, would be
22 looking for?
23 A. So I think it's -- it goes back to the supply chain
24 design. And in this case, you know, you're looking at
25 the forward distribution design of how you're going to

1 architect the supply chain. So you would be looking for
2 the ability to scale.
3 And the one thing -- you know, one of the things
4 that restricted that was the commercial contract with
5 SCCL, but that was -- you know, as I've explained, the
6 contract was designed in a time -- at very different
7 time, when we thought the future was predictable.
8 You've then got the digital ability to scale, so use
9 of much more modern information systems, where you can
10 integrate them with partner systems, or just scale into
11 wider capacity.
12 And then you've got the network itself. So some of
13 our larger third-party logistic companies now are
14 partnering and have multiple sites across the
15 United Kingdom, so how do you have the commercial
16 freedoms to scale into those in an affordable manner?
17 So digital, commercial.
18 There's also a mindset piece here, and it's -- you
19 know, we've started using wargaming much more in
20 defence. We've done an industry wargame, which has
21 never been done before, to test the upstream supply
22 chain. And I think it came out in previous evidence,
23 I think it was Emily's, but, you know, the scale of the
24 stress you put on the supply chain in 2019 would be very
25 different to the scale of the stress you would put on it

1 now.
2 I don't think, actually, as
3 Professor Manners-Bell -- I don't think we ever thought
4 that a pandemic would be a global pandemic that would
5 put a global demand signal on the global supply chain.
6 I think we always thought that it would be a national
7 pandemic that the global supply chain would have the
8 capacity to respond to.
9 So we've just -- I think our -- and our
10 understanding of the threshold of risk and the scale of
11 risk that we would put on the supply chain in wargames
12 has changed in the last five years, and I think for
13 every new contract we have to stress test it with, you
14 know, a worst-case scenario or a bad day at the office
15 type scenario.
16 **MR SHARMA:** General Prosser, thank you very much. I don't
17 have any further questions for you but there are some
18 from Core Participants.
19 **LADY HALLETT:** Just before those questions, could I just ask
20 you this, General Prosser: you've mentioned the
21 exercises that were conducted, and, as you may know,
22 I reported on people not learning lessons from those in
23 my Module 1 report.
24 But by the sounds of it, you're saying they weren't
25 even addressing the right questions. Were the military,

1 do you know, involved in any of the exercises?
2 **A.** I assume they would have been --
3 **LADY HALLETT:** -- (overspeaking) --
4 **A.** -- in the same way other government departments were,
5 but I'm not an expert on them.
6 **LADY HALLETT:** Right.
7 Do you know the extent to which logistics were
8 involved in the exercises or you don't?
9 **A.** I don't, I'm sorry.
10 **LADY HALLETT:** Okay. Don't worry.
11 Mr Stanton.
12 **Questions from MR STANTON**
13 **MR STANTON:** Thank you, my Lady.
14 Good afternoon, General Prosser. I hope you can
15 hear me.
16 **A.** I can hear you, yes, thank you.
17 **Q.** I ask questions on behalf of the British Medical
18 Association. For context, the areas of my questions are
19 around an apparent disconnect between the narrative that
20 the UK never ran out of PPE against the experiences of
21 frontline healthcare workers who didn't have what they
22 needed on the front line. And I'd like to refer you,
23 please, to a number of BMA tracker surveys, the first of
24 which is at INQ000562457_0021.
25 Hopefully you can see that on your screen.

1 **A.** I can see it, yes, thank you.
2 **Q.** I beg your pardon. General Prosser, these surveys were
3 regularly undertaken by the BMA across its membership
4 during the pandemic. You might be aware the BMA has
5 a membership of approaching 200,000 doctors. The
6 response rate to these surveys was generally several
7 thousand doctors.
8 The graph that you have before you shows the
9 outcomes of several surveys between April and June and
10 you'll see, from a fairly low base, a provision of PPE
11 to a level that the doctors described as inadequate,
12 ticks upwards, but by June you can still see some
13 significant shortages and you'll see face mask, gowns,
14 aprons, only at 68% at that point.
15 Over the page on to page 22 there's a further
16 similar survey. Hopefully, you have that.
17 This one is slightly different, it becomes a little
18 bit more sophisticated, it separates out the types of
19 mask and takes us into the end of the year, end of 2020.
20 There you'll see in the final column, fluid repellent
21 surgical masks were being provided to an adequate level
22 in 79% of cases, but really quite significant shortages
23 of FFP3 respirators by the end of the year.
24 And it's probably worth making the point that we're
25 yet to go into the second wave and the worst of the

1 pandemic at this point.
2 And then the final graph I'd like to show you is
3 a GP-specific graph, over the page on page 23. And this
4 graph is a period of between April and August 2020, and
5 you'll see fairly low levels, lower levels for GPs than
6 in other healthcare settings and in particular, the
7 final column in August 2020, gowns, aprons, and face
8 masks were provided to an adequate level in less than
9 50% of cases.
10 So with that information in mind, General, I note,
11 or the BMA has noted at paragraphs 58 and 59 of your
12 witness statement you refer to the need to model demand,
13 and you've spoken earlier in your evidence about demand
14 management and reading the signals of demand. And you
15 also mentioned that the modelling, the demand modelling,
16 was carried out with McKinsey and Company and also
17 a company called Palantir, I think.
18 Can I ask you, in regard to this modelling, how were
19 you able to ensure that the data used in the modelling
20 was accurate? And did that modelling include the type
21 of feedback that we've just gone through from frontline
22 healthcare workers where you took account of their
23 experience?
24 A. Yeah, thank you. And I guess the first thing I'll say
25 is, you know, the mission statement we came up with

1 about making sure that frontline healthcare workers had
2 the trust of the supply chain, drove everything that we
3 did. And part of that -- and that is an important but
4 subtle change from just delivering goods, because that
5 meant we brought people in to give transparency in our
6 decision making as quickly as possible.
7 I don't remember looking at the BMA, I personally
8 don't remember looking at the BMA graphs but I'm sure
9 they would have been looked at, and we had clinicians
10 and some chief execs on the call, as well, to make sure
11 that representation was made.
12 So we would have taken that into account, but
13 I can't hide from the fact that there were demand and
14 supply chain challenges. The way that the supply chain
15 had been established meant that we didn't have
16 visibility of frontline stock, and I know there was --
17 and you'll understand the end-to-end supply chain, there
18 was challenges across the entire network -- the entire
19 end-to-end supply chain. And I think frontline
20 healthcare workers would have experienced any number of
21 those problems, you know, and the bottlenecks that
22 Professor Manners-Bell talked about.
23 So what we needed to do was get the data in as good
24 a place as quickly as possible, and that meant asking as
25 many people to contribute. We started bringing in

1 a hospital situation report, a sitrep, as we would call
2 it. When we got -- when we started -- when we did the
3 distribution meetings, 1800 every single day, we would
4 have a proposed pick list that we would send out to
5 every hospital. They would come back and say,
6 "Actually, you know, we need more here, we need less
7 here." So we would get that frontline response.
8 We'd then get a combined pick list, which was always
9 a compromise because, you know, I can't avoid the fact
10 that, you know, the data was imperfect and the supply
11 was being disrupted. And then we would send what we
12 needed out.
13 So it wasn't perfect. But every time we, you know,
14 that point about the mission statement is really
15 important to me, that we move beyond just delivering
16 stuff. This was about instilling confidence in your
17 membership and the wider frontline healthcare workers,
18 every single one of them, a hundred per cent, so yes, we
19 listened to the feedback and we included as much as we
20 can the feedback.
21 Q. Thank you, General.
22 Just still on this, in this area, can I ask whether
23 the modelling itself involved demand management or, to
24 put it another way, rationing?
25 A. So the modelling would have described what the demand

1 rate was going to be. The stock position and the
2 supply, inbound supply, would have had meant we never
3 used the word "rationing", we used "centralised
4 distribution to meet demand on a short-term basis", I
5 don't think we ever used that term but that's what it
6 was.
7 So we never held -- rationing would imply that, you
8 know, we've got stuff and we're holding it back. We
9 very rarely held stuff back because, it was, you know,
10 in some of the days in April and May it was very much
11 hand to mouth. But as I step through that process, the
12 proposed pick list would have been that, "Look, we've
13 had a look at what usage you're going through, we've had
14 a look at the infection, you know, the waves of
15 infection if it's going to get worse or going to get
16 better. We've looked at the inbound confidence levels,
17 and this is what we think you need".
18 And immediately, the hospitals would then come back
19 and say, you know, have that preferred that -- that
20 agreed position. So I never used the word "rationing",
21 the model would have expressed the demand, and then
22 collectively we would have decided how to get through
23 that stock position over the next 72 hours. And we did
24 that every night at 1800.
25 Q. Thank you. I'll just move to one final area of

1 questioning, please.
2 This is taken from paragraph 77 of your witness
3 statement and I'd like to ask you to clarify
4 a particular sentence in that paragraph.
5 And I think it might help if we could bring it up on
6 screen, please. It's INQ000560895_0024.
7 General Prosser, I'd just like to draw your
8 attention to the third sentence of paragraph 77, it
9 starts:
10 "Given the paucity of stock", I hope you can see
11 that?
12 **A.** Yeah, I've got it, thank you.
13 **Q.** I'll just quickly read the sentence for the transcript.
14 The particular passage is:
15 "Given the paucity of stock, there was often
16 a risk-based approach whereby the SROs would make the
17 decision when stock was needed rather than try and
18 predict where stock was required too far in advance."
19 Just quickly, I think the SROs that you're referring
20 to there would be Emily Lawson, Jonathan Marron and Lord
21 Deighton; would that be correct?
22 **A.** Correct.
23 **Q.** Yeah. Thank you. Can I ask, what were the risks that
24 needed to be balanced? And what type of level or demand
25 triggered a decision that PPE was needed in a particular

1 location?
2 **A.** So the demand was what people were asking for. The risk
3 was that we couldn't treat every hospital individually;
4 we had to look at the entire system. We had to look at
5 everyone who needed PPE. And therefore, this wasn't
6 about individual need; it was about the collective need.
7 And sometimes we had to balance off. When I'm talking
8 about risk, it's where the data and where the hospital
9 was asking us for more stock in order to build a stock
10 position. In some cases we just didn't have that
11 inbound supply where we had the luxury of creating that
12 stock position.
13 We all wanted that stock position, something in the
14 hospital to reinforce the mission and reinforce our
15 purpose of instilling confidence in the frontline
16 healthcare workers. But the supply position was just
17 too volatile for us to get there. So the risk was:
18 we're going to satisfy your short-term demand for
19 three days, and then you're going to have to bear with
20 us, because we're going to have to make a decision again
21 tomorrow at 1800".
22 So it's that inability to really get ahead of it,
23 get ahead of the supply situation, by building stock at
24 the frontline.
25 **MR STANTON:** Thank you. That's very helpful.

1 Thank you, my Lady.
2 **THE WITNESS:** Thank you.
3 **LADY HALLETT:** Thank you, Mr Stanton.
4 Ms Morris, I think you've got some questions.
5 **Questions from MS MORRIS KC**
6 **MS MORRIS:** Thank you, my Lady.
7 Major General Prosser, I ask questions on behalf of
8 the Covid Bereaved Families for Justice UK. One topic
9 which is around the Clipper arrangements, but two
10 subtopics, if you like. The first around the engagement
11 of Clipper. You've touched already in your answers to
12 questions that Mr Sharma asked you about your connection
13 with Mr Ashworth.
14 In your first statement you said that Mr Ashworth
15 observed to you that there were in fact many logistics
16 companies who would have spare capacity, as routine
17 operations they would be conducting, such as deliveries
18 to non-essential shops, would have stopped, and he
19 offered to reach out to Clipper specifically as he had
20 some contacts with their senior leadership; is that
21 correct?
22 **A.** Correct.
23 **Q.** Okay. The following day we understand that Clipper
24 attended a meeting with you, the SCCL, Unipart and
25 NHS England and they were very quickly engaged, I think

1 within a couple of days, to provide those additional
2 logistics services and the contracts, the Inquiry
3 understands, were worth around £200 million.
4 So my question is around that contact and that
5 procurement process.
6 There was no open procurement process and Clipper
7 was not on the Crown Services Commercial Service list.
8 Did Mr Ashworth, to your knowledge, reach out to anybody
9 other than Clipper as part of that introduction process?
10 **A.** Just before I -- I don't think he did, to answer the
11 question. But there's a bit of context in there.
12 He mentioned Clipper specifically because they were
13 known to have the agility to do things like this very
14 quickly. I can't think of the examples that he gave now
15 but I remember him saying how they'd been brought on at
16 really short notice to do retail operations. It
17 wouldn't have been this short. But the thing that
18 marked them out from the other third-party logistic
19 companies was their ability to adapt and react really
20 quickly.
21 **Q.** Okay. I guess my question is, really, why -- if there
22 are multiple companies with spare capacity, why did he
23 only contact one, with which he had a personal
24 relationship? You've given an answer to that in part
25 but do you consider that contacting one to be good

1 practice within contracting for public services, public
2 sector services?
3 A. So if you asked me today, where we are now, absolutely
4 not. If you asked me on Sunday, 21 March, I would say
5 yes, because I had received emails saying that we were
6 within 24 hours of the supply chain reaching capacity
7 and not being able to survive -- sorry, not being able
8 to deliver goods.
9 I remember Emily Lawson's statement on 14 March
10 saying hospitals are going to Screwfix to buy goggles,
11 on 16 March Oxford said they're down to two days of
12 gowns and masks. This was a really urgent situation.
13 I didn't make any decision, what I did was connect
14 Mr Ashworth and Clipper Logistics to the logistics
15 experts of the NHS and they took the decision away.
16 Q. I understand that. Thank you.
17 Second topic, still asking about Clipper though,
18 this about their inbound supplies. On 6 May, so moving
19 forward some sort of six weeks into time, you emailed,
20 is it Lieutenant Colonel Dutton, regarding a concern
21 around the capacity that Clipper had.
22 I think you were informed that there was 50-plus
23 vehicles that were inbound in the next 24 hours and
24 there was concerns around product details, POs -- are
25 they product orders?

1 A. Purchase orders.
2 Q. Purchase orders. Thank you.
3 And generally that there'd be an issue about moving
4 stock off the dock and identifying what was there and
5 how to move it forward. You said it sounded like chaos,
6 and that -- the reference by you to more work needs to
7 be done around the inbound logistics data.
8 Does this show that the data problems you'd
9 identified persisted even six weeks after you'd started
10 work, and there was a lack of paperwork and clarity
11 around inbound supplies?
12 A. So a lot of the goods arriving on 6 May would have been
13 procured much earlier, so the purchase orders would have
14 been completed much earlier. Once complete, we'd have
15 captured the data, probably on Excel in the early days,
16 and then moved on to the next deal. So the consequence
17 of poor paperwork much earlier than the 6 May was now
18 manifesting itself.
19 Q. I see, okay.
20 Was this is an issue caused by the suppliers or by
21 NHS England systems -- you mentioned Excel
22 spreadsheets -- not being able to sort of keep track of
23 anticipated deliveries, or was it still a legacy
24 problem?
25 A. So I think it was all of that. So this is new

1 suppliers, new buy team, suppliers providing multiple
2 customers, so all of that friction in the supply base
3 was now manifesting itself in a number of different
4 ways.
5 So, you know, when we -- when you go to a new
6 supplier, we'd have gone through as much due diligence,
7 and Andy Wood and Gareth Rhys Williams would have gone
8 through that in quite -- in some detail, would have gone
9 through the due diligence, but you can't get away from
10 the fact that we were entering contracts much quicker
11 than ever before, so there was -- you know, some of the
12 paperwork was not as perfect as it could have been.
13 **MS MORRIS:** Okay. Thank you. Those are my questions.
14 Thank you.
15 **THE WITNESS:** Thank you.
16 **MS MORRIS:** Thank you, my Lady.
17 **LADY HALLETT:** Thank you, Ms Morris. Very grateful.
18 That completes the questions we have for you,
19 General Prosser. It's not the first time I've heard
20 about the role, the critical role, that the military
21 played during our response to the pandemic, but I think
22 it's the first time I've had a serving member of the
23 armed forces to be able to thank.
24 Not just this module but I've heard it in other
25 modules, and I don't know if you heard Mark Drakeford

1 talking about the role of the military in Wales -- where
2 I think you might have a connection -- but what you did
3 to try to get PPE to frontline healthcare workers and to
4 their patients when they were desperate was amazing. So
5 thank you very much indeed for all your help, to them on
6 their behalf, and thank you for your extraordinarily
7 helpful evidence to the Inquiry.
8 **THE WITNESS:** Thank you, my Lady.
9 **LADY HALLETT:** Thank you.
10 I shall adjourn now, I think, Mr Sharma?
11 **MR SHARMA:** Yes, my Lady.
12 **LADY HALLETT:** 10.00 tomorrow.
13 Can I warn all the Core Participants, and I'm sorry
14 about this, but instead of just having a day of closing
15 submissions we have to have a witness who was too ill to
16 attend previously, and that means that we're going to be
17 tight for time and I'm going to have to be very grumpy
18 about making people keep to their time limits.
19 10.00 tomorrow, please.
20 **(3.58 pm)**
21 **(The hearing adjourned until 10.00 am the following day)**
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