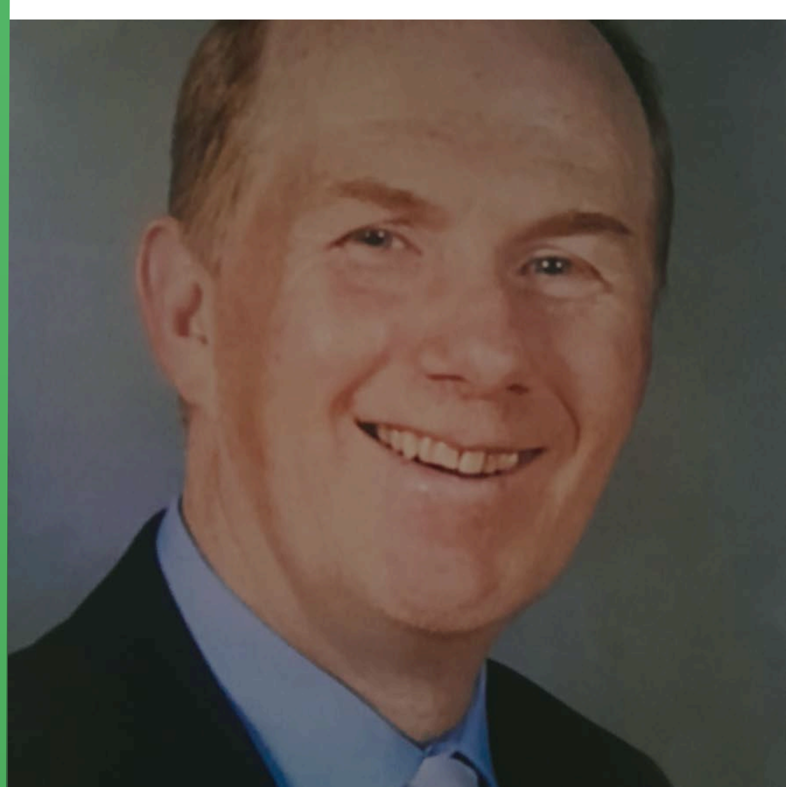

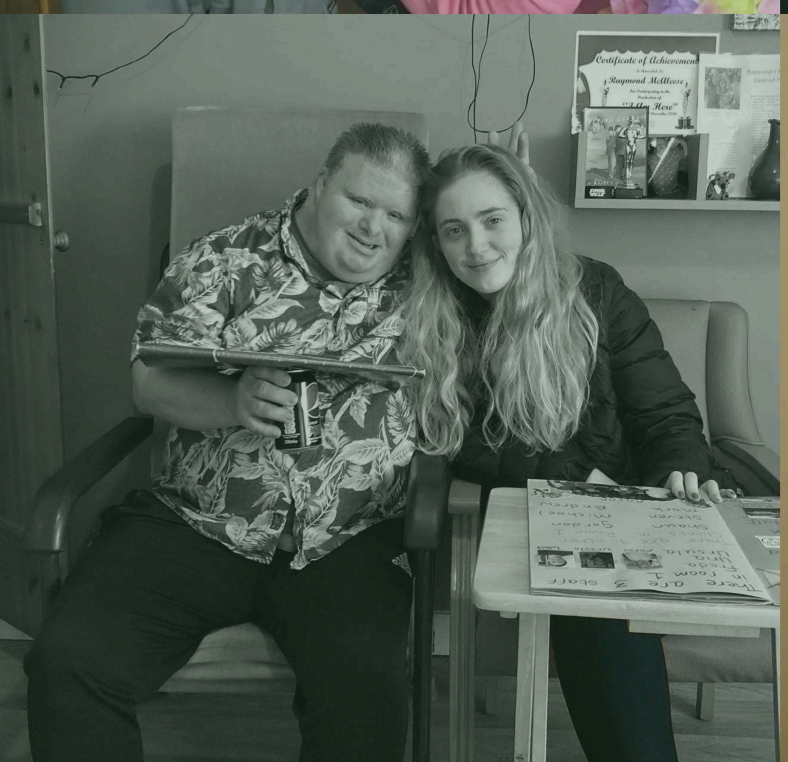

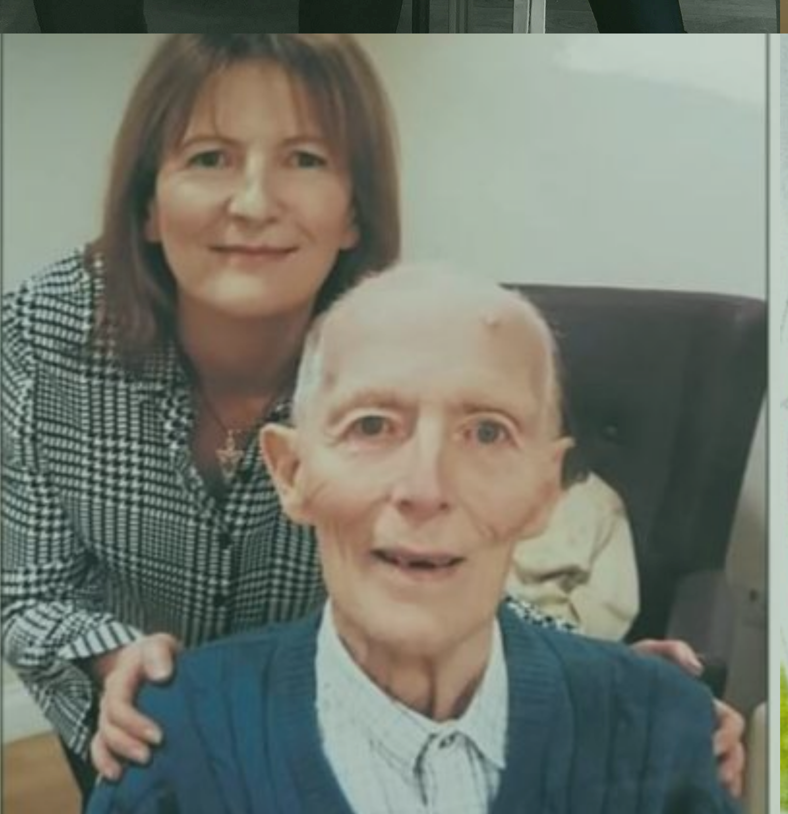
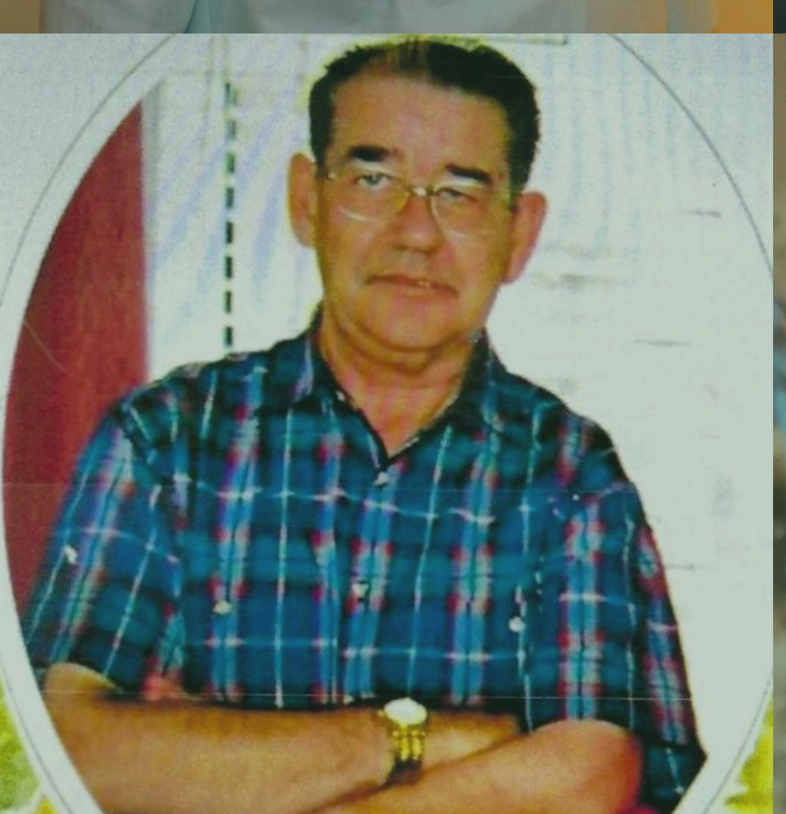

FOR THOSE LOVED AND LOST

A commentary on the Module 1 Report and Recommendations

P.A.DUFFY & CO
SOLICITORS

The fallacy that the UK was one of the most prepared states in the world was 'dangerously misleading.'

In her Module 1 report, ***the Chair, Baroness Hallett***, noted that the 2011 Pandemic Flu Plan failed to adequately consider prevention and was not suitable for a novel respiratory virus in 2020. It was reported in expert evidence that the legislative framework and associated national guidance was 'widely acknowledged [by public health specialists and practitioners] as being outdated and did not relate to contemporary structures, roles and responsibilities.'

The Inquiry did not hesitate 'in concluding that the processes, planning and policy of the civil contingency structures within the UK government and devolved administrations and civil services failed their citizens.'

The Northern Ireland Covid Bereaved Families for Justice (NICBFFJ) sadly have first-hand experience of the fatal consequences of an ill-prepared and fragile Government response to the Covid 19 Pandemic.

Although the findings cannot change what happened and cannot bring back loved ones, they can seek to ensure that these mistakes are never repeated, if the recommendations made by the Inquiry are properly implemented by the UK Government and the Devolved Administrations. It is essential that the recommendations made by the Inquiry are fully and promptly implemented by Government in order to prevent further unnecessary deaths, and the grief of the bereaved, in the event of a future pandemic.

As Lady Hallett stated when giving her overview of the Module 1 report, 'The harrowing accounts of loss and grief given by the bereaved witnesses and others who suffered during the pandemic, serve to remind us why there must be radical reform.'

The conclusions of the report are now a matter of public record and provide a foundation for radical systemic reform. What is clear is that none of this would have been achieved if not for the campaigning of bereaved families who have identified the failings, pointed out those responsible and pursued a Public Inquiry from the very early days of the pandemic.

"When we took mummy up into the hospital, there was very limited [PPE] – just a plastic apron on staff, and my sister actually asked about Covid, and we were told not to worry, it would be a flash in the pan and gone by the summer … I am here to remind everybody of the human cost that we paid as bereaved people. My mummy was not cannon fodder. My mummy was a wonderful wee woman who had the spirit of Goliath, and I know she's standing here with me today, because she would want me to be here, because she knows that she lived a life, as did all our loved ones, and it's very important that we remember the human cost, because there are too many people out there now that think Covid has gone away. People are still losing their life to Covid."

Brenda Doherty, one of the group leads of Northern Ireland Covid Bereaved Families for Justice (extract from the final Module 1 Report).

Reform for Those Loved and Lost

Why Reform Matters to Brenda Doherty

‘Everyone will know Ruth Burke, and everyone will know who she was, the life she had and not just of how she died.’

Brenda Doherty has been campaigning tirelessly in honour of her mother and in search of reform for the system that let her down. Her mother Ruth was the first woman in Northern Ireland to die of Covid, however, that is not the lasting legacy Brenda wishes for her mother. Brenda is striving for hope and for reform, and for her mother to be remembered for her life and the lives she touched; not simply as a statistic. Ruth was a beloved wife, mother, grandmother and great grandmother and because of Brenda’s campaigning with the NICBFFJ, Ruth’s life, and the lives of other loved ones, have exposed the need for radical reform in our jurisdiction.

When Ruth was admitted into hospital in March 2020, Brenda’s sister questioned the staff about Covid, and the effect it might have on her mother’s mortality. She was told not to worry, that it would be a flash in the pan and it would be gone by the summer. Unfortunately, this was not the case and because of the Government’s lack of resilience and preparedness many people after Ruth suffered and died unnecessarily.

The Chair of the Inquiry firmly concluded that, ‘the UK prepared for the wrong pandemic.’ The Inquiry found that ‘one of Exercise Cygnus’s key learning outcomes was: ‘The UK’s preparedness and response, in terms of its plans, policies and capability, is currently not sufficient to cope with the extreme demands of a severe pandemic that will have a nation-wide impact across all sectors.” 'Exercise Cygnus was the Government co-ordinated hypothetical pandemic preparation and response exercise that took place in October 2016.

The Government had just over 3 years to alter their systems and policies to be able to withstand a severe, nation-wide pandemic. In that time, they did nothing or next to nothing.

The Government’s failure to identify and act upon the need to prioritise pandemic preparedness and to prepare for the pandemic that we faced had catastrophic consequences. Unfortunately, for Northern Ireland (NI) there, even if there had been the will (and there was little evidence of that) there was no opportunity to adjust our pandemic strategy in the 3 years since Exercise Cygnus because there was no Executive in place to pass policies and legislation since January 2017. As Mr Swann MLA, who was the Minister for Health. at the time of the pandemic, told the Inquiry, ‘Opportunities...were firmly missed’ in the 3 years prior to the pandemic. Therefore, reform needs to urgently occur so that we do not miss any more opportunities, and as Brenda Doherty said during her evidence, ‘legislative change needs to come in.’

The Inquiry has presented 10 recommendations based on the evidence heard and read in Module 1. The recommendations aim to create a more resilient and prepared system for any future pandemic. They strive for a more simplified, transparent and organised system so that others do not have to suffer unnecessary loss like Brenda and so many others. As Brenda powerfully stated in her evidence, ‘I know she [Ruth] is standing here with me today, because she would want me to be here, because she knows she lived a life, as did all our loved ones, and it’s important that we remember the human cost.’

Accountability for those Loved and Lost

Why Accountability Matters to Sean Scullion

'Nurses held her hand and soothed her whilst her family cried in anguish 29 miles away, unable to kiss their mother or say goodbye.'

Sean and his family had a devastating experience during the pandemic. Like so many families in the NICBFFJ, he was unable to be with his mother Nuala in person as she suffered and died from Covid and was only able to say goodbye to her virtually. It was only after Nuala had been reassured by her family via FaceTime that she finally let go after a strenuous battle against Covid. 'Moments after she had been reassured that we could cope, she breathed her last.'

Unfortunately, the lack of pandemic preparedness of the Government directly resulted in greater trauma and acute grief as many were unable to be with their loved one on their deathbed or have a proper burial or wake to say goodbye.

As the Inquiry stated in their Module 1 Report, the 2011 Pandemic Flu plan was outdated and lacked adaptability. The Chair stated in her oral overview, 'The UK government neither applied [the pandemic flu plan], nor adapted it and the doctrine that underpinned it. It was ultimately abandoned. As was the 2011 strategy itself.'

Without preparedness, it is difficult to be resilient. The families of the NICBFFJ have experienced the effects of this first hand. Therefore, it is imperative that our political representatives listen to the experiences of the bereaved, adapt the weak and flawed strategies from the pandemic and implement the recommendations made by the Chair as a starting point towards a more prepared and resilient State.

Clarity for those Loved and Lost

Why Clarity matters to Catriona Myles

'Imagine ending life alone and scared, on a covid ward resembling a field hospital, having not seen a human face for more than a month. I don't have to imagine; this was my daddy's story...failed by so many on so many levels.'

Catriona lost her father on 23rd December 2020 due to delays in diagnosis for her father's liver cancer and then being exposed to covid in hospital. In her oral evidence to the Inquiry, she describes her tumultuous experience and the devastating impact on her family, 'Daddy had none of his family with him, Daddy had nobody with him. We don't know what time my father expired, he was found dead on 23 December, we suggest between 7 and 8 pm.' Catriona and her family had multiple instances where the lack of clarity impacted her and her family's experience: from the lack of clarity regarding his diagnosis; to the hospital procedures and policies; to his chances of survival; and in the end his death.

The Inquiry also found that 'the institutions and structures responsible for emergency planning were labyrinthine in their complexity,' contributing further to the narrative that lack of clarity resulted in 'fatal strategic flaws.' Catriona stated in her oral evidence, 'There certainly wasn't clarity. If anything, the opposite.'

The Chair's recommendations urge the UK Government and the Devolved Administrations to be more strategic, to have a simplified, streamlined system, that promotes clarity and flexibility to be better prepared and more resilient. There were many contentious deaths during the pandemic, Catriona's father being one of them. We need clarity, accountability and hope because, as Catriona said, 'He was Gerry McLarnon, and he deserved better.'

Progress for those loved and lost

Why progress matters to Julie McMurray

'I am left with profound sadness that I couldn't protect Robert in his vulnerable state.'

Everyone feared the possible effects of the pandemic, but those who were vulnerable or had loved ones deemed vulnerable had an added fear and reliance on the system. Whether they were vulnerable because of their underlying health issues, their current health status, or because they were part of a minority group; many people lived in fear and leant on their loved ones for support.

Robert was a loving husband and father, who relied on his wife and kids for consistency and normalcy due to his early onset dementia. Unfortunately, Robert went into hospital for an operation, caught Covid and died. During his time in the hospital, he was moved 5 times in 1 month, which was detrimental to his mental health and his recovery. It made him confused, anxious and upset. Julie remembers him saying that he thought he'd done something awful to be 'locked away', and that he felt abandoned.

Professor Jim McManus told the Inquiry that, 'From time immemorial, every pandemic has hit those worst who have been least able to bear the burden.' Those vulnerable, whether financially or physically, have been the most affected by pandemics in the past. Knowing this, it is imperative that those most vulnerable have the most efficient structures in place to ensure their safety in the event of a pandemic.

It is important that those most vulnerable are adequately cared for, surrounded by familiar faces so that they do not die alone like Robert. Part of this will be utilising modern technology and advanced medical knowledge to best prepare for a nation-wide pandemic.

Fortunately, the Chair has put forward recommendations that enable her to monitor the implementation of the recommendations to change the civil emergency system, in order to ensure meaningful progress.

Lessons Learned for those Loved and Lost

Why it matters to Lauren Mallon that lessons are learnt

'He died in hospital at 6.29am with a nurse by his side, with my mother finally making it there at 6.31am.'

Lauren's uncle Raymond loved and was loved. His family feel that the provisions in place for someone with Down's Syndrome like Raymond were not resilient enough to withstand the pressures of a pandemic. There are many people with disabilities who suffered during the pandemic, and Lauren has been campaigning tirelessly alongside the NICBFFJ to ensure that their voices are heard. As Lauren has said, 'His life mattered and he should have been protected, especially given his particular vulnerability.' It is important that all members of society are accounted for in our preparation for future pandemics.

With regards to the strategy in place prior to the pandemic, in Matt Hancock's written evidence, he admitted that 'instead of a strategy preventing a pandemic having a disastrous effect, it was a strategy for dealing with the disastrous effect of a pandemic.' The Inquiry conceded that the 2011 Pandemic Flu Plan did not account for prevention strategies which resulted in numerous contentious deaths like Lauren's uncle Raymond.

It is likely that Raymond struggled to understand what was going on because of his disability. Struggling to understand why his family was not visiting him, and when they did why there was a window between them. Struggling to understand the dangers of Covid, why he needed to wear a face mask, and why he wasn't home.

'We were grossly underprepared for a pandemic in NI, and ultimately families like mine paid the price for it.' It is difficult to imagine the struggle of having to watch a loved one suffer alone, and no one should ever have to experience it. Lauren hopes that the entirety of the Government commits to enacting changes from lessons learned, as they have a duty of care to safeguard the rights of those with disabilities in legislation. The Inquiry's recommendations in the Module 1 Report demonstrate hope for a safer community against another pandemic, should they be properly implemented.

Hope for those Loved and Lost

Why hope matters to Martina Ferguson

'Compassionate care is what families and their loved ones wanted and had a right to expect.'

NICBFFJ is dedicated to ensuring that the voices of bereaved families are at the centre throughout this investigation. Martina Ferguson has been calling for answers from the very early days of the pandemic for her mother (a care home resident). Martina has been a lead campaigner for Care Partners, initially introduced for care home residents in September 2020. Care Partners was extended by the Department of Health to Hospital settings in Feb 2022. Martina is calling for the public to make themselves aware of what a Care Partner is and hopes this will be legislated one day. She states – you could be going to Hospital or accompanying someone or know someone living in a care home. No doubt thousands of citizens across our country had issues with visiting whether in a hospital or care home during the pandemic. Martina adds, did you know that Care Partners are additional to normal visiting and can be for some of the situations below (list is not exhaustive):

- A birth partner
- Supporting Dementia patients
- Supporting someone with Autism
- Supporting a person who is receiving end-of-life
- Accompanying children in hospital
- Supporting someone with a mental health issue
- Supporting someone with a learning disability
- Supporting someone with delirium
- Help encouraging someone to eat, drink or dealing with your loved ones personal hygiene
- Supporting someone receiving life changing treatments/ illnesses
- Providing someone with emotional, physical and psychological support

Outbreaks. You can be a Care Partner for someone even if there is an outbreak in a Hospital Ward OR Care Home. Martina believes the Care Partner guidance was introduced too late and when it was the Government and the Trusts' done very little to ensure Care Homes and Hospitals implemented the guidance. This is just one of many examples of how the Government's lack of preparedness resulted in fatal shortcomings. Unfortunately, a safeguarding investigation found that Martina's mother's basic needs were inadequately met. There are many reasons why the NICBFFJ is campaigning so strongly for change. Families want to know that there are safeguards and systems in place that will ensure compassionate care is delivered.

Enforced separation was hard for many families, and it is just one of many examples of unnecessary suffering. It is therefore important that we gain wisdom from our mistakes.

The NICBFFJ has had a profound impact on the Inquiry, its recommendations, and the families of future pandemics. We have hope for future modules, that lessons are learned, and recommendations are put into action so that we can feel more secure and confident in our system of governance, when we are faced with another pandemic.

"So much heartache and trauma for families that can never be forgotten."

THE 10 RECOMMENDATIONS

1 Recommendation 1 – A simplified structure for whole system civil emergency preparedness and resilience

A call from the Chair to simplify and reduce the number of structures responsible for preparation and resilience towards national whole-system civil emergencies. One of the core structures would include a single Ministerial Committee responsible for the whole-system civil emergency response. On a practical level, it would be expected that mandatory members include the senior Minister for Health and Social Care, as well as the First Minister and/or deputy First Minister, who would be responsible for chairing the Committee. The other core structure would be a single cross-departmental group of senior officials to monitor and apply policy towards civil emergency preparedness and resilience. It is expected that the Committee would be obliged to report regularly to the Executive, so as to ensure satisfactory action was being taken in relation to civil emergency policies.

At first glance this appears to be a positive step away from the complex and confusing spaghetti organogram. The lead Government department model did not work during the pandemic and whilst many would have preferred greater responsibility placed on our devolved Government and not the Cabinet, this is a step in the right direction. Should the recommendation be implemented correctly, this structure could provide the simple, solid foundations necessary to build an effective civil emergency response plan.

It is expected that this simplified structure is to be implemented within 12 months of the publication of the Module 1 Report. This is with the expectation that within 6 months of its creation, the Committees would provide a review with proposals to decrease the number of structures in civil emergency planning to ensure a more streamlined system.

2 Recommendation 2 – Cabinet Office leadership for whole system emergencies in the UK

This recommendation involves the abolition of the lead government department model across the UK with regards to whole-system civil emergency responses which was ineffective during the pandemic. The purpose of this recommendation is to ensure that a whole system response can be effectively co-ordinated across Government departments.

The Inquiry's recommendation aims to abolish the lead Government Department model and to place the Cabinet Office in charge of 'preparing for and building resilience to whole-system civil emergencies across UK government departments, including monitoring the preparedness and resilience of other departments.'

Furthermore, this involves the Cabinet Office 'supporting departments to correct problems and escalating issues to the UK Cabinet-level ministerial committee and group of senior officials in Recommendation 1.'

In relation to Northern Ireland, the Chair has stated that 'the constitutional arrangements in NI do not lend themselves to The Executive Office (TEO) directing the work of other departments, and it is beyond this Inquiry's remit to recommend changes to those arrangements.'

In Module 1, and particularly in Module 2C, we heard evidence of siloed working arrangements and decision making in Northern Ireland, where individual departments operate alone under the direction of their respective Minister as part of an insular team, leading to barriers in communication and collaboration across departments. The evidence is overwhelming that this had a detrimental impact on pandemic preparedness and response and is a sub-optimal approach for future pandemics.

Although the Chair appears to have felt constrained in the M1 Report by the particular constitutional arrangements in NI (which were borne out of the peace process and the Good Friday Agreement) the reality is that the combined evidence across M1 and M2C has revealed that the status quo of the lead Government Department model and siloed work practices are highly detrimental to any pandemic response in Northern Ireland. It is likely that the Inquiry will revisit this issue in the Module 2C Report, and we hope that having heard more evidence from an NI perspective, the Chair feels empowered to formulate an NI specific recommendation for change.

3 Recommendation 3 – A better approach to risk assessments

In support of a more transparent system, the Inquiry recommends a more collaborative risk assessment system between the UK Government and Devolved Administrations. This new approach would replace the previous 'reasonable worst-case scenario' approach which was undefined and misunderstood in preparing for the Covid pandemic.

This Recommendation would include: broader risk assessments that cover a range of scenarios representing different risks and their consequences; consideration of the prevention and mitigation necessary to handle an emergency and its consequences; and a full analysis of the combined impacts of risks that may complicate an emergency.

The purpose of this Recommendation is to 'assess long-term risks in addition to short-term risks and considers how they may interact with each other,' to assess the impact of these risks on vulnerable people and to consider the 'capacity and capabilities of the UK.'

As previously stated, this would create a more transparent risk assessment approach across the UK. If properly implemented, this new approach would require Devolved Administrations to produce their own risk assessments, allowing for a more flexible and individual approach.

4 Recommendation 4 – A UK wide civil emergency strategy

As proven during the pandemic, the UK was distinctly lacking a clear civil emergency strategy. As a result, the Inquiry recommends a 'UK-wide whole-system civil emergency strategy which includes pandemics to prevent each emergency and also to reduce, control and mitigate its effects.'

The Report found that this strategy as a minimum should be adaptable, it should consider a wide range of potential scenarios, it should identify key issues and potential responses, it should identify how it should be applied, and its proportionality should change in accordance with the circumstances.

The strategy should also include an assessment of any infrastructure, technology and skills required for the UK to respond effectively, as well as the short, medium and long term potential health social and economic impacts of the emergency and the response required with special consideration for vulnerable people.

The Chair has recommended that clear roles should be assigned for UK and DA Governments, and that the strategy should be reassessed at least every 3 years, 'incorporating lessons learned between reassessments.' This aims to ensure that the strategy remains up to date and effective in response to the risks and challenges of a pandemic and other emergencies.

5 Recommendation 5 – Data and research for future pandemics

To further strengthen our preparedness and resilience the Inquiry recommends that the UK Government, alongside Devolved Administrations, establish mechanisms to acquire data for developing emergency responses as effectively, reliably and securely as possible. The Inquiry further suggests that the data systems be tested in pandemic exercises. It is also recommended that the UK Government commissions a wide range of 'research projects ready to commence in the event of a future pandemic.' It is recommended that 'better working with international partners should be encouraged.'

Whilst it is positive that the recommendation requires the Government to identify which vulnerable groups were hit the hardest during the pandemic and why, a unique issue arises in relation to Northern Ireland which requires to share data with the Republic of Ireland on a reciprocal basis.

The report does not cover this issue explicitly but does reference a need to collaborate with international partners.

6 Recommendation 6 – A regular UK wide pandemic response exercise

Every 3 years, the UK Government and Devolved Administrations 'should together hold a UK-wide pandemic response exercise' and should 'test the UK-wide, cross-government, national and local response to a pandemic at all stages, from the initial outbreak to multiple waves over a number of years.' It is also emphasised that consideration must be given to how a broad range of vulnerable people may be helped in a pandemic.

The exercise has a reasonable waiting time and includes local response in its consideration, which is beneficial from an NI perspective, allowing for more specific information to be considered. Furthermore, the explicit call for consideration of vulnerable people, and how they might be supported during a pandemic, strengthens our call for lessons learned to build a more prepared and resilient response for those who are vulnerable.

7 Recommendation 7 – Publication of findings and lessons from civil emergency exercises

Following the exercise, the UK Government and the DAs are required to produce an exercise report summarising 'the findings, lessons and recommendations, within 3 months of the exercise.' Six months following the conclusion of the exercise, it is expected that an action plan will be published, outlining the steps to be taken and the entity involved.

Furthermore, it is expected that the exercise reports will be kept in a UK-wide online archive accessible to those involved in emergency preparations.

This will ensure that there is greater transparency, scrutiny of and accountability for future pandemic plans.

8 Recommendation 8 – Published reports on whole system civil emergency preparedness and resilience

This Recommendation requires the NI Government and the other devolved governments to publish reports every 3 years on their civil contingencies. Furthermore, the Report must include an assessment of who might be vulnerable to risks and how those risks might be mitigated.

Finally, it is recommended that the UK and the Devolved Administrations should publish lessons together along with an action plan all to be archived in one place.

This will also improve transparency, scrutiny and accountability of Government in relation to lessons learned and action plans.

9 Recommendation 9 – Regular use of red teams

The Inquiry has called for each Government to introduce red teams as third-party observers in the Civil Service to 'scrutinise and challenge the principles, evidence, policies and advice relating to preparedness for and resilience to whole-system civil emergencies.' Red teams are required to be independent from Government and the Civil Service.

This is to reduce group think within the Civil Service, so as to prevent officials failing to identify issues and overlooking possible alternative solutions.

10 Recommendation 10 – A UK wide independent statutory body for whole system civil emergency preparedness and resilience

The Report recommends the creation of an independent statutory body for whole-system civil emergency preparedness and resilience which would provide advice to the UK Government and Devolved Administrations. It would include engagement with civil society groups for their input, particularly in relation to protection of vulnerable people in civil emergencies. The body would assess 'the state of planning for, preparedness for and resilience to whole-system civil emergencies across the UK' and make 'recommendations on the capacity and capabilities' required by the UK and DAs in order to be adequately prepared for a future pandemic.

Furthermore, the Inquiry has recommended that a non-statutory body should be established as an interim measure within 12 months of the publication of the Report. This is to allow work to begin while legislation is being passed.

Northern Ireland's Outcome

The Module 1 Report deals with high level, UK wide issues in a comprehensive manner, however, there are some issues that and/have been fully addressed or, we anticipate, will be revisited in the M2C report. These include:

- The shortcomings within our unique constitutional arrangements that contributed to NI's lack of preparedness and resilience;
- The suspension of power-sharing;
- The lack of proper legislative protections;
- The financial support for Northern Ireland; and
- The absence of a general NI Chief Scientific Advisor (CSA)The report also doesn't fully address the evidence that, epidemiologically, the island of Ireland is a single epidemiological unit nor the evidence of the stunted communication between NI and the Republic of Ireland (ROI) and the contradicting guidance contributing to confusion across the border. These are issues to which, we anticipate, the Chair will return in the M2C report.

In our closing statements, we had submitted that to ensure and efficient structure and flow of information from scientific advisor to civil servant to politician, statutory duties would have to be imposed through the introduction of legislation. The Civil Contingencies Act 2004 applies only partially to Northern Ireland. Therefore, prior to and during the pandemic, there were gaps in our devolved legislation. In his oral evidence, Dr McMahon, the former Head of the Civil Service, outlined the need for legislative reform in NI to fill those gaps stating, 'we do need protections in legislation that ensure that, first of all, we have duties that are clearly set out.' He later went on to state that, 'I think we need to have a legislative base that prioritises emergency planning and the resourcing of it.'

Again, it is possible the Inquiry might propose more NI specific recommendations regarding legislation and structures in the Module 2C Report.

With regards to the suspension of power-sharing arrangements, it was stated in the Report that it 'had an adverse impact on pandemic planning.' The Inquiry recognised the detrimental effect of the suspension in the context of the preparedness and resilience of NI institutions. During the hearings, multiple witnesses reported major effects due to the absence of a functioning Government. In his written statement, Sir David Sterling stated that there was a lack of 'the ministerial direction and control that is a prerequisite of our democratic constitution', which 'left public services in a state of, what I described publicly at the time, 'decay and stagnation' due to the absence of ministerial direction on matters of strategy, policy and the prioritisation of resource allocation.' Furthermore, Robin Swann told the Inquiry that 'opportunities...were firmly missed' in the 3 years prior to the pandemic.

The Inquiry has not set out recommendations on what should happen in the event that power-sharing should collapse again. We expect to see a recommendation from the Inquiry in the M2C report so more opportunities for progress and preparation are not missed.

There Report does not make any specific recommendations on austerity or a lack of resourcing as this is traditionally considered a political issue, although it does state that 'money spent on systems for our protection is vital and will be vastly outweighed by the cost of doing not doing.'

There was limited financial support for NI both prior to and during the pandemic. Evidence was presented to the Inquiry showing that the NI Civil Contingencies Branch had been chronically under resourced and underfunded and had suffered because of it. It is further stated that 'it may be tempting for them [politicians] to focus on the immediate problem', it is important to note that 'the massive financial, economic and human cost' of the pandemic demonstrates the need for states to invest in pandemic planning as it is vital for our preparedness and resilience.

The absence of a general Chief Scientific Advisor for the NI Executive was recognised to be an 'inherent weakness' in the system by Professor Sir Michael McBride CMO. The Inquiry was told by multiple witnesses that TEO is working to appoint a general CSA to rectify this issue. Unfortunately, during his oral evidence, Dr McMahon admitted that they were unsuccessful 'in securing an appointment' and were 'looking at other options now for trying to get a person into that role.' It is understood that this role has now been filled.

Although in the body of the report, the Chair recognised that 'preparing for and building resilience to whole-system civil emergencies requires the governments of the devolved administrations to have a chief medical officer and a chief scientific adviser with broader responsibilities, comparable to those of the Chief Medical Officer for England and the UK Government Chief Scientific Adviser' there is no CSA specific recommendation in the M1 Report. Again, however, further evidence on this topic was heard in M2C, including from the current CSA himself and, as such, it may be revisited in the M2C Report.

Finally, the issue of treating the island of Ireland as a single epidemiological unit and how that might work in practice. According to Michael McBride, since NI and ROI share an island and a land border, 'they are [therefore] considered epidemiologically to be a single unit.'

However, due to 'the suspension of the power-sharing arrangements, approximately 46 meetings of the North South Ministerial Council did not take place between 2017 and 2020.' Both failures had a serious adverse impact on pandemic preparedness.

In the M1 Report, the Inquiry acknowledges the importance of cooperation between the Governments and officials of the UK, Northern Ireland and the Republic of Ireland.

During the Module 2C hearings, the Inquiry heard some evidence of the potential benefits of a potential 5-nation, 2 island approach to reach full efficacy in an emergency. We anticipate that some of the recommendations will be built upon in the Module 2C Report and anticipate a better understanding of the Northern Ireland specific position following its publication.

What Next?

→ The Chair has confirmed that an oversight mechanism will be established as well as instituting a fixed period to ensure the implementation of recommendations. The Chair intends to monitor the progress by requiring the relevant public authorities to provide written updates to the Inquiry. Furthermore, there are recommended mechanisms to ensure that Government are held accountable in a democratic sense. Clear examples are recommendations 3 and 4 which require the relevant Minister to provide a full update on pandemic planning to Parliament.

→ As a group, NICBFFJ have requested that, as part of her role in monitoring the implementation of her recommendations, the Chair recalls witnesses so that they may provide evidence under oath on the implementation of the recommendations. NICBFFJ has also written to the First Minister, deputy First Minister, Head of the Civil Service and the NI Secretary of State requesting a meeting to discuss the Report and implementation of the recommendations.

→ NICBFFJ continue to campaign for a brighter future, with those loved and lost at the forefront of their mind.