Wednesday, 21 May 2025

(10.01 am)

MS CARTWRIGHT: Good morning, my Lady. Please could Baroness Arlene Foster be sworn in.

LADY HALLETT: Baroness Foster, I'm sorry you had to be called back but I'm sure you understand.

THE RIGHT HONOURABLE BARONESS ARLENE FOSTER (sworn)

Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 7

MS CARTWRIGHT: Good morning.

A. Good morning.

Q. Please could you give your full name to the Inquiry.

A. Yes, Arlene Foster, otherwise Baroness Arlene Foster of Aghadrumsee.

Q. Thank you. Baroness Foster, we thank you for the Module 7 statement you provided to the Inquiry. It's 47 pages, and can we turn to page 47, where we see the statement is dated 6 March of this year.

Can I ask you to confirm, have you had an opportunity to review the statement?

A. I have indeed, yes.

Q. And are the contents of the statement true to the best of your knowledge and belief?

A. They are.

Q. Baroness Foster, we know you've given evidence already to the Inquiry, but perhaps by way of context can we

identify your background but also some relevant context matters to your evidence to Module 7 today by reference to Northern Ireland. But let's start with you first of all, please. It's right, isn't it, that you're presently a member of the House of Lords, having assumed this office on 24 November 2022?

A. Yes, that's correct.

Q. You were the First Minister of Northern Ireland, firstly from 11 January 2016 to 10 January 2017?

A. Correct.

Q. And again from 11 January 2020 until 14 June 2021?

A. Yes.

Q. And as we're going to hear also from Michelle O'Neill today, it's right, isn't it, that between 11 January 2020 and 14 June 2021 you served alongside the deputy First Minister Michelle O'Neill?

A. Yes, that's correct.

Q. You are a member of the Legislative Assembly for Fermanagh and South Tyrone from 2003 until you resigned from the Northern Ireland Assembly in October of 2021?

A. Correct.

Q. And you were the leader of the Democratic Unionist Party from December 2015 to June of 2021?

A. Yes.

Q. And prior to becoming First Minister in January of 2016,

you held a number of ministerial posts?

A. I did indeed.

Q. Thank you. And by profession, you are a solicitor?

A. Yes.

Q. Thank you.

Now, can we perhaps identify and give some context to Northern Ireland. First of all, you've already touched upon it, in January of 2020, it's right, isn't it, that the Executive had only just started reconvening again? And it would be fair to say that essentially it was a fragile time for the government of Northern Ireland?

A. Yes, my Lady, we hadn't been in government together for three years, and relationships had been understandably quite tense during that time, and there was, from January, when the agreement was reached to go back into government again, a sense of trying to build relationships again and to focus on the programme for government that we were engaged in, in January, February time. So it was really a new beginning, as it were, for the Executive.

Q. Thank you.

Can I ask to be displayed, please, your paragraph 12, which is page 4 of your statement, please.

Again, I'm going to briefly deal with this because

I know that you dealt with it in Module 2C. You detail that:

"As was explored in Module 2C, in the system of government in Northern Ireland, each Minister is responsible for the work of his or her department and the First/deputy First Ministers and the Executive Committee does not have an express role in directing the work of individual Ministers and departments. However, where a matter is deemed to be significant and/or cross-cutting, it must be brought to the Executive Committee for decision. The Ministerial Code in Northern Ireland does not have a direct equivalent of the doctrine of collective responsibility as set out in the Westminster Ministerial Code for UK Cabinet Ministers."

Can I ask you first of all, I think essentially you deal with two issues or two topics there that I think are going to be relevant to the context and the major focus of my questions today, which is going to be around the decision making when the UK Government and other governments went from the 'contain' phase to the 'delay'.

So, first of all, can you identify, or just give the context to the ministerial responsibility point you make first of all, and why that's relevant when we look at

decision making of the Minister of Health, Mr Swann.
A. So I think the system of government, my Lady, in Northern Ireland is unique. It is a mandatory coalition. At that time there were five different parties in the Executive, all with different philosophical outlooks, and indeed policies, on the way forward. And the system was set up to try to be as inclusive as possible. And in that respect, each of the ministers really hold authority in their own area, so in education, in health, in enterprise and trade.

And so the First and deputy First Ministers' role is really to coordinate the Executive ministers to chair the meetings that take place, and we certainly do not have a role in directing the work of individual ministers, but rather, if something -- if a decision is deemed to be significant or cross-cutting, then the individual minister would bring a paper to the Executive Committee and then there would be a discussion on that paper and a decision made on the paper as opposed to us directing into that particular ministry.

I know it's different from the other devolved administrations and it's probably something, my Lady, you'll have to take into consideration in your recommendations.
Q. Thank you.

And just to then explore the point a little further, can we please display your paragraph 29 at page 8. You tell us that:

"... only those papers which [the Department of Health] deemed to be significant or cross-cutting, such as the Urgent Decision Request mentioned above, were raising to the Executive Committee. Moreover, the Executive Committee was not capable of directly 'steering' the work of Department of Health. As the situation developed, executive ministers increasingly asked questions of the Health Minister, and [the Chief Medical Officer] (when he attended Executive meetings), but otherwise, without papers being brought to the Committee, we did not have the capability or information to scrutinise or challenge the detail of the work being done within [the Department of Health]."
A. That really is the case and, to be fair to individual ministers, they did treat their own areas as their area of competence, and they would have control and direction in that area, and would have been, quite rightly I would say, quite protective of their own particular department and its functions and would really only raise something to the Executive if it was significant or cross-cutting.
Q. Thank you. And so are you able to assist us, and it may be too broad a question, but were issues relating to

test, trace and isolate that were being dealt with by the Department of Health treated as cross-cutting issues that needed to be brought to the Executive?
A. No, they weren't treated in that way. And whilst we did discuss test, trace and isolate, and indeed support later on, quite frequently, it was very much within us asking questions of the Department of Health rather than us taking decisions on the policies and strategies.
Q. Thank you.

Now, before dealing with your attendance at the COBR meeting in particular of 12 March, can we have some context, please, to testing capacity as it existed in Northern Ireland.
LADY HALLETT: Sorry, just before you move on, I'm terribly sorry to interrupt.
MS CARTWRIGHT: No, of course, my Lady.
LADY HALLETT: Can I just go back to test, trace and isolate issues not considered to be cross-cutting. And I do understand the system in Northern Ireland. It may have taken me a while, but I think I do now.

Why isn't test, trace and isolate a cross-cutting issue? Because the impact is on so many different government departments.
A. I think, with hindsight, one could very well make the argument that it should have been a cross-cutting issue

but because we were in such a state of flux at that time, the Department of Health operationally were dealing with the issue and then continued to deal with the issue. I think if you were to say to me now: was that not a cross-cutting issue? Was it not a significant issue? I would probably say, yes, it was and probably should have came to the Executive for a decision. However, would that have changed the decision-making process? It probably would have made it slower because the Department of Health would have had to share all of the information with the Executive and put together papers, and I know that there was a very real concern at that time that the amount of work officials were being asked to do was quite significant, and I'm not suggesting that it didn't come to the Executive for this reason, but it would have certainly slowed decision making down at that time.

And would it have changed the capability and the scalability and the resourcing? I'm not sure that it would have, my Lady, but I certainly can understand why you would ask the question, looking back now, "Should it not have come to the Executive?"
MS CARTWRIGHT: Thank you. Perhaps just to identify the relevant departments for the scalability of both contact tracing and testing, is it right that that would fall

within the Department of Health but PHA were essentially the operational arm for the delivery?

A. Yes, so they were an arm's-length body who were delivering the operation of testing and tracing.

Q. Thank you.

Can we then please move to your paragraph 72, please, which is on page 18 of your witness statement. Just to get some context for testing capacity and capability in Northern Ireland before the decision to stop testing and contact tracing -- thank you.

You helpfully detail in your statement that:

"... by the end of February 2020, there was no concern brought to or raised within, the Executive, so far as I can recall or is apparent within the Executive minutes, about the scalability test and trace capability. Perhaps naively, I believed that during this period there was an assumption within [the Department of Health], and more widely, that the capability would be sufficient to identify cases as they arose. For example, it is recorded in the handwritten minutes of the Executive meeting on 24 February 2020 that there had been '49 [tests] in NI -- all negative -- if confirmed -- held in isolation in Royal' ..."

So really was that your understanding of the position in February 2020? There was not an issue about

the scalability of the testing in Northern Ireland?

A. Certainly we didn't hear from the Department of Health or from the Chief Medical Officer that there were any significant concerns about the issues around capability or scalability.

Q. Thank you. And my Lady has already heard evidence in Module 2C that, essentially, Northern Ireland was different at this time to what was developing in the mainland, in England?

A. Mm.

Q. It's right, isn't it, that Covid was not as advanced in Northern Ireland, particularly in February or March?

A. That's correct, yes.

Q. Thank you. Can we then, please, look at your paragraph 73, if that can be expanded, please. You tell us:

"By early March, despite a rise in cases in the United Kingdom, and concern over the potential scale of the pandemic, the issue of scalability or any concerns about it, was not raised to the Executive by [Department of Health]. Rather, on 2 March 2020, at the Executive meeting, the [Chief Medical Officer] advised that Health and Social Care Boards and Health and Trusts were coordinating; including planning to place single cases in side rooms; that staff were being trained to support

patients outside of intensive care; discussions were taking place on 'prioritisation -- clinical decisions, ethical issues'; and that regular work to test systems was taking place."

Now, I think similarly, we can see that in your notebook, and perhaps just briefly to display that, please, if we could display INQ000232519 -- and thank you for providing your handwritten notes. Thank you.

A. I apologise about the writing.

Q. Well, it's certainly better than mine.

We can see there from your notes of that meeting of 2 March, there is a reference to Northern Ireland:

"130 tests, 1 positive, [and] checked by Public Health England."

So I think it perhaps gives some idea as to where things were up to at the beginning of March in Northern Ireland; would you agree?

A. Yes, indeed.

Q. Then below that:

"At peak, 50% of population infected, (planning assumption)"

And is that then --

A. "5% hospital" --

Q. Hospital admissions. So can you perhaps -- are you able to give us a little bit more context about that, and

particularly if we see the next note:

"Higher mortality rate in Italy than reported in Far East ... (China ... 2%)"

So if you can just give us some context of what your understanding was, linked to those notes, please?

A. This was the time, I think, when Covid-19 really became the issue it was to -- this was really the first point, if you like, in our discussions where, you know, 50% of the population are going to be infected, yes, it was only a planning assumption, 5% were hospital admissions. The figures were now becoming very real, my Lady, in terms of what was happening.

Our first case, positive case, I think was on 27 February. So we'd only really had our first positive case by this stage, and so information was really starting to flow into the Executive then about what was happening.

Q. Thank you. And I think if we look below, is it right then the notes that you've made of the COBR meeting of 2 March was the first such COBR meeting you attended?

A. Yes, I think that's correct.

Q. Thank you. And we can see the reference to "guided at all times by the science", and then "calibrated steps to" -- is it tackle virus -- "protecting more vulnerable groups", and below that "[Chief Medical Officer, 2

cases". But is your note "Client know where came from"?
A. "Don't know where came from".
Q. "Don't know where came from". Thank you. And then an arrow to --
A. -- (overspeaking) --
Q. -- is it "community transmission"?
A. Yes.
Q. Thank you. Now -- thank you, that can be removed.
Now, can we now look, please, on the topic of 'contain' to 'delay', because, again, we're grateful to you that you have provided the coronavirus action plan dated 3 March that has your annotations on, and the reason I'm dealing with this first of all is to try and get some context to the COBR meeting that you then attended on 12 March where it's said that was where the four nations agreed to move from 'contain' to 'delay' to stop contact tracing and testing, and I think immediately, or thereabouts, after that meeting, the UK Government said as much and announced the position that we'd moved from 'contain' to 'delay'.
Now, can we display then, please, INQ000232520.
We can see "FM" -- I think that references First Minister.
A. Yes.
Q. Over the page, please. And again, I do apologise --

thank you.
And over the page again, so we've got the -- this the Coronavirus Action Plan, again with your annotations on the top, and I think if we look throughout the document, we see notes that are made and can you confirm, please, Baroness Foster that those are your notes that suggest that there was a review of this document including, if we move along, please, thank you --
A. Yes, those are my notes and annotations.
Q. Thank you. Just pause there.
So again, we can see, particularly around the overall phases with the reference to contain and delay, "calibrated steps led by science"?
A. Yes.
Q. And are you able to give us some idea when you would have made those notes on this document or when you would have had it available to you? Because certainly there's reference to the action plan in the COBR minutes of 12 March?
A. Well, this document, as I understand it, would have been shared with myself and the deputy First Minister by the Department of Health, after -- as you can see from the frontage of the document, it was signed off by the Department of Health in Northern Ireland and then it

would have been shared with us.
Q. I think the email on the first page, was it 5 March that it was --
A. Yes.
Q. Can we go just back to page 1, please, just to check that date. Yes, 5 March, thank you.
A. Yes.
Q. Now, I'm not going to take time going through the document but is it correct that you've reviewed the action plan as part of your preparation for evidence?
A. Yes.
Q. And does the action plan anywhere say expressly that if you move from 'contain' to 'delay', what that means is testing and contact tracing will stop as a result?
A. No, I don't believe that's so.
Q. Was it in your knowledge, when you reviewed that document, that the effect of moving from 'contain' to 'delay' would mean that contact tracing and testing in Northern Ireland would follow?
A. No, I don't think that it -- certainly not testing. I think testing did continue although not in the same way that it had been. But it wasn't my understanding that contact tracing would stop from that action plan, when it was furnished to us, no.
Q. Thank you. That can be removed from the screen and

could I ask to be displayed your paragraph 81, please, which is at page 20 of your statement. Thank you.
Now, you tell us that:
"While on 11 March 2020 COBR(M) took the decision to move from the 'Contain' to the 'Delay' phase ..."
Is that correct, should that be 12 March or did you have an understanding there had been a meeting the day before as well?
A. No, I think that probably should be 12 March.
Q. Thank you. You say that:
"... the Northern Ireland SitRep indicated that this would in practice result in little change, with those showing mild symptoms now simply being advised to self-isolate at home for 7 days rather than phoning 111 ... A such, I do not believe or recall that any significant changes were made in terms of the Executive's response for Northern Ireland. However, that decision may have played into the [Department of Health] decision the following day to limit testing to the hospital setting and no longer test in the community."
Can I just ask for complete clarity, then, as to, first of all, your attendance at the COBR meeting and I think you've had an opportunity to review the minutes of the COBR meeting --

A. Yes, I have.
Q. -- of 12 March. It's right, isn't it, that you and Michelle O'Neill along with Robin Swann dialled into that meeting?
A. Yes, we did --
Q. And -- sorry.
A. Yes, we did, we dialled in from Stormont, yes.
Q. Thank you. And again, in terms of your understanding in that meeting, can you help us to the extent to which you participated, please?
A. Well, when you say participate, I think we were very much, my Lady, in "receive" mode at that stage, and especially when you're remotely dialing into a COBR meeting -- it may seem strange now given that we, during Covid used Zoom and Teams and Google Meet all of the time, but at that stage it was something new and there was very little opportunity to engage in the meeting. So we were listening to the Cabinet members who were around the table, I think that the other devolved administrations had been asked to dial in as well, so they would have been there as well, but there was very little engagement during the meeting.
Q. Thank you. Can we then, please, display your paragraph 82 following on, please, you say:

"By 12 March ... [the Department of Health]

considered that the spread of the virus and testing capacity was such that testing needed to be confined to hospital settings. This decision was taken without any consultation with the Executive Committee. The decision was only raised to and discussed within the Executive on 16 March 2020 -- after the decision had been implemented. I do not believe any discussions took place regarding the decision having been made without recourse to the Executive, or the delay between the decision being taken on 12 March 2020 and the discussion at the Executive on 16 March 2020."

And we'll come on to look at 16 March in a moment.

Then can I have clarity of understanding, because we are going to hear from Mr Swann this afternoon, and I think you've had an opportunity to consider his witness statement where he indicates and sets out his belief that the decision of 12 March was in line with UK-wide agreed protocol from moving from 'contain' to 'delay' and the UK-wide Coronavirus Action Plan dated 3 March 2020 which was agreed by the four UK governments with advice from the UK chief medical officers and government scientists.

He details that he referenced this in his statement to the Northern Ireland Assembly of 9 March 2020, and then a little further on in his statement in that

paragraph he says:

"The [Northern Ireland] First Minister and deputy First Minister also attended the COBR meeting, along with officials from [The Executive Office], and I do not recall that at any point it was queried whether [Northern Ireland] should continue contact tracing. As the First and deputy First Minister were also at the meeting, I did not consider there was a need to refer the matter to the [Northern Ireland] Executive. As they made no such referral either, I can only assume they also thought it was not necessary."

Now --

A. There's quite a lot to unpack there. There's two ways to refer something to the Executive Committee. It can either come from the minister in the department or the First and deputy First Minister can ask the minister to bring it in to the Executive meeting. So that's what Minister Swann is referring to in the latter part of that answer.

I think there was a decision on 12 March in COBR to move from 'contain' to 'delay', although, having seen the minutes from the COBR meeting it doesn't specifically mention that; it just talks about different actions that are taken. And as we've already touched upon, the strategy when it talks about moving from

'contain' to 'delay', it doesn't precisely mention contact tracing in the strategy.

I've also noted from the COBR minutes that it does talk about stopping all contact tracing from other geographical areas. I would have taken that as international, you know, so if somebody arrives internationally, and they have tested positive for coronavirus, that they would then be traced in terms of the contacts that they've had. I wouldn't have taken that to mean stop contact tracing.

Q. Well, let's, because you've identified the importance of that, can we briefly display that on the screen if possible. INQ000056221. Thank you.

And I think these are the minutes. If we move over the page we see you dialing in, but I think the particular reference you make there is, if we go to page 7, please, thank you, and paragraph 12 says:

"The [Chief Medical Officer] said once the policy of seven days self-isolation was in place the plan would be to stop all testing of people entering into self-isolation and to stop all contact tracing from other geographical areas."

Is that what you're referencing there?

A. That is what I'm referencing, yes. I didn't have the understanding, after that COBR meeting -- clearly

wrongly now -- that we were going to stop contact tracing as a consequence of the discussions at that COBR meeting. The Department of Health clearly did have that understanding, and stopped the contact tracing. It was then discussed at the meeting of 16 March by the other Executive ministers -- including myself.

Q. Thank you.

LADY HALLETT: What does footnote 1 say?

MS CARTWRIGHT: My Lady --

A. I think it's the strategy.

MS CARTWRIGHT: Yes.

"As agreed in the Coronavirus (COVID-19) action plan, published 3 March."

Which, sorry, my Lady, was the document we looked at before. I do apologise.

Thank you. That can be removed from the screen then.

So can I explore with you, and I think it builds on a topic you were asked about in Module 2C, so I don't want to go over old ground, but particularly in the context of available capacity in Northern Ireland in March of 2020, but particularly bearing mind the limited number of cases in Northern Ireland, do you consider, first of all, the decision to stop widespread testing in Northern Ireland was the wrong decision at that stage?

A. Well, because we were behind the rest of the United Kingdom at that stage, I think we could have continued with contact tracing, perhaps not for very much longer, because it did then become wider in a community transmission type of setting, but I do think we should have continued it for a while.

I have to say, my Lady, however, given that, at that stage, we were dealing with this very much on a UK-wide basis, resourcing may have been an issue as a result of that. And to be fair to Minister Swann, he does say in his statement, you know, what was the rationale for us doing something different from the rest of the UK? The only rationale is that we were behind the rest of the UK in terms of numbers. I think that's -- that would have been the only rationale for doing that.

Q. Thank you.

And perhaps just to confirm the numbers as of 11 March, please could we display INQ000083097, please.

LADY HALLETT: Sorry, whilst the document comes up, you say the only rationale would be behind the rest of the UK.

A. Yes.

LADY HALLETT: That is linked to the fact that you also have a different epidemiological unit?

A. Yes, yes. It would have been, yes.

MS CARTWRIGHT: Thank you.

If we can move within these situation report -- in fact, if we go back to the first page, sorry, I do apologise -- in fact, it is:

"Information correct as at 17.00 on 12 March 2020."

Thank you.

If we move then to page 2, we can see the position as of 11 March, and for Northern Ireland it was 20 cases.

A. Yeah.

Q. And with 43 -- perhaps of relevance with the epidemiological unit that her Ladyship has just referenced, 43 in the Republic of Ireland. Thank you.

So would you agree that with you being essentially of all of the four -- well, similar to Wales, or just -- that there was an option for Northern Ireland to make a different decision about stopping testing, but certainly stopping contact tracing?

A. There was an option, and there was an option for Wales, and I'm sure for Scotland as well, but those options weren't taken. I think we were quite early in the pandemic and were not prepared for what was coming at us, to be honest with you. And we were following what we were being told by COBR and by SAGE at that time.

Q. Thank you.

And perhaps just to contextualise what you've just

said, if that could be removed from the screen and your paragraph 77 be displayed, please, at page 19. You say this -- so paragraph 77, please, page 19. Thank you.

"With the benefit of hindsight, it does appear there was insufficient consideration or planning of ways to prevent transmission into Northern Ireland generally. However, I do think it would have been very difficult to limit the movement of people from Great Britain, the [Republic of Ireland] or farther afield before the true scale of the pandemic emergency became apparent in mid to late March 2020."

And you go on to say:

"The Executive followed the advice and recommendations of [the Department of Health] and the [Chief Medical Officer]."

Thank you.

Is there anything else you want to add to that, having drawn your attention to your paragraph 77?

A. No, I don't think so.

Q. Thank you.

Can we please then briefly deal with 16 March, when the decision to stop contact tracing and community testing was discussed.

And can we display your paragraph 88, please, which is on page 22. Thank you.

Now, we've got the minutes -- well, the notes that were taken by the note-taker of the meeting of 16 March, and we'll come on to the advice the minister had said about the preparations having been taken for seven weeks, but perhaps -- you've had an opportunity to review the notes, could you just give a summary or an impression of the mood in that meeting, the discussion that took place, because certainly by reference to Michelle O'Neill, who we're going to hear from, there's certainly repeated references to "test, test, test", which I think had been the mantra that had been issued on 16 March from the WHO.

Can you give us your overview of that meeting, the discussion, particularly in the context of 12 March and the decision of the Department of Health to stop testing in the community and contact tracing, please.

A. This was a particularly fraught time within the Executive, and unfortunately there were a few fraught times in the Executive, but on 12 May the Republic of Ireland, as I think was shown in the sitrep, decided that they would close schools.

LADY HALLETT: 12 March?

A. 11 March, I think it was, was it?

LADY HALLETT: You said 12 May.

A. Oh, sorry, sorry, sorry, March.

And we had taken a decision at the Executive the day before that schools would remain open. The deputy First Minister and her Sinn Féin colleagues then went to a press conference and said that schools should close, thereby giving mixed messages in terms of the direction of travel for the Executive.

So that was the background to the meeting of 16 March, and you can see, if you read the minutes of 16 March, there are references from me and indeed from the Department of Justice Minister, Minister Long, about mixed messaging coming from the Executive and the need to stop the mixed messages coming from the Executive.

So, into that context the Department of Health comes to tell us about testing and tracing. He doesn't -- the minister doesn't specifically refer of a move from 'contain' to 'delay', but everything that he talks about in the minutes would indicate that that's what's happening.

He talks about the need to redeploy resources, and he said he would rather use those resources to combat Covid-19 rather than count the number of cases. So that was the sort of atmosphere that was happening at that time. The Sinn Féin ministers had been playing close attention to what was happening at the WHO. They brought that information into the Executive.

In it you will see reference as well to supporting our Chief Medical Officer. I think that was because there was some commentary outside the Executive about the Executive should follow the WHO instead of our own Chief Medical Officer. It was a particularly tense time, my Lady, and that's the circumstances into which we then discussed testing and tracing.

MS CARTWRIGHT: Thank you.

Can I ask you then, in terms of the 'contain' to 'delay' and the stopping of contact tracing and community testing, was there any discussion about that that was the wrong decision, in fact it wasn't too late, and not follow that path of the -- of adopting essentially the approach that was being utilised in England and the other nations?

A. I think a number of ministers challenged the Minister of Health about the decision which had been taken, and quoted "test, test, test", as you've rightly said, and the need to have contact tracing. But the Health Minister -- and I don't think the Chief Medical Officer was at that meeting -- the Health Minister pushed back and said that there was a strategy in place, there was an action plan, and we were following that action plan.

Q. Thank you. And if we go back to where we started in terms of the responsibility of ministers, you're

obviously expressing the challenge that the Executive were deploying in that meeting.

A. Mm.

Q. But, ultimately, does that decision come down to the decision of the Health Minister to stop the contact tracing?

A. I don't think there was any suggestion that we should bring test, trace and isolate as a policy and as a strategy and, indeed, even in its operation, into the Executive at that time, because there was so much else going on at that time, so it was left to the Department of Health to operationalise the strategy and the plan.

Q. Thank you.

Now, is it fair to say that if I was to ask you for a detailed overview about the tests available in Northern Ireland at this time but also the ability for contact tracing, would you have knowledge? Or is it better asked of others?

A. I think it would be better asked of the Minister of Health and the Chief Medical Officer because they were working with the PHA at that time, the Public Health Agency.

Q. Thank you. But by reference to your paragraph 88 that's still displayed, you obviously have indicated the fact that there is reference to seven weeks of preparation

that the Health Minister had referred to?
A. Yes.
Q. And you've recorded at the time:
"... I believed that those preparations were adequate."
A. Yes.
Q. But I think the paragraph also identifies that, actually, now, on further review and reflection, you offer an opinion that in fact those -- there were inadequacies in the preparations.
A. Yes, because the number of contact tracers were not in place, and weren't really in place until later on in the year. We found that out later on.
Q. Thank you.
Thank you, that can be removed from the screen.
Now, can I ask for clarification, please, just by reference to your paragraph 101, please, if that could be brought up on the screen, which is at page 25.
I think this is a question more broadly around scaling up of testing. And we're at a later period now in March.
Perhaps if we go to the paragraph above, so we've got the context to the date of this.
So this is 30 March now, another Executive meeting of 30 March 2020.

And if we look at paragraph 101, please -- thank you.
You are referencing that at that meeting of the Executive on 30 March:
"The [Chief Medical Officer] responded ..."
In respect of the international examples that were in the previous paragraph, relating to career:
"... that [the Department of Health] were: 'rapidly ramping up testing capability. Shortage of testing agents. 800 a day -- [Republic of Ireland] [query] [Northern Ireland] -- 600 a day... Testing plan -- not in deficit -- is ahead of Scotland, Wales. ROI -- 1500 tests per day'."
So can I just ask you to summarise, is that what was being said at the time in that meeting by reference to Northern Ireland having more tests than Scotland?
A. I think, when the Finance Minister challenged the Chief Medical Officer, the response back from the Chief Medical Officer was that in fact we were doing more testing than in Scotland and Wales per head of population. So we were actually doing just as well, it was sort of a reassurance to the Executive ministers.
Q. Now, there's been a clarification sought in respect of this, because in fact I think we have evidence from and we'll hear from Mary Morgan, of National Services

Scotland, that essentially, she said, at this time in fact Scotland capacity had increased from 600 to 6,000 --
A. Mm.
Q. -- by 3 April, and they had greater lab capacity as well --
A. Mm.
Q. -- of 2,250 samples per day in March, and 19,484 in April. So, in terms of the notes you've made, would that be information that you were being provided with from your Chief Medical Officer?
A. So those notes, I think, are from, handwritten notes from whoever was taking the minutes of the Executive, so they would have written those down from the Chief Medical Officer.
Q. So this is really not information within your purview but you were told at that time. I think Scotland --
A. It -- was it my notes or was it --
Q. No, no, so it was the minute taker's notes --
A. Yes.
Q. But as to the information, I think Scotland in particular are anxious that the position, that was their testing -- which is more than in fact was being referenced in this meeting -- is clear and known rather than that being the -- (overspeaking) -- position?

A. Yes, I can understand that.
Q. But essentially, you didn't bring that information to the meeting?
A. No, no.
Q. Thank you. That can be removed, please.
Now, can I then ask you by way of a broader context relating to your paragraph 84, please. Thank you.
I think this is a-- we've heard reference to there being no playbook or plug and play, but paragraph 84, please, at page 21. Thank you.
We can see you detail there:
"... there was no 'plug and play' system available for tracing and isolating significant numbers of infected individuals ..."
Meaning that even if sufficient tests had been available, there was no mechanism in place for tracing close contacts or any policy to support those required to isolate.
A. Yes.
Q. Now, in light of this context, are you able to assist as to at what stage you or the Executive as a whole began to actively question or advocate for measures that would accelerate the scaling up of testing and contact tracing in Northern Ireland?
A. So in terms of testing, I think we did that quite early

on. We asked about the capacity. We were told there were capacities in terms of labs at hospitals, but also the Department of Agriculture offered up the Agri-Food & Biosciences lab, as well. So there was an attempt to increase the number of lab spaces available.

In terms of contact tracing, the -- there was a pilot run towards the, I think the end of April, and then that was run out in May. So the contact tracing started again at the end of April, and beginning of May, as I understand it from memory.

Q. Thank you. You've just referenced, again, contact tracing. But now can I ask you a reference to contact tracing, but relating to a different period of time --

A. Yes.

Q. -- and the December of 2020.

Now, there's an article from the Department of Health dated 11 December 2020 where you are quoted as saying, "Effective contact tracing is an essential element of our response to this pandemic," which reflects, I think, the WHO advice earlier in the year.

And in your witness statement you are identifying that during early March and April, the Executive were repeatedly told that there was not the capability within the system to carry out widespread contact tracing, and you've also detailed that you do not recall at this

stage the discussions on increasing contact tracing generally.

And it is said that that's in the face of calls from other MLAs, including Minister Dodds, that contact tracing be increased as a matter of urgency.

So can I ask you, using that article as a context, it's -- what's the response, please, as to why the urgent need to scale up contact tracing was not treated as a top priority in the Executive discussions from the outset of the pandemic?

A. So I think the article comes from a visit that myself and deputy First Minister made to the contact tracing centre in Ballymena that had been set up, and we had gone to see it and we were pleased to see it in operation and the way in which it was working, particularly in dealing with clusters which had arisen at funerals and weddings, and things like that.

So that's where the article comes from.

Minister Dodds' comments come from later in the year, as well, because she was very concerned about the fact that the economy was being closed down with the prospect of circuit breakers and lockdowns and was hoping that contact tracing would allow the economy to stay open. So her comments are from later in the year as well, in terms of the contact tracing.

In terms of why did we not have it in place earlier in the year? Because we didn't have a contact tracing system in place, as I said in my earlier point about having a plug and play system that we just activated, and I suppose now I hope that one of the learnings from all of this is that we will have the ability to scale up at speed if something like this were to happen again.

Q. Thank you.

Could we please display INQ000425652. That's INQ000425652.

Now, we're now -- this is 17 November 2020. This is a memo from -- addressed to you and the deputy First Minister, and I think, again, you've had an opportunity to review this. The memo is on the theme of self-isolation, but we see described within it that there's:

"... a recurring theme in our many discussions on the measures to decrease the spread of the virus ..."

It was expressed by Mr Swann that he was becoming "increasingly concerned to see no visible action or movement" in the context of targeted measures and frustration at the lack of discernible action on this front.

And do you accept that the Northern Ireland Executive was slow to act in introducing measures

designed to promote public compliance?

A. I don't think that we were slow to promote compliance, because day after day at press conferences we were urging the public to comply. As my Lady is aware, there was a breakdown in compliance after the attendance of senior members of Sinn Féin at a high-ranking Republican funeral at the end of June which caused severe difficulties in Northern Ireland with compliance and adherence. This is November time now, and Minister Swann, and this is reflected in the minutes of the Executive meeting, had been pushing for more work to be done on adherence and compliance and enforcement.

We had attempted to do that through working with the Police Service of Northern Ireland. We had given money to local councils to employ Covid marshals to try to ensure compliance. But there was a difficulty which still hung over the Executive around that non-compliance piece because of what had happened with that large-scale funeral at the end of June.

Q. Thank you. Now, I think time is not going to permit me to ask questions in respect of inequalities but it is right that you've given a good portion of your statement to address the relevant evidence you have about inequalities as you were able to provide in your witness statement; is that correct?

A. That is correct, yes.
Q. Then, finally, on recommendations, please, can I ask you, please, what structural changes do you believe should be made within the Northern Ireland Executive to ensure that ethnic minority communities are better supported during future public health emergencies, particularly regarding timely access to testing, financial support and isolation?
A. Yes, so I think again, given where we were in February/March, just coming back in after not having government for three years and then we were hit with this pandemic, I am on record as saying that not enough consideration was given to vulnerable groups, to ethnic groups, to those with disabilities, to those who lived alone, and all of that needs to be factored in to any strategy that is forthcoming after this Inquiry.
Q. Thank you. And I think you yourself have detailed within your witness statement at page 46 the lessons learning, and I think you've already addressed her Ladyship around what you said at the outset: the need for that to be considered particularly in a Northern Ireland context?
A. Yes, and I had given some thought, my Lady, to could there be an emergency committee of the Executive Committee, in other words a smaller decision-making body

to try and make things work quickly? Of course, we always have to reflect that it has to be inclusive and have everybody involved, so it is more challenging in a Northern Ireland setting, but I do hope that the experience of this pandemic will urge people to look at what's important, and not get bogged down in political differences.
MS CARTWRIGHT: My Lady, that's my time. There are Core Participant questions.
LADY HALLETT: Mr Thomas.
Mr Thomas is over there.

Questions from PROFESSOR THOMAS KC

PROFESSOR THOMAS: Good morning, Baroness Foster. Can you hear me?
A. Yes, I can, thank you.
Q. I'm representing FEMHO, that's the Federation of Ethnic Minority Healthcare Organisations.
First question is, can you help us, where did you get your advice about the disproportionate suffering either from deaths, self-isolation or lockdown, that was experienced by the black, Asian, and minority ethnic population in Northern Ireland?
A. Well, that information would have came to us during 2020 as to the impact on different vulnerable groups. It would have came to us, I think probably from the

Department for Communities I think would have been responsible for looking into which of the different groups -- how they were impacted and the differences in the impact upon them.
Q. At paragraph 170 of your witness statement you say and I quote:
"I do have concerns that while there was a significant amount of data capture and modelling in terms of the spread of the virus, first from SAGE and later from the JBC, I do ... believe there was enough consideration given to vulnerable groups in the light of existing inequalities. I consider that this was especially acute during the first phase of the pandemic in particular."
LADY HALLETT: I think you missed out a "not".
PROFESSOR THOMAS: Oh "not", sorry, I misread that.
A. Yes, yes, I have that.
PROFESSOR THOMAS: Forgive me.
Question: what considerations, in terms of data capture and modelling do you believe ought to have been given for ethnic minority groups at risk of significant harm as a result of the Covid-19 virus?
A. Well, I think I reference the fact that that was particularly acute during the first stage of the pandemic because we were relying on data from UK-wide

bodies, as it were. I think during the pandemic we set up our own bodies, including our own SIG, Strategic Information Group, to try to understand how the virus was impacting in Northern Ireland in particular, but during the first part of the pandemic, we were definitely taking information from UK-wide bodies.
Q. Okay. And what is your understanding on how the NPIs, such as lockdowns, self-isolation, could have foreseeably affected minority ethnic communities in Northern Ireland at a disproportionate rate compared to their white counterparts?
A. Well, in terms of their working conditions, we have a large migrant community in Porter Down and Dungannon, they work in some of our agri-food companies. Sometimes they live in very because quarters with each other, and we should have had more consideration as to how the spread of the virus was operating in those houses of multiple occupation. So we needed to have more consideration of that.
Q. Thank you. In hindsight, and given what you say at paragraph 170, do you think that the black, Asian, and minority ethnic groups suffered any consequences due to the government's failure to give enough consideration on how their pre-existing inequalities may have put them at a significant disadvantage, and if so, how?

A. Well, I think, unfortunately, that's true of a number of different groups. There wasn't, I believe, enough consideration taken and that's because we were in an emergency situation and we were trying to do all that we could to save lives across the board. But when those NPIs were put in place they did have disproportionate impacts on different groups, young people, for example, were denied chances in life that they would have otherwise had. Those living alone were isolated and lonely. People who -- were dying alone in hospital, and if I could change one thing, my Lady, it would be that: we should have given families all of the information, told them about the risks, and allowed them to make the decisions as to whether they wanted to be with their loved ones as they were dying, because I think it is quite inhumane, when one thinks about it, to allow someone to die alone in the way that so many people did.

Q. You say at paragraph 171 of your witness statement:

"There was perhaps an opportunity missed in failing to learn more about the adverse impacts on certain groups ..."

And I think you've just touched upon that.

"... in the first wave to enable better mitigations to be designed for the second wave. However, everyone had been working at a pace and was under extremely

stressful conditions for months, and resources were therefore very stretched."

I have the following questions: firstly, would you agree that learning about the adverse impacts is crucial to any government who takes seriously their duty to protect population of people experiencing a novel pandemic?

A. Yes, I do. Absolutely.

Q. And that -- without analysing the impacts and trends, you risk failing to mitigate against them, essentially?

A. Yes, and I do think that we were trying to grapple with the different impacts that the NPIs had on the different groups but I think what I'm reflecting is the reality of the situation at the end of June/July, when physically and mentally, officials and ministers were exhausted by that stage, and in the normal run of things, would have been looking at that more proactively. I think that's just what I'm trying to reflect: the reality of that time.

Q. And I do want to be sympathetic for the situation that you found yourself in, but would you agree that everyone working "at a pace", to quote you words, may not be a reasonable excuse in the eyes of those who then suffer those consequences? Would you accept that?

A. Yes, I think what I'm trying to, and perhaps badly,

communicate, was the actual reality of the way in which people were working at that time. They were exhausted -- that's no excuse, of course, but it's just by way of explanation as to what was happening at that time.

Q. Understood. Two more questions and I've finished. In hindsight, do you believe that there should be a dedicated cultural competency advisory group within the NI Executive to ensure that, you know, for example, the needs of ethnic minority communities were consistently considered in the pandemic response measures including isolation support and access to testing?

A. I think that's a very interesting suggestion and one that I hope the new Executive will take under consideration. We did try, and I don't want you to think that we were completely blind to what was happening -- we did try and engage with ethnic and minority communities, particularly around language difficulties and to make sure that they understood what the different requirements were at that particular point in time. But could we have done more? Undoubtedly. And that's why I think this is a very useful place to have this discussion, and I thank you for your suggestion.

Q. And my final question is this: considering the gaps in the data for ethnic minorities, do you believe that Northern Ireland needs a system that collects disaggregated data by ethnicity during public health emergencies, and how do you believe this, if we go down this path, could impact policy decisions during perhaps a future pandemic?

A. Yeah, I mean, I do recall asking for data at a postcode level, and being told that because Northern Ireland is such a small place, that if you take data at a particular level, you run the risk of actually identifying the individuals. So we have to be careful around data capture that we don't do that. But I do think, obviously, and I am a great believer in the more data you have, the more analysis can be completed and the better policy making that can be achieved. So I do think if there's an opportunity to do more data capture then we should take it.

PROFESSOR THOMAS: Baroness, thank you very much. My Lady.

LADY HALLETT: Thank you, Mr Thomas. Mr Wilcock. He is just there.

Questions from MR WILCOCK KC

MR WILCOCK: Baroness, good morning.

A. Good morning.

Q. I represent Northern Ireland Covid Bereaved Families for Justice, and I've been granted permission to ask you questions on two topics. Some of the ground you've traversed already when answering questions from Mrs Cartwright, but with my Lady's permission, I'm going to try and paraphrase some of the questions I've been granted permission to try and draw out a few key points.

The first topic is the Executive's knowledge of the capability and scalability of test and trace in early 2020. Do you accept that at the start of the pandemic, there was an overreliance by the Executive on unchallenged information from the Department of Health?

A. I think we certainly relied very heavily, and I think I reflect that in my statement, on the Department of Health, for couple of reasons. First of all, they were the experts, and we certainly weren't in any position to challenge them, given our limited knowledge of the different areas that we were trying to grapple with. And I think, as I've explained, in the mandatory coalition, and you will know this, the Department of Health's remit was that particular area, and there are always sensitivities about other ministers trying to overreach into other people's departments.

Q. Secondly, you told us this morning that you now felt that perhaps naively, you believed during this period,

there was an assumption within the Department of Health and more widely, that the capability of test and trace would be sufficient to identify cases as they arose. Do you accept that the information given to the Executive by the Department of Health in early 2020 gave a false confidence to the administration about the ability of test and trace to scale up?

A. I don't know about a false confidence but we certainly believed that the Department of Health were the people who had the knowledge and the capability, and therefore were the people who would operationalise the testing and the tracing capacity.

Q. Do you agree things didn't happen as quickly as you would have hoped?

A. Yes, with hindsight, I think that's right.

Q. Do you want to revisit whether you had a false confidence --

A. Well, I think it wasn't -- at the time it wasn't a false confidence, because we had a belief that the Department of Health were doing all that they could, and we should never shy away from the fact that we were in a pandemic that nobody was prepared for in the way that they should have been. And obviously that's what this Inquiry is partly here to look at. So yes, those are your words, and I can't shy away from them.

Q. Second topic, and it's in relation to the decision to stop community testing in the middle of March 2020.

A. Mm.

Q. And as you know, Professor McBride has made a statement to the Inquiry that in Northern Ireland, prior to 12 March, there was a relatively small number of confirmed cases, and therefore contact tracing, perhaps -- my words, not his -- perhaps in contrast to the rest of the United Kingdom, had the potential to have a significant impact on the course of the pandemic and in delaying community transmission.

You've explained to us that you were at a COBR meeting on 12 March and you've told us what you understood was happening, and what you were being told at that meeting. And you describe yourself and Mrs O'Neill as being in "receive" mode during that meeting.

A. Yes.

Q. You then describe that on 16 March was the first time the Executive were fully made aware of the full implications of what was going on.

A. Mm-hm.

Q. And you've told us that that meeting was a fraught meeting --

A. Mm.

Q. -- and a tense meeting. And can I just try to give some colour to what you mean by that.

At that meeting there were lots of discussion about closing schools, whether to follow Dublin, whether to follow London. The meeting itself talks about people being shouted down, doesn't it?

A. Yes, it does, yeah.

Q. Putting the two together, the "receive" mode on 12 March, the, I'm sure you'll accept, inappropriate method of discussion on the 16th?

A. Yes.

Q. Do you think, in retrospect, that the Executive was distracted by peripheral issues and paid insufficient attention in March 2020 to the obvious advantages of departing from the rest of the United Kingdom and continuing to do what it could in terms of testing, and therefore giving a greater understanding of the spread and modelling of Covid in Northern Ireland? Were you distracted?

A. I don't think we were distracted. I think it's right to put the context in that it was a fraught meeting, and one that doesn't give me any joy to read again, I have to say, when I read the minutes, but it was -- I think we did have fulsome discussion about tracing and testing --

Q. What do you mean by "fulsome"?
A. Well, the Department of Health, if you look at the minutes -- or the notes from the minutes, I should say -- did give us a rationale as to why he felt that contact tracing should stop. He made the comments, as I think I've already referenced, about he would rather combat Covid than count it. He felt that he wanted to use his resources to do other things, and hospital testing was still ongoing at that time, as you know.
So I think the rationale that he gave, although it was challenged, was eventually accepted.
Q. Thank you very much, Baroness.
Just one thing. You say that there was a discussion about whether -- that testing would stop. It had already stopped, hadn't it?
A. Yes, it had, it had, on 12 March. This was a retrospective look at it.
Q. The horse had already bolted?
A. It had. I accept that.
MR WILCOCK: My Lady, those are all the questions I wish to ask of the ones I've been given permission to.
LADY HALLETT: Thank you very much indeed, Mr Wilcock.
That completes the questions we have for you, Lady Foster. I appreciate there are decision makers around the United Kingdom who had to take decisions

under huge pressure and in very difficult circumstances who are worried that I'll come along with the benefit of hindsight and say "This should have been done."
Please don't worry, virtually not a day goes past when I don't remind myself of the wise words of Anthony Hidden, a friend and colleague of mine, that there's virtually no decision that hindsight can't -- (overspeaking) --
THE WITNESS: Yes, exactly.
LADY HALLETT: I can't remember his exact words but it's a very sound principle. So thank you very much indeed for your help. I'm not allowed to give guarantees that we won't be calling on you again, because I've checked, but we don't think we will.
THE WITNESS: Thank you.
LADY HALLETT: So thank you very much indeed for your help so far.
THE WITNESS: Thank you, my Lady, thank you.
LADY HALLETT: Very well. I've been asked to break now, so I'll return at 11.20.
(11.05 am)
(A short break)
(11.20 am)
MS CARTWRIGHT: My Lady, thank you.
Could I ask, please, for Ms O'Neill to stand while

she's affirmed, please.
MS MICHELLE O'NEILL (affirmed)
Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 7
LADY HALLETT: Ms O'Neill, I know how busy you must be, so thank you very much for coming back to help us.
A. Thank you, madam.
MS CARTWRIGHT: Can I ask, please, for you to give your full name to the Inquiry.
A. Yes. Michelle O'Neill.
Q. Thank you. Please can we turn to your Module 7 witness statement, please. It's 40 pages long, please, and on the last page, at page 40, we see it was signed and dated on 7 April of this year. And can I ask you to confirm, are the contents of that statement true to the best of your knowledge and belief?
A. They are indeed.
Q. Thank you.
Can we firstly identify yourself, Ms O'Neill, and in doing so, can I identify you've already given much evidence in witness statements but in oral evidence also, and so necessarily today the questions I have for you are focused on a particular issue and, most significantly, the decision making of 12 March of 2020 and 16 March 2020.
But before we move to that, can we identify what has

already been adduced as to you and your role, please.
It is right, isn't it, that you are currently a member of the Northern Ireland Assembly and you were first elected for the Mid Ulster constituency in 2007?
A. That's correct.
Q. You were First Minister in the Executive since 3 February 2024?
A. That's correct.
Q. You have been vice president of Sinn Féin since 2018?
A. That's correct.
Q. And between 11 January 2020 and 4 February 2022, you served as deputy First Minister?
A. That's correct.
Q. Now, I think you were observing Baroness Foster's evidence online, and I don't want to go over the same ground about the unique position in Northern Ireland in January 2020 when the Executive began to sit again, or about the fragile government, but is there anything you want to add to give context to the evidence we want to touch upon, or to deal with the cross-cutting issues that Baroness Foster also spoke about?
A. Well, I think just to underline, I suppose, the uniqueness of our circumstance, which we have explored in previous modules so I'll not repeat, but suffice to say that our system of governance is quite unique and

different to other devolved administrations, and therefore makes, sometimes, decision making even more complex, with an added layer, given the ministerial autonomy that's set out under the 1998 legislation that underpins our agreement.

Q. Thank you.

Now, in terms of what was said by Baroness Foster as to cross-cutting issues, and ministerial responsibility, was there anything that she said that does not fit with your position of the understanding in Northern Ireland?

A. No, I think that was correct, it's just that unique point that makes those Executive decisions sometimes a bit more complex. But mandatory coalition, the all four parties coming together -- five, actually, at that time -- coming together, uniting around trying to create a programme for government, but then, obviously, only into post and facing a pandemic.

Q. Thank you.

Then can I capture your view on the topic of whether test, trace and isolate, or Test, Trace, Protect in Northern Ireland, you would consider a cross-cutting issue that needed to be brought to the Executive?

A. Well, it certainly was a significant matter that you would have expected would have been brought back to the Executive as the decision-making body.

So I think that for me, certainly, and I know we'll come on to this somewhat later, but the first we were aware that a decision was taken to end testing was at the Executive meeting on 16 March. And to me, then, that was a moment of alarm in terms of a decision being taken without the whole of the Executive having an opportunity to discuss this.

Q. Thank you. Can we then move to that issue, please, and could I ask, please, for your paragraph 34 to be displayed, please, which is page 10 of INQ000587291.

Thank you.

Now, you tell us:

"I do recall that at an Executive meeting on 16 March 2020, the [Department of Health] communicated at that meeting that a decision had been made, on 12 March 2020, to stop contact tracing strategy and to redeploy those resources ... I was of the view that this approach seemed self-defeating and I made the point at the Executive meeting that the WHO advice was to test, isolate and contact trace, and that we needed to adjust. I said that if everyone who was symptomatic was not tested then efforts to combat Covid could fail. I did not believe that we had reached the point where the prevalence of Covid in the community was such that community testing would have had less value."

Now before we deal with the 16th March, can we look back to what you reference, which is the 12th March meeting of COBR. The meeting minutes were displayed with Baroness Foster and I know you've also had an opportunity to review those minutes. Can you confirm that you dialled into that COBR meeting on 12th March?

A. I did indeed.

Q. Can I ask you for your recollection and summary of your involvement, but also what had been decided at that meeting, please?

A. Yeah, so my, I suppose, general experience of COBR was that this was a meeting in which we were told by the government that this was the decision that they had made. They sometimes would have shared modelling information, for example, but it was very much, I think, it appeared more to be of a tick box that devolveds were included but it certainly wasn't a decision-making forum for our local Executive, and particularly in the area of health because that's a devolved issue and something that we have local responsibility for.

So I think the experience that has been articulated by Welsh colleagues and perhaps also Scots colleagues will show that the nature of these meetings were one where information was imparted as opposed to seeking our view or agreement to particular issues, and in this case

the move from one phase to another.

Q. Thank you. Now, we know that on that date the announcement was made that the move had been made from 'contain' to 'delay' and so when that announcement was made, I think almost after this meeting, did you have an understanding that that meant that community testing and contact tracing was going to cease to take place in Northern Ireland?

A. Certainly not. That was not my understanding. The first I became aware that that was in fact the case was at our Executive meeting on 16 March.

Q. Thank you. Now, can we then look at the response, just by reference to your paragraph 35, please. And in terms of you referencing here the response from the Health Minister, was that:

"... he was following his [Chief Medical Officer's] advice, that circumstances and timings in the North of Ireland were different to the South and to Britain, that countries which flattened the curve too soon would have a recurrence, and he appeared to question the effectiveness of isolating people and our capacity to do so. He cited modelling behaviours that suggested that 80% of people would comply and expressed the view that if we moved too early, this would impact on families, it would not be sustainable, and that point in time was not

the right time to act."

Then you go over to the next paragraph, please, at paragraph 36 to detail:

"I am unaware of the extent to which that decision was informed by any interaction with the UK Government, and the Department of Health should be able to assist. As appears, it was a decision about which I was dissatisfied. The system was not one designed by the Executive Office or one which the Executive Committee was involved in developing or putting into operation. These were primarily operational matters for the Department of Health."

And so you've helpfully summarised that you were dissatisfied with that decision, and perhaps can you just make clear your recollection of what you were expressing in that meeting of 16 March, please.

A. So I, I suppose to put it in context, previous even to the COBR meeting on the 12th and this meeting on the 16th, I had expressed publicly that I was dissatisfied with the approach of the government in London. I thought that the approach was at odds with international experience, at odds with the WHO advice, the World Health Organisation's advice, which was very clearly and repeatedly on the message of test, trace and isolate as a matter of fact to test, test, and test

again.

So I publicly had been unhappy with the approach in the direction of public health in England.

At the meeting of the 16th, when it became -- we became aware that this was now in fact a policy decision being taken by Health that was implications, obviously, for the society that we represent, I was very dissatisfied by the fact that it seemed to be just blindly following an approach that perhaps was relevant in England at that time, but wasn't relevant to our own situation, given that all the World Health Organisation advice pointed to the fact that when you have low transmission, you have an opportunity to actually drive down numbers even further by taking the approach of test, trace and isolate.

So I think that we had -- we were in a very different circumstance. I think alongside that, there was no consideration taken to the fact that we live on an island, one epidemiological unit, and the fact that that wasn't taken into account in terms of the modelling and what potentially this would mean for us.

So I think there were a number of things that fed into my disagreement with the decision to stop. I wasn't, you know, I had to obviously take on board what was being said from the Department of Health as to,

you know, capacity issues and resource issues but, for me, those were issues that we should have resolved together in the aftermath of being able to continue with testing at this point, for how long I don't think any of us would know, but certainly I believe that we should have continued with testing at this juncture.

Q. Thank you.

And can we capture, then, your understanding of transmission and the position in Northern Ireland at that time.

A. I can't remember the exact numbers but I know that our numbers were really low and I think that we were absolutely at that time in the position where we should have moved towards having a greater impact in suppressing the virus by dealing with the test, trace and isolate approach. I think that, by the World Health Organisation's example, and also by other international examples when you looked around, because we were so many weeks behind other countries that were going through the same, that we had something to learn from them. And I just didn't feel that that was reflected in our decision -- or the Department of Health's decision to end testing.

Q. Then can I just clarify, because you've referenced then "our decision" and then corrected yourself and said "the

Department of Health's decision", so whose decision in fact was it to confirm -- to stop community testing in Northern Ireland and to stop contact tracing?

A. It was absolutely the responsibility of the Department of Health and a policy decision for the Department of Health; it was an operational one for them and I believe they and -- whether it's the minister, the CMO, the Public Health Agency, altogether, but certainly under the remit of the Department of Health.

Q. Now, we're going to briefly look at the handwritten notes that capture, I think, the strength of feeling that you were expressing at the meeting. And do you agree in this meeting you were performing and discharging the role of a deputy First Minister to challenge the decision making?

A. Yes, absolutely. I think it's -- well, that is your role: to try to lead the Executive and try to shape. But I think that, for me, this was not the right approach and therefore needed to be said. I think that the -- there was a -- as you can see from the minute itself, there was a fair exchange across -- not just myself but other ministers also raising similar concerns, and I think -- I suppose I didn't agree with the decision at that time, but I think this was a juncture where there was a turning point in terms of

change of approach because of that actual challenge, because we didn't just accept that that was the right decision that was made by the Department of Health.

Q. Thank you.

Well, let's look at those minutes briefly together. INQ00065689. Thank you.

We can see the date in the top right-hand corner.

Is it correct that this is the note-taker that's present in the Executive meeting that's created these notes?

A. That's correct.

Q. Thank you.

And we know that they use a summary at the left-hand side. So "DOH", that's Department of Health, so would that reference Mr Swann --

A. Yes.

Q. -- and his account?

And we can see there he is referencing "Matt Hancock [on] Friday", but:

"Will issue numbers later.

"1,083 tests.

"45 confirmed cases."

So is that likely to be the up-to-date position that was being provided as to the current position on Northern Ireland on 16 March?

A. I think that would be fairly accurate, yes.

Q. Thank you.

Then perhaps if we go over the page, we can see on page 2, the penultimate entry for the Department of Health:

"Prefer to use resources to combat COVID 19 rather than count.

"Self-isolate for 7 days first rather than testing."

Are you able to give any further clarity about what was being said by Mr Swann in relation to this entry.

A. I think perhaps it could be characterised as a defensive statement, that let's not just go into it, let's do something else. But I believe that, again, it wasn't the right approach, and I just believe that the Health Minister was trying to -- as you can see throughout the minute, trying to offer up rationale as to why they took the decision that they did.

Q. Thank you. We move to page 4, I think by reference to -- thank you -- DfM.

So, three up from the bottom:

"If don't test everyone who has symptoms -- will fail."

Does that need any expansion on as a reflection about what you were saying in the meeting?

A. No I think it just reflects the whole tone of my

approach to Health in that meeting.

Q. Thank you.

If we can move over to page 6, please, we can see the note again attributed to you:

"Enormity of situation.

"GB approach -- nightmare compared to rest of world/Europe.

"Scotland -- own approach.

"Testing healthcare workers?"

Are you able to give a bit more context to what it's likely that you were saying in the meeting linked to this summary?

A. Just the gravity of the situation that we were facing. We were being briefed in great detail around the potential predictions of the impact of Covid, the potential loss of life. It was begetting -- it was becoming, I suppose, a hugely challenging situation for everybody. However, we had the advantage of being somewhat behind the rest of the world, and I felt that enough learning wasn't being taken from how others have conducted themselves.

I also didn't feel, as I've said, that the World Health Organisation advice was being taken into account in the way in which it should. And I also fundamentally disagreed with the approach in Britain. I thought that

the approach led by the then Prime Minister, Boris Johnson, was one that was akin to herd immunity, and I did not agree with that approach, and I felt that our own Department of Health was solely following that advice as opposed to adding another layer of our own local knowledge and our own information, and the fact that we live on an island and that we needed to have that taken into account also.

Q. Thank you. And I think we see that on the bottom entry on this page that is attributed to you:

"WHO -- test every case, every contact.

"Trying to do right thing.

"GB nightmare.

"Suits island of Britain, doesn't suit this island.

"We won't get this right.

"Need to adjust."

A. Mm.

Q. So by reference to the "need to adjust", were you expressing what Northern Ireland should have been doing differently, please?

A. So I was making the point that to blindly follow what was happening in Britain was the wrong approach. I was trying to influence that the Minister might take a change of approach, that we look and followed the World Health Organisation's advice. So I think that's

what's reflected there.
Q. Thank you. Again over the page, please, to page 7, you can see:
"Contain, delay, mitigate.
"Lost control from 2 weeks ago.
"People taking own decisions."
Can you help us any further with what you were saying in relation to this entry, please?
A. So I suppose because of the unprecedented nature of the pandemic and members of the public being rightly concerned about the spread, they were looking towards decisions being taken elsewhere. I think particularly -- and I think this is around the period of the time of school closures, around -- in the south of Ireland, parents were voting with their feet and taking their children out of schools because they were unsure. Why was it okay in Monaghan for your children not to go to school but in Tyrone you could, so across the two jurisdictions on the island. And I felt they were losing control of the public because they were watching what was happening with mass gatherings, for example, in Britain also.
So I just think that people were starting to make up their own mind and what they needed from us was the plan and that they needed to know that we were testing

because people were also very alert to the World Health Organisation's advice around testing.
Q. Thank you.
Thank you. Now, the minutes go on and, in fact, I think it looks as if it got quite tense and there was a 15-minute break and then it returned. But is there anything else, I think the entries we've looked at summarise what you tell us in the witness statement, but is there anything else that's relevant to that meeting of 16 March and the views that you were expressing that you'd wish to further tell us about, please?
A. Just that whilst they reflect that it was a difficult meeting, I do believe that it created a step change in terms of approach from thereon in, so I think further down the line it did lead to better, better decisions in terms of how testing was conducted in the months ahead.
Q. Thank you. Now, I think you've already referenced in your statement the test, test, test, and the Inquiry has already heard evidence that in fact that was a statement, I think, that the WHO, Dr Tedros had said that day. So would you have been aware on the same day that that was the mantra that was coming from the World Health Organisation on the very same day of this meeting?
A. I was following the World Health Organisation very, very

closely, downloading the documents, taking their advice, and trying to apply it locally to our own circumstances. So yes, I would have been following it, minute by minute in terms of the updates that they would have been providing.
Q. Thank you. The minutes can be removed from the screen, please.
Now, can I ask you about the position of Mr Swann, who we're going to hear from this afternoon, who -- I think again, you were following Baroness Foster's evidence where essentially I put the entry that's from Mr Swann's statement, to the effect of there was no objection from you or the First Minister, Baroness Foster to the decision of 12 March and, essentially, that it was the understanding that there was an agreement to the 'contain' to "delay", and the stopping contact tracing and community testing.
A. Well, I agree with the comments that she made, that COBR is not a decision-making forum for us. These decisions need and ought to be brought to the Executive. Health is a devolved matter, so I think that -- but as I said earlier, the experience of the COBR meetings was that we received information as opposed to being part of a decision-making process.
Q. Thank you.

LADY HALLETT: Ms O'Neill, I'm sorry to interrupt. Putting to one side responsibility for the fraught relations which, on occasion, I know occurred in Northern Ireland during this time -- they probably occur all the time -- but to what extent, when you have the kind of tense relationship that politicians in Northern Ireland can have, when some comes along and says something, you obviously felt strongly about this as an issue to protect the people of Northern Ireland. To what extent, when you say something like that, or somebody else has a similar view about a particular issue, is it thought that you're just saying it because of your political beliefs? Do you see what I mean? To what extent do your listeners, your colleagues around the table, say, be it you or Baroness Foster when she was there, to what extent do they attribute it to your political beliefs rather than to a genuine concern about the issue and what you're saying?
A. Well, obviously I can't speak for how others feel. However, I would make one point: there's more that unites us in politics in the North than divides us. There's more areas where we work together than we have difficulties in. I think just the nature of the pandemic, the newness of it, everybody trying to get to grips with it, meant that there were challenging

meetings, but I believe the meeting of the 16th actually led to better decisions further down the line.

I never brought my politics into it. For me, this was about the right thing, and, you know, the fact that we live in Ireland, the fact that we were one single epidemiological unit, that was not factored into the decision making. That's not a political point, that's just a logical point. And I didn't feel like that was being taken on board. So I think perhaps that at times could be seen as I wanted to follow everything in the South. I didn't. I wanted to follow everything that worked. And I didn't find where it came from as long as it worked for the people that we represented.

LADY HALLETT: Thank you.

MS CARTWRIGHT: Thank you.

Can we then as, please, building on your views, please, go back to your witness statement, please, paragraph 85 which is internal page 22, please.

Thank you.

You've essentially built on the evidence that you've given in Module 2C to assist the work of Module 7 for which you were grateful. You say:

"... I said 'there were tools that could and should have been used better and much earlier and which were not used to their maximum benefit. Test, Track, Trace,

Isolate and Support, is one example'. This reflects my concern at the fact that in March 2020, at the outset of the pandemic, testing and tracing was stop by the Department of Health, in a decision made by them, without consultation with other members of the Executive. As indicated, the Minister was entitled to take such a decision, however I thought it was the wrong decision. As I have indicated above, eventually testing in the community was reintroduced, but it remains my view that the decision on 12 March 2020 was a misstep."

Is that correct, Ms O'Neill?

A. Yes, that's still my view.

Q. And again, would it be in light of the question asked by her Ladyship, that is your considered view as a politician, irrespective of political allegiance?

A. Absolutely.

Q. You then tell us at paragraph 86:

"As outlined above, this issue was raised by me and others at the Executive Committee of 16 March ... and thereafter at the Executive Committee meeting of 3 April 2020, the Minister was asked to bring forward a paper on testing strategy and ultimately testing in the community was reintroduced in and around about May 2020."

And then perhaps moving on to paragraph 88, please.

Again, building on the evidence that we already have in earlier modules, you say:

"... I described the system of test and trace as 'initially inadequate for the scale of the challenge'. This was a specific reference to the decision of the Department of Health to end community testing in mid-March 2020. Prior to the meeting of the Executive Committee on 16 March ... I was not aware of the inability of the Department or the Public Health Agency ... to undertake effective testing for the population. I was also of the view that this testing should have been a priority in terms of allocation of resources."

And so can I ask you, then, about your understanding of capacity in Northern Ireland in March. Would you have had the detail of how many tests were available in Northern Ireland, or is that the sort of information that's not brought to you and the First Minister?

A. Not brought to us at that stage. I think there's a reference to the Department of Health talking about being in preparation phase for seven weeks, and given the operational nature of those things, they weren't brought to our attention.

Q. Thank you. And are you able to assist as to your understanding in March of what was available by way of contact tracing in Northern Ireland?

A. Only now, you know, looking back, I think -- I can't recall at this juncture what we were told at that stage apart from to say that the Department of Health told us that they didn't have the capability. Again, that was something that I would have challenged because I believed that we did have the capability, particularly whenever it came to contact tracing, by using the fact that we're a small community, very well connected to each other, and that we had opportunities to use grassroots community and sporting groups and others to try to assist us. People were volunteering to assist us so I thought there were other ways to look at the resource issue.

Q. Thank you.

Now, then, is it your view, having just detailed that you think that there was the ability to continue contact tracing in Northern Ireland, that if the Department of Health had essentially reversed their decision and did what you were essentially asking, looking at those minutes, that it could have made a difference in Northern Ireland by way of -- if they -- if community testing was continued, and if contact tracing continued in the context of the spread of infection in Northern Ireland at that time?

A. Well, I think that, given the World Health

Organisation's advice, if we had have followed that route and given the actual numbers that we had at that time, there absolutely was scope for an improved picture. How to quantify that, I can't.

Q. Thank you.

Can I just ask a few brief questions around SAGE advice and Northern Ireland's input to SAGE meetings.

Can we go to your paragraph 28, please, which is at page 9. Thank you.

I think you are referencing here SAGE advice and you say:

"[You] do not know why Executive representatives were not present at initial meetings, but it was a serious and, in my view, unnecessary gap and could only impact negatively as the absence of Executive representatives meant that our unique position on the island of Ireland may not have been recognised or taken on board by a government system based in London and often unaware of our circumstances."

Can I also then display some SAGE advice, please, which is INQ000249693.

Whilst that's being done, can you just, again, give the context to Northern Ireland's input to SAGE, the classical SAGE advice in this time of the pandemic, please.

A. Yes, so as I've said in the statement, we thought this was a gap in that we weren't represented at the early meeting, so therefore our local circumstances weren't taken into account.

The Inquiry will know that we've since employed our own Executive Chief Scientific and Technology Adviser, which was as a direct result of our experience in the early days of the pandemic, so this was something that we recognised was a gap in terms of having that constant engagement and back and forth, I suppose, around challenge in terms of our own local circumstances.

Q. Thank you. And I think we'll hear from Mr Swann and others about how the scientific advice then developed in Northern Ireland, so unless there's something specifically you want to say about that, I'll address that with Mr Swann.

A. No, I've nothing else to add.

Q. Thank you.

Now, this is the Independent SAGE report from May 2020, but it was making comment on what was happening in Northern Ireland.

And so can we move in this document, please, to page 21. Thank you.

I think it details:

"While the general position has been to adhere to

the decisions made in Whitehall, each administration has the opportunity to determine the distinctive measures needed to safeguard the well-being of the population for which it is responsible. The pattern of infection with the virus appears to vary markedly across the [United Kingdom] and the devolved administrations should take the opportunity, where possible, to engage fully in the introduction of our strongly recommended approach of case finding, testing, tracing, and isolation. This should be a cornerstone of their approach.

Northern Ireland is a particular case, having a land border with the Republic of Ireland. We urge the Northern Ireland Assembly Executive to seek to harmonise their policies with those of the Republic of Ireland in keeping with the commendable Memorandum of Understanding that has been agreed between the two jurisdictions in relation to the coronavirus [case]."

LADY HALLETT: "Crisis".

MS CARTWRIGHT: "Crisis", sorry. Thank you, my Lady.

So was the Independent SAGE advice from May of 2020 ever brought to your attention, to the best of your recollection?

A. I can't recall now at this juncture.

Q. Thank you.

Can I then ask you, in terms of this being a call

for, again, Northern Ireland to do something different in May 2020, or to do more to harmonise its policies on test and trace with the Republic of Ireland, are you able to provide any comment about then what flowed, particularly from May onwards, as to what was happening in Northern Ireland around find test, trace, isolate, support?

A. Yes. So, as you can see, we did sign up to a memorandum of understanding, which was important in terms of sharing information, because our experience in the early -- those early days in early March, particularly in relation to the issue of schools, where in the south of Ireland they moved to close schools and we did not have a heads-up and therefore left a sort of state of panic among parents around what did it mean for their child in school in the north. So this was an attempt to try to address some of those things.

Over time, I think this relationship really developed more in terms of the sharing of modelling, and I know that perhaps CMO and Health, Department of Health, might say more about that later, but it was important for us in terms of the nature of living on the island of Ireland, two jurisdictions, people freely move across the island, some people live in one jurisdiction and work in another, so when it came to tracing and

finding cases, then it was important that we were able to share that information, and I think that did develop more positively then, particularly when we got to a digital app further down the line.

Q. Thank you.

Thank you, that can be taken from the screen.

Can I ask to be displayed INQ000425652.

This is a memo that was addressed to yourself and Baroness Foster regarding compliance and enforcement measures. And we can see within this memo from November of 2020, Mr Swann was describing the issue as:

"... a recurring theme in our many discussions on measures to reduce the spread of the virus ..."

And also expressed increasing concern "to see no visible action or movement" in the context of the targeted measures, and noted his frustration at the lack of discernible action on his front.

Can I ask whether you -- your views on whether the Northern Ireland Executive was slow to act in introducing measures designed to promote public compliance?

A. No, I think we tried our best to bring people on the journey that we were all on, in terms of encourage them in terms of public messaging, in terms of our online messaging, our press conferences, working with the

Department of Justice, the PSNI. I think we were constantly trying to communicate this message of the importance of enforcement or of compliance.

Q. Thank you.

Now, can I ask that, given that this issue had been specifically raised with both you, Baroness Foster, how do you explain the absence of discernible action in November 2020, please?

A. I think obviously the Health Minister wanted to put on record that he had raised this issue, but, I mean, I can remember numerous conversations that we had at Executive level to try to drive home the message of enforcement.

I think there were challenges even for the PSNI in terms of enforcement which have been articulated in previous modules, but I do think that we were continually revisiting this and trying to improve where we could.

Q. Thank you.

Now, on the issue of adherence, you detail within your witness statement the attendance at Mr Storey's funeral on 30 June 2020. I know you've already been questioned about that issue in module 2C, I'm not going to deal with it, bearing in mind you've already given oral evidence and you've addressed it again within this witness statement.

Then can I ask you, in terms of the digital contact tracing app, are you able to provide any insight as to the Northern Ireland decision to essentially develop their own contact tracing digital app, not using the United Kingdom's app that was being developed and was available then at the end of September of 2020?

A. So I think this was a good example of how the situation evolved, where there was more of a recognition of the need to take into account our circumstance, and I think the digital app was something that we can reflect on as something that we did well, that we got out early on, and we had it -- it in itself being designed that it had north/south operability, east/west as well, that that actually really was a good development and reflected our circumstance. So I think that was something that we worked our way through and actually got right very early on.

Q. Thank you.

Now, can I ask you some additional questions on issues of inequalities, please. Are you able to assist as to what structural changes do you believe should be made within the Northern Ireland Executive to ensure that ethnic minority communities are better supported during future public health emergencies, particularly regarding timely access to testing, financial support

and isolation services?

A. Yeah, I think this is one of the areas that certainly we have to and have taken on board in terms of learning. I think that whilst all the general supports that were put in place, whether that be the self-isolation grant, whether that be our investment in terms of Advice NI to provide welfare advice and support, the wraparound services we provided with food parcels, et cetera, working with local councils, we had an emergency leadership group which was about bringing together all different representative groups, however, whilst that in itself is good, however I think the recommended -- or the learning that we've to take from this is that we could do better, and we have already started to reflect that in our own civil contingencies framework, which is a document called Building Resilience Together, and we've now identified the vulnerable groups and we've now set that out very clearly, that's actually on our Executive website.

So there is some learning already applied, and obviously the Inquiry will help us to direct us in terms of anything else that perhaps would be the right thing to do, but I think this is an area of learning for us all.

Q. Thank you.

And then, finally, for my purposes, please, you've addressed lessons learning from your perspective at page 39. If we just could go to paragraph 151, please.

Thank you. And then over the page, please. Can I ask you, please, you detail that it's your view that effective public services -- this is paragraph 154:

"... including in particular the health service, require adequate and consistent investment ahead of the next pandemic. This responsibility falls to us all, including the [United Kingdom] Government, to ensure sufficient resources are available to the devolved administrations here."

And you also say:

"I am also conscious of the criticisms made of the Executive during Module 2C by groups representing people with disabilities, and their sense that people with disabilities were not heard by their political representative. This is something I, as First Minister, takes seriously and it will be to the forefront of our minds as an Executive should a pandemic strike again".

Ms O'Neill, is there anything else you wish to address her Ladyship on in respect of lessons learning or your perspective as to potential consideration of recommendations informed by your experience during the pandemic and as First Minister?

A. Thank you. I think I'd make three points, one which I've made in the statement, which is around general preparedness, pandemic preparedness. We had 14 years of austerity, 14 turn years that decimated our health service, and 14 years that meant that our public health system was not in a state of readiness. That's a lesson to be learned by all in terms of investing in the public health infrastructure that when a situation arises, as it inevitably will again, that we have a system that is ready to be scaled up and ready to respond to any crisis that we would face.

I think, secondly, to build on that, then, I think is around the capacity, having the structures in place around being able to scale up a mass testing programme, being able to scale up a tracing programme. Those are certainly things, but that naturally flows from having the proper budget in order to be able to advance or invest in our public health infrastructure.

Then I suppose thirdly for me, particularly in relation to the conversation we just had, I think that, you know, there's no doubt that from the outset of the pandemic, moving at pace, I believe all ministers were there to do their best and to get the public through this. We tried to mitigate as best we can. You will never mitigate the whole impact of a pandemic. However,

we did put together a number of things that we thought provided support to people, at least as best as we could, but the lesson I think in all of this, that even though we set up a community leadership group to, sort of, give information, to get feedback, I don't think that was reflective enough as it should have been of, particularly, the black and ethnic minority community, people with disabilities and other groups, but I hope that we've went already somewhat towards trying to address that for future planning.

But those are three, sort of, lessons that I think that we take from this.

Q. Thank you.

Then, very briefly then, with you identifying the support to isolation, the Inquiry has already heard evidence that the approach in Northern Ireland for packages of support to assist isolation was a discretionary scheme. Were you involved at all in the fact that there was, early on in Northern Ireland, I think from as early as March of 2020, the availability of a discretionary scheme of support to assist self-isolation?

A. Yes, this, again, I think is an area that worked very well. We had our self-isolation grant, as you said it was, early in March. We used a ready-made discretionary

support scheme that we already had, we scaled it up and it allowed us to be able to turn that around very quickly and have it up and function very quickly.

We were able to invest in other advice agencies that were already on the ground because people were obviously very anxious about their lives, particularly with having to -- with workplaces shutting down, etc, so people were worried financially, so we invested in Advice NI.

But also, I think, the work we did with local councils. As I said, we're a small area, we're very connected, so we worked around our local councils around food parcels and other areas of work. So this is an area, I think, that we tried to reach as many people as possible and I think, particularly in relation to the self-isolation grant, that was a good early thing to be able to deliver upon but, of course, we have to take on board learning and all of that even whenever you believe you've done something well, I think there's always going to be learning in it as well.

MS CARTWRIGHT: Thank you, Ms O'Neill, those are my questions, thank you.

My Lady, there are Core Participant questions.

LADY HALLETT: Just before Mr Thomas asks you questions, I understand why Ms Cartwright didn't go down the Storey funeral path, and I didn't intend to, but forgive me for

returning to a sensitive issue, I just feel I need to give you, Ms O'Neill, a chance to answer what Baroness Foster said this morning: that in her view, after the Storey funeral, there was a breakdown in compliance. I just wanted to give you the opportunity to address it if you wished to.

A. Okay. Look, I think, unfortunately, I believe Arlene Foster raised that issue again today in the Inquiry, because the comments are politically motivated. I don't believe there's any evidence to suggest that actually is the case.

LADY HALLETT: Thank you. I just wanted to give you that chance.

THE WITNESS: Thank you.

LADY HALLETT: Mr Thomas.

Questions from PROFESSOR THOMAS KC

PROFESSOR THOMAS: Good afternoon.

A. Good afternoon.

Q. My name is Leslie Thomas and I'm representing FEMHO, the Federation of Ethnic Minority Healthcare Organisations.

You note, at paragraph 133 of your witness statement, you can turn it up if you need to, but I'll read out the quote:

"The daily updates took the form of joint press conferences by the First Minister and I, further, at

a relatively early stage, we took steps to ensure that those press conferences were supported by sign language interpreters, both British and Irish sign language, to ensure that the deaf community had access to Executive advice. We were extremely alive to the need for effective communication and clear messaging."

What's missing there is any mention of those within Northern Ireland who were non-English or Irish speakers, non-English Irish speakers are usually from the black, Asian, and minority ethnic communities. So my question is: was consideration given to public messaging for those groups who didn't speak the predominant two languages, namely Irish and English?

A. Yes, so I think that where we tried to reach the black and ethnic minority community was in terms of the advice that we published, the guidance that we published, that was published on multiple languages. We also had particular approaches to where, for example -- and I think perhaps Arlene Foster might have used this example earlier -- where we had a large ethnic minority community working in a large factory at Moy Park in Dungannon, and we deliberately sent representatives into explain the scenario that we were in, how to get testing, and all of the processes. And we did that on a number of occasions.

But I do think that, as I just said, that I believe that there is a lot to be learned here, and more that we could do, and I'm absolutely determined to take that on board.

Q. Second question. If, as you say, you were extremely alive to the need for effective communication and clear messaging, can you tell us what work your office did to coordinate public messaging with local religious groups or stakeholders to ensure translation of information for those who did not speak English or Irish?

A. So we had a local group, an emergency management group, which bought together all sector leaders including faith leaders and others, to try to create the space where we would advise of the current situation but also to hear feedback around particular needs of communities, and I think that's one of the things that I've said, that we've had, we've moved to improve, in terms of our civil contingencies framework for going forward. So there's a recognition that that group could have been more representative.

So for me, that's, a lesson that's already been learned but obviously we probably need to reflect then on the Covid Inquiry itself and what else we can do.

Q. You've touched upon my next question but I'll ask it. So I take it from your last answer, you would support

formalised engagement with community leaders in future public health crises?

A. So, yes, we do have a mechanism in which to do so, but I think the reflection on the Covid experience will be that did it work as best as it could, and where can we improve it?

Q. You say at paragraph 31 of your witness statement that:

"The decision to impose non-pharmaceutical interventions was taken by the Executive after consideration of advice from the Chief Medical Officer and Chief Scientific Adviser and updates from the Minister of Health."

And yet we understand from the evidence of Baroness Foster that the first -- that the First Minister, that the advice you received was never granular in terms of what were the adverse impacts of the NI -- the NPIs on the black, Asian and minority ethnic population. So my question is this: can you definitively say that the advice you got on NPIs, such as lockdown effects and self-isolation, were sufficient for you to understand how these decisions were impacting the minority ethnic communities and groups?

A. I think it's fair to say clearly not. I mean, I think we took our advice and data from a range of sources, and departments, but I think again, we can do better in this

area.
Q. In hindsight, do you believe there should have been a dedicated cultural competency advisory group within the NI Executive to ensure the needs of ethnic minority communities were consistently being considered in the pandemic response measures, including isolation support and access to testing?
A. So I don't know if that's the correct model but I think the wider point around how we can factor in to decision making the needs of our black and ethnic minority community, then that is something that we have to do and get right.
Q. Finally this: considering the gaps in data for ethnic minorities, do you believe that Northern Ireland needs a system that collects disaggregated data by ethnicity during public health emergencies, and how do you believe this would or may have impacted the policy decisions during the pandemic?
A. I think that's something I would have to explore further, but I think, in a general point, anything that leads to improved outcomes for individuals facing a pandemic is something that we need to embrace. Anything that can be learned in terms of what didn't work throughout this pandemic is something that we need to apply.

PROFESSOR THOMAS: My Lady, thank you very much.
LADY HALLETT: Thank you, Mr Thomas.
PROFESSOR THOMAS: Thank you.
LADY HALLETT: Mr Wilcock is just there.

Questions from MR WILCOCK KC

Q. Good afternoon. If I may address you by your title, First Minister, I represent Northern Ireland Covid Bereaved Families for Justice and I just want to ask you two questions that you will have heard me ask Baroness Foster just before you gave evidence.
The first question is: do you accept that at the start of the pandemic there was an overreliance by the Executive on unchallenged evidence from the Department of Health in relation to the capability and scalability of test and trace in Northern Ireland?
A. No, I don't believe so, and the reason I say that is because I consistently challenged the health advice that was given.
Q. And the second question is: do you accept that the information given to the Executive by the Department of Health gave false confidence about Northern Ireland's testing capability and scalability in those early stages?
A. I don't know if you could characterise it as false confidence, but I think that there was an understanding

that the operational responsibility of health, that those things that needed to have us in a state of readiness in terms of test, trace and isolate, that they would be in place. It was only on 16 March that we knew then that these were all the challenges that actually came with keeping testing in place.
Q. Well, there you are. It seems the one thing that yourself and Baroness Foster can agree on is the definition of false confidence. Thank you very much.
LADY HALLETT: Thank you, Mr Wilcock.
Thank you very much indeed, First Minister.
THE WITNESS: Thank you.
LADY HALLETT: I agree with Mr Wilcock that you should be addressed by your title. Thank you for your help. I don't know if you heard me say to Baroness Foster, I can't promise, but I don't think we are going to need to call upon you again. I appreciate the added burden to all your other responsibilities would not be welcome, so we'll do our best not to so thank you very much -- (overspeaking) --
THE WITNESS: Thank you very much, my Lady, and I was happy to participate because I do believe that we genuinely all want to get to a position where we have lessons learned and apply them, so thank you.
LADY HALLETT: Thank you.

MS CARTWRIGHT: Thank you, my Lady.
LADY HALLETT: Ms Malhotra.
MS MALHOTRA: My Lady, the next witness is Professor Sir Michael McBride. May he be sworn.

PROFESSOR SIR MICHAEL MCBRIDE (sworn)

Questions from COUNSEL TO THE INQUIRY

LADY HALLETT: Sir Michael, I'm sorry to have kept you waiting. I'm afraid we are not going to be able to finish before lunch because I have a commitment at lunchtime, but thank you for your patience.
THE WITNESS: My Lady, I'm happy to be of assistance.
MS MALHOTRA: Could you state your full name, please.
A. Yes, I'm Michael Oliver McBride.
Q. Thank you.
Now, you've provided a witness statement to Module 7 of the Covid Inquiry. We can see that displayed now. It's dated 7 April 2025. Have you had an opportunity to familiarise yourself with that statement recently?
A. I have, yes.
Q. Your witness statement is provided on behalf of the Department of Health for Northern Ireland, and in respect of your specific roles and responsibilities as Chief Medical Officer for Northern Ireland; is that correct?
A. That is correct, yes.

Q. You have the benefit of liaising with others, such as Professor Ian Young, the Chief Scientific Adviser, Professor Lourda Geoghegan, the Deputy Chief Medical Officer with oversight for Covid-19 testing and contact tracing, and Dr Naresh Chada, the Deputy Chief Medical Officer, who, along with the Public Health Agency, provided advice to the Department of Education, and Kieran McAteer, Director of COVID-19 Response; is that right?
A. That is correct.
Q. So, in essence, this a corporate statement that has had the benefit of a number of individuals who were able to feed into it; is that a fair summary?
A. That's a fair summary, yes.
Q. Now, you signed that statement, and it exists on page 295. Can you confirm that the contents are true?
A. I can confirm that the contents of the statement are true.
Q. I'm grateful.

Now, a large body of evidence sits behind this statement. It's 295 pages and covers the test, trace and isolate in Northern Ireland and the department's involvement.

Before we touch upon what that involvement was, this is not your first time giving evidence before my Lady.

I believe this is in fact your fourth appearance before my Lady, you having previously given evidence in Module 1, Module 2C and Module 3.

So you will be, no doubt, familiar with the process.

Could I just invite you, and perhaps remind you to speak into the microphone in front of you so that the stenographers can hear you clearly for the purposes of the transcript. And if you can give your answers at a steady pace so that your evidence can be fully captured.

Now, Professor McBride, there are seven topics perhaps rather ambitiously that I hope to cover with you this afternoon, time permitting.

The first is the decision to move from 'contain' to 'delay'. Secondly, the decision to pause testing and contact tracing in Northern Ireland. The testing strategy in Northern Ireland. Fourthly, the contact tracing. Fifthly, self-isolation and adherence. Sixth, inequalities, including public communications. And finally, recommendations.

Before I turn to each of those topics, for those who are not familiar with you or haven't had the benefit of hearing your evidence previously, you are the Chief Medical Officer for Northern Ireland; is that correct?
A. That is correct, yes.

Q. And you have been since 2006; is that right?
A. That is right.
Q. Your role sits within the Department of Health; is that so?
A. That is correct.
Q. The Department of Health is one of nine departments which comprise the Northern Irish Executive; is that correct?
A. That is correct.
Q. The Department of Health -- I suspect the answer is very much in the title -- it is the department with responsibilities for health and social care in Northern Ireland; is that right?
A. That is right.
Q. The department was and is the lead government department for health issues; is that correct?
A. That is correct.
Q. And it was the lead government department for Northern Ireland in the response to Covid-19; would you agree with that?
A. For managing the health consequences of the pandemic, yes.
Q. Turning to the departmental role relevant to test, trace and isolate, in terms of your role at paragraph 26 of your witness statement -- that's INQ000587301, at page 9

at paragraph 26 -- we can see there that you give an explanation as to what the departmental role was:

"... the Department retained control of all strategic and policy matters in relation to testing and contact tracing and setting isolation policy advice throughout the pandemic, the [Public Health Agency] ..."

Which is a regional body within the health and social care system; is that right?
A. That's correct, yes.
Q. "... was the lead operational and coordinating body in [Northern Ireland] for both the testing and contact tracing programmes."

Is that right?
A. That is right.
Q. Now, in your next paragraph, at 27, you go on to assist us with the Department's role, and you say that:

"... operational delivery of the Covid-19 Contact Tracing programme transferred to the [Public Health Agency] at the end of September 2020, while the Department continued to retain control of all policy matters in relation to testing, contact tracing and isolation advice."

Can you help us with this: between the Department of Health and the Public Health Agency, who was ultimately responsible for oversight and governance with regards to

testing, tracing and isolating?
A. Well, the operational responsibility continued to reside, my Lady, with the Public Health Agency. The strategic and policy aspects, including the coordination of both the testing and the contact tracing programme, resided with the Department.
Q. Did the Public Health Agency report to the Department of Health?
A. We -- as I say in the statement, we worked very collectively. The challenges on both organisations, both the PHA and the Department, were significant at that time, and, as I've indicated in the statement, we had significantly less in the way of resources available to us. So we effectively worked as a team in a collaborative partnership arrangement, whereby there was a division between the operational delivery of testing and contact tracing, which was led by the PHA, the strategic policy elements of that, which were led by the Department, and we put in place a number of groups which managed those interfaces effectively to ensure that there was alignment between the operational delivery and the policy on both programmes.
So I would say it was very much as an integrated team approach, but very clear in terms of where the respective roles and responsibilities resided.

Q. Now, Dr Joanne McClean, now Director of Public Health at the Public Health Agency, who has provided a statement to this module concerning the Public Health Agency's role, the operational role, as you've described, she was seconded to the Department of Health from the Public Health Agency as Associate Deputy Chief Medical Officer on 1 June 2021 and then returning to the Public Health Agency on 1 September 2022; is that right?
A. That is correct, yes.
Q. Right.
I think we can take that down, thank you.
Just turning to departmental decision making, please, with regards to the overall decision making within the department, does that rest with the Health Minister?
A. Ultimately yes, the department operates under the direction of the Minister.
Q. And your role as Chief Medical Officer was and is to provide advice to ministers -- to the minister; is that right?
A. That is correct. And in addition to providing that advice, medical, professional and technical advice, I also at that time had significant policy responsibility in the area of health protection, health improvement, research and development. Many of those

policy responsibilities I still retain.
Q. Now, you are the most senior health professional within the department; is that correct?
A. That is correct, although I work very closely with my chief professional officer colleagues, of which there are a number, as outlined in the statement.
Q. I'm grateful.
I'd like to turn, then, to our first topic: the move from 'contain' to 'delay'. My Lady has heard evidence this morning and in previous modules regarding the decision to move from 'contain' to 'delay'. This module is concerned with decisions relevant to test, trace and isolate, so my questions, and hopefully your answers, are viewed through that lens.
A. Mm.
Q. Could we please have up INQ000398439.
And at page 1, at paragraph 1, let's just orientate ourselves to this document. This is an email on 8 March 2020, and it records there in the section that's highlighted:
"The move from Containment to Delay: the CMO is working on advice which seems likely to conclude that we are a week or two behind England and hence it seems likely he will advise we should not move to Delay here immediately. He will be in the lead on this through the

CMO network but we will need to oversee the advice to ministers ..."
Firstly, is this is an accurate description of where you were at on 8 March 2020, that Northern Ireland should not move to 'delay' immediately and that Northern Ireland was a week or two behind England?
A. Well, obviously any decision to move from the 'contain' to the 'delay' phase was a policy decision for ministers and not a decision for me myself. It is correct, however, that at that time we were probably, at best, several days, maybe upwards of a week, behind, particularly, London at that time, in terms of the trajectory of the pandemic and the level of community transmission.
However, at that time, because of the lack of availability of tests, realistically we had no way of knowing where we were on that very sharp upward curve towards community transmission.
So I think this email, I think I picked it up at -- after midnight on a Friday evening, and it was -- this is in response to -- my response to that email, which was basically saying, "Look, I think we need to look at this", that was a request for a return by lunchtime on the Saturday, and it needed further assessment.
Q. Forgive me for interrupting you.

A. Sorry.
Q. Can I just press you upon that?
A. Yeah, yeah.
Q. Does this reflect your advice at the time?
A. Essentially what I was reflecting was the accurate position that we were probably a little behind, although marginally so in terms of the trajectory of the pandemic. So, to that extent, it is accurate.
Q. Then, with regard to not moving to 'delay' here immediately, is that an accurate --
A. No, I don't think that's an accurate interpretation. I think that I was providing some initial thoughts in relation to the implications of the move, the level of preparation that there had been and the implications of a move from 'contain' to 'delay', the state of readiness in Northern Ireland for such a decision, and that any such decision needed to be informed as best it possibly could by the availability of local data.

At that time, when I responded to that, I didn't have all that comprehensive data available to me in order to make or provide informed advice to ministers, and that did become clearer over the coming days.
Q. I see.

Did you change your view?
A. Yes.

Q. When did you change it?
A. We -- there were subsequent SAGE meetings on 10 March, as I recall, when it became clear at that meeting that there were certainly more cases in the United Kingdom than had been initially envisaged, because again, we were only at that stage testing individuals who had returned from certain geographical areas and those who were symptomatic. We did not then know the full extent of community transmission that had already been occurring, and from that date, from 10 March up to the decision that was increasingly clear to me that we just didn't know how far along in the pandemic that we were, and that the prudent decision was to advise ministers to move from 'contain' to 'delay'.
Q. So just to summarise, so we're clear about why your view changed, could you summarise that for us, please?
A. Yes. It became clearer over the succeeding number of days that in the United Kingdom, including in Northern Ireland, we were further into the pandemic wave than we had initially suspected. As I recall, at the SAGE meeting on 10 March, Sir Patrick Vallance estimated that there were somewhere in the region between 5,000 to 10,000 cases in the United Kingdom. At that stage, we had evidence, if not on that day, on the following days of community transmission that couldn't be traced back

to travel in the Republic of Ireland. There was evidence of community transmission elsewhere in the UK, and we had our first potential case, as I recall at that stage, again, not related to travel.

So that was indicating that community transmission was already established, and that it -- to continue to try to contain the virus was not going to be a successful strategy.
Q. Well, let's move on, please, to the decision to pause testing and contact tracing, then, although the two topics are interlinked.

Could we look at INQ000587301, your witness statement, at page 39, paragraph 86, please.

So you can see here you say:

"As in the rest of the UK, the PHA [the Public Health Agency] was undertaking contact tracing for all cases of Covid-19 until 12 March 2020, when contact tracing was paused in line with a decision which was taken by the Cabinet Office Briefing Room Ministerial Meeting (COBR(M))."

Just to be clear, what decision are you referring to?
A. That was the decision to move from the 'contain' phase of the domestic response to the 'delay' phase of the pandemic response, as had been outlined in the UK

Coronavirus Action Plan of the 3 March --
Q. 3 March.
LADY HALLETT: Sir Michael, as I remember, the Coronavirus Action Plan had, as part of the delay phase, trying to stop the spread of the virus.
A. Mm.
LADY HALLETT: If you stop community testing, how were you going to limit the spread of the virus?
A. At that stage we simply did not have the tests available to us to continue community testing. Without community testing, particularly where there was established transmission within the community, we were not going to be able to detect all of the cases that we needed to start contact tracing to advise people to self-isolate and to take appropriate precautions.

So at that stage it was the limitation in testing capacity which didn't enable us to start contact tracing and, at that stage, from a public health perspective although from a very narrow public health perspective, the sensible approach was to extend the measures which had previously only applied to individuals with symptoms who had tested positive, to population-wide measures, such as asking everyone's symptoms, whether it was confirmed as Covid or not, to stay at home.
MS MALHOTRA: I think we have that strategy document and it

might be helpful to take a look at it. It's INQ000232520.

And if we go to page 3, please, just to orientate ourselves to the document, is this the Coronavirus Action Plan published on 3 March 2020 that you're referring to?

A. That's correct.

Q. And if we go to page 12, please, here we can see, just so everybody is clear, this is an exhibit that's been provided from Baroness Foster and that's the manuscript that we can see on it. There we've got "Contain", "Delay", "Research", "Mitigate" towards the bottom of the page. Under "Contain" it says:

"detect early cases, follow up close contacts and prevent the disease taking hold in this country for as long as is reasonably possible."

And then the "Delay":

"slow the spread in this country, if it does take hold, lowering the peak impact and pushing it away from the winter season."

So, by definition, that would seem to be how those particular phased are termed; would you agree with that?

A. Yes, although I think if you refer to the foreword of the document, it also refers to the fact that the response, the precise nature of the response, will be

tailored to the particular circumstances of the pandemic at any one time.

So I wouldn't suggest, for instance, this is a prescriptive plan to be followed. Viruses and pandemics don't follow our plans. This was a phased response, and with proposed interventions at each stage, but as, you know, the best well -- laid plans, we moved very rapidly, effectively, from delay almost to a measure which was suggested later in the document.

Q. Just -- you're familiar with this document, aren't you?

A. Oh, I am, yes, yes.

Q. I think you've been taken to it a number of times before. But just help us with this: with your familiarity of it, would you accept that there is no reference to stopping or pausing testing or contact tracing within it?

A. Oh, there is, I think it's in paragraph 4.46 somewhere where it talks about mitigation phase, where it says that there will be less reliance on population preventable measures such as --

Q. That's at page 14. Let's just have it up. Paragraph 4.6. Does that help you with the part that you're looking for?

A. No.

Q. All right, well, let's just put that to one --

A. I think it's later in the mitigate phase, I think it's further on in the document.

Q. Let's put that to one side and just turn to the COBR meeting that I believe you attended. I know that you have been shown some minutes of that COBR meeting, which show that you dialled into that call on 12 March 2020. Do you agree with that, that you dialled in?

A. That's correct, yes.

Q. And can you help us with your recollection of what was discussed with regards to testing and contact tracing at that meeting?

A. I mean, I -- obviously, it's at some distance removed now --

Q. Yes.

A. -- so it's difficult to be clear of the precise nature of the conversation, things were moving very, very quickly at that time, I think that is evident.

There was certainly discussion around the fact that, as I referred to at the SAGE meeting of 10 March, that we were further into this wave of the pandemic than had been anticipated; there was established community transmission; that there was and had been discussion in the days before that at previous COBR meetings and, indeed, the public announcements by the then Prime Minister about the need to move beyond the

'contain' phase, and it was agreed at that meeting that the point had been reached where we needed to move from the 'contain' to the 'delay' phase.

It was also discussed at that meeting and reflected in the minutes that that would mean an end to community testing, and contact tracing. So that was -- that's my recollection of the meeting, and it seems consistent with the minutes.

Q. And was your understanding of that meeting that moving into the 'delay' phase meant ceasing or pausing testing and contact tracing?

A. Well, there wasn't an alternative in that we simply did not have the tests.

Q. Yes.

A. It made no sense to continue to test individuals who were otherwise well in the community when we needed to prioritise tests for those who were in hospital who were unwell, those who were likely to end up in hospital and unwell, and those tests were required to determine their clinical care, and to redirect what limited testing that we had at the time, also to potential outbreaks in care homes, and in hospital environments, which is what we did.

Q. Can I ask you this, and perhaps you can assist us as far as you can, but was there any epidemiological basis for

the decision to pause contact tracing on 12 March 2020?
A. With the new virus, with severe limitations in our ability to test in the community, it was very difficult to get firm epidemiological data in terms of how widespread the infection was. Clearly, the measures that had been in place around the 'contain' phase had not prevented community transmission and, of course, it wasn't that the plan was a bad plan, and we needed to be flexible in terms of how we interpreted and applied the various phases, but what we didn't know then, and we know now, is that from February there was significant infection and cases that had occurred in the United Kingdom at a widespread nature that had been introduced from France, from Italy and from Spain.

So, in essence, we were further into the pandemic, although we weren't quite certain, because of poor testing data, of how far in we were.
Q. If I could press you a little bit further, Professor McBride, was there an epidemiological basis at that stage to pause contact tracing on 12 March?
A. We didn't have the capacity to continue contact tracing; it was as simple as that.
Q. So would it be fair to say that it was resource driven?
A. There simply was not the tests available, and those tests needed to be prioritised and redirected. So there

were significant resource considerations in that decision. Absolutely, yes.
LADY HALLETT: I have found the reference, sorry to interrupt -- I've found the reference in the Coronavirus Action Plan, just for those who don't know it intimately. It's: contain, delay, research, mitigate phases. They are separate phases sequentially, are they? Except research goes on all the time, presumably.
A. Yes, and I think that's and obviously the basis of the question that, you know, including in the response to the pandemic in 2009, no plan -- I mean, every plan has to be flexible and adaptable and I think in the introductory comments to the plan it makes that point: that we will need to flex and adapt. And you're absolutely right, it's in the 'mitigate' phase of the plan where that reference is made.
LADY HALLETT: What it says is, it's the final bullet point under the 'mitigate' phase:

"There will be less emphasis on large-scale preventative measures such as intensive contact tracing."

Less emphasis, but it doesn't say it will be stopped.
A. No, and, you know, had we had the testing capacity, it certainly may have been possible to continue that

approach for longer but simply, as counsel has indicated, we did not have the tests available to us, and those that we had, had to be re-prioritised.
LADY HALLETT: Thank you.
MS MALHOTRA: I'm just wondering whether we can have a little bit clarity in terms of the decision to move from 'contain' to 'delay', the decision that was one decision --
A. Yes.
Q. -- in terms of the phases and the strategy, and the, sort of, secondary part to that, or what the consequence, perhaps, of that, because of resourcing, was the pausing of contact tracing and testing. Is that fair? Would you agree with that?
A. Well, the primary factor was the limits in testing capacity, and obviously, if you can't test, you can't confirm someone has the infection, and then you cannot begin the process of contact tracing. So the pause in contact tracing, I would agree, was a second order consequence of the limitation in testing capacity.

However, to answer that more fully, there were also limitations at that stage in our ability to scale up contact tracing to the level that would have been required.
Q. Could I invite you, please, to look at your statement at

page 173, paragraph 453, please. And it says here:

"As described at paragraph 86, community population-based contact tracing was paused following the policy decision taken at COBR(M) to move from the containment phase to the delay phase on 12 March 2020 with the move to wider population-based public health measures and advice. At that time, contact tracing was then restricted to high-risk contacts such as residents in care homes or patients in hospital."

And so if we go down and we look at -- forgive me, go up -- at paragraph 452, you say halfway down:

"Prior to 12 March, there was a relatively small number of confirmed cases and therefore contact tracing had the potential to have a significant impact on the course of the pandemic and in delaying community transmission."

Can you provide some context to what "significant impact" is for us.
A. In the weeks leading up to 12 March, the majority of the cases that we were seeing were imported cases, so those are individuals that had travelled in from other countries where the virus was more prevalent.

So we had provided advice about individuals to self-isolate, to get a test if symptomatic, and then began the contact tracing process.

So in those early days there was sufficient testing when we were largely dealing with imported cases. However, when it got to the point where we were no longer dealing with imported cases and we were seeing transmission within the local community in Northern Ireland, and indeed within the rest of the United Kingdom, then what limited testing capacity that we had was insufficient to maintain that at the scale required.

I mean, it's just worth bearing in mind that, even a week after 12 March, we had less than 200 tests available to us in Northern Ireland on a daily basis, and even that was limited because of the lack of reagents that we had and swabs that we had, because of global supply issues.

So there were major, major issues with testing capacity.

Q. Just going back before we do break, in terms of significant impact, can that be qualified in any way?

A. I think it's theoretically possible to calculate and model the impact of contact tracing, although that is different from the actual impact. I know that there were studies carried out by the Welsh Government and by UKHSA in terms of the impact of contact tracing, although be it that was later in the pandemic, in

February -- published in February of 2021, the Rùm study, looking at the impact of contact tracing and the various elements of it.

We did not carry out, in Northern Ireland, any specific analysis of the theoretical impact of contact tracing. But I have absolutely no doubt that it was effective in lowering community transmission, preventing excess deaths, and preventing our health service from being overwhelmed.

MS MALHOTRA: Thank you.

I think -- is that a convenient moment?

LADY HALLETT: It is indeed.

For those who are here in the hearing room, I'm afraid we're going to need the hearing room empty between 1.00 and 1.30, and I shall return at 1.50.

Sorry about the breaks.

(12.45 pm)

(The Short Adjournment)

(1.50 pm)

LADY HALLETT: Thank you.

MS MALHOTRA: Thank you, my Lady.

Professor McBride, I was about to ask you to go on to another document. It's one that we've had up before and I'm sure one that you're very familiar with: INQ000083097. This is the report from Northern Ireland

Office titled "Covid-19 Situation Report 1", dated 12 March 2020.

If we go to page 2, please, we can see there the case numbers: for England, 491, and then, looking at Northern Ireland, 20 as of 11 March 2020, and, sadly, ten deaths.

We can see underneath there that:

"COBR(M) today took the decision to move from Contain to Delay. In practice, this initially means a change to the advice to those suffering mild symptoms, to not phone 111, to self-isolate at home for 7 days. This was communicated today."

And it goes on in terms of isolation requirements.

Looking at that, and the case numbers as of 11 March, would you accept that the case numbers in Northern Ireland were low by comparison?

A. Well, that is the number of confirmed cases.

Q. Yes.

A. Northern Ireland has a smaller population than other parts of the United Kingdom. I think that what that figure doesn't tell us is the number of unconfirmed cases that there were at that time, given the fact that there was, in all likelihood, sustained community transmission.

Q. Northern Ireland was a different epidemiological unit,

would you agree with that?

A. To an extent. I think that Northern Ireland shared a land border with the Republic of Ireland and there was free movement of people between the rest of the United Kingdom and Northern Ireland.

Q. Why did you advise that testing and contact tracing is paused?

A. The -- there was insufficient testing capacity at that time to continue community testing. We were, at that stage, still in the middle of the winter/spring respiratory virus season. There were significant numbers of people with respiratory symptoms. It was no longer wise or prudent to assume that only those with symptoms who were returning from other countries would have Covid, and at that time, it was necessary, if we'd had the testing capacity, to expand the testing to everyone with symptoms.

Now, notwithstanding the fact that, unfortunately, the symptoms of Covid were very non-specific -- and we simply didn't have the contact -- or sorry, we didn't have the testing capacity at that stage, and what tests we did have we needed to prioritise for those in receipt of clinical care either at that time or those who were about to become unwell and required clinical care.

Q. Now, does it follow that the strategy in England, for

where it may have been epidemiologically different to that of Northern Ireland, with the caveats that you have given, would you accept that that did not necessarily fit Northern Ireland at this stage of the pandemic, so around 11 March 2020?

A. No, I mean, I don't accept that. At that stage there was evidence of community transmission in the Republic of Ireland. So we were very mindful of the fact that that was the case. It was extremely unlikely, in my view, from a professional perspective, that this virus was behaving anywhere differently in the rest of the United Kingdom compared to Northern Ireland or the Republic of Ireland.

What we didn't know at that time was the extent of community transmission, and in my view, it would have been extremely unwise to seek to advise ministers that it was sensible to remain in the 'contain' phase when we already knew that we had community transmission and that that community transmission was likely to increase exponentially.

Q. We have within the documents that's been provided to you an Independent SAGE report. It's INQ000249693. It's dated 12 May 2020.

If we go to page 6, paragraph 9, relatively small but it says:

"Managing the risk of importing cases from other countries, with consequence high risk of transmission is vital. This should be introduced as soon as possible, treating Great Britain and the island of Ireland as distinct health territories."

Pausing there, do you accept that? Would you agree with that?

A. Not entirely. I think that there were differences in the epidemiology between the two islands, and that at times the epidemiology and trajectory of the pandemic in Northern Ireland was more similar to that in the Republic of Ireland than it was to the rest of the United Kingdom. There are other times when that was not the case.

I think that the learning point for me, from this, as I've indicated previously, was that there needed to be greater harmonisation of policy approaches across the islands and, as I've summarised before, a five-nation, two-island approach. Again, there was the Common Travel Area, there was the freedom of movement of individuals at key points throughout the pandemic.

There were clearly -- apart from the health considerations, there were many other considerations which the ministers would have reflected upon which are outwith my remit in terms of the societal and economic

consequences, the supply issues, which such an approach may have resulted in. But obviously those were matters which were beyond my remit to provide advice on.

Q. I want to come back and touch upon that in another context.

Thank you, we can take that document, down.

Without wishing or wanting to invite you to enter into the fray, but the evidence that this Inquiry has heard and received -- and I'm going to ask, please, that the statement of Baroness Foster, INQ000475070, is brought up, just so that we can see it in writing, rather than me trying to summarise or paraphrase the evidence -- at page 23, thank you, at paragraph 109.

Ah, maybe it's -- it should be paragraph 109. Forgive me. Thank you.

Baroness Foster says here:

"I believe the most significant catalyst for the increased rates of Covid-19 in Northern Ireland in August 2020 was a lack of compliance driven primarily by the actions of the deputy First Minister and other members of Sinn Féin, at the funeral of Bobby Storey on 30 June 2020. The public had complied with onerous restrictions from March to the end of June on the basis of a level of public confidence in the measures that we had introduced to try to keep people safe."

She then goes on to say that the very public breaking of trust and people questioned why they were sacrificing their personal life and relationships when people at the highest level of authority in Northern Ireland didn't.

So at the top of that paragraph, Baroness Foster is saying:

"I believe the most significant catalyst for the increased rates in Northern Ireland in August 2020 was a lack of compliance ..."

And I've given you some further context there.

Can you help us at all with whether or not there is any evidence to support that?

A. From a purely scientific and public health perspective, I don't -- I'm not aware of any evidence that that's the case. I think the major driver of the increase in cases throughout that summer, into September, into October, were the relaxations in the non-pharmaceutical measures which had been agreed by the Executive. That's what led to the increase in transmission: there was more mixing, with more people coming together, in a range of environments, and that led to an increase in the pandemic.

Q. Just in a similar vein, and see if you can help us with this: had testing not paused in Northern Ireland on

12 March of 2020, is it likely that more positive cases would have been picked up, positive cases identified?
A. That is undoubtedly the case.
Q. And does it follow that the spread of the virus for Northern Ireland after March 2020 is likely to have been constrained if testing hadn't been paused?
A. Sorry, could you repeat the question?
Q. Perhaps I'll simplify it. That might be easier. Does it follow, do you accept, that if contact tracing -- if testing, forgive me, hadn't been paused, that the spread of the virus would have been less?
A. We shifted approaches. I mean, the policy position then shifted from testing everyone with symptoms to accepting we didn't have enough tests to test everyone with symptoms given that there was community transmission, although the extent of that we didn't then know --
Q. Yes.
A. -- to then population measures. So at that stage, everyone with any symptoms of any nature was advised to stay at home --
Q. I appreciate that's the rationale and the reasoning and that's important context, but just in terms of likelihood and what -- the impact of that, could you help us?
A. I don't think -- I mean, that would be -- I mean,

I think that would be mere conjecture on my part. I mean, the fact of the matter was that we did not have the tests to continue community testing, and to seek to do that when we needed to re-prioritise those tests and not take the decision to move to wider population measures such as individuals with symptoms staying at home, their household contacts staying at home, work from home, avoiding unnecessary travel, avoiding pubs, theatres, et cetera, had we not moved to those measures, I think the consequences, given the limitation in testing at the time, would have been much greater.
Q. And I think you've touched upon this already and I said I would return back to it, but do you have -- I want to give you an opportunity to say whether you have any reflections on the decisions of the department with regarding to pausing testing and contact tracing in March 2020?
A. Yeah, I mean, I think it's probably one of the most important learnings, lessons learnt from the pandemic, which is that we had insufficient tests and an inability to scale up testing capacity as quickly as we needed. As a result, difficult policy choices were made by ministers, and undoubtedly, had we had more testing capacity, we would have continued community testing and contact tracing for longer, and in all likelihood we

would have been able to remain in the containment phase for a longer period of time. Sadly that wasn't the case.

And I think for the future we need to ensure that that diagnostic capacity and capability is built in as contingency, and if it can't be built in as contingency because of budgetary constraints or competing priorities, that we retain the knowledge and wherewithal to how we would surge that very quickly.

And as we did in Northern Ireland, that will mean working in partnership with academic institutions and with the commercial sector, which we did through the Scientific Advisory Consortium and that was hugely successful in building Pillar 1 capacity within the province.

LADY HALLETT: Can I just follow up, you've been frank enough to admit the decision to pause testing was resource driven, you just didn't have the capacity. Do you think the governments of the United Kingdom were frank enough with the public when the community testing was ended?
A. It's very difficult for me to cast my mind back in terms of the communication and messaging at that time, because many of us -- we weren't at home watching the television; we were working at such a pace. I think

that the one message, and I've reflected this in my own reflections on learning from the pandemic, is that as counsel said earlier, that in any crisis and/or emergency, trust is the most important thing.

It's hard to maintain and it's easily lost, and when you lose that trust, then it's very difficult to convince the population to have a test, to contact trace or to comply with the advice around isolation.

So all the behavioural science and the science we were seeing at the time was you've got to be open and honest with the public. You've got to tell them what you know, what you don't know, and they need to understand why you're asking them to do the things you're asking them to do.

I think we tried hard to do that. I'm not certain that we were successful in doing that. My impression was, certainly in Northern Ireland, that we were very open and honest in terms of what we knew, what we didn't, and the limitations in testing capacity and why we were making some of the decisions that we were making.

Otherwise, people were not going to come with us. And I think that's particularly important when you're depending on people doing the right thing, even when doing that right thing has had huge consequences for

them personally.
LADY HALLETT: Thank you.
MS MALHOTRA: Thank you very much. I just have a few more areas that I'd like to deal with, which I might just canter through, if I may, because I really would like to ask you about inequalities and any further reflections in terms of recommendations that you might have for a future pandemic.
But before I turn to those two topics, notifying the Executive on 16 March, we've heard evidence that the decision to pause testing and contact tracing was communicated to the Executive on 16 March and not sooner. Do you accept that?
A. I mean, that's the factual position. I mean, the First Minister, deputy First Minister and Health Minister were at the meeting where the decision was made, but I think it was probably first discussed with other ministers at that meeting on 16 March.
LADY HALLETT: Sorry, I'm not sure that's exactly what I've heard from, certainly Ms O'Neill this morning. You say the First Minister and the deputy First Minister were present with the Health Minister when the decision to pause community testing was taken.
A. At COBR on 12 March.
LADY HALLETT: Ah, I think -- but they didn't understand

that was what the decision was.
A. Okay, but I can't --
LADY HALLETT: You thought it was clear?
A. I thought it was clear and I thought it was, you know, clearly reflected in the minutes of the COBR meeting.
LADY HALLETT: Thank you.
MS MALHOTRA: Was it perhaps clearer to you because of your background, the medical background, and information that you might have received prior to that COBR meeting?
A. I think in fairness to ministers in Northern Ireland, they had only returned -- the Executive had only been established on 11 January, after a hiatus of three years. The First Minister and deputy First Minister attended their first COBR meeting on 2 March. The Health Minister and I had been immersed in this for many months at that stage, so I think it is understandable that the First Minister and deputy First Minister may not have been across the detail. But obviously they were relying on officials to brief them on that detail -- and those officials obviously included myself.
Q. Just following on from that, then, should the decision to limit testing to hospital settings have been raised with the Executive before 16 March?
A. Again, that would have been a matter for the minister to

decide, and other ministers to determine, not a matter for myself. I mean, certainly the Health Minister had been briefing the Executive from 3 February every week at Executive meetings, and he'd made at that time seven statements, both oral and written, to the Assembly.
So -- and we as a department were extensively briefing other departments in terms of the preparation that was required for potentially what lay ahead.
Q. We've heard from the First Minister this morning that that decision led to better decisions being made, sometimes being described as tensions that followed, and that there were concerns about transparency following and flowing from that. Do you have any insight that you can offer as to what the trajectory of meetings were after that? Does it fall on --
LADY HALLETT: That discussion, not that decision. That discussion.
MS MALHOTRA: Yes.
LADY HALLETT: That discussion yesterday to better decision making.
A. I mean, I had not previously until that point attended Executive meetings. My first Executive meeting was 2 March. I did attend a significant number of Executive meetings thereafter. I've my own view, and experience was that the professional advice that myself and the

Chief Scientific Advisor was listened to respectfully. It was taken on board. Ministers were juggling a number of other priorities, not just the health implications but the wider societal and economic implications.
And yes, there was at times robust discussion. I think that was healthy because these were decisions that were impacting on people's everyday lives, and I think that the people of Northern Ireland benefitted from having a restored Executive which was actually making decisions for them at one of the most challenging times possible.
MS MALHOTRA: Thank you.
In fairness to you, the Inquiry has received evidence from Baroness Foster in her witness statement. I don't think I need to take you to it; I think you may be familiar with the passage. It's regarding a decision where she says:
"... use resources to combat Covid-19 rather than count -- self-isolate for 7 days first rather than testing ..."
To provide you with some context, it's discussions following on 16 March, and that's a handwritten note that's provided. Is that something that you recognise or can remember?
A. I don't remember the comment, and I didn't see the

handwritten note prior to preparation for giving evidence to the various modules of this Inquiry. My only reflection is that they are handwritten notes, and those were quite fast-moving conversations and, again, I don't know and can't account for the complete accuracy of the recorded handwritten note.

That's not a criticism; it's just that there were complex issues being discussed. So I can't attest to how accurate or otherwise it is.

Q. Right. Thank you. Let me turn, then, please, to one matter that I just want to ask you about for clarification purposes. It's been attributed to you, and I think we should have the document up for this. It's Baroness Foster's witness statement INQ000475070, page 25, paragraph 101.

And it's regarding the 30 March 2020 meeting where it says:

"The CMO responded to these concerns stating, *inter alia*, that [Department of Health] were: 'rapidly ramping up testing capability. Shortage of testing agents. 800 a day -- [Republic of Ireland] ..."

And it goes on to say:

"... [Republic of Ireland] -- 1500 tests per day'. The CMO further stated: 'Delay phase, advice to anyone who is symptomatic -- contact tracing, sustained during

containment phase... next phase of epidemic -- increased testing... nos at this juncture -- too many nos/pressures'. The Executive Committee were therefore effectively being told in this and earlier meetings that [the Department of Health] were doing everything that was capable of being done in line with advice about moving from the containment to the delay phase, and in the context of pressures including, for example, shortage of testing agents, and the need to create testing infrastructure. The strategy in terms of moving from 'contain' to 'delay' has been set out ..."

In the action plan that we have gone to.

Can you help us with some context around that?

A. Well, again, with the caveat around the handwritten notes previously, I think this was the Executive meeting of 2 March, which was the first Executive meeting that I attended, and we were at that stage rapidly seeking to increase testing capacity. We would have had, then, a knowledge of testing capacity in other jurisdictions as recorded. Again, I'm not sure of the accuracy of those figures.

And again, I've alluded to the 'contain' to 'delay' phase in the action plan of 3 March, and again, I've gone on to say that obviously, if the virus becomes more widespread and established, that we would be moving to

that delay phase. And then I've alluded to the introduction of shielding at a later stage.

Q. Okay. Just on contact tracing, you chaired the Contact Tracing Steering Group; is that correct?

A. That's correct, yes.

Q. And as part of that role, did you have some oversight of the Public Health Agency and their contact tracing operational role?

A. Yes, both the contact tracing and the testing, from their operational role in both of those areas.

Q. And you touch upon, in your statement and indeed we have the statement from the Public Health Agency as well, Dr Joanne McClean, do you think that vital time was lost by the Public Health Agency's difficulties in contact tracing capacity?

A. Well, I think we'd paused community testing and contact tracing at the same point right across the United Kingdom. The Public Health Agency was the first public health agency to begin contact tracing again, firstly in a pilot phase on 27 April, and then fully on 18 May, which was some ten days ahead of the resumption of contact tracing in England for instance, and I recall that -- in England and Scotland, and it wasn't until 1 June that it was commenced in Wales.

So I do believe that the Public Health Agency worked

extremely hard to recommence the service that had been paused and did so as early as was possible.

Q. Okay. In your statement, you do say that the Department did not set up specific targets in respect of delivery of the Test, Trace, Protect strategy, rather -- Test, Trace and Protect strategy, rather requiring the Public Health Agency to deliver and report against the overarching strategic objective.

Why did Northern Ireland prefer not to set specific targets?

A. There's an old adage that, you know, hit the target and miss the point. And we didn't set headline targets for the sake of setting headline targets. The clear objective, strategic objective set of the test -- to the testing programme and to the contact tracing programme, was to scale up capacity as quickly as possible. In my view, the PHA working with the Regional Virus Laboratory, working with the Scientific Consortium and working with the National Testing Programme, scaled up PCR testing as quickly as possible. Similarly, I believe the PHA did scale up contact tracing as quickly as they possibly could, notwithstanding the technical challenges with that, moving from, initially, a telephone-based module to a hybrid-based module using digital support, as well.

So I'm not certain that, if I'm honest, that setting targets would have improved the commitment of all to achieve that.

There were specific performance targets set by the PHA, for instance in relation to the number of individual positive cases that were contacted within 24 hours, the number of their contacts that were contacted within 48 hours. Those were reported on a weekly basis, published in the public domain, and were shared by the minister with the Executive.

The capacity and expanding capacity on testing was again considered at every meeting of the Test, Trace, Protect Oversight Board, which I chaired, and we received a weekly report from the Northern Ireland Pathology Network about the efforts that were under way to expand Pillar 1 PCR testing.

So there was no lack of scrutiny or oversight and I think all were committed to expanding both programmes as quickly as possible.

Q. Thank you. Just turning, then, to topic 6, inequalities. In your statement -- we don't need to turn it up -- but you acknowledge that the department did not engage with community groups in great depth due to the emergency situation. Do you believe that that was a mistake, not to prioritise communication with

community groups?

A. I'm not certain that that's exactly what my statement says. I think we've indicated that we would have wished to engage to a greater extent than was the case, and there were limitations in the middle of an emergency response to the pandemic. There was extensive engagement with community groups. I can give a couple of examples if that's of assistance.

Early in the pandemic response, the Public Health Agency produced Health Inequalities Report which demonstrated the impact that the pandemic would have, the NPIs would have, and indeed the contact tracing programme would have in terms of health inequalities, ethnic minority groups, et cetera.

They developed a vulnerable -- a contact tracing vulnerable groups action plan to specifically target those groups, to offer differential testing. For example, they established a helpline dedicated for the Roma community in Northern Ireland, all of the information leaflets were available in many languages. There were videos, there were animations, all of which had subtitles.

Another example in terms of the Northern Ireland Smart Programme which was the community-based rollout of LFDs, lateral flow devices. There was extensive

engagement with third-sector organisations. And indeed, the community or the Contact Tracing Steering Group which had been established in early May to support the Public Health Agency, engaged with the human rights commissioner, the equalities commissioner, the children and young people's commissioner, the older people's commissioner, and indeed, third sector organisations, again representing the homeless population and underserved population.

So we were very clear because we knew that unless there was equitable access to contact tracing and testing and that that was based on engagement with community leaders who were trusted in those populations that we would not be able to provide those populations with the protection and the service that they deserved.

MS MALHOTRA: Thank you. Thank you very much, Professor McBride. I'm afraid, we turn to -- not afraid at all, but we turn, I believe, to some CP questions now.

LADY HALLETT: Thank you.

Mr Thomas.

Questions from PROFESSOR THOMAS KC

PROFESSOR THOMAS: Good afternoon, Professor, my name is Leslie Thomas.

A. Good afternoon.

Q. I'm representing FEMHO, that's the Federation of Ethnic Minority Healthcare Organisations.

At paragraph 346 of your statement, you confirm that the Department did not have a specific policy in relation to testing in places of worship or those living in overcrowded accommodation.

As ethnic minority communities are more likely to live in multi-generational households, do you accept that the absence of culturally competent policy guidance in specific relation to this, what I've just indicated, was a missed opportunity to protect these minority groups?

A. I don't think that's in accurate reflection of my statement, and indeed I go on to state later in that same section where I referred to hard-to-reach populations that we did go to significant lengths, as I've just outlined to counsel, to ensure that we had culturally-sensitive programmes which were accessible to a range of people living in Northern Ireland, including those from ethnic minority groups.

We had specific targeted testing programmes, again, where we knew that individuals predominated from those ethnic minority groups, and that included those working in the agri-food sector, those working in manufacturing, central retail and construction.

We worked very, very hard with local employers, for instance in the meat processing plants within Northern Ireland, where we had a significant number of outbreaks, and the Public Health Agency engaged extensively with individuals working in that sector, who, you're absolutely right, lived in homes of multiple occupancy, shared transport. And it was important that the advice that we were providing, the access to testing, and the contact tracing, was culturally sensitive, and was something that those populations found acceptable.

So -- I mean, I was not across the detail of that, but certainly, as chair of the Oversight Board, I was appraised by the PHA of the efforts that they were making in that respect.

Q. At paragraph 362 of your statement, you say that:

"The Department's advice to the NI Executive to inform reviews of the Regulations took account ... of available disaggregated data regarding patterns of those testing positive for example in relation to age, gender and deprivation."

It's important for FEMHO to understand also whether this data was disaggregated by way of race.

Can you comment on whether the data was disaggregated in this way?

A. No, unfortunately it wasn't, and I think that was a gap, and I think it's an important learning point that not only do we need to be able to disaggregate the data, as we did, at the, sort of, age, gender, socioeconomic group, for instance, that we need to be able to do that by ethnicity. That was a gap that needs to be addressed.

We have subsequently rolled out a new electronic care record to all trusts in Northern Ireland, which has five specific fields, which will now ask about ethnicity, country of origin, preferred language, et cetera. So hopefully that will be addressed in the future.

Q. I'm glad to hear that that gap's been plugged. I suppose the only follow-up question I would have is, do you have any explanation as to why there was that gap? Was that just an oversight?

A. No -- well, basically, ethnicity is poorly recorded. It was poorly recorded in healthcare systems in Northern Ireland. We weren't recording, for instance, ethnicity on testing forms. We did -- and had some attempt at -- we did attempt to disaggregate that data by country of birth. However, again, the ability for us to do any qualitative assessment on that was actually limited by the fewer numbers of people from ethnic minority groups

living in Northern Ireland compared to other parts of the UK.

That doesn't make it acceptable but I do think that we have the means now to address that.

Q. Okay. At paragraph 694 of your statement you say that it was not possible to analyse trends relating to ethnicity in Northern Ireland due to poor coding of ethnicity in healthcare records, as "routine data flows did not allow for the identification of trends in the transmission and infection rates" of Covid in different ethnic backgrounds.

Just a couple of questions. Can you explain how this lack of data impacted policy decisions, and what strategic or policy outcomes could have potentially been achieved that were undermined by this lack of data?

A. I mean, I think certainly it would have been absolutely preferable had we the ability to have carried out that analysis. At the time we didn't. We now do have. But again, it still is based on the voluntary disclosure of that information by the individual themselves, and indeed the coding of that by the health professional.

We -- whilst we didn't have access to that data specific to Northern Ireland, we did have access to the data that was being generated in other parts of the United Kingdom. So, for instance, my Deputy Chief

Medical Officer, Dr Naresh Chada, was a member of the working group chaired by Professor Fenton looking at the disproportionate impact of the Covid pandemic on individuals from ethnic minority groups, and we were fully aware of that data and that did inform policy decisions in Northern Ireland.

We had no reason to think that the data and the research findings would be different in Northern Ireland but, again, I agree it would have been preferable to have local data.

Q. Okay. Final question, then, is this: in hindsight, do you believe that empowering local ethnic minority-led organisations could have improved testing uptake and compliance with isolation measures in their communities? And what steps could be taken to implement such measures going forward in the future?

A. I completely and wholeheartedly concur. It is important that when -- you know, whether it's any -- public health messaging is about affecting behavioural change; it isn't about telling people what to do. And it is about working with local communities and trusted leaders in those local communities to community a message in a way that is actually culturally sensitive and is understood by that population. So I entirely accept the point.

PROFESSOR THOMAS: Thank you, Professor.

Thank you, my Lady.

LADY HALLETT: Thank you, Mr Thomas.

Mr Wilcock?

Questions from MR WILCOCK KC

MR WILCOCK: Good afternoon, professor. I represent, as you know, Northern Ireland Covid Bereaved Families for Justice. In fact, 90% of the questions I wanted to ask you have been covered by other people, so I'm not going to repeat them. I'm going to ask you about a different topic in terms of this module but an all too familiar topic in relation to previous modules, which is the heavy workload that was placed on you by the system in responding to Covid.

In your statement, you mention a number of boards in relation to testing issues which you set up, including the expert advisory group in testing, the TTIP board that you referred to earlier on in your evidence this afternoon, and the SMART board established on that asymptomatic testing in March 2021.

Now, the then Minister for Health, Robin Swann, has made a statement to the Inquiry that, while he greatly benefited from you having a policy role in addition to his advisory role during the pandemic, it also served to highlight the heavy workload of, and reliance on, the CMA role in the pandemic response.

First question is this: was the heavy workload that we've been referred to by Mr Swann and that we've heard about, one of the reasons you set up the several boards I've mentioned and the others that you've listed in your statement?

A. I'm not sure that follows, if I'm really honest. I think that the establishment of those various working groups was essentially to ensure that we were making best use of the finite expertise that there was from a professional and scientific basis in Northern Ireland, and as I said earlier, my Lady, we worked in a very integrated way with local science, with academic partners, with the Public Health Agency.

The truth of the matter is Northern Ireland was just too small to maintain discrete organisational boundaries where it was much more efficient and effective to work in a much more joined-up and integrated way, and that's what we did.

So if I take, for example, the various boards in relation to testing and contact tracing, my own view that those were a very efficient way of working together to provide support to the Public Health Agency, which in relative terms is a small organisation, but also, ensured alignment between operational delivery and policy. So it reduced fragmentation, it ensured greater

efficiency and effectiveness, and worked well.

I think I would accept the point, and it was made in expert witnesses to Module 2C, that too much was asked of the department. By any comparison, it's one of the smallest departments in the Northern Ireland --

Q. I'm talking specifically about the CMO at the minute.

A. I'm going to come on to that.

It's one of the smallest departments in Northern Ireland, despite having the biggest budget, and at that time, in my view, looking back on it, the Chief Medical Officer role had both significant professional advisory responsibilities and also significant policy responsibilities. That has now changed, in that in significant areas, the policy responsibility no longer sits with me, although I provide separate advice to policy colleagues who lead on that.

And I think that, should a similar situation arise again, I think that's a much more effective division of responsibility.

Q. So if I could just test that answer by asking you about the change you've just referred to, because what Mr Swann says in his statement is that the Department of Health has since, and I quote "reacted to the heavy workload and reliance on the CMO by making sure the CMO no longer has a policy remit".

You've told us about that. When did that change take place?

A. Well, the change began in and around, I think, April '22, and has evolved since that time. So it's probably towards the latter end of the pandemic response. I may not be correct in that --

Q. I don't think anybody is going to quibble about a month --

A. But it was certainly in the latter part of '22 -- probably early '23, if I'm honest, actually, it might have been in April '23.

Q. I think a more important question I need to ask you is, did you support the proposal that your policy role be curtailed?

A. Fully. I mean, these are individuals who I've worked with for the past 16-odd years. I still have close liaison with them and we work effectively as one team. So I think the fact that I don't have budgetary responsibility, I don't deal with the HR issues, I think actually frees me up to concentrate and focus on the professional and technical aspects and actually to ensure I can provide more professional advice across more policy areas.

Q. And does it follow from that that no matter how hard you undoubtedly tried to cover the heavy workload placed on

you, too much was being asked of the CMO during the pandemic?

A. Well, you know, I was supported throughout by a very able team. I had two deputy chief medical officers, I had a Chief Scientific Advisor, an extremely experienced team, and I had a number, a small number of senior medical officers. And as I say, we worked in a very integrated way with the Public Health Agency and also I benefited from tremendous support from academic colleagues working in both of our universities, in Queen's University of Belfast and the University of Ulster.

So, you know, it wasn't just me. There was a team of able people supporting the roles and responsibilities that I had at that time.

Q. But equally, that team of able people was still in existence when the role was curtailed in late '22, early '23, whenever it was?

A. Yes, but I think the point I would make is that we all had to step up at a time of unprecedented challenge. The job that I had was the job that I applied for, and was appointed to. And whenever the department activated its emergency response plan, which it did on 27 January, the responsibility for the coordination of the health service response, and the public health response, as

defined in that plan, fell to me and my team. And we did that and we were supported by other colleagues across other policy areas within the department, and we were supported by other government departments in terms of loneliness, additional people, to assist with the responsibilities that the department was carrying at that time.

MR WILCOCK: Professor, thank you very much for those. Thank you.

LADY HALLETT: Thank you, Mr Wilcock.

That completes the questions we have for you, Professor McBride. I can't -- I think we are calling you again, I think. So I'm definitely not --

THE WITNESS: I'm afraid you are in July, my Lady.

LADY HALLETT: Well, what I'll try to do is ensure that we don't call you again thereafter --

THE WITNESS: Can I hold you to that?

LADY HALLETT: -- unless we absolutely have to.

But, thank you very much for the help you've given. There may be those who criticise the overall response but I don't think anyone could criticise you and your colleagues for the amount of dedication you showed during the pandemic in trying to save the lives and the health of the people of Northern Ireland.

So thank you for your efforts and thank you for your

help with the Inquiry so far.

THE WITNESS: Thank you, my Lady.

LADY HALLETT: Right, I think we're ready for Mr Swann?

Sorry you've been waiting so long, Mr Swann. I'm afraid you're the last witness.

MS CARTWRIGHT: Thank you, my Lady. Please can Mr Swann be sworn.

LADY HALLETT: Thank you.

MR ROBIN SWANN (sworn)

Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 7

MS CARTWRIGHT: Could you please give your full name to the Inquiry.

A. Robert Samuel Swann.

Q. Mr Swann, you've provided evidence to the Inquiry before but in respect of your Module 7 statement could we please move to page 101 of that statement. It's a statement dated 8 April of 2025, and can I ask you to confirm that the contents of that statement are true to the best of your knowledge and belief.

A. I can, yes.

Q. Thank you.

Now, in respect of you and your background, can we just confirm that which you've spoken about in other modules. It's right, isn't it, that at the time of the pandemic, you were the Health Minister from

11 January 2020 to 27 October 2022, and again on 3 February 2024 to 28 May 2024?

A. That is correct.

Q. Thank you. And is it right, more broadly, that you are the Ulster Unionist Party MP for South Antrim and have been an MP continually since 4 July -- could you just confirm the date?

A. 2024.

Q. Thank you very much indeed.

Now, obviously, the focus of your evidence today is going to be on your role as the Minister of Health during the pandemic and particularly it's going to be helpful to look at the decision making in the March time. But before doing that, and I think to contextualise some of the decision making and the issue of cross-cutting issues, you helpfully detail within your witness statement the Ministerial Code and the relevant paragraphs -- I think it's 2.4 of the Ministerial Code, but perhaps so it's absolutely clear from your perspective as the relevant minister, and let's confirm this first of all, you accept and tell us throughout the statement that you were essentially responsible for the policy and strategy and decisions relating to TTI?

A. That's correct, yes.

Q. So can I ask you to explain from your perspective the issue of cross-cutting but also matters relating to TTI that needed to be taken to the Executive?

A. I think, my Lady, in regards to this, when people talk of cross-cutting issues within the Northern Ireland Executive in that sphere, there's two very different perspectives in regards to that. There's that which comes under the Ministerial Code, which is cross-cutting and controversial and has to be deemed so and can be deemed so by the First and -- First and deputy First Minister acting jointly where a decision or a step taken by a minister can actually be called in and challenged by the Executive; or there are those issues that could be more colloquially known as cross-cutting as where actually ministers can work together and work in partnership without it having to be a large Executive issue or a problem or even that it's controversial, that that actually shows, I think, the good working relationships that we see across politics.

And in part in regards to TTI, especially in Northern Ireland, I think, I had that cross-cutting partnership approach, especially in the early stages with the Minister for Communities in regards to how they were able to set up, you know, the discretionary support payments so that the people that we were asking to

isolate actually had those supports.

There were also those cross-cutting when it comes down to testing whereas later on we were able to work with the Minister of Agriculture in the utilisation of the AFBI labs, so we were actually increasing testing capacity as well.

So in regards of what can be deemed as cross-cutting, it's not always controversial in Northern Ireland and I think in stages of this part we actually saw good partnership working in that.

Q. Thank you. Perhaps if we can display, please -- it's page 8 of your statement and it's paragraph 13 -- because in giving that answer you've obviously identified the different departments where you had to liaise, and I just want to be clear from your perspective.

So we can see there's the:

"... paragraph 2.4 of the Ministerial Code [which] requires ministers to bring matters to the Northern Ireland Executive ..."

And obviously one of those features being a matter which "cuts across the responsibilities of two or more Ministers", and I think you've identified different departments and ministers there.

I suspect we could probably spend a week talking

about cross-cutting issues, and the litigation that's arisen out of it in particular, but what we really want assistance with -- if it's a straightforward answer, but if it's more complex, please tell us -- in respect of the issues of test, trace and isolate, that we know you that the responsibility for, was there a requirement under the Code for those to be taken to the Executive?

A. Not specifically under the Code, but under the cross-working of the Executive in regards to how we were actually working as a newly formed Executive, just formed on 11 January of that year, you know, a few weeks later being forced into it in regards to that, there were those issues that needed to be discussed, needed to be understood, I believe by all Executive ministers, and that's why we brought those -- our Test, Trace and Protect, our testing strategies, always to the Executive, to make sure that they were informed of what we were doing under a policy decision, but also why we were taking those decisions, but also to give them the opportunity to input and also challenge, if they saw fit.

Q. Thank you.

Now, we've identified the strategic policy decision role you had for TTI, but it's right, isn't it, that the PHA, the Public Health Agency of Northern Ireland, was

essentially the operational arm to implement testing and contact tracing?

A. They were the delivery body for that. They were our public agency in regards to that was their standard role, that was their responsibility, and that's where the professional delivery mechanism actually lay. They were an arm's-length body with their own board, their own chief executive, you know, accountable to themselves.

Q. Thank you.

Now, quite separately we know that Public Health England existed in England, but can you just confirm that throughout the pandemic that Public Health Agency in Northern Ireland remained, it was a constant agency in Northern Ireland?

A. It was, throughout the pandemic, because of their expertise and what they did in regard to that public health messaging, in regards to the contact tracing side on -- with experience of testing for other diseases and other issues that they had to deal with, they had that expertise.

There was a step taken during the pandemic when Public Health England was stepped down, with its functions devolved across different departments of health and social care in England. I didn't think that

was the right thing to do, again because of the expertise within the organisation, but also the size the scope that we had in Northern Ireland, even the additional capacity that was within the Department of Health where those responsibilities could possibly have been transferred to.

So to me, it made sense to retain PHA in its existing form in its entirety.

Q. Thank you. I think perhaps can you slow down slightly so the stenographer can keep up with both of us, please.

Now we've already identified that you were the Health Minister from 11 January 2020, and you've just contextualised that essentially this was when the Executive started and the government in Northern Ireland commenced its work again, at the same time as a pandemic is coming towards all of us, and in particular in Northern Ireland for the context of your evidence.

Can you give some context, then, to her Ladyship -- obviously you're a new Health Minister in a newly formed government again -- as to any relevant context when we're looking back and analysing the decision making and the infrastructure at that time in Northern Ireland, please.

A. I think, my Lady, to really put that into context, we as a party didn't decide until the Saturday morning that we

were actually going back into the Executive. So it was a decision that was made by my party's executive that that morning we went in. And then, as ministerial positions are given out by D'Hondt rather than pick, we had the penultimate pick, and at that stage Agriculture and Health was left, and my then party leaders elected Health and asked me to take up the role in regards to that for what was meant to be a short period of time, while things could settle, because I'd actually stood back a few months previous as the party leader in regards to that.

But it developed then in regards to having to get into the role very quickly, you know, what actually came about, the challenges that were faced, the party leader, Steve Aiken at the time, asked me to stay on in the role. I did throughout the pandemic and then subsequently went back in the second time as well because I saw the value of the point, I saw the value of the post, and I thought there was -- I thought there was actually merit in our party taking it in regards to the fact that we were a single ministerial position within a multi-party Executive.

So whereas, in other instances, throughout periods of challenge in Northern Ireland, where party lines can fall and separate between the two larger parties, as us

being a single-party minister within that, I thought, and I hoped I did, and I believe I did, was able to work across those party boundaries, because we weren't coming with any other agenda apart from public health agenda in regards to how we were operating and working within the Northern Ireland Executive.

Q. Thank you.

Can I ask you, prior to January 2020, had you ever had a ministerial portfolio?

A. I hadn't, no. I had chaired the Public Accounts Committee and the Employment and Learning Committee, but not a ministerial role.

Q. Thank you. Then, can I ask you, in terms of relevant expertise, particularly where it's health, do you have any particular skills and expertise from experience before that time that helped inform health matters?

A. I think, my Lady, and it is a personal reflection, and I do, and I used it during my time as minister -- he does know I use this example -- our son was identified pre-birth with a congenital heart defect, a single kidney and a (unclear) of the bowels, so when he was actually born he spent the first 13 months of his life in the children's hospital in Belfast. So, from an operational point of view and from a personal point of view, we got a very hands-on, very family approach in

regards to actually what our health service meant, what it can deliver. But it also showed me as well, when it came to the two open-heart surgeries that he had, but also he has -- he had a pacemaker in place before he was one, that was done in Birmingham.

So it showed me that that partnership, working, looking across, looking outside Northern Ireland was a benefit we can actually do, we can work from.

His health -- since had that pacemaker replaced, at 10 year old, my Lady, in Dublin, because of the all-island paediatric cardiac collaboration we have. So I experienced from a personal point of view what our health service in Northern Ireland is, but was able to come to the role with an understanding that, for us to do what we needed to do, there was help out there when we needed it. And I think that actually helped shape how I was able to approach not just the internal relationships that I spoke earlier in regards to the internal workings of the Northern Ireland Executive, but also on that cross-departmental, cross-jurisdictional boundaries as well.

LADY HALLETT: I'm sorry you had to get experience in that way, Mr Swann.

THE WITNESS: My Lady, I was sorry as well, but I can assure you our son is now in his first year in secondary school

and has -- comes with his own challenges now!
LADY HALLETT: I can imagine.
MS CARTWRIGHT: Mr Swann, obviously completely appreciating the very personal and lived experience of the healthcare system, can I then look at it from a different perspective as to infrastructure, but also the particular skills and knowledge that were needed in a pandemic.
Can I seek to capture with you the infrastructure that existed pre-the decision in March of 2020. And to do that, can we use your witness statement, please.
It's paragraph 34, please, page 15. Thank you.
So I'm going to come to the infrastructure that existed. When we come to the ministerial meeting of 16 March, we see there reference to the fact that you say, essentially, "I've been preparing for the past seven weeks", so if we give a rough and ready to that, it looks like around the end of January, then, that you are referencing that you had started making preparations. And so can we then work through together whether you'd appreciated, by 16 March or before then, 12 March, the laboratory capacity that existed in Northern Ireland?
A. Well, my Lady, I think in preparing for this statement and, again, it goes back to Northern Ireland politics,

there was a review of pathology services and labs in Northern Ireland actually completed, in my understanding, 2016. It went out to public consultation in 2017, and then the Executive fell, so there was no minister in place. So when I come into post in 2020 there was a pathology review that was put forward in regards to what we needed to do to expand and enhance our laboratory capabilities in Northern Ireland, at that point not specifically in regards to testing for Covid-19.
So I took that forward at that time. Two of the steps within it was actually that electronic update in regards to a single electronic system working across all their labs that were reporting into one central location, but also re-establishing whereas our labs are working in the five different geographical trusts, our virology labs, that's under the Belfast Trust, actually bringing them into one network as well. So that work commenced early 2020.
The challenge that I think is unfortunate in regards to Northern Ireland, following the public consultation in 2017, ministers could have made those decisions to start to actually build our lab capacity, in regards to that.
And specific in regards to the comment in regards to

we've been preparing, we've been preparing in different ways, in regards to how we were going to prepare health, working with our GPs, community pharmacies and the hospital were provision as well, so different across the health service family.
In regards to the laboratory provision as well, until we actually knew the pathogen we were working with, and I think (unclear) know the genome, I don't think we had that available until early February.
Q. Thank you. So what I'm wanting to explore with you, because obviously you as a Health Minister have a very unique perspective of what was needed and what had to happen, a number of individuals and evidence we've got from other health ministers is essentially there was no playbook for what was happening, and so what I want to understand is, we get to January, you start to talk about preparations. How quickly did you identify the laboratory capacity that was going to be needed to respond to the coronavirus pathogen?
A. Well, in regards to, I suppose at that point January to March, it was that period in regards to we weren't really aware of what was coming in the large scale in regards to that. We weren't -- and again, this is about being able to scale up a laboratory facility for a known pathogen and a non-known pathogen in regards to what

assays were going to be used, all the rest of it.
So it's how we actually started to (unclear), I think the CMO referenced how we were working across academia, how we were working with the different departments in regards to what lab capabilities were going to be or what we could actually access.
Q. Can I ask you about that in the context of the evidence we have about the Public Health England assay and see if you can assist when, essentially, the assay was available in Northern Ireland. So the Public Health England assay was used at the Public Health England Colindale laboratory to diagnose the first case in England on 31 January 2020. Thereafter, the information suggests that PHE isolated and grew the SARS-CoV-2 virus from that first UK diagnosed case which provided the essential control material for the use of the assay, which on 10 February 2020 was rolled out to 12 Public Health England labs across the United Kingdom.
Do you know that as part of that rollout of the assay, would that have been also been provided to the laboratories in Northern Ireland as of around about 10 February 2020?
A. My understanding was that the Royal Virology Lab within the Belfast Trust received that assay on 10 February and was able to do that work as well.

Q. Thank you.

Can we then look at the different laboratories then noting, then, that the assay existed in Northern Ireland from 10 February. You tell us in your paragraph 34, please, by way of the infrastructure that the Regional Virology Lab and regional services for genetic testing is based in Belfast, and you tell us that in January 2010 the baseline PCR capacity across all of the HSC laboratories -- and can we just confirm how many HSC laboratories there were, please?

A. My understanding is there were ten across the five trusts.

Q. Thank you. And obviously you've given us an indication that there were 40 tests per day capacity.

If we go over the page, please, just to look at the capacity, at paragraph 35. So we've got ten of the HSC trust laboratories. How many of the virology laboratories were there?

A. Sorry, I don't know off the top of my head an answer in regards to that, but in regards to the 35 we're actually looking at the additional scale-up in regards to that, it was actually about that academic consortium that we established, utilising, as we say, the Queen's University of Belfast, the Ulster University, Agri-Food and Biosciences Institute, my Lady, is the veterinary

service laboratory that sits under the Department of Agriculture, so we were also actually working with them, they were part of the academic consortium, as were representatives from Almac who were a private provider as well.

So it was actually utilising all that laboratory capacity we had in Northern Ireland in a partnership approach rather than solely going for a single contractor and buying that in.

Q. Now, I think you tell us a little later in your statement at paragraph 40, we don't need to move to it at the moment, that it was March when the academic consortium was created; is that correct?

A. That's correct, yes.

Q. And so was it then -- can you help us, when in March that the identification of other laboratories to be utilised and the -- essentially the pivoting of the use, particularly of the university laboratories and the agricultural and the, I think the veterinary laboratory capacity was essentially adapted to be able to make the PCR tests?

A. Yeah. Again, I think it went to the other health trusts labs around 27 March, and the AFBI lab around the middle to the end of May, in regards to that, and then Almac as at the private partnership, or the private partner we

had in that was around August '20, as well. Because again, it's not just a matter of the labs, it was also the virus itself that we were worried enough to make sure that all the protocols, all the safety protocols were in place for those labs, actually, to handle those samples as well.

Q. Thank you. And then in terms of Almac, does that stand for anything, or is it just the name --

A. It's the name of the -- it's the laboratory provider in Northern Ireland, it's a private company.

Q. Thank you. Now, we know that Randox laboratory was being utilised particularly also by the mainland. Did Northern Ireland utilise the Randox laboratory that was based within Northern Ireland?

A. As part of the national testing protocol, so the contract with Randox was with DHSC and we had our Barnett consequence or our Barnett share of those tests as well, so the overall contact was with Randox. We classified that as our Pillar 2 testing programme whereas we were still operating the Pillar 1 testing programme which is our own labs, and I say AFBI and the Almac labs as well.

MS CARTWRIGHT: Thank you.

My Lady, I think that's probably a convenient place to take the break. Thank you.

LADY HALLETT: Certainly. I shall return at 3.15.

(3.00 pm)

(A short break)

(3.15 pm)

LADY HALLETT: Ms Cartwright.

MS CARTWRIGHT: Thank you.

Mr Swann, can we continue, please, with the theme of infrastructure and scaling up from the February to the March, please. So in respect of testing, once the assay was in the laboratories in Northern Ireland, are you able to help us as to any oversight you had for the scaling up of testing in that first month from around about 10 February to 10 March, please.

A. Well, again, in regards to oversight that I had, that was actually under the academic consortium that we had established under the chairmanship of the Chief Medical Officer in regards to how, again, those laboratories protocols, the practicalities and also the safety measures, but also one of the limiting factors, not just in regards to the assays was --

Q. Sorry to interrupt you, Mr Swann. We really are going to have to slow down to help the stenographer, please. I'm sorry to interrupt.

A. No, you're okay. So it was about the capability, also the supply of reagents, of swabs, you know, a lot of the

platforms that the assay was being developed on, if I recall rightly, was actually what was a Roche-based assay as well. So I know it was a problem actually getting the reagents and some of the protocols that we needed for that.

Q. Thank you. And I just want to just check on that answer because the academic consortium I don't think was created until the March.

A. The March, yes.

Q. So for the February period of time, is there anything you can assist before the academic consortium was convened, that you can help us with as to what was practically being done to scale up testing in Northern Ireland?

A. Well, again, it was the work through the RLV, the Regional Virology Lab, who that the expertise in regards to how they actually maintained and worked with what were extremely, you know, contagious pathogens at that stage.

Q. Thank you. And again, we know again that the handling of the pathogen, again, within this period was changed from containment level 3 to containment level 2. Do you have any of the detail as to how many containment level 3 laboratories existed in Northern Ireland?

A. That's not something I would have the detail of.

Q. Thank you. Can I then move on to assistance as to the infrastructure around contact tracing, please. Can you help us as to what existed in January thorough to March. We can certainly see there was scaling up of contact tracing that came on in April thereafter, but what existed in Northern Ireland, please?

A. At that stage the PHA's contact tracing was a relatively small unit, based in Linenhall Street in Belfast, and it was contact tracing for things like whooping cough, tuberculosis, so very small numbers, very specific groups in regards to how they were testing. The scalability capacity of that even within that facility was quite limited, so that's why at a later stage we actually moved to the County Hall, larger facility, just outside Ballymena, which was able to actually accommodate physically the infrastructure that was needed for that larger-scale testing, cohort of personnel.

Q. Thank you. Again, just coming back to the seven-week preparations that we see in the Executive meeting that we'll look at in the minutes for 16 March, anything else that we've not dealt with that identifies what you were headlining as seven weeks of preparatory work?

A. I think in regards to that, my Lady, and I think it was covered in 2C, they've been referred to as minutes.

Those are handwritten notes that I hadn't sight of prior to preparing for the Inquiry as well, so they weren't actually something that was either validated for the content or taken in context in regards to how that facilitated or where it actually sat in terms of a conversation or a debate that was going on with the Executive, but it was with that general preparation that the Department of Health was doing in preparing for Covid.

Q. Thank you. Well, we'll bear that context in mind when I do use those notes to ask you for your assistance about the discussion.

Can we then, please, move on to the issue of the decision around 12 March at that COBR meeting, what that meant from the moving from the 'contain' to 'delay'. And can we please, then, highlight your paragraph 21, please, it starts on page 10 -- sorry, the paragraph starts on page 10 but I want us to move to the paragraph on page 11, so perhaps if we can orientate, first of all, please -- thank you.

If we can move on to the next page, please, thank you.

You tell us in paragraph 21:

"On12 March 2020 contact tracing was paused in line with the decision which was taken by the Cabinet Office

Briefing Room Ministerial Meeting ... Contact tracing in [Northern Ireland] remained paused until it was reintroduced by the [Public Health Agency] on 27 April 2020, initially through a pilot phase, and then with a full launch on 18 May 2020."

You tell us that:

"In the intervening period from 12 March 2020, contact tracing continued in health and social care settings, including care homes."

Is that correct?

A. That's correct, yeah.

Q. So is that the contact tracing through the existing infrastructure you've told us about?

A. Of PHA, yes.

Q. Thank you.

Can we then, please, move, again on the same topic, just to contextualise 12 March, what you say in your witness statement, please.

It's paragraph 155, please, which is at page 51. So paragraph 155, please, at page 51. Thank you.

So this is the rest of the context for 12 March. You say this:

"... on 12 March ... contact tracing was paused in line with the decision which was taken by the Cabinet Office Briefing Room Ministerial Meeting ... I believe

the decision was in line with the UK-wide agreed Protocol for Moving from Contain to Delay and with the UK-Wide Coronavirus Action Plan dated 3 March 2020, which was agreed by the 4 [United Kingdom] governments with advice from the UK CMOs and government scientists. I referenced this in my statement to the [Northern Ireland] Assembly on 9 March 2020. I do not now recall any specific discussion or advice that [Northern Ireland] should adopt a different approach, but there were operational pressures on contact tracing services and limited testing capacity at this time, which made it difficult for both to continue in the community. The [Northern Ireland] First Minister and deputy First Minister also attended the COBR meeting, along with officials from [the Executive Office], and I do not recall that at any point it was queried whether [Northern Ireland] should continue contact tracing. As the First and deputy First Minister were also at the meeting, I did not consider there was a need to refer the matter to the [Northern Ireland] Executive. As they made no such referral either, I can only assume they also thought it was not necessary."

And so, would you indicate or accept that that is your position around this difference of opinion that appears to exist between yourself, the First Minister at

A. I didn't, my Lady, but in regards to reflecting on what I've heard this morning, but also reading, I do think there maybe is that -- not a misunderstanding but not understanding what was agreed or what actually those points in the Executive papers and especially the COBR minutes actually mean in regards to that. But I think in the COBR minutes, Professor Chris Whitty is very clear that it is about the stopping of testing and contact tracing in all geographical areas. So to me that was pretty clear in what it meant now.

I can't -- I suppose make assumptions of the other two.

In regards to the questioning and querying both from the First Minister and deputy First Minister and other ministers, they weren't behind the bush in coming forward in regards to asking queries or clarifications, or indeed submitting to my department what -- what was an FIR, which is a further information request. So we used to receiving those additional queries in regards to: what does this mean? What is this? What is the capacity?

I don't recall any on that specific issue on that timeframe but it was quite a hectic timeframe.

MS CARTWRIGHT: Mr Swann, can I ask you, then, from the perspective of health being a devolved matter, and you

the time, Baroness Foster, and Ms O'Neill, who we've heard from today.

A. I would agree, that was my perception of -- I spoke of the sequence of events from 3 May -- March conversations in regards to that, and I think it was the first COBR meeting that the First and deputy First Minister had attended in that role, that was the first one that was chaired by the Prime Minister in regards to that. So that decision, that sequence of events is as I recall it, and that's my perception of it. As I referred earlier in regards to those issues that can be cross-cutting or controversial, the First and deputy First Minister have the power to call any decision or -- well, any decision that's made by a minister actually in to the Executive for a different approach to be taken, and that's why I made that -- as they made no referral at that stage, it was my perception that they understood the process of events, the sequence of events, and the decisions that had been made.

LADY HALLETT: Mr Swann, Professor McBride was generous to the former First Minister and deputy First Minister, now First Minister, suggesting that they may not have understood the decision at COBR. Did you think there was any doubt about the decision having been taken at COBR to pause contact tracing?

being the Health Minister with knowledge of the unique position of Northern Ireland and the communities and essentially how people live across the five counties, and, beyond the city of Belfast, the unique aspect of the communities that exist in Northern Ireland, what I want to ask you is, you say, "I do not now recall any specific discussion or advice" that a different approach should be adopted, and what I want to ask you, as the relevant minister living in those communities, knowing Northern Ireland, but also that Northern Ireland did not have that many cases at that time, why you didn't consider a different approach? Whether in fact Northern Ireland should be saying: actually, it's not right for us at this stage where we're at to stop testing or to stop contact tracing?

A. And I think, my Lady, in regards to, sorry, the six counties of Northern Ireland --

Q. Six, I apologise.

A. -- in regards to that --

Q. -- I just insulted the whole of Northern Ireland, so apologies.

A. No, you're fine. In regards to that, and I think it was about the testing capacity that we had at that point I think -- and there's the statement, there's about a 100-plus, 120 tests we had per day, and it was

actually how we utilised those in regards to that. So we'd moved from 'contain' to 'delay'. We were asking people with symptoms to self-isolate in regards to that.

So the need of using a test to verify what was already guidance in regards to that, where we were actually then -- we used that testing capacity within those healthcare facilities that were mentioned in the earlier paragraph as well. So it wasn't that the testing stopped; we were testing what we thought was that highly -- I suppose critical, highly need in regards to using tests within hospital settings, care home settings as well, but also using that tracing capacity then to follow up on those cases too.

Q. So then can I be clear, Mr Swann, that at any point did you give consideration that you should have been saying that a different approach was needed in Northern Ireland?

A. Not in that specific point, no.

Q. Not at that point, but at any point, Mr Swann?

A. In regards to this incident? No, not at that point, no, not in this instance.

Q. So did there come a time when you thought a different approach was needed for Northern Ireland?

A. Well, there were different aspects where we did use different approaches in Northern Ireland, but in regards

to this one, no.

Q. Okay. Can we, please, then before looking at the minutes, look at the action plan, which has been referenced in the evidence today, of 3 March 2020 please, which is INQ000232520.

I want to go to page 3, where we see the action plan having essentially the badges of the four nations.

Now, obviously this is the document that seeks to detail what it means to move from 'contain' to 'delay', and can we perhaps just look at some of the pages, because although it was plainly highlighted by Professor McBride, there is one paragraph that references moving from 'contain' to 'delay' would suggest a change to contact tracing.

But when you go through the whole of the action plan, what was your understanding about what a move from 'contain' to 'delay' meant?

And perhaps if we go to "The Delay phase", and go into page 16. It's internal page 14 but page 16. Thank you.

So this is where it says "The Delay phase". At paragraph 4.23:

"Many of the actions involved in the Contain phase also act to help Delay the onset of an epidemic if it becomes inevitable. These include case finding and

isolation of early cases."

So, with that being set up there, that sounds like contact tracing to me, within a 'delay' phase.

A. Well, if there had have been, I suppose, my Lady, the available of testing at that capacity -- and I think it is important to put into context in regards -- when I talk to people now about the Covid pandemic and testing, everybody automatically recalls the LFDs that people were able to order to their homes in regards to the utilisation and the availability of those, rather than going back to March 2020 where we were talking about a limited number of PCR tests as well.

Just by my understanding of that in regards to these include case finding, which was the identification of case, but also to separate out the isolation of early cases, so at that stage we were advising anybody with symptoms to isolate and then further after that anybody who had come in contact with someone who had symptoms as well.

So my reading of that in context and at this point is that it's not necessarily contact tracing that that sentence specifically refers to.

Q. All right. Let's then move forward, please, to internal page 17 but it's page 19 of the INQ, please, which is "The phased response -- what we will do next".

And you can see:

"In the event of the outbreak worsening, or a severe prolonged pandemic, the response will escalate, and the focus will move from Contain to Delay, through to Mitigate. During this phase the pressures on services and wider society may start to become significant and clearly noticeable.

"The decision to step up the response from Contain to Delay and then Mitigate will be taken on advice from the UK's Chief Medical Officers, taking in to account the degree of sustained transmission and evident failure of measures in other countries to reduce spread."

And so again, would you agree that this looks like it required a very bespoke view of the position in Northern Ireland, not following what the UK was doing, where the pandemic was more advanced, but a bespoke consideration of whether, in fact, Northern Ireland needed to move from 'contain' to 'delay'?

A. I think, my Lady, in regards to that, the ability of what testing capacity we had, there was an assumption of, you know, that Northern Ireland, yes, was behind the curve in regards to the numbers of cases in regards to England and Wales, but specifically in regards to London, but I think also one of the findings I think that has come from earlier modules in regards to this,

the fact that we closed down earlier, in regards to that was actually a benefit in regards to the response to Northern Ireland, so although it was done at a time and a date that reflected across the United Kingdom, we were actually in a different sequence or a different part of the pandemic wave at that time in regards to when we actually took that decision.

Q. Thank you. Now if we move along, please, to internal page 19, page 21, again, we've got "The Mitigate phase -- next steps":

"[In the event that] transmission of the virus becomes established in the [United Kingdom] population the nature and scale of the response will change."

I'm not going to go through all of the bullet points but it is right to look at the bullet point over the page which is the one that Professor McBride referenced. We can see that included in those mitigation next steps was:

"There will be less emphasis on large scale preventative measures such as intensive contact tracing. As the disease becomes established, these measures may lose their effectiveness and resources would be effectively used elsewhere."

So would you agree that in this document it is not saying if you move from 'contain' to 'delay', contact

tracing stops altogether?

A. Yeah, but this moves on to the mitigate phase, which is the next step as well, and in March we were moving from 'contain' to 'delay' in regards to that. So in regard to that pause of contact tracing between March until they re-established the pilot in, I think it was towards the end of April and then for the reestablishment in May in regards to, you know, where we were in regards to capacity, so that was being built up over those stages as well.

Q. Thank you. And so, please, Mr Swann, using this document and what it seems to be calling upon is a nation-by-nation consideration of the factors and where the pandemic was up to, did you at any point before 12 March, sit down with the relevant Chief Medical Officer within Northern Ireland and perform the analysis of: is it correct for us to follow the UK approach, or whether we should be saying, actually, we're going to take a different approach whilst we have less cases in Northern Ireland, and have an ability to stop the spread through continuing to test with the limited capacity we have and to contact trace those cases"?

A. But I think at that point there was already -- the virus was already established within the community and I think

that has been referenced by the Chief Medical Officer, in his evidence as well. So again, we were bringing about those measures at an earlier part of the curve or the wave, as they spoke about in regards to that.

Up until that point, the discussions that we'd been having, I suppose as a four nations approach, was that COBR was, again, chaired by Matt Hancock and it was that lead from a health point of view from the four CMOs' point of view in regards to that, and it was about us taking a consistent approach across the United Kingdom in regards to how we reacted at different steps.

Q. So it seems there's multiple features that you're referencing there, and what I really want to then consider is, you've given the answer about whether in fact there was a pause moment, and do almost a bespoke risk assessment for Northern Ireland, but particularly, when we come to look at 16 March, where very clear views are being expressed by the First Minister, Baroness Foster, and Ms O'Neill who was effectively saying, "I think we're on a wrong path, the wrong trajectory; we should be test, test, testing, we should be contact tracing", when the Executive and the two senior officials, the First Minister and the deputy First Minister, were saying, "We think we're making a mistake", at that stage was there ever a reflection

and a review of the risk assessment and the plan for Northern Ireland?

A. I don't think at that stage we'd already moved from 'contain' to 'delay', so my reading, my understanding of that conversation and their statements is that none of them thought we had taken that step too early, in regards to that. In regards to the comments "test, test, test", I think was an easy soundbite because it didn't match, actually, our capacity in regards to the tests that we had. It was the World Health Organisation's approach at that stage in regard to using those abilities, but there was very few countries across, I think, the developed world who had the capacity to test and do those large-scale population tests at the start of March 2020.

Q. Thank you. Well, I don't think, in terms of your position, I need to take you to the COBR minutes of the 12 March, but can I then take you to the -- in fact, let's do that, in fact, because Baroness Foster did raise an issue.

Can we briefly then, please, display INQ000056221, that's INQ000056221. Thank you.

If we go to page 2, we can see that you dialled in, along with Baroness Foster, Ms O'Neill, and then if we -- and also Dr McBride.

If we then move, please, to the minutes, please, at page 7, paragraph 12, we can see that it records that:

"The CMO said once the policy of seven days of self-isolation was in place, the plan would be to stop all testing of people entering into self-isolation and to stop all contact tracing from other geographical areas."

And, again, the footnote is to the action plan we've looked at together of 3 March:

"It was recommended the following symptoms be used in public communications: a high temperature and persistent new cough. A 'new persistent cough' in the symptoms reflected that some people always have a cough at this time of year. If it was needed to help communicate this to the public, a date could be set, but that would be an arbitrary decision."

And certainly the evidence we've heard from Baroness Foster and Ms O'Neill is that it was not clear to them, having been on the call on 12 March, that the effect of the decision was stopping testing and contact tracing, can I be clear on your view about what you took from that 12 March meeting, please?

A. That my understanding was, because I think it goes back to the comments from Chris Whitty in regards that it would actually involve the stopping of testing and

contact tracing.

Q. Can we then move to the -- I apologise -- the minutes of 16 March, please, INQ00065689. Thank you.

Now, again, you've already caveated these are not verbatim notes, it's not a transcript --

A. My Lady, and I would like to note as well, these are not the minutes of the Executive meeting. They're a very different document in regards to this, in regards to that, so ...

Q. Please can you give clarity about this document and what it is, please?

A. It's a hand-transcribed note of a note-taker who up until this Inquiry started I didn't know existed. They are, I suppose, snapshots of what was said at different points in a conversation. I think this document itself moved to somewhat of 42 pages of, around that, in regards to handwritten notes in regards to what was a very tense and fraught meeting in regards to number of issues that had actually presented itself to the Executive at that point.

Q. Thank you. And then do you want to then give the overview? You describe it as you've just done it as "a tense and fraught meeting over a number of issues". Again, to give the context as I go necessarily to selective entries, do you want to give the overview as

your recollection of that meeting and the various issues that were being considered, please?

A. I think prior to that meeting itself, the Executive had quite a solid unified position in regards to that, my Lady, in regards to one of the core issues was when we would close or not close schools. Up until that point, the Executive had agreed that we would keep our schools in Northern Ireland open and we actually did a joint press conference in the Department of Health with all ministers standing behind the podium agreeing that was the approach. On 13 March, the then deputy First Minister now First Minister, Michelle O'Neill went out and announced that she thought schools should close, in regards to that. So that was -- this was the Executive meeting that followed what had been a unified position being, I suppose, broken not in regards or in the context of an Executive meeting but also straight to the media.

Q. Thank you. Now, would you agree that even though you plainly query the accuracy and completeness of these notes, that where we see "DoH", that refers to you from the Department of Health?

A. Yes.

Q. Thank you. So is there any dispute that it is likely you would have been referencing a meeting with

Mr Hancock on the Friday and that there had been 1,083 tests with 45 confirmed cases as of the date of this meeting?

A. That's correct, but I'm not sure over what timeframe that report would have been made at that point.

Q. Thank you.

Now, can we go over the page, please.

We can see again, by reference to you, "Contact tracing, need to redeploy resources."

Then a little further down you say, we've got "Capacity for checking numbers" and you said "100 per day". Is that likely to be in the context of the checks that could be done by contact tracers at that time?

A. That's probably the number of tests, I believe, at around that point.

Q. Okay. Again, if we look, then, you say this:

"Prefer to use resource to combat Covid-19 rather than count, self-isolate for seven days first rather than testing".

And I think particularly that summary of what's attributed to you has been something that a number have commented upon about the statement. Do you want to clarify what you said, to the best of your recollection, but what you meant or what you intended by what you were saying?

A. Again, for a meeting that was five years ago, over five years ago, my Lady, from this handwritten note, I believe what I was referring to there was actually the use of the resources to combat Covid-19, so it was actually using those tests within the healthcare facilities that they referred to earlier on, in regards to ICUs, haematology patients, oncology patients, and also where there was outbreaks within care homes, because what we had done at that point was actually recommend anyone with symptoms to isolate for seven days first, rather than seeking the test to confirm that they had actually a positive case for Covid.

Q. Thank you.

Now, again, Mr Swann, I don't mean any disrespect to you because I'm not going to go to every entry that's attributed to you, so I hope it's not considered that I'm being selective in the entries I take you to.

A. No.

Q. If we can move over the page, please, to page 4, the question was asked as to how many people in Northern Ireland have Covid, and the response attributed to you is:

"Worst-case scenario -- 80% of population.

"Some -- no symptoms, [some] mild, [some] serious".

And then:

"Medical system can check figures", I think.

So it appears there that you've recognised and identified, as of 16 March, that it was known that there was an ability for asymptomatic transmission with referencing "some no symptoms"?

A. I'm not sure that's actually what has been referenced there in regards to the worst -- I think that was coming from the CMO briefing that we'd had previously in regards to the worst-case scenario, it was 80% of the population could have Covid. The fact that some could have no symptoms at that point doesn't necessarily imply that they were asymptomatic in regards to transmission at that point. It was the case numbers that we could potentially face.

Q. And so then can I be clear, as of March of 2020, did you have any understanding or knowledge, information provided to you that suggested that someone could be asymptomatic or pre-symptomatic, no symptoms, and be transmitting Covid?

A. I think that established itself as a known fact up until the point of May, 2020, was when that was agreed as a possibility and a consequence.

Q. Thank you. Now then we can see over the page, please, again, we can see there appears to be challenges, as well, from the DoF -- is that the Department of Finance?

A. Yeah.

Q. Saying:

"Trying to prevent spread.

"Wait for people to present.

"Doesn't chime with delaying.

"Better to test more.

"Resourcing issue -- discuss more."

And then can't quite read the next bit:

"More cases we can identify, the better we can address."

And again, the response attributed to you suggests you were saying, "Self-isolate ... containment phase, self-isolate (sic) ... delay phase"

So can you assist us anymore about, again, what appears to be others beyond those we've heard in this Inquiry, challenging a decision to stop testing?

A. Well, I'm not sure that was the challenge, to stop testing in regards to that, as -- and again, the same difficulties we were having in disseminating what it actually does say in regards to some of the comments there, but again the Department of Finance would have been at that point a Sinn Féin minister in regards to where they were coming from in regards to their point as well.

Q. Thank you.

Can we then, please, again move forward again, appreciating there's many of your entries attributed to you that I'm not taking you to.

Page 7, please.

Can you help with this. We've got what appears to be:

"Exec direction?"

Query or question mark.

"I'm following the advice of my CMO.

"Spikes/clusters -- not same here as [Republic of Ireland].

"Medical advice.

"Timing different to [Republic of Ireland and] GB ..."

Then there seems to be a reference to north, south, east, west and so on.

Can you help at all with the Executive direction with the question mark. Whether this helps at all with any recollection about what was being discussed?

A. My Lady, in regards to that, I think it reflects back to an earlier comment in regards to that, and it was that point of Executive ministers had a problem with the direction of travel that we had taken at that point.

I think my point was, was that did the Executive want to give me a direction to change what we had done

in regards to that. And I don't think -- as I said earlier, there was no recollection of anybody actually doing that. So there was challenges, there was queries in regards to what we were doing, but there was nobody actually coming back and saying, "Will you go the other way? Can you do something different?"

In regards to the testing capacity, I think I've already covered that a number of times in regards to the capacity that they've actually had.

Moving through, you know, timings different to RoI versus GB, I don't think there was, in the early stages, in regards to -- a big differential in regards to the steps that we were taking in regards to that, north, south, east, west. I don't know what that refers to, in regards to the other comments as well.

Q. Now, you -- can I look at it from a different perspective. You're saying that the Executive weren't saying -- asking you to take a different direction?

A. No, well, they weren't telling me to take a different direction. I referred to earlier on there were issues that were cross-cutting can be called in by a minister in regards to that, so there was challenge, there was questioning, there was robust debate around the direction we were taking, but there was no direction from the Executive, First Minister or deputy

First Minister, actually to change course.

Q. Again, we've heard evidence from Ms O'Neill today that she was saying just that: we need to be "test, test, test", we're making a mistake. And the notes reflect that -- from her perspective, when she was taken to them.

So their position would be: you're the decision maker as to the relevant minister, they are robustly challenging the path of travel that you had taken Northern Ireland on, but, notwithstanding their challenge in this meeting, that was fraught, that you didn't alter the course?

A. But in regards to, again, that approach for saying "test, test, test", just because you say it doesn't mean to say tests will miraculously appear, reagents will appear, swabs will appear, or the machines that were necessary across the labs would suddenly materialise in regards to that. So in regards to the tests that we had, again, as I say, we'd redirect them -- redirected them to the healthcare facilities where we thought they were appropriate to use.

Q. Thank you.

Would you agree also, in terms of the difference of accounts linked to the 12 March, certainly these notes don't suggest at any point any note to suggest you were

saying: well, actually, Baroness Foster and Ms O'Neill, this was dealt with on 12 March, so -- there's certainly no entry to suggest a suggestion that that had been decided on 12 March, and so why is it being discussed again?

A. No, but neither is there any reference to the deputy First or First Minister at that point saying that this was agreed on 12 March. It's now the 16th, we've had four days where they could have stepped in to direct me to do something else or called an Executive meeting because they didn't agree with the direction of travel in regards to the decisions that were taken.

Q. Well, on that point, Mr Swann, their evidence is that they had not appreciated that the decision of 12 March and moving from 'contain' to 'delay' meant that testing and contact tracing in Northern Ireland was what had been signed up for. The clarity about that came in the meeting on 16 March, when they say they were challenging the decision to stop testing and contact tracing.

A. But in regards -- and it goes back to the minute of that COBR meeting where it says to stop testing and tracing in all geographical areas. So again, it's -- it goes back to that point in regards to what their understanding of what was agreed to, what was discussed at that COBR meeting in reflection. And again, maybe it

is, in regards to future pandemics, a recommendation, as that officials who attend those meetings actually come back with that detailed breakdown so that all who are attending the meeting, even if it is -- you know, the meeting on 2 March was the first that they had attended, so there's a catch-up or an official briefing in regards to what it actually means going into the meeting but also, after, what it means coming out of the meeting.

LADY HALLETT: Can I just say, Ms Cartwright, my notes suggest that Baroness Foster didn't say "She said test, test, test", she said that at the meeting there were those who challenged the minister on the decision to cease -- pausing --

MS CARTWRIGHT: You're entirely right, the "test, test, test" is attributed to Ms Michelle O'Neill, thank you.

LADY HALLETT: Michelle O'Neill.

MS CARTWRIGHT: Thank you.

Can you then, I'm not going to go through all the other entries but can I, just briefly, take you to then to page 31, and then I'll allow you an opportunity to say anything else about this meeting and the approach, but again, we've another example here of the deputy First Minister, which is recorded as saying:

"Approach is fundamentally flawed.

"WHO says -- test [and] test again. We're not doing

this."

Your response then seemed to be that:

"[We] Don't have capability."

The Department of Finance said there was a resource issue. And then we see -- is it the Department of Justice giving a contribution?

So again, in terms of what appears to be capturing the deputy First Minister certainly saying: what we're doing is fundamentally flawed.

A. But I think that is what is -- she is saying, but her approach for test and test again, we're not doing that, that's correct, because we didn't have the capacity to test and test again. So it's putting into context what tests were available at that stage, where we were using them compared to where we were, you know, January 21 with the LFDs and lateral flow devices where we were able to test, test, test. So it's a matter of perception in regards to that.

Look, also at that point in time, the deputy First Minister was being highly critical of all my responses in terms of how we were combating Covid-19 in regards to that.

Q. Thank you.

Mr Swann, out of fairness, in terms of the resolution that will have to be made of these issues, is

there anything else that you want to say from your perspective about the meeting of 16 March and the position, then, to continue, as part of the delay phase, not to test, the community testing, and not to continue with the contact tracing until it came back on again at the end of April?

A. Well, I think, my Lady, in regards to if we'd have kept the community testing without being able to follow up with an effective contact tracing programme at that point, I could have been equally sitting challenged here today as why we actually weren't using those tests within the hospital, care home and care facilities in regards to ICU, as to how we were actually using them as well. So it's -- it's a challenging position in regards to that. If we had had the capacity and the number of tests at the start, certainly the approach of test, test, test and test again is the right one, if you have the tests.

Q. Thank you.

Can we then, please, just to give a context as to the position in Northern Ireland, please.

If we can look at the situation report for 12 March, please, which is INQ000083097, please. That's INQ000083097. Thank you. We can move to the next page.

Again, if we look for Northern Ireland as the

position as of 11 March, just 20 cases; would you agree?

A. Yeah.

Q. Thank you.

Then if we can move into -- again, just have an understanding about how the testing was increasing your April testing strategy, please.

Which is INQ000103649, please.

This is, as we can see, your testing strategy of 6 April 2020. And if we move into this document, please, to page 12, that -- if we look at paragraph 3.3, we can see that:

"Testing [had] been scaled up from 40 tests per day in January 2020 and the current testing capacity is up to 736 tests per day. The factors influencing the number of tests carried out each day depends on the number of swabs received, availability of testing reagents and testing kits."

So would you agree, Mr Swann, that the numbers of tests being available with the steps, particularly with the input of the Academic Consortium, was increasing the availability in Northern Ireland?

A. Yes, and that was the intention of it, but there were those limiting factors in regards to it, as I state there: you know, the availability of testing reagent and also the kits as well. Because we were at the end --

the end of a very long supply chain in regards to a number of these reagents and testing kits, as well, which were, you know, swabs which were easily available and easily purchasable from China and -- you know, just-in-time supply chains all of a sudden became high demand across the world in regards to that.

Q. Thank you.

The start of this section, I just want to make sure there's absolute clarity, it's described within your strategy document as "scaling of nucleic acid testing". It's right, isn't it, when you're talking about that, that's essentially the PCR --

A. PCR, yes.

Q. -- because it's the ribonucleic acid in the PCR test?

A. Yes.

Q. Is there any reason why you were describing as the nucleic acid testing rather than the PCR testing?

A. I'm not aware of why there had been any change of names in regards to that and that.

Q. Thank you.

Can we then move forward again just to get a snapshot of how scaling up happened in Northern Ireland, and then move, please, to your 20 May testing strategy update.

Which is INQ000103650. Thank you. Again, if we

move into page 3 but internal page 2, please, again, we get an idea of the testing -- thank you.

We can see you've identified:

"Since publication of our strategy we have increased our testing capacity significantly. At the beginning of this pandemic, HSC laboratories were processing 40 tests per day. This figure has now increased to 1,700 test per day in our HSC laboratories, with an additional 800 tests per day under the National Initiative, and I am confident that we will continue to increase our testing capability and capacity to ensure we continue to deliver a robust response to this unprecedented pandemic ..."

So, again, would you agree these are helpful for identifying how testing was increasing?

A. Yes. And again, they work across I think all sectors in regards to how we were scaling up in partnership with others.

Q. Thank you.

Can we then move, please, into page 19 of this document. It's a helpful document because there's lots of graphs that identify the improvements and the increases, but we can certainly see "Estimated Daily Testing Capacity by Testing Platforms", that was anticipated for the next period of time, from the May to the June.

Can I ask you just to assist us, in the left-hand side, we've got a number of breakdowns, and the shading is not helpful, but can we just -- so we understand the practicalities of the equipment, the first, the Seegene, which testing platform was that? Was that the one operating in the hospitals or in the --

A. I honestly can't comment in regards to where they were actually positioned in regards to our different labs, but the first four would be within our health estate in regards to that, and the two bottom ones, as you can see, is the Almac partnership and the AFBI partnership in regard to those.

Q. Thank you.

Thank you.

Then I think we know on the timeline -- if we move forward, please, to INQ000120704.

That's INQ000120704. Thank you.

Then the test, trace and protect strategy of 27 May was introduced, when all the four nations essentially by then had identified their strategy.

Thank you.

If we can turn into page 9 of this document, please. Again, this helpfully identifies that the PHA had reintroduced the contact tracing in the April, and from 18 May they had been contact tracing all confirmed

cases.

Over the page:

"This ... is likely to become a part of everyday life ..."

Thank you, that can be taken down.

So, Mr Swann, looking at what was possible, if a decision was made on 16 March to not follow the decision to stop testing and contact tracing, would you agree that there was an option to have a different approach in Northern Ireland that could have assisted in stopping transmission of Covid?

A. Well, I think to take that different approach, as I've said earlier, would actually have been to use those tests not in healthcare facilities, in regards to where we currently were and where we were actually using them at that point in time.

So it was a decision to redirect those tests within healthcare facilities and increase the numbers we were actually using there or continue to use the contact tracing position that wasn't robust enough, actually, to stand up at that point.

Q. Now, on the decision to stop contact tracing, the statement that's been referenced of Dr McClean from the PHA indicates that the PHA also were not involved in discussions about the decision to stop contact tracing

in March of 2020. Do you agree with that position?

A. As far as I'm aware, but I think I've also seen a statement from Dr McClean and the PHA where she goes on to say that neither did they then challenge it with the Department of Health, or the Executive as well.

Q. Thank you. Now, can we then, please, look at an issue of public communication because I think your statement helpfully identifies how the other testing strategies increased in Northern Ireland in the testing centres.

But before doing that, can I just deal with, very briefly, your April strategy identified the use of LAMP testing, LamPORE testing, and can you just give us a bit more evidence because, obviously, Northern Ireland was quite unique for trialling the LAMP testing from April of 2020 which is right, is it, that's where you can test for Covid through saliva, a spit test almost?

A. That's a very specific test in regards to that, not a large-scale one, as well, but we used a pilot of it because we could use it in specific facilities, we used it in number of special schools, my Lady, where we were, you know, seeing that increased challenge in regards to how we were able to test.

We also used it in a number of health facilities where, especially, I think, residents with dementia had quite an adverse reaction to the physical swab.

So again, I think it was a small-scale test or a small capacity that they had but we saw advantage in using it as a pilot, especially in those special needs schools, and to enable those people who were uncomfortable or either just physically couldn't do the swabbing, where we could use that saliva test, basically a precursor for LFDs, only I think the turnaround time was a 20-minute result at that point as well.

So when there was the advantage, and again, I think that was the strength of having the academic consortium, so when pilots like that appeared, you know, we made sure we took full facility and full use of them and made sure they were used in a targeted approach.

Q. Thank you. And was that LAMP Testing taking place in Northern Ireland or was that done through Oxford University?

A. It was done in the -- the facility itself was actually on-site facilities, as well, so you were able to do it within those special schools within those geographical settings as well, but we were part of that wider pilot.

Q. Can I just be clear, where did the actual -- the LAMP machinery, my understanding is that to do LAMP testing it's very cumbersome machines that enable you to process the test?

A. And that's why it was small scale so we were able to do

that within Northern Ireland. My understanding, my Lady, and I will check with the CMO in regards to that but we were part of the pilot. I assume we had the facility in Northern Ireland and --

Q. Thank you, I won't press you further about that. Thank you.

Can I just be clear about -- we know that you got your, when the Lighthouse laboratories went online, can you just help, so we're absolute clear what access to testing were you able to utilise of the Lighthouse laboratories?

A. The Lighthouse laboratories, the contract, again, as I said earlier on, was between DHSC and Randox and those Lighthouse suppliers, or agreements, and it was the memorandum of understanding signed across all four nations was -- actually we got our Barnett consequential of the capacity, which was 2.85% of the available overall testing capacity in regards to that.

But on special occasions, and I suppose with special representation we were able to ask for additional resource in regards to that, as well, should we need it or should we see specific spots where we needed to do additional testing.

What we did in Northern Ireland in regards to those, we had the regional facilities that were permanently set

up with a large number of tests available. So we had local facilities which were permanently there but it was a smaller number and then we'd mobile testing units which we could deploy to different areas, different facilities, to make testing, I suppose, geographically accessible, as physically accessible as possible.

Q. Thank you. So did that mean that the PCR tests were being shipped off from Northern Ireland to England?

A. Well, no, because of the Randox facility that we were able to use, so the samples that were being taken were being tested, so it was the Lighthouse facility.

Q. So you're describing Randox as part of the Lighthouse facility?

A. Yes.

Q. Thank you.

Can I very briefly, then, just to deal with an accessibility or issue relating to these tests, INQ000373440, I think this is 8 September 2020 where you had contacted Mr Hancock by reference to issues facing the national Covid-19 testing system where it appears that when people were seeking to book tests, they were being offered tests in the United Kingdom rather than Northern Ireland?

A. My Lady, again, that was, I suppose, one of the geographical challenges of Northern Ireland and

(unclear) the system was actually set up in regards to that, so people, when they put in their postcode, were directed to their closest available test, and test facility, and in some cases because there's only 14 miles between us and Scotland, some people were actually being directed to Scotland to go for a Covid test. So when the system had been set up, that particular peculiarity of the Irish Sea hadn't been taken into consideration and had caused some significant concern in regards -- it became a media issue over that specific weekend in regards to that, so it was something we were able to resolve as well.

Q. Thank you. For my purposes, Mr Swann, I've two short topics left, please, if you can assist me. And the next topic is public communication.

Can we please display your paragraph 231 at page 72. Thank you.

Now, you detail that the Public Health Agency established targeted communications aimed at ethnic minority groups and also communities where individuals lived in cramp accommodation. You specifically recall that this work was undertaken by PHA.

Can you assist to what extent the Department of Health was involved in this?

A. We were part -- that was undertaken by the Contact

Tracing Steering Group, the department had representation on that as well, along with Business Services Organisation, Patient Client Council, the Ulster University, Queen's University, but also NICVA which is the Northern Ireland Community and Voluntary Associations, as well, so under PHA's remit they were able to do that.

That Contact Tracing Steering Group also engaged through their preparation for that work with the commissioners in Northern Ireland, so with their older people's commissioner or children's commissioner, as well, in regards to that.

Q. Thank you.

If we can then go backwards, actually, apologies, 223, and page 69. Thank you.

You note that you are aware of the potentially disproportionate impact of the pandemic, including isolation restrictions on certain socioeconomic groups and ethnic minorities. Can you recall at what stage you became aware of the disproportionate impact of the pandemic on the ethnic minority groups specifically?

A. In regards to specifically, it wouldn't have been latterly on in regards to Northern Ireland specifically, it was the work that, I suppose, Dr Chada was doing within the ethnic forum across all healthcare systems

across the United Kingdom in regards to what was actually being seen in regards to that.

In Northern Ireland, in regards to the socioeconomic groups, I think the biggest and I think the positive step, because of that cross-cutting nature, was actually those discretionary payments that the Department of Communities along with ourselves, were able to bring in at the start of this as well.

Q. Thank you. And was that the discretionary scheme that was available for isolation payments --

A. Yeah.

Q. -- from, was it, 25 March --

A. 25 March. So I think the Northern Ireland was the first of the four nations, actually, to introduce that payment and that support mechanism, as well, which I think -- I recall, my Lady, I think came up to a sum of £4 million during the duration of the pandemic, but it was something that we saw was necessary, and again, working with, and working with in partnership with the Department of Communities we were able to facilitate.

Q. Thank you.

Can we move to the next paragraph, 224, please.

You recall that the Public Health Agency commissioned reviews that considered the impact of the pandemic including isolation, and that evidence on

inequalities from these reviews were shared with your department and subsequently used to inform policy.

How were these reviews used to shape policy and what was the disproportionate impact of isolation on minority ethnic groups considered at this stage please?

A. Well, in regards to the inequality that the health intelligence unit it had also identified the harder-to-reach groups across Northern Ireland, including our ethnic minorities, but also our aged population and our rural population as well, my Lady.

One of the challenges that we've had and that we've addressed it and I think the work that does need done in Northern Ireland is actually the identification through health records of our ethnic minorities in regards to that, not just those who work in the health service but also who are part of our greater society as well.

In earlier modules we've referenced the encompass programme which was brought in, which is a single health record that will be -- sorry, is available now across all five of our geographical trusts, so that will start to feed into how that data is actually collected and utilised.

Q. Thank you.

Can we next move, please, to your paragraph 127a on page 42, please.

I think to understand paragraph 127a we just need to briefly look at -- this is a time around prioritisation and eligibility for lateral flow devices, which we know came on the end of 2021 and certainly you're suggesting January 2022 here.

You say:

"At the time I agreed this change in the guidance, I considered that it was clear; however, 5 years on, and no longer as immersed in the pandemic response as I was then, I can appreciate that at times the fast-changing nature of advice and guidance may have been challenging for some members of the general public. The Department made significant efforts to provide clear communications to accompany policy changes ... Clear communication and advice will be critical once again in any future pandemic response and I believe that recommendations and lessons learnt from the Inquiry will be particularly important in this regard."

Are there any particular further lessons or recommendations you would wish to bring to the Inquiry's attention?

A. My Lady, in regards to, I suppose, building on this and it is about communication in regards to clarity and understanding, while we changed our interim testing protocol, as well, you know, with ten iterations in

Northern Ireland over the period of the pandemic, we understood in working closely with the system, you know what it was changing, and what it meant, but in regards to making sure there's a clarity of understanding, and I think at times, especially useful in regards to the interaction with the children's commissioner in Northern Ireland, who was a very strong advocate of making sure language being used was as simple and as understandable as possible. So I think in regards to future productions of policies, strategies, that that is something that should be very clearly embedded in regards to steps that should be taken.

In regards to wider recommendations, I think my concern is the scalability of our laboratories in Northern Ireland was only possible because of the partnership working that was established in the heat of a pandemic. I would like to see that strengthened, maintained and made more robust. The concerns that I have like Lighthouse facilities, already we're seeing actually closed down across the United Kingdom, because I think it was Mark Drakeford who actually said in regards to his evidence as well, it's hard for politicians to sustain the investment in large-scale testing facilities and infrastructures in case they may be needed, but I think there has to be that watching

brief across all four nations working in partnership as to how, if, and I sincerely hope it's never needed again, but should that large-scale laboratory system be ever need to be utilised, that there is ability to switch it on, should that also be in terms of physical capacity but also in the workforce as well, so that there is -- it's as collaborative as possible, there is a memory muscle there as well as to how it was done, when it was done, and what steps were taken.

Referring that specifically back to Northern Ireland would be part of my concern. Many of the senior medics and professionals that we relied upon came back out of retirement or from other parts of service simply because of their dedication to the Northern Ireland health service, but also the personal relationship, I believe, with our Chief Medical Officer. When I asked, they answered the call in regards to that. So I'm concerned, you know, five, ten years down the time, will we have that professional capacity in reserve, and standby, whose experience can be actually called on and utilised?

Q. Thank you.

You've given a great deal of reflection there to her Ladyship. We've also got paragraph 99 to 100 where you have given further personal reflections as well on earlier pages of other reflections, but can I just

finally for my purposes ask one question. At paragraph 310 on page 99, you -- thank you, that's page 310, page 99.

Can I ask you, you're referencing there the use of the Covid-19 proximity app. We know that Northern Ireland developed and got their proximity app out first. Do you have any reflections on the fact that essentially yourself in Northern Ireland and Scotland were using different apps than was then not the Covid-19 app that was then deployed from the end of September in England and Wales?

A. I think part of that, my Lady, and I really don't want to take away the fact that our digital communications information officer, and his small team were actually able to produce a Covid-19 proximity app in Northern Ireland, considering the size and the ability that we have, that it was the first international cross-border app that was developed across the United Kingdom. We were the first, actually, to deploy a Covid-19 proximity app out of the five nations, as well, in regard to that. We had a successful uptake, I think, and complete over the duration and the period of time 6,700 people actually downloaded the proximity app in Northern Ireland, which, out of a population of 1.9 million, is actually, I think, a very positive story.

But it goes back to some of the communications we had around building up to it. We were very clear that our app wouldn't be there to capture data, it wouldn't hold any personal information, and again, that was because of that interaction working with the children's commissioner, you know, the information commissioner, and in regards to that as to how we developed it.

So we moved at pace in regards to the operation with the other apps that eventually was under -- interoperable with those apps as well over a period of time, but I don't think it had been right that we waited in regards to them developing our app to make sure that it worked with them. What we were able to do was work with the Republic of Ireland in regards to making sure that cross-border mechanism actually worked. I think it was the first international cross-border app that there was developed around the world using that platform.

So it wasn't the fact that our platform didn't work with the English one; I think it was the English one didn't work with ours in regards to that. They were able to adapt, you know, the care app that they already had.

MS CARTWRIGHT: Thank you, Mr Swann. Those are my questions.

My Lady, there are Core Participant questions.

LADY HALLETT: Mr Thomas.
Mr Thomas is that way.
Questions from PROFESSOR THOMAS KC
PROFESSOR THOMAS: Good afternoon, Mr Swann, just a couple of questions, if I may. At -- I'm sorry, I should introduce myself: Leslie Thomas, I represent FEMHO, the Federation of Ethnic Minority Healthcare Organisations.
At paragraph 255 of your statement, you say that it was not possible to analyse trends relating to ethnicity:
"Due to poor coding of ethnicity in health care records ..."
As:
"... routine data flows did not allow the identification of trends in the transmission and infection rates of Covid-19 ... [for] different ethnic backgrounds."
Question: can you explain how this lack of data, disaggregated by ethnicity, impacted on policy decisions?
A. Well, it was the fact that that data wasn't collected in regards to health records in Northern Ireland, as I referred to in an earlier answer.
The development of the encompass digital record now asks for ethnicity, and I think first language and

country of origin as well. So one of the learnings, not just coming out of an earlier module, but the deficiencies within our previous healthcare system, was that that data was not recorded.
Q. Just following on from that, what strategic and policy outcomes could have been potentially achieved which were undermined by this lack of data?
A. Well, I don't think there was any -- in regards to that lack of data, when we talked earlier on in regards to the work of the PHA and the guidance that it actually put out, it put out its guidance, how to access testing and later vaccination, in a number of actually ethnic languages, you know, from Timorese through to a number of other languages. In Northern Ireland, because of our food sector, we have quite a number of ethnic groups within Northern Ireland.
So in regards to those policy decisions, because we didn't have that health data, by the ethnicity, it made it challenging for us to do that.
I do hope -- and that's why, when I was Health Minister, I saw the benefit of encompass in regards to rolling out that single health record across Northern Ireland so that everybody accessing our health service has that ability built into it. But also that, centrally, the department, the PHA and others have the

ability to follow that through, to make sure those weaknesses don't present themselves again.
PROFESSOR THOMAS: Thank you, Mr Swann. Thank you, my Lady.
LADY HALLETT: Thank you, Mr Thomas.
Mr Wilcock, who is just there.
Questions from MR WILCOCK KC
MR WILCOCK: Good afternoon, Mr Swann.
As you know, I represent Northern Ireland Covid Bereaved Families for Justice, and I've been granted permission to question you on four separate topics, none of which you've been asked about so far.
Topic 1. According to your statement, at paragraph 48, you cannot now recall receiving information on the pre-pandemic capacity of the existing laboratories' testing capabilities in Northern Ireland.
When your then permanent secretary for the Department of Health gave evidence in Belfast this time last year, he stated that, "By any measure, Northern Ireland had a low testing capacity in February/March 2020."
Does it follow that you never discussed the issue of the pre-pandemic capacity of Northern Ireland's existing laboratories with your permanent secretary after you took office on 11 January 2020?
A. Again, I think in an earlier answer, my Lady, I spoke

about the pathology review that had been started in 2016. It went out to public consultation in 2017 and then was commenced under 2020 as well, so there's work been done in regards to that within the department, about actually development of the broader region in Northern Ireland, so that -- in that context, that was about how we bought about a single electronic recording system, LIMS, so it is actually interoperable with encompass as well. But bringing those -- rather than those labs been under the five trust structures, were bought under one single structure as well.
So the capacity as to the number of testing machines or platforms I don't recall being mentioned at that level at that stage, but there was a bit of the structural review of our laboratories.
Q. So is your answer: yes, I didn't speak to Mr Pengelly but work was going on nevertheless?
A. There was work going on. Not every conversation I had in regards to every structure, every statement, every strategy, was with the permanent secretary.
Q. Topic 2, Public Health Agency.
In your statement you state that:
"[You] consider that the collaborative way in which the Department in the PHA worked throughout the pandemic in delivering the [test, trace and isolate] programme

significantly helped meeting the unprecedented demands of the pandemic and helped make the most of available experience, skills and expertise. This close joint working [you] believe had a positive impact in [Northern Ireland]."

Can I ask you four questions on that statement. One, whilst it's clear that the Department of Health and the PHA did work together in delivering test, trace and isolate and protect, do you accept that, as we heard in Module [2C], the relationship was not without its tensions?

A. The relationship I don't think was without its tensions, my Lady, but that isn't in opposite to the fact that we weren't or couldn't work closely together in regards to what needed done and indeed what was done.

Q. So what impact, if any, did those tensions have on the delivery of test, trace and isolate policy in Northern Ireland?

A. I'm not sure that -- well, first of all, I'm not sure specifically as to what tensions were where within the system or when you're referring to, but I'm not aware, during my time as minister, that those tensions were -- what was referred to as tensions actually had any impact on the delivery of test, trace and isolate.

Q. When you gave evidence in M2C, for example, you stated

that the Public Health Agency was "not in a robust enough situation to scale up as was necessary". That's one of the tensions that we were talking about.

Was that one of the reasons why, in late 2020, your department commissioned a rapid, focused external review of the Public Health Agency for Northern Ireland's resource requirements in response to the pandemic over the next 18 to 24 months?

A. But I think the assertion of the assessment of PHA at that point in time, my Lady, isn't a tension. It was my perception at that stage that it wasn't. And if it's stating, I think there was previous --

Q. That's not a tension, thinking something -- the operational body is not in a fit state --

A. Sorry, it never presented itself as a tension with any conversations I had with the chair of the PHA. It was my impression at that stage doesn't mean to say that if you've an assessment of something being in that state that it necessarily produces a tension. I don't think there was any counter in regards to those conversations at that time in regards to how that relationship worked.

I think when you actually look at some of the board and some of the interactions that were set up, there was that good working relationship between the organisations and ourselves. And as minister, my Lady, I set up

a regular interface with the chairs, and meetings of all my arm's length bodies, and it's not something that I ever recall the chair of the PHA raising with me.

In regards to the review that was brought about at that point in time, was actually commissioned by I think it was Professor Ruth Hussey, who was a former Chief Medical Officer from Scotland (sic), and what that was, was to assist working in partnership with the PHA board in regards to making sure that they were as robust and as ready as they could be for the next 18 months, following what had been a very challenging time.

Q. In fact, the review confirmed, didn't it, that among the structural weaknesses that the PHA had had to content with in carrying out its test and trace functions were the fact that it had, and I quote:

[As read] "... had temporary leadership arrangements for some years, a new interim CEO, and a new Director of Public Health came into post [I'm quoting from the review] as the first wave of the pandemic took hold. They faced a substantial challenge to pick up the reins of the organisation at such a crucial time. And when the organisation had to embrace remote working at speed whilst mounting an effective response, there were vacancies in senior posts. The health improvement function, for example, had 46% of its staff in temporary

posts as a result of delays to approval mechanisms at regional level."

The report goes on to refer to the initial service being extremely stretched by demand, insufficient project management.

None of this is to criticise the efforts that PHA made, but the fact was, it was starting well behind the starting line, wasn't it?

A. Yes. And that's where my original statement -- I think the first quote that you actually gave -- was the reflection from that. But it was also, my Lady, the work that then came out and the recommendations that come out from that Hussey review to reshape and refresh the PHA in regards to that.

And I think one of the recommendations, and I know we talk about that change in leadership, but all organisations go through change in leadership at various stages.

Q. Topic 3. This is partially in the context of the meeting you've been asked so much about, about 16 March 2020.

In your statement to the Inquiry you state at paragraph 16 that you as the Minister for Health set the overall course of the TTI programme, you approved strategy and policy decisions, and that while you, and

I quote from your statement:

"... regularly updated the Executive on delivery of the programme and policy changes, with a few exceptions, the Executive was generally asked to note the changes."

Do you agree that the few exceptions that you refer to all post-date August 2021?

A. I don't remember each of those papers in detail as to whether they finished to noted or to approve or what their action was, was taken at that stage. But I think it goes back to, again, the earlier answer about those issues that were cross-cutting and controversial, or those issues that were actually cross-cutting or those that I felt, you know, the need and the ability to update the Executive as to the steps that we were taking.

Q. Well, I don't want to repeat the various arguments either way. We've been through those at length.

Can I just ask you this: in retrospective, do you accept that it might have been better for you, and the First Ministers, and the Executive, to have worked in a more collaborative and transparent way at the outset of the pandemic?

A. I think, my Lady, from -- I think this has been covered in M2C and earlier in regards to this. The challenges of working across a five-party mandatory coalition

weren't without its challenges, especially during the period of a pandemic. In a transparent way, I know -- I appreciate your comments in regards to that, my Lady. I think one of the criticisms that wasn't levelled in regards to any of our Executive meetings was a lack of transparency, because I think it was covered widely in M2C, was the fact that those meetings were often directly linked to media as they were having -- as well as we were having those conversations.

Q. I think you know very well, don't you, I'm not referring to that as transparency.

A. Right, well, no --

Q. -- transparency within the Executive.?

A. I think there was a level of engagement and I'm sorry, that's what I took as transparency in regards to that comment and in regards to the wider point. But I think in regards to that communication within our Executive, I think it was healthy. It was robust, but it was also part of that challenge that we have in Northern Ireland of a five-party coalition.

Q. Which we understand. Thank you.

Topic 4. This is to do with targeting of testing. In your statement to the Inquiry, you point out that after March 2020, testing was primarily targeted in clinical care of the sickest individuals requiring

inpatient care, protecting those caring for them, and in the management of outbreaks, for example, in care homes.

Now, Professor Arden has provided an expert report to the Inquiry pointing out that policies prioritising certain groups, such as testing for NHS staff and patients early on in the pandemic may have had implications for other groups, including vulnerable person in the community.

Do you agree with Professor Arden?

A. I think it goes back to the abilities, if you look at the interim testing protocols I referred to earlier on, my Lady, there were ten of them throughout the duration of the pandemic, it was about the utilisation of the capacity that we had. As Health Minister, if we'd have been able to start in March 2020, at the point in regards to testing that we finished with, with LFDs, you know, it would have been a very different picture. Something I wish we'd been able to do far quicker in regards to that.

And I think it was in regards to LFDs first become available at the end of that year, I asked for 4 million from Matt Hancock and I got them, in regards to that, because I valued the ability for testing but it's also that testing of those people in those critical care facilities as well.

Q. In terms of the knock-on implications, this Inquiry has heard evidence from one of my clients, who you know, Hazel Gray, who contacted you in December 2020 about the fact that her wheelchair-bound mother's home carers were never tested because of the policy of their employers, the Western Trust home care, and that this had more than likely led to her 80-year old father contracting Covid and being taken to hospital, given that he rarely left the house.

She described in the text messages that she exchanged with you, "This is a major flaw in the system".

Sadly, as I believe you know, both Mrs Gray's parents died shortly afterwards. Do you agree that her description of what she'd been told as "a major flaw" was in fact an understatement?

A. Well, in regards to the testing of all healthcare workers and again (unclear) through those protocols, my Lady, there was regards to where we could get testing in regards to facilities. In regards to Mrs Gray, I do want to pass on publicly my sympathies to her and her family in regards to the trials that she went through at that stage. I do know from reading her statement and also listening to her commentary, both in the impact video but also in media reports back home of the

challenges that that presented and also the report, and the response that the Western Trust has gave to her in regards to that.

So it goes back to that point of symptomatic and asymptomatic healthcare workers testing. My Lady, if I had had the ability to test everyone regularly when they wanted it, as they required it, I can assure you, my Lady, and this Inquiry, and the members that the counsel represents, that I would have been doing that from the very beginning.

Q. But the world is as was, rather than what we wish it to be. Do you agree that in fact her statement of what happened was much more than a major flaw?

A. Well, in regards to the loss of a parent, basically in regards to the loss of two parents from this pandemic, my Lady, when we look at the number of lives lost across this United Kingdom and indeed across the world, the flaws that were there, the challenges that have been made, and hopefully the recommendations that come out of this Inquiry, make sure that that sort of a case and occasion never arises again.

MR WILCOCK: My Lady, they are all the questions I wish to ask.

LADY HALLETT: Thank you very much indeed, Mr Wilcock.

Mr Swann, that completes our questions we have for

you today.

The pressure on health ministers was extraordinary. Do you ever question why you didn't go in the opposite direction when your party suggested you took on health in January 2020?

THE WITNESS: My Lady, I have many times gone back to that, and I don't want to make light of anything that we've been through today. When I said we'd those two choices, I was, you know, the former president of the Ulster Young Farmers Clubs of Ulster. The two departments that were left was Health and Agriculture. And there is many a reflection, I wonder, when we look back now, five years on, if I'd been Health Minister rather than Agriculture, how things could have changed differently.

But, my Lady, I hope the input that I was able to make as Health Minister made some positive difference in regards to how we responded in Northern Ireland. I think I was fortunate to have a very dedicated healthcare professionals around me working in health and social care, but also at a departmental level, PHA level, and all those other organisations who were providing input at what was a very challenging time.

LADY HALLETT: Well, Mr Swann, I don't know if you heard what I said to Professor McBride, but whatever criticisms people may have to make of the system, no one

doubts the commitment and dedication that people like you, and indeed the professor, put into responding to the pandemic. So thank you very much for all that you did then. Thank you for your help in the Inquiry, and I know for a fact that we have not ended the burden on you. So thank you for the help that you'll also be giving, I think again in July.

THE WITNESS: Yeah, I think so, my Lady.

LADY HALLETT: Well, thank you very much. We shall end there, and I shall return at 10.00 tomorrow.

MS CARTWRIGHT: Thank you, my Lady.

(4.36 pm)

(The hearing adjourned until 10.00 am the following day)

I N D E X