Witness Name: ROBIN SWANN, MP
Statement No.: 1
Exhibits: RS5/001 to RS5/064
Dated: 21 January 2025

UK COVID-19 INQUIRY

WITNESS STATEMENT OF ROBIN SWANN

Minister of Health (11 January 2020 – 27 October 2022 & 3 February 2024 – 28 May 2024)

Department of Health, Northern Ireland

Contents

I, Robin Swann, former Minister of Health for Northern Ireland, will say as follows: -

1. I make this statement in response to the request from the UK Covid-19 Public Inquiry ("the Inquiry"), dated 7 October 2024 under Rule 9 of the Inquiry Rules 2006 (SI 2006/1838), requiring me to provide the Inquiry with a witness statement in respect of specified matters relating to Module 5.

SCOPE OF THIS STATEMENT

2. This statement is provided from the perspective of my former role as Minister of Health in relation to the Department of Health's role in the procurement and distribution of health-care equipment by the government in Northern Ireland during the Covid-19 pandemic between 1 January 2020 until 28 June 2022.

3. In providing this statement any references to 'key healthcare equipment' should be read as including "PPE, ventilators and oxygen, lateral flow tests and PCR tests." I will also refer to 'PPE' in the context that it includes 'RPE' viz., that it includes "eye protection, face shield, fit test kit, gloves (sterile and non-sterile), masks (including Type II R, FFP2 and FFP3), shoe protectors, scrubs, aprons and gowns (isolation gowns and surgical gowns)." Any references that I make to PCR tests should be read as incorporating the equipment and logistics which are required for the end-to-end process, including: (i) commencing with sample collection, i.e. the sample collection kit comprising: vial, swab, and relevant packaging; (ii) transportation to a laboratory; (iii) the laboratory testing itself, i.e. PCR assays comprising: the specialist (as opposed to general purpose) laboratory equipment necessary for processing PCRs, and consumable reagents; and (iv) ending with the return of results.

4. In my statement below, I have only referenced those elements above in which I was involved. In other words, if a piece of equipment is not referred to individually then I had no involvement in any part of its procurement or distribution.

A. Background

5. I was first elected to the Northern Ireland Assembly at the 2011 election, representing North Antrim, and was re-elected in 2016, 2017 and 2022. From 6 April 2012, I served as the Ulster Unionist Chief Whip, which I retained until I was elected unopposed as the Ulster Unionist Party leader in April 2017. I resigned from that position in November 2019.

6. I served as the Chairman of the Committee for Employment and Learning from 27 February 2013 until the Committee was dissolved on 30 April 2016 when the Department of Employment and Learning was closed, and its mandate transferred to other departments.[1] During the short 2016 Assembly mandate I was Chairperson of the Public Accounts Committee which commenced the Inquiry into the Renewable Heat Incentive scandal. From 11 January 2020 until 27 October 2022, I served as Minister of Health.

7. The table below sets out the entirety of my roles in office between 2011 and 2022.

Period	Position	Office/Committee
31/03/2020- 28/03/2022	Committee Member	Ad Hoc Committee on the COVID-19 Response
11/01/2020 - 27/10/2022	Minister of Health	Department of Health
31/05/2017 - 13/01/2020	Committee Member	Northern Ireland Assembly Commission
31/05/2016 - 25/01/2017	Committee Member	Committee for Agriculture, Environment and Rural Affairs
25/05/2016 - 25/01/2017	Committee Chair	Public Accounts Committee
25/05/2016 - 25/01/2017	Committee Member	Chairpersons' Liaison Group
12/05/2016 - 25/01/2017	Committee Member	Business Committee

[1] This was as a result of the reduction in the overall number of Ministerial Departments in Northern Ireland.

01/03/2016 - 30/03/2016	Committee Member	Concurrent Committee of the Committee for Enterprise, Trade and Investment and the Committee for Agriculture and Rural Development
30/06/2015 - 30/03/2016	Committee Member	Committee for Agriculture and Rural Development
09/02/2015 - 14/09/2015	Committee Member	Assembly and Executive Review Committee
10/09/2014 - 30/03/2016	Committee Member	Chairpersons' Liaison Group
02/09/2013 - 10/09/2014	Committee Chair	Chairpersons' Liaison Group
09/04/2013 - 05/11/2013	Committee Deputy Chair	Committee Review Group
27/02/2013 - 30/03/2016	Committee Chair	Committee for Employment and Learning
27/02/2013 - 01/09/2013	Committee Deputy Chair	Chairpersons' Liaison Group
25/02/2013 - 11/03/2013	Committee Member	Committee for the Office of the First Minister and deputy First Minister
11/02/2013 - 04/07/2014	Committee Member	Concurrent Committee of the Committee for Agriculture and Rural Development and the Committee for Health, Social Services and Public Safety
21/01/2013 - 04/07/2014	Committee Member	Committee for Agriculture and Rural Development
23/11/2012 - 03/02/2013	Committee Deputy Chair	Ad Hoc Committee on Conformity with Equality Requirements, Welfare Reform Bill
23/05/2011 - 04/03/2013	Committee Member	Committee for Culture, Arts and Leisure
23/05/2011 - 03/12/2012	Committee Member	Committee for Agriculture and Rural Development
12/05/2011 - 30/03/2016	Committee Member	Business Committee

1. Role in the procurement of healthcare equipment

a. Background

8. My role in the procurement of healthcare equipment and supplies, including PPE, ventilators, lateral flow tests, PCR testing equipment and oxygen, was very limited. This is because the Department of Health, while having overall responsibility and legal competence for the procurement of all goods and services within its remit, has delegated operational procurement to an appropriate Centre of Procurement Excellence (CoPE) in accordance with Northern Ireland Procurement Policy. CoPEs are centres with specialist procurement expertise across the Northern Ireland public sector and undertake procurement activities in the area of responsibility which they support. The CoPEs used by the Department of Health are:

- Business Services Organisation Procurement and Logistics Service (BSO PaLS) – this is part of the BSO which is an Arm's Length Body of the Department. They are responsible for procuring healthcare equipment and supplies;
- Department of Finance Construction Procurement Delivery (DoF CPD) Health Projects Divisions (now Health Estates Directorate in the Department of Health), which procures for capital construction works and services, and
- DoF CPD Supplies and Services Division for the procurement of office supplies used by the Department of Health.

9. Throughout the pandemic BSO PaLS maintained its direct operational responsibility for procurement of key healthcare equipment and supplies for Northern Ireland's Health and Social Care system.

b. Personal Protective Equipment

10. Under my stewardship as Minister, the Department explored every known viable channel, both locally and internationally, to procure personal protective equipment (PPE). In this respect officials in the Department, BSO and Department of Finance (DoF) worked in collaboration with officials in The Executive Office (TEO) to

purchase significant stock on behalf of the Northern Ireland Executive directly from China ('the China contract') through a company that was identified by the Northern Ireland Bureau in China and Invest NI and which had been approved by the Chinese government to export PPE. Work to facilitate this import was as follows:

a) Completion of a positive Due Diligence Report for DoF [RS5/001 INQ000377348];
b) An assessment by BSO PaLS that the costs represented reasonable value for money compared to the market highs at that time;
c) Validation of the products by experts in Infection and Control from the Medicines Optimisation and Innovation Centre, and

10. I understand that the Department does not hold documents relating to (b) – (c) above.

11. Following this work to ensure value for money, I wrote to the Minister of Finance on 30 April 2020 [RS5/002 INQ000572014 seeking financial approval to proceed and confirmation of the funds held centrally. I received a response the same day [RS5/003 INQ000505644] confirming financial approval to the value of £61.3million. The order was primarily for Type IIR surgical masks and regular and long-cuffed examination gloves.

12. While the procurement of the China contract was led by BSO PaLS and DoF CPD Supplies and Services Division, the contract, as a cross departmental arrangement, was signed by me, as Minister of Health, the First Minister and the deputy First Minister, all on behalf of the NI Executive. I do not have details of the negotiations undertaken and the export processes.

c. Ventilators

13. The process of ordering, distributing and monitoring demand for ventilator stock across Northern Ireland's critical care units was led by the Critical Care Network Northern Ireland (CCaNNI) in conjunction with the BSO PaLS. In March 2020 Trusts initially estimated that there was a need for 40 additional mechanical ventilators (30 adult units and 10 paediatric units) to bring the total available ventilators in Northern Ireland to 179 by the end of March. [RS5/004

INQ000417498]. While Trusts had initially estimated their need for another 40 mechanical ventilators, further work was underway by the Trusts and CCaNNI, to scope the full extent of critical care equipment that may have been needed to be purchased to ensure that Northern Ireland could respond to the potential number of people who would need such specialised care. This fed into a costed proposal from Health Silver, received by the Department on 19 March 2020, which was based on the advice of the clinical lead for CCaNNI), and proposed an additional 100 ventilators. I agreed the spend with the Chief Medical Officer (CMO) and Health Gold Command for a further additional 100 ventilators and other equipment for critical care and respiratory services in preparation for the first wave of Covid. The costed proposal and approvals from DoH are referenced in an updated submission briefing me on the situation, dated 15 April 2020 [RS5/004 INQ000417498].

14. The Health and Social Care Board (HSCB), now the Strategic Planning and Performance Group (SPPG), through the Critical Care Network supported the distribution of equipment received from UK national stock allocation and facilitated the distribution to Trusts and provided updates to DoH on which equipment could be returned for use elsewhere.

d. Lateral Flow

15. Delivery of the National Testing Programme in Northern Ireland was underpinned by a Memorandum of Understanding (MoU) [RS5/005 INQ000467330] between the Department of Health and the Health Secretary acting through the Department of Health & Social Care (DHSC), England. Each DA Health Minister signed the same MoU with only minor adjustments to take account of local issues where relevant.

16. The National Testing Programme (NTP) was led and managed by DHSC/ UKHSA and the Department, through BSO, made Lateral Flow Devices (LFD) kits available to HSC Trusts to support testing of HSC Trust staff and hospital visitor testing. The Department, BSO and HSC Trusts did not undertake any LFD procurements as this was undertaken at a UK level. I therefore played no role in this area.

17. Operational delivery of the Covid-19 testing programme for care homes was overseen by the Public Health Agency (PHA). Between 28 July 2020 and 15 June 2021, the Department issued correspondence to the care home sector about the introduction of Covid-19 testing arrangements for care home residents, staff and visitors. This correspondence included information on the availability of tests for residents, visitors and care staff and how these can be obtained [RS5/006 INQ000437742]. Again, this testing fell under the overall auspices of the NTP and I had no role in its implementation.

18. Most of the actual distribution and delivery of test kits was managed and delivered through the DHSC/ UKHSA NTP and supporting parcel delivery contracts. In relation to LFD kits, this was assisted by BSO storage and distribution under its existing contracts and service delivery models. I had agreed to the establishment of a NI SMART (Systematic, Meaningful, Asymptomatic, Repeated Testing) Programme Board in March 2021 (described more fully below) to rapidly expand asymptomatic testing using LFDs for Covid-19 in Northern Ireland. This support team worked closely with DHSC/ UKHSA who lead the National Testing Programme and with BSO and a range of local delivery partners - including the Department for Communities, local government, other public sector agencies, and a range of business sectors – to assist at times with coordinating distribution of LFD tests to sites across NI. As such the NI SMART support team had an advice and administration role in relation to some aspects of distribution.

19. While the NI SMART support team did not undertake any significant distribution itself, it did manage a small LFD Collect site for Department of Health staff. The team worked with Local Government and a number of third sector organisations to help establish local LFD collection sites in leisure centres and community centres across Northern Ireland. Again, these sites were under the NTP MoU and were managed by delivery partners – not by the Department. The NI SMART Programme Board and its supporting team had no direct role in procurement.

e. PCR testing equipment

20. The delivery of public facing Covid-19 PCR testing sites and the supporting laboratory processing capacity, and procurement of new Covid-19 test

technologies all fell under the NTP. I approved the establishment of a Covid-19 Response Directorate in October 2020 to oversee testing and contact tracing policy. The remit of the Covid-19 Response Directorate was to provide policy direction and oversight for the Covid-19 testing policy for NI, including the interface with the National Testing Programme led by the Department of Health and Social Care, and the Test, Trace, Protect Strategy which detailed the approach to contact tracing in NI.

21. To inform policy options, the Directorate worked extremely closely with and secured inputs from senior professional colleagues, DCMOs, the CSA, Departmental policy officials, and a range of other key stakeholders and partners including principally the Department's EAG-T and the Test Trace Protect (TTP) Strategic Oversight Board and public health professionals from the PHA. It worked, together with the PHA and the Expert Advisory Group on Testing (EAG-T) (described more fully below), with the following bodies:

- National Testing Programme (Pillar 2) procurement; distribution & standards: Worked with DHSC London/ latterly UKHSA
- Pillar 1 Testing: Department provided funding to support testing arrangements managed by BHSCT for PCR testing at AfBI and ALMAC, and WGS at QUB
- Worked with BSO under its existing contracts coordinating aspects of storage and distribution of LFD test kits.

22. The HSCB (now SPPG), through the NI Pathology Network, worked closely with the DHSC/UKHSA Reagents and Operational Supplies Team on the issue of availability and distribution of PCR testing kits. The Network set up a regional group, from HSC Trusts and BSO, to enable planning and coordination of the expansion of SARS-CoV-2 PCR testing in HSC Laboratories (Pillar 1), reporting to EAG-T.

f. Oxygen

23. The Chief Pharmaceutical Officer led the medical supplies and medicines cell, which reported to Health Gold. The scope of this work included oxygen supply availability, oxygen system delivery capacities and related consumables. Modelling undertaken in March 2020 to inform the first Covid-19 surge plan

[RS5/007 INQ000439817] indicated that large numbers of patients would require high intensity treatments including oxygen therapy. In addition, it was anticipated that levels of cylinder and concentrator oxygen use in domiciliary settings would also increase. A number of interlinked work-streams were progressed, and two regional groups were established to consider the likely acute hospital and community clinical demands. Coupled with this, mathematical modelling was used to establish the oxygen system capacity across Northern Ireland.

24. An Oxygen Supply Working Group was established on 25 March 2020 within the HSCB (now SPPG) to oversee and coordinate work in Health and Social Care Trusts to increase oxygen supply capacity in acute hospital sites and community settings (including nursing/residential homes) and to ensure it was both sustainable and adequate at times of peak demand.

25. The Department worked with Health and Social Care Trusts and the existing regional oxygen supplier, BOC, to coordinate and authorise a prioritised work plan to enhance Trusts' infrastructure and capacity for oxygen supplies but was not directly involved in the procurement of oxygen supplies. I also had no direct involvement in the procurement of oxygen supplies.

B. Other ministers, Northern Irish and UK government departments, devolved administrations and Irish government

1. The Northern Ireland Executive including the First Minister and deputy First Minister and other relevant Northern Irish Ministers

26. I have described above how my Department and I worked with the Minister of Finance and DoF to procure PPE stock from China. I jointly signed the contract, on behalf of the NI Executive, with the First and the deputy First Minister. I cannot recall having any other role in procurement of healthcare equipment with my former Executive ministers.

27. As described above in section A(1)(d), the NI SMART board worked with a range of delivery partners to distribute LFD tests across Northern Ireland and this included the Department of Communities. I do not know if the Minister for

Communities had any direct role in this. I cannot recall any other time that my former Executive colleagues had a role in the distribution of any healthcare equipment.

2. The Chief Medical Officer and Chief Nursing Officer

28. The Chief Medical Officer (CMO) and the Chief Nursing Officer (CNO) were not involved in the procurement of key healthcare equipment and supplies and therefore I had no involvement with them in respect of procurement.

29. I cannot recall the CMO having any role in the distribution of key healthcare equipment and supplies.

30. I am also not aware of the CNO playing a role in the distribution of equipment; however, she alerted me to a shortage of gowns in England by the CNO and agreed to send 25,000 gowns to England on 18 April 2020 as Northern Ireland had sufficient supplies at that point.

3. Department of Health for Northern Ireland

a. Procurement

31. I have described above that the Department of Health has delegated responsibility for procurement of healthcare equipment and supplies to the BSO PaLS CoPE. In order to assist BSO I approved a request [RS5/008 INQ000185387] in May 2020 from the BSO to establish a Dynamic Purchasing System (DPS) for personal protective equipment [RS5/009 INQ000377397]. This was in recognition of the significant increase in demand encountered in the first wave of Covid 19 and was considered an opportunity to mitigate supply chain issues such as the rapidly changing supply and demand position. A Dynamic Purchasing System is a procedure available for contracts for works, services and goods commonly available on the market and was set up under Regulation 34 of the Public Contract Regulations 2015. A Dynamic Purchasing System, unlike a traditional framework, allows an organisation (in this instance the BSO) to work with suppliers with much more agility and speed as it was designed to allow the Health and Social Care system access to a pool of checked and pre-qualified suppliers, thereby greatly

reducing avoidable delay. The Department of Finance's Central Procurement Directorate concurred, given BSO's expertise regarding personal protective equipment products, that BSO should establish and manage the Dynamic Purchasing System arrangements both for their own use and that of the wider Northern Ireland public sector.

32. Upon my approval a departmental direction issued [RS5/010 INQ000185391] which enabled the setting up and administration of a Dynamic Purchasing System for personal protective equipment which came into operation on 25 June 2020.

b. Distribution

33. In order to ensure that there was a sufficient supply of adequate PPE for healthcare workers in Northern Ireland, I approved the establishment of a PPE Strategic Supply Cell with a remit of providing oversight and support for the BSO who had responsibility for procuring PPE. This included monitoring of the stock position and supporting BSO in their exploration of potential avenues of supply; this involved engaging on a near daily basis with BSO and CPD in DoF (responsible for leading on the procurement of PPE for the non-health sector) to ensure efforts were coordinated and that opportunities were explored to source PPE locally and internationally. The Supply Cell also oversaw the implementation of a revised process [RS5/011 INQ000120711] for Health and Social Care Trusts to order personal protective equipment on the High Demand Management List (those items which were in high demand) and undertook a monitoring role with regards the distribution of PPE from Trusts to the Independent Sector. The Cell also supported the progression of actions across the HSC to strengthen the system's ability to respond effectively to meeting PPE needs within what was a new challenging operating environment.

34. The revised process for HSC Trusts to order PPE on the High Demand Management List commenced on 24 March 2020 and I was informed of it prior to it being communicated to the Trusts. The revision saw the introduction of new measures for the handling of supplies from BSO PaLS at ward level within Trusts. From 24 March 2020, orders for the products on the High Demand Management List at ward levels within Trusts were no longer processed by BSO. Instead, Trusts

would work with BSO PaLS to establish a centralised system with nominated Trust contact points for managing the ordering and delivery of products, with the aim of ensuring a more even distribution of stock across all Health and Social Care sites. The process was introduced in recognition of the significant issues being experienced at that time globally in the procurement of personal protective equipment and was to ensure that available stock was evenly distributed across the region, whilst also enabling Trusts to continually review and prioritise the distribution of its available stock.

4. HSCB, BSO, HSC Trusts and Commissioners and the PHA

a. HSCB

35. The HSCB (now SPPG) worked through BSO in ensuring the procurement of critical care equipment, such as ventilators and oxygen supply. It also supported the distribution of equipment, through the CCaNNI, received from UK national stock allocation and facilitated the distribution to Trusts and provided updates to the Department on which equipment could be returned for use elsewhere.

36. Whilst I received updates from the HSCB through Health Gold Command in the Department, I did not work with the HSCB on the procurement and distribution of key healthcare equipment and supplies.

b. BSO

37. As described above BSO is the CoPE for the Department of Health and has delegated responsibility for the procurement of key healthcare equipment and supplies. Other than approving the BSO's request to establish a Dynamic Purchasing System, described at section B(3)(a) above, I did not work with BSO on procurement and distribution of key healthcare equipment and supplies.

c. HSC Trusts and Commissioners

38. I cannot recall working with the HSC Trusts and Commissioners on the procurement of key healthcare equipment and supplies.

39. As described at section B(3)(b) above, I established a PPE Strategic Cell and this oversaw the implementation of a revised process for Health and Social Care Trusts to order personal protective equipment on the High Demand Management List.

d. PHA

40. Operational delivery of Covid-19 testing programme for care homes was overseen by the Public Health Agency (PHA). I do not recall working with the PHA on the procurement or distribution of key healthcare equipment and supplies.

5. UK Department of Health and Social Care

41. In April 2020 a new United Kingdom national allocation programme was established for the allocation of critical care equipment, which was managed for the United Kingdom as a whole by the Department of Health and Social Care (DHSC) in England in conjunction with the Cabinet Office and the Department for Business, Energy and Industrial Strategy (BEIS). Under the first of the national programme's components (a central programme of procurement and United Kingdom-wide distribution of stock) I was advised [RS5/004 INQ000417498] that National Health Service England was in the process of procuring a large volume of ventilators, and other equipment, with the intention of allocating this as 'National Health Service loan stock' to devolved nations and crown dependencies on a population basis, i.e. Northern Ireland would be set to receive 2.8% of all stock when received.

42. As described above in section A(1)(d) & (e) the Department of Health also worked with DHSC as part of the NTP and I was kept apprised of the work.

6. UK Cabinet Office

43. I do not believe that I had any direct contact with the UK Cabinet Office in respect of procurement and distribution of healthcare equipment other than already described in the preceding section. I also cannot recall having any conversations on procurement and distribution of healthcare equipment with either the Prime Minister or the Chancellor of the Duchy of Lancaster.

7. HM Treasury

44. I cannot recall having any contact with HM Treasury, including the Chancellor of the Exchequer and the Chief Secretary to the Treasury on matters relating to the procurement and distribution of healthcare equipment.

8. Ministry of Defence

45. I had no contact with the Ministry of Defence regarding the procurement of healthcare equipment, including the Secretary of State for Defence; however, in April 2020 I requested military assistance to redistribute medical equipment between hospitals across Northern Ireland and to provide technical advice and assistance to explore the potential for the development of the proposed temporary Nightingale Hospital facility. In January 2021 I requested Combat Medical Technicians to assist across the health and social care system [RS5/012 INQ000276399, RS5/013 INQ000276400 and RS5/014 INQ000276401] and in March 2021 to roll out Northern Ireland's Covid-19 vaccination programme [RS5/015 INQ000276665].

46. I also made use of the Military Aid to Civilian Authority (MACA) provisions to transport seriously ill patients for treatment outside of Northern Ireland. However, this falls outside the scope of Module 5 and further details are contained in both my Module 2C and Module 3 statements.

9. Department for Business Energy and Industry Strategy

47. My only memory of working with BEIS is that referred to above in relation to the national allocation programme for critical care equipment. Even then, it was officials in the Department of Health who liaised with officials in DHSC and BEIS on the matter and not ministers.

10. Foreign, Commonwealth and Development Office

48. I cannot recall liaising with the Foreign, Commonwealth and Development Office, including the Secretary of State for Foreign, Commonwealth and Development affairs, on issues relating to procurement and distribution of healthcare equipment.

11. Any other relevant Ministers in the Northern Ireland Executive, UK government and other Devolved Administrations

49. As described above in section A(1)(c) I wrote to the Minister of Finance on the China contract requesting financial approval and confirmation of funds. I also worked with Minister of Finance in Northern Ireland and the Minister of Health in the Republic of Ireland in mid-March/early April on a joint order for PPE from China facilitated through the Republic of Ireland's Industrial Development Authority. However, given the changing market conditions at that time in China and the competing demands of other countries, this became increasingly difficult and consequently the Republic of Ireland's Industrial Development Authority confirmed that they had no further capacity to pursue the collaborative order.

12. Irish Government

50. I engaged regularly with my counterpart in the Republic of Ireland through quad meetings, North-South Ministerial meetings and 1-2-1 meetings. However, I cannot recall any discussion on procurement and distribution of equipment other than that referenced in the preceding section.

13. Key Officials

51. As described above, the Department of Health has delegated responsibility for the procurement of healthcare equipment and supplies to the BSO PaLS CoPE, BSO. I understand that BSO would be best placed to identify its key advisers involved in the procurement of key equipment and supplies generally during the pandemic. In the instances where I had limited involvement, as referred to in sections 1 (a) - (b) and H of this statement, the following departmental officials provided me with advice, and updates generally, on the procurement of key healthcare equipment and supplies:

Department of Health officials

Permanent Secretary – Mr Richard Pengelly

Deputy Secretary Health Policy Group – Mr Jackie Johnston

Chief Medical Officer – Professor Sir Michael McBride

Chief Pharmaceutical Officer – Mrs Cathy Harrison

Chief Scientific Adviser – Professor Ian Young

Chief Nursing Officer – Professor Charlotte McArdle;
Director of Covid-19 Response Directorate – Mr Kieran McAteer
PPE Strategic Supply Cell – Ms Sharon Gallagher & Ms Martina Moore

Public Health Agency officials
Chair of the Expert Advisory Group on Testing – Dr Brid Farrell
Executive Director of Nursing, Midwifery and Allied Health Professions in the Public Health Agency (PHA) and Chair of the Infection Prevention Control Cell (COVID-19) – Rodney Morton

14. Issues in the Structures, Processes and Procedures

52. There is no doubt that there were issues in the structures, processes and procedures for the procurement of key healthcare equipment and supplies during the pandemic. This was because there was a significant and intensified demand for PPE across all health and social care settings, across all nations, at a time when the global supply chain was experiencing extreme pressure due to the huge uncertainties associated with a significant decline in the export of personal protective equipment by China, a leading global provider. Demand was also exceeding supply in terms of tests and ability to process tests.

53. I have described above at section B(3)(b) how I established a PPE Strategic Supply Cell to provide oversight to, and support for, BSO in procuring PPE. The PPE Strategic Supply Cell supported BSO in their exploration of potential avenues of supply, facilitating engagement with other Departments and jurisdictions and providing the necessary authority, decision-making and financial support where these matters were outwith the control of the BSO and /or required an expedient response. I have provided further information below on how domestic industries scaled up or switched to producing items to assist in fighting covid-19.

54. BSO, or the relevant senior official in the Department of Health responsible for sponsorship of BSO, is best placed to answer further questions regarding actual procurement issues.

C. Preparedness for procurement in a health emergency

1. Pre Covid-19 Pandemic

55. As stated above I took up post as Minister of Health on 11 January 2020; as such, I had no involvement in actions to ensure preparedness for a pandemic by way of implementing effective systems and infrastructure that took place prior to this date. Equally I had no involvement in the stockpiling of key healthcare equipment and supplies; inventory management; assessment of suitability of these supplies, and the scaling up of domestic industry to manufacture PPE, lateral flow and PCR testing equipment, ventilators and oxygen. This is because BSO, as described above, has delegated responsibility for the procurement of healthcare equipment.

56. I am aware that, as part of the UK Pandemic Influenza Preparedness Programme (PIPP), the Department's Emergency Planning Branch (EPB) holds and manages PIPP stockpiles for use in an emergency, which acts as a buffer to the HSC normal supply chain. These stockpiles include medicines such as antivirals and antibiotics as well as clinical consumables and PPE including gloves, aprons, gowns, facemasks, visors, and eye protection. During the initial response to the pandemic, the four UK countries worked closely together regarding management of PIPP stock, with Public Health England leading on 'Just in Time' contract negotiations (where an organisation keeps minimal stocks and relies on its supply chain to provide supplies when they are needed). However, this system was in place prior to my taking up office.

57. I set out below, at section F, the steps taken in Northern Ireland to scale up domestic industry during the pandemic.

2. Lessons Learned from previous pandemics, epidemics and pandemic exercises.

58. Following previous pandemics, epidemics and pandemic drills, lessons learned exercises were carried out and implemented. The recommendations in the lessons learned exercise from the 2009 H1N1 pandemic [RS5/016 INQ000188790; RS5/017 INQ000183435] focused on the stockpiling of equipment, specifically PPE, rather than the actual procurement of healthcare equipment. It recommended that:

- Trusts should maintain contingency stockpiles of PPE and consideration should be given to the level at which future stocks are held;
- Stock management processes should be put in place to ensure that rotation occurs to minimise wastage due to stock expiring. There should also be an ongoing annual review process of stockpiles regarding their use, recycling and disposal.
- Trigger points should be identified to clarify the release of regional stock to supplement Trust stockpiles and earlier decisions should be made in future emergencies.

59. Stock management processes are in place which are regularly reviewed along with contents of the stockpiles. I do not believe that it is possible to identify trigger points to clarify the release of regional stock as it is considered on a product by product basis. It is also dependent on a number of factors that can only be assessed at time of the emergency/pandemic. During the Covid-19 pandemic, for example, it was necessary to release emergency stock to BSO PaLS to enable it to supply the needs of HSC Trusts, as well as to support the PPE needs of adult social care homes, domiciliary care providers, GPs, community pharmacists, and urgent dental services given my policy decision to support these health and social care providers.

60. Equally, Exercise Cygnus took place in 2016 and focused on a more severe pandemic than had been experienced during the 2009 H1N1 response. Lessons learned from Exercise Cygnus were identified at local [RS5/018 INQ000188775] and UK level following the exercise and the Department's Emergency Response Plan [RS5/019 INQ000184662] was updated. This did not contain any references to procurement of healthcare equipment.

61. While I was not Minister of Health during Exercise Cygnus in 2016, I understand that it identified gaps in capabilities to overcome a severe pandemic. As a result, in 2017, the UK Government established the Pandemic Flu Readiness Board (PFRB), co-chaired by the Cabinet Office (CO) and DHSC to improve resilience in five key areas highlighted by Exercise Cygnus. The PFRB held its first four nations meeting on 31 May 2017. Meetings were initially monthly (determined by

CO/DHSC). In addition, in early 2018, a NI Pandemic Flu Sub-Group of the TEO-led NI Civil Contingencies Group was established to align with this work and oversee the recommendations from the NI perspective. I do not believe any recommendations focussed on procurement issues.

62. A Lessons Learned report was also written specifically for NI [RS5/017 INQ000188775] but, again, it did not contain any reference to procurement of healthcare equipment and supplies. In order to implement the recommendations within the NI report, a NI Pandemic Flu Oversight Board (NIPFOB) was established in May 2018 to oversee the development of service-facing surge guidance for NI, incorporating primary, secondary and social care. However, this work was paused in preparation for EU Exit and the subsequent response to Covid-19.

D. EU Exit

63. Preparations for EU exit did take the Department's focus away from pandemic preparedness planning as work was paused between November 2018 and November 2019. Some of the work for EU exit, however, was advantageous for emergency planning. While I hold no detail, I understand officials from the Department joined the DHSC led Medicines Supply Contingency Planning Programme, which had been established to mitigate risks to the continuity of medicines supply across the UK arising from EU Exit. Through this programme a multi-layered approach to continuity of supply was implemented in the UK, including stockpiling, trader readiness, rerouting shipments, securing additional freight capacity, and developing enhanced UK-wide arrangements for managing medicines shortages. I cannot be sure, as I do not believe any exercise was carried out to assess the success of this work in the context of the Covid-19 pandemic, but I imagine that this would have assisted in the procurement of medicines.

64. I am not aware of procurement of key healthcare equipment being affected by EU exit. I believe there was a fear at the start of the pandemic that NI would be adversely impacted by EU exit during the pandemic, but I do not consider that these fears came to fruition.

E. Absence of Power Sharing

65. The absence of power-sharing in Northern Ireland for a period of over three years undoubtedly had many adverse impacts and these have been discussed in detail in previous statements. However, I do not consider that it had an impact on procurement during the pandemic or the suitability and resilience of supply chains for key healthcare equipment and supplies because, while the absence of power-sharing prevented the agreement of a budget that would have been subject to political input, the responsibility for procurement of healthcare equipment was delegated to BSO.

F. Principal issues with procurement as Northern Ireland entered the pandemic

1. Strategy and Guidance

66. As referenced above, the Department has delegated responsibility for operational procurement to BSO PaLS; I do not recall any issues relating to the strategy and guidance for procurement during a pandemic being raised with me.

2. Industrial capability and flexibility

a. PPE

67. In terms of the industrial capability, flexibility and scalability for the domestic design and manufacture of key healthcare equipment and supplies, the Department received many offers of assistance. I agreed, in April 2020, to establish a dedicated PPE mailbox (elaborated on in section H below) to allow concerned members of staff across the Health & Social Care workforce to raise issues of concern over the supply, quality and usage of Personal Protective Equipment. While this mailbox did receive emails raising concerns, it also received 27 offers of supply of PPE. The offers were mainly of a commercial nature and ranged from local and national, to international manufacturers. All offers to supply PPE were forwarded to the Supply Cell at the Department for onward communication to the BSO.

68. In April 2020 Invest NI collaborated with Departmental and BSO officials to put out a call to local manufacturing companies to develop new products to support the

need for PPE in the fight against Covid-19. Several local companies were successful in this call – BSO should be able to provide this information if required - and 'Conditional Letters of Offer' were made in July 2020 by BSO PaLS, to companies for the manufacture of Type 2R masks and to Denroy for the manufacture of an FFP3 mask.

69. Denroy had undertaken its own research into FFP3 masks before responding to the call and came forward with a proposal to develop a suitable prototype for the HSCNI. Given the complexities and technical standards of the FFP3 mask, HSCNI (primarily the IPC Cell from HSC, MOIC and BSO), collaborated closely with Denroy in development of prototypes. This included a series of workshops and rigorous testing of prototypes until a suitable one was devised. The company invested heavily in product development and designed 6 prototypes before finalising on one with which clinicians, technical staff and frontline staff in HSCNI were content.

70. I also recall another local sportswear company, O'Neills, making clinical scrubs and masks for HSCNI.

b. Testing

71. Testing capacity within the NI Health and Social Care laboratory network (known as Pillar 1) was also bolstered through local providers. In March 2020 I approved the establishment of a NI Covid-19 Testing Scientific Advisory Consortium comprising Queen's University Belfast, University of Ulster, Western HSC Trust's Clinical Translational Research and Innovation Centre, the Department of Agriculture, Environment and Rural Affairs Agri-Food and Biosciences Institute (AFBI) laboratory and a commercial partner the Almac Group.

72. While the Department did not undertake any direct procurement, funding to support discrete areas of Pillar 1 PCR testing at AfBI and at ALMAC, and to support whole genome sequencing (WGS) at Queens University Belfast was secured in line with extant Departmental arrangements.

3. Expertise within Government and the Civil Service

73. I consider the expertise within government and the civil service in Northern Ireland for procurement during a whole-system civil emergency to be very good. Arm's Length Bodies worked at pace to assist in sourcing and delivering key equipment, as demonstrated by the success of the China contract, referred to above.

4. Expertise within the Private Sector

74. Given what I have described above in section F(2) in terms of local manufacturers flexing from their usual products to producing and supplying clinical masks and scrubs, and helping to increase local testing capacity, I consider that the private sector in Northern Ireland proved to have valuable expertise and was a huge asset [RS5/020 INQ000371472].

G. Key decision-making forums and groups

1. The Northern Ireland Executive Committee

75. With the exception of the China contract, which was signed by myself, the First and the deputy First Minister, and the general availability of PPE, I do not consider that the Executive Committee played a role in relation to the procurement of other key healthcare equipment and supplies, as defined by the Inquiry, because this was viewed as a health matter and the Department of Health had delegated responsibility for operational procurement to BSO.

2. The Northern Ireland Executive Covid-19 Taskforce

76. It is my opinion that the NI Executive Covid-19 Taskforce (ECT) played no role in the procurement of key healthcare equipment and supplies. The establishment of the ECT had little, if any, impact on most of the areas of the work of the Department and HSC in relation to the operational response to the pandemic including contact tracing, procurement, testing and vaccination.

3. The UK Cabinet

77. As I had no direct role in the procurement of key healthcare equipment I had no engagement with the UK Cabinet on procurement issues.

4. COBR

78. As I had no direct role in the procurement of key healthcare equipment I did not discuss or engage with COBR on procurement matters.

5. General Public Sector Ministerial Implementation Group

79. The General Public Sector Ministerial Implementation Group was established to coordinate and advise on public sector issues relating to the Covid-19 pandemic across the UK. The NHS and social care system were excluded from its remit and, therefore, I do not consider that it had any role in relation to the procurement of key healthcare equipment and supplies.

6. Covid-19 Daily Strategy Meetings (the 9.15s)

80. As I had no direct role in the procurement of key healthcare equipment I had no involvement with this group in respect of procurement.

7. Ministerial Implementation Groups

81. As I had no direct role in the procurement of key healthcare equipment, I did not have any involvement in this group on matters relating to procurement.

8. Covid-19 Strategy Committee

82. As I did not have a direct role in the procurement of key healthcare equipment, I had no engagement with this group on procurement issues.

9. Covid-19 Operations Committee

83. As I played no direct role in the procurement of key healthcare equipment, I did not engage with this group on procurement.

10. The Quad

84. As I was not directly involved in the procurement of key healthcare equipment, I did not have discussions relating to procurement matters.

11. The British-Irish Council and the North-South Ministerial Council

85. I did not discuss issues relating to procurement at these bodies.

H. My key decisions and policies during the pandemic

86. As the Department has delegated responsibility of operational procurement to BSO I do not believe I made many key decisions in respect of procurement. I have listed those that I can recall below.

1. PPE requirements

87. In March and April 2020, I decided to support the PPE needs of adult social care homes, domiciliary care providers, GPs and community pharmacists because I felt it was necessary to ensure that all sections of the health care family had access to PPE, particularly considering that their usual purchasing and supply lines had disappeared almost overnight [RS5/021 INQ000371468; RS5/022 INQ000137317; RS5/023 INQ000371494; RS5/024 INQ000103694]. From the onset of the pandemic, I recognised that nursing and residential Care Homes would be at the forefront of the battle against Covid-19 and therefore it was important to focus on both limiting infections and their impact in Care Homes, as well as ensuring Care Homes could continue to function as an important part of the wider health and social care system. I was clear that ensuring that Care Homes had sufficient supplies of PPE was a priority.

2. Provision of PPE to the Independent Sector

88. The provision of personal protective equipment to the independent sector through nominated points of contact within Trusts where they were unable to source their own supplies [RS5/025 INQ000353600; RS5/026 INQ000120717] was also introduced in March 2020. A reporting mechanism was introduced from week ending 11 April 2020 whereby each Trust reported to the Department on the volumes of personal protective equipment they provided to the independent sector – Care Homes and Domiciliary Care on a weekly basis [RS5/027 INQ000417493; RS5/028 INQ000417495]. Reporting and collation of this information concluded on 31 March 2023.

3. Rapid Review of PPE

89. In April 2020, I commissioned a rapid review of personal protective equipment to focus on the appropriate receipt, storage, distribution, and use of personal protective equipment across the health and social care system [RS5/029

INQ000120712, RS5/030 INQ000120813 and RS5/031 INQ000120814]. The terms of reference also included an assessment of readiness for continuing response during the pandemic wave at that time and by way of preparation for a second wave of Covid-19. A Review Panel led by the Department's Internal Audit carried out the Rapid Review with input from across the health and social care system.

90. I received the final report on 14 May 2020 [RS5/032 INQ000130338, RS5/033 INQ000120815, RS5/034 INQ000120816, RS5/035 INQ000120817, RS5/036 INQ000120820, RS5/037 INQ000120821 and RS5/038 INQ000120822] and agreed to set up an oversight board to oversee the implementation of the recommendations. The report highlighted a number of areas that required attention to prepare for any further waves, and made specific recommendations for the short-term improvement of the personal protective equipment position, in the following areas:

- demand management and use of PPE;
- modelling;
- stock management and management of supplies across the system;
- resilience of supply chains;
- PIPP release mechanisms; and
- supporting staff.

91. The Review made 19 recommendations for the short-term improvement of the personal protective equipment position, which was in preparation for a second wave of Covid-19. Seventeen associated actions were identified to implement the 19 recommendations. The actions were assessed as either Critical (to be completed within 2-4 weeks) or Essential (to be completed within 4-8 weeks). A lead official was identified as being responsible for their implementation [RS5/039 INQ000120714]. Progress on the actions was monitored by the Personal Protective Equipment Strategic Supply Cell and, whilst some of the actions were completed in a relatively timely manner, the initial timeframe for completion proved challenging given the nature of some of the actions. Of the 17 actions 15 actions were considered closed by end of August 2020, prior to the commencement of the second wave, and all were considered closed by December 2020.

92. Twelve of the actions were deemed critical and, of these, none were completed within 2-4 weeks of my receiving the report on 14 May: three were closed by mid-July, five by the end of July, two by the start of August and one at the end of August. The remaining action was not closed until mid-December. Of the remaining 5 actions, considered essential, four were completed within 4-8 weeks of receipt of the report: three were closed by end of June, one mid-July and the other action was completed at the end of October.

93. I understand that the reasons for the delay in completing the actions related to needing to consult with stakeholders and waiting on sign off from appropriate areas. The two actions which took longer to close were in relation to the appropriateness of the reuse of personal protective equipment in a period of critical shortage in line with expert scientific advice (an essential action) and the development of systems to enable feedback from end users around the quality of personal protective equipment across all the health and social care system and independent sector which could be used to better inform procurement (a critical action). Both actions required the lead owner, the Public Health Agency, to engage with key stakeholders and develop supporting products which impacted on the overall timeline. The Department sought regular updates from the PHA lead on progress of the actions required to ensure implementation of the recommendation [RS5/040 INQ000130392].

4. Dynamic Purchasing System

94. As detailed in section B(3)(a) I approved a request [RS5/008 INQ000185387] in May 2020 from the BSO to establish a Dynamic Purchasing System for personal protective equipment [RS5/009 INQ000377397].

I. Calls to Arms

1. Operation Moonshot

95. Operation Moonshot was an initiative formulated by the UK Government in September 2020 for mass testing of up to 10million a day in England by early 2021. I had no role in this and cannot recall ever receiving information or advice on it.

2. The Ventilator Challenge

96. I understand the Ventilator Challenge was a group of manufacturers who worked together to produce ventilators at speed. They were approached by the Cabinet Office in March 2020 to consider scaling up a prototype configured from existing anaesthesia equipment. I do not know whether this was progressed or if any such produced ventilators were deployed in Northern Ireland and cannot recall receiving information or advice on it. BSO may be able to provide further assistance in relation to the extent to which Northern Ireland was involved in this initiative.

J. Overall value of the contracts awarded

97. Ensuring there was overall value in the contracts awarded with respect to the procurement of key healthcare equipment and supplies during the pandemic was the responsibility of BSO in their role as CoPE for the Department. I had no role in this area, I therefore did not introduce, adapt or oversee any processes or procedures in this regard. I cannot comment on the effectiveness of the systems.

K. Spending Controls

98. Circular HSC(F) 52-2016 [RS5/041 INQ000503821] set out the delegated limits for the Department, HSC bodies and the Northern Ireland Fire & Rescue Service (NIFRS) at the start of the pandemic. This was subsequently updated in February 2022 by circular HSC(F) 04-2022 [RS5/042 INQ000503822]. Table A in the circular summarises the main financial delegated limits where the Department gave delegated authority to HSC and NIFRS to spend within those limits.

99. Except in specified circumstances (e.g. External Consultancy, IT spend), Revenue Business Cases were fully delegated to the Department and to HSC Bodies, with a limit of £250,000 set for NIFRS Revenue Business cases. No departmental approval was therefore required for revenue business cases except for NIFRS cases above £250,000.

100. Circular HSC(F) 25-2020 [RS5/043 INQ000503823], dated 27 July 2020, provided updated guidance, including delegated limits, for Covid-19 specific funding. All proposed expenditure which was expected to exceed the relevant delegated limits

had to receive the appropriate prior approval from the Department (or DoF) as required before commitment to spend was provided.

101. These circulars are drafted and updated by DoF and I had no role in producing them. I did not introduce, adapt or oversee processes and procedures to ensure there was effective and timely coordination between the Executive, DoH, DoF and the UK government on spending; this would have been the role of the Minister of Finance. Equally, I did not introduce, adapt or oversee processes and procedures to ensure the programmes for the procurement of equipment were adhering to any conditions imposed upon spending nor to ensure the programmes were effectively monitoring inventory and expenditure.

102. My Department followed the usual financial procedures in place of bidding for additional money through "Monitoring Rounds" in-year (June, October and January). Transfers of funding both between other Northern Ireland departments and from other United Kingdom departments (via His Majesty's Treasury) are also processed through DoF at a Monitoring Round.

103. The information in the following paragraphs describes additional funding exercises that were commissioned by the DoF to determine requirements and redistribute ring fenced Covid-19 funding in addition to and/or alongside Monitoring Rounds. The money was used to fund a range of initiatives and was not limited to healthcare equipment and supplies.

104. The Department received a 'Budget Cover Transfer' from the Department of Health and Social Care in England for Covid-19 Testing during the pandemic. This Budget Cover Transfer supplemented the general funding arrangements underpinning the National Testing Programme across the four United Kingdom nations whereby, in summary, Northern Ireland and the other Devolved Administrations received a Barnett (population-based) share of National Testing Programme capacity in lieu of the consequential funding they would otherwise have received from health spending in England. Outputs funded under the National Testing Programme, managed centrally by the DHSC, included, for example, delivery of the public facing Covid-19 polymerase chain reaction (PCR)

testing sites and the supporting laboratory processing capacity, and procurement of new Covid-19 test technologies (for example Lateral Flow Devices).

105. There were limited stipulations on what the funding had to be used for, other than the overarching description of Covid-19. In 2020/21 these included the following [RS5/044 INQ000400146]:

> "*2.9 Budget 2020-21 was set at the start of the coronavirus crisis. Only limited funding for the COVID 19 response was able to be incorporated into the Budget position. The majority of COVID 19 response measures were handled outside the Budget process. COVID 19 allocations, while being announced on an ongoing basis as they were agreed, will be formalised at the next financial exercise through the in-year process.*
>
> *2.10 COVID 19 allocations will be processed on the public expenditure database by PSD at the first opportunity. PSD will contact departments about setting up the necessary ring-fenced Units of Business and record lines for this new funding as part of that process.*
>
> *2.11 As with all allocations, those related to COVID 19 response measures are ring-fenced for a specific purpose and should be treated as ceilings, with departments managing activities within those ceilings. If this funding is not required for the specific purpose intended it should be notified as an easement at the earliest opportunity and a reduced requirement keyed to the next monitoring round.*"

106. In 2021/22 they included [RS5/045 INQ000400147]:

> "*2.7 Covid-19 allocations were incorporated into the Budget position. Should any COVID 19 allocations be announced outside of the formal monitoring rounds, these will be processed on the public expenditure database by PSD at the first opportunity. PSD will contact departments about the necessary ring-fenced Units of Business and record lines for this funding as part of that process.*

2.8 Allocations related to COVID 19 are ring-fenced for a specific purpose and should be treated as ceilings, with departments managing activities within those ceilings. If this funding is not required for the specific purpose intended it should be notified as an easement at the earliest opportunity and a reduced requirement keyed to the next monitoring round."

107. In 2021/22 this was broadened in agreement with DoF to include activity related to the recovery of health services from the pandemic. In practice, the conditions in relation to spending on health matters were broad in nature and enabled funding to be spent on the complete range of measures required to address the challenges of the pandemic both directly and to assist with early recovery of the service in 2021/22.

108. Funding for individual initiatives was considered in line with the guidance issued by the command-and-control structures and later the Covid-19 Finance Process and Approvals Guidance issued by the Department [RS5/046 INQ000130406]. Early in the pandemic the Department of Health was given assurances, both written [RS5/047 INQ000370677] and oral, by the DoF that its Covid-19 funding needs would be met.

109. This assurance was passed on to Health and Social Care organisations and in 2020/21 funding was then provided in accordance with applications made via Covid-19 funding templates. In 2021/22 the process returned to the normal allocation process whereby appropriate funding needs for the Health and Social Care Trusts were assessed by the Health and Social Care Board and notified to the Department. Also, in line with normal processes, the needs of other Arm's Length Bodies (which were comparatively minimal) were advised directly to the Department. In both years all funding needs were met in full. In the 2022/23 financial year no additional funding was provided to the Department specifically for Covid-19. However, Health and Social Care organisations were again assured that their Covid-19 funding needs would be prioritised and all requirements (again assessed via the former Health and Social Care Board in the case of the Health

and Social Care Trusts) were fully met in the period covered by this statement (Q1 of 2022/23).

110. I believe the procedures in place during the pandemic were effective and I did not direct HSCNI to adapt the systems to make them more effective.

L. Steps taken to eliminate fraud and the prevalence of fraud

111. I did not take additional steps to eliminate fraud or the prevalence of fraud as there is already a robust system in place, nor did I direct the HSCNI to make any changes. As set out in the Departmental Anti-Fraud Policy [RS5/048 INQ000503814], the Department endorses a zero tolerance to fraud. Every staff member must complete mandatory fraud training on an annual basis and managers are responsible for ensuring that an adequate system of internal control exists within their areas of responsibility and that controls operate effectively to deter, prevent, detect and investigate fraud. Guidance is circulated both within the Department and its ALBs.

112. If fraud is suspected either in the Department or in one of its ALBs, preliminary enquiries are carried out and cases are reported to BSO Counter Fraud and Probity Services (CFPS) and, if necessary, also referred for further investigation, including onward referral to the Police Service of Northern Ireland (PSNI). Probity checks and reporting requirements would also be carried out by CFPS in line with policies and procedures.

113. Fraud Control in Emergency Management – COVID-19 (FMD 07-2020) [RS5/049 INQ000503815] and Fraud Control in Emergency Management – COVID-19 (FMD 10-2020) [RS5/050 INQ000503817] (both issued 03/04/2020) set out specific guidance on fraud controls during the Covid-19 pandemic. COVID-19 Fraud Risks – NI Audit Office Publication (HSC (F) 30-2020), Procurement Fraud – NI Audit Office Publication (HSC (F) 41-2020 and Internal Fraud Risks – NI Audit Office Publication (HSC) (F) 20-2022 [RS5/051 INQ000503818, RS5/052 INQ000503819 and RS5/053 INQ000503820] communicated the NI Audit Office guidance on procurement fraud and the need to consider additional fraud risks due to Covid-19.

114. In relation to the China contract a Due Diligence Report was obtained to provide reassurance that the procurement opportunity was not fraudulent or suspicious [RS5/001 INQ000377348].

115. I believe the processes already in place were highly effective and appropriate and I am not aware of any cases of fraud having occurred.

M. Conflicts of Interest

116. The Department requires all senior staff to complete a declaration of interests annually and to immediately declare any conflicts of interests that arise relating to their work activities. A register of interests is maintained for senior staff by the Department and the register is published on the internet. In general terms, the Department provides guidance on conflicts of interest on its intranet available to all staff. The guidance requires all staff from Grade 7 and equivalent upwards to complete a 'Declaration of Interests' form upon appointment and review and update that form annually. The requirement may also apply to individuals or teams at lower grades, depending on their role and circumstances.

117. As this procedure was already in place there was no need for me to introduce new processes and I did not direct the HSCNI to do so. I consider the system was effective and I am not aware of anyone, or any company, who received preferential treatment as a result of their status as a donor or because they had a connection with the Northern Ireland Assembly or Parliament in relation to the system for procurement or the award of contracts.

N. Contractual provisions and performance by suppliers and manufacturers

1. Contractual Terms

118. I did not introduce, adapt or oversee any key processes on the procurement of key healthcare equipment and supplies to ensure that contractual terms provided suitable protection to the government. This would have been a matter for BSO PaLS as the CoPE with delegated responsibility for the procurement of key healthcare equipment and supplies.

2. Contractual Performance

119. It was also BSO's responsibility to ensure that contracts were performed, and I did not introduce, adapt or oversee any processes in respect of this.

120. BSO had responsibility for ensuring that, in the event contracts were not performed, there was an effective means of redress. I did not introduce, adapt or oversee processes and procedures on this.

121. I cannot recall any issues on the effectiveness of BSO processes in respect of the above being raised with me. I did not direct the HSCNI to adapt those systems to make them more effective.

O. Compliance with public law procurement principles and regulations

122. I did not introduce, adapt or oversee any processes to ensure that there was compliance with public law procurement principles and regulations during the pandemic; this would have been for BSO to ensure. I was never made aware of concerns that there were problems with compliance so I can only assume that the processes in place by BSO were effective.

123. I also did not direct HSCNI to adapt any systems.

P. Operation and effectiveness of regulatory regimes

124. I did not make any changes to regulatory regimes relating to key healthcare equipment and supplies to improve procurement during the pandemic.

Q. Decisions as to what to buy at what cost

125. It was the responsibility of BSO to liaise with the Critical Care Network Northern Ireland and Trusts to ensure that the equipment they purchased was to the correct specifications, quantities and quality. I had no involvement in this nor did I have any involvement in the cost of the purchases.

126. No concerns on the effectiveness of the processes were ever raised with me;

127. I did not direct the HSCNI to make any adaptations to the processes.

R. Disposal strategies

128. I did not introduce, oversee or adapt any strategies relating to the procurement of key healthcare equipment and supplies to ensure that if there was over purchasing there were strategies for disposal.

129. I am not aware of any concerns as to the processes in place and I did not direct HSCNI to make any changes to the system to make it more effective.

S. Distribution of key healthcare equipment and supplies

130. I have described above at section H(1) that I was keen to ensure PPE needs of adult social care homes, domiciliary care providers, GPs and community pharmacists were met, along with the needs of the independent sector. To this end, I ensured the provision of personal protective equipment to the independent sector through nominated points of contact within Trusts where they were unable to source their own supplies [RS5/025 INQ000353600 and RS5/026 INQ000120717]. This was introduced in March 2020.

131. In April 2020 I requested military assistance to redistribute medical equipment between hospitals.

132. There are always things that we could have done better, but in a time when global demand was at an all-time high and outstripped supply, I believe the processes in place were reasonably successful. While supplies did fall lower than desired, at no point did Northern Ireland run out of PPE, for example, and, as described above, we were able to assist NHS England by sending 25,000 gowns on 18 April 2020 when they were running dangerously low on supplies. When we had a temporary surplus of tests over the Easter weekend, I agreed to procced with an offer of mutual aid in regard to testing to NHS colleagues [RS5/054 INQ000485693]. The email expresses my reluctance to do this because I wished to ensure that all efforts had been expended to use them in Northern Ireland and I asked officials to confirm this, which they did.

133. The NI Audit Office report on PPE, described below in section V, has highlighted a number of lessons learned and I understand from it that BSO have started addressing these.

134. I directed the HSCNI to ensure the independent sector had adequate supplies of PPE.

T. Suitability and resilience of supply chains

1. Immediately Prior to the Pandemic

135. Frameworks and other procurements were put in place and operated by BSO PaLS to supply healthcare equipment and supplies. BSO PaLS were responsible for the supply chains to meet its procurement requirements including HSC equipment supply chain and procurement activity on behalf of HSC Trusts.

136. As BSO was responsible I do not feel I can comment on the suitability and resilience of the supply chains as I was not closely involved.

2. During the Pandemic

137. BSO was responsible for procurement of key healthcare equipment and supplies during the pandemic. I am not familiar enough with the processes to be able to provide any reflections.

3. Following the Pandemic

138. BSO remains responsible for procurement of key healthcare equipment and supplies. I understand from the NI Audit Office's report (see section V(3) below) that they have started to address lessons learned in that. As highlighted in that report, in July 2021 BSO had accumulated a year's supply of aprons and masks when they were actually aiming to accrue 12 weeks' supply. I agree with the report's statement that demand modelling requires further work to avoid over-purchasing, at potentially higher cost, coupled with the need to store the additional supplies.

U. Changes to procurement processes

1. Robustness and Effectiveness of Procurement Processes during the Pandemic

139. As BSO was responsible for the procurement of key healthcare equipment and supplies during the pandemic it would be better placed to comment on how robust and effective the processes were. However, I consider that the BSO performed well during the pandemic in procuring equipment: while stocks did run low, at no point did Northern Ireland run out completely.

2. Effectiveness of Changes made to Procurement Processes

140. I approved BSO's request to establish a Dynamic Purchasing System (DPS) which allowed BSO access to a pool of checked and pre-qualified suppliers, thereby greatly reducing avoidable delay. I believe this enabled BSO to work with suppliers with more agility and speed.

141. This DPS is in operation for 5 years and suppliers can apply to be part of it at any point and can also leave it in at any point.

3. Improvement of Procurement Processes

142. As I was not over the procurement processes, I do not feel I can offer any observations on how they could be made more robust and improved in the future.

V. Lessons Learned

1. Rapid Review of PPE

143. I have described the Rapid Review of PPE that I commissioned in April 2020 in section H on the key decisions I took during the pandemic relating to procurement.

2. Fit Testing of Masks

144. Concerns were raised around the number of staff failing the fit testing of masks due to the range of products being supplied [RS5/055 INQ000120710]. An audit review of fit testing for respiratory masks was carried out on a precautionary basis by Trusts across the health and social care system after it emerged that on some occasions an independent contractor had inadvertently applied a fit testing setting

not normally used in Northern Ireland. I received briefing on the incident [RS5/056 INQ000485689]. No report was produced.

145. A Serious Adverse Incident (SAI) investigation was conducted by the PHA and the resulting report received in August 2024 [RS5/057 INQ000474613; RS5/058 **INQ000477525** RS5/059 INQ000474614; RS5/060 INQ000474615; RS5/061 INQ000474616; RS5/062 INQ000474617 and RS5/063 **INQ000120710** While I had left post by that time, the Department has shared the report with me and I understand from it that face fitting supply and management arrangements varied across Trusts and many made reference to the need for a Regional Face Fitting Procedure, something that had, it was stated, been in discussion from as far back as 2014. I was unaware of this during my time as minister.

146. The report also refers to there being "*no obvious evidence of provider competency being required as part of the selection criteria, prior to the time of the safety alert.*" Again, this was not something I was aware of during my time as minister.

147. The review team observed fit testing in May 2021; from the report I understand that this fit testing incorporated the changes already made in the intervening period from May 2020 when the fit testing failure was reported. However, the report notes where improvements could still be made, including an explanation of the mask by the fit tester to the wearer.

148. The report recommends the adoption of a regional policy and guidance on fit testing and I understand from the Fit testing SAI Action Plan, dated October 2024, that a number of actions have been taken to address this and other observations from the SAI report.

3. NI Audit Review of Supply and Procurement of PPE

149. The Northern Ireland Audit Office also carried out a review on the "Supply and procurement of Personal Protective Equipment to local healthcare providers" which was published on 1 March 2022 [RS5/064 INQ000348882]. It highlighted the challenges faced by the health and social care sector in sourcing and securing

adequate PPE in response to the Covid-19 pandemic. Among its lessons learned were:

- The need for improved contingency and emergency planning to avoid a repetition of any supply shortages;
- Less reliance on uncompetitive procurement processes;
- Better controls for managing potential conflicts of interest;
- More comprehensive documenting of decisions over high cost procurements; and,
- Greater clarity over longer-term procurement and funding arrangements for PPE provision to the independent care sector.

150. While I am no longer Minister for Health, it is my belief that recommendations made in any of the reports I have referenced should be considered for implementation if they have not already been so considered. This should be monitored to ensure that where changes have been made that they continue to be reviewed if new research or reports merit it.

151. Equally, recommendations made by the Inquiry should also be considered even if not addressed directly to Northern Ireland.

STATEMENT OF TRUTH

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed:

PD

Dated: 21st January 2025