STANDING COMMITTEE
OF
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PUBLIC ACCOUNTS COMMITTEE

Isle of Man Steam Packet Company

HANSARD

Douglas, Wednesday, 23rd June 2021

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Members Present:

Chairman: Hon. J P Watterson SHK
Vice-Chairman: Mr L L Hooper MHK
Mrs C L Barber MHK
Ms J M Edge MHK
Mrs J P Poole-Wilson MLC
Mr C R Robertshaw MHK

Clerk:
Mrs J Corkish

Assistant Clerk:
Ms N Lowney

Contents

Standing Committee of Tynwald on Public Accounts

Isle of Man Steam Packet Company

The Committee met at 2.30 p.m.
in the Legislative Council Chamber,
Legislative Buildings, Douglas.

[MR SPEAKER *in the Chair*]

Procedural

The Chairman (Mr Speaker): Good afternoon. Welcome to this public meeting of the Public Accounts Committee. I am Juan Watterson, Speaker of the House of Keys and Chairman of the Committee. With me are Vice-Chair Mr Lawrie Hooper MHK, Mrs Jane Poole-Wilson MLC, Mrs Clare Barber MHK, Ms Julie Edge MHK and Mr Chris Robertshaw MHK.

If I could ask everyone to make sure that their phones are silent, so they do not interrupt proceedings.

This afternoon's session is being held as part of the Committee's inquiry into the Isle of Man Steam Packet Company and the border protocols during the pandemic.

EVIDENCE OF
Mr Stephen Hind, FCCA

Q323. The Chairman: We would like to welcome Mr Stephen Hind, who was appointed to conduct a review into the circumstances of the outbreak of COVID-19 in February 2021 in relation to the Steam Packet Company. This session will focus on Mr Hind's final report, dated 18th May 2021, titled 'Review into the February 2021 COVID-19 outbreak and its relation to the Isle of Man Steam Packet Company'. Welcome, Mr Hind.

Mr Hind: Thank you, good afternoon.

Q324. The Chairman: Just to start off by perhaps looking at the ownership of risk, that being something that is very much your area of expertise, how would you characterise the borders policy at the time of the first lockdown as things started to gear up?

Mr Hind: In terms of ownership of risk? (**The Chairman:** Yes.) Then I would be saying that obviously the Council of Ministers are having an oversight of the management of the whole COVID situation. Obviously, they are taking advice and there are statutory responsibilities in relation to the Director of Public Health, and the Steam Packet and other carriers would have an element of ownership in terms of relation to those risks, so I think it is a complex risk picture and is probably a shared responsibility.

Q325. The Chairman: Do you think, in looking back on this, that everybody really understood the level of risk and what part of the risk picture they owned?

Mr Hind: I would be surprised if everybody did at that point. It was a fast-emerging, totally new situation. We have to bear in mind that, even looking in terms of Government responsibilities, the whole responsibilities within Government, there are whole new teams that just did not exist at that time. It was very fast moving. I am not even sure that across the globe there was a good understanding of risk and risk ownership in terms of that.

The Chairman: Mr Hooper, do you want to quickly come in on that?

Q326. Mr Hooper: Yes. We have heard that quite a lot from various parties in Government – that this was fast moving, it was all new – and that was absolutely true in March 2020. The incident we are really looking at actually happened in December. Would you characterise the situation in August, September, October, November and December as still completely new, unchallenged, uncharted territory? By that point we had been managing the lockdowns and the virus for a period of months.

Mr Hind: In relation to border risk, I think we were privileged on the Isle of Man in terms of the position we were in. My experience from reviewing, just in terms of Government, is there were parts of Government where that never let off in terms of the amount of change that was being managed. I think, just purely lifting up the number of statutory changes that were going through, in terms of trying to regularise the situation through the regulations and things like that, that alone is an indicator of how unprecedented it continued to be, and continued to be post the introduction of the Public Health Regulations at the end of December. Even post December, if you look at the number of amendment regulations on those Public Health Regulations, I think it shows what a continuing, fast-moving, evolving position and risk position it was, and how certain parts of Government were continually working at pace. We have to bear in mind that a lot of these areas have day jobs – or had day jobs; those bits are needing to be managed when supposedly things are letting up on the COVID bit – but contact tracing and the issue of the Travel Notification Service documentation was all being required to be managed as new, additional workload throughout the period and on a fast-changing statutory backdrop and risk backdrop as well. That would be my view on that.

Q327. The Chairman: I appreciate that in the first few weeks it was going to be difficult to get it all right first time. We are talking about a period over nine months. Do we, after that point, nine months in, have a view as to what 'good' would look like?

Mr Hind: Yes, I would hope so. It has evolved, and I think Government has evolved with that, and in fact everyone involved in the management of the risk has evolved in what 'good' looks like. Even if we take away from Government and we look at what is happening internationally in terms of the particular area under review, in terms of maritime regulations and health and safety, certainly as I understand it from the review work that I undertook, there was no update on maritime regulations globally. Globally, there was guidance issued but no direct updates in terms of regulatory requirements. I think that is showing how this was – I know is an overused term – an unprecedented risk framework.

Alongside the general borders risk, obviously these risks were being brought together alongside trying to manage the continuity in terms of business support risks and those sorts of areas as well. So, it was not just one aspect of risk that needed to be managed in this scenario, it was multi-faceted. I know we are particularly looking at one area, but I think that context is really crucial, and the Island, whilst it had its benefit in terms of being an island and managing the borders, the risk apparently, in terms of the evidence, was well managed in terms of management

of COVID – that we were not in lockdown for prolonged periods would be, surely, circumstantial evidence of that – but there were, ongoing, other risks that continued to need to be managed, and wholly new and novel in terms of that.

Q328. The Chairman: Reading your report, even as late as December, at which point groups started to come together, but up until that point there does not seem to be a single strategic-thinking mind that seems to own the borders problem. Is that a fair representation?

Mr Hind: As a specific issue and a single point of ownership, then Council, of course, would be managing that. There was a COVID Response Team, which was formed as a response to trying to bring the management of all risks together, and that, to my understanding, was formed in the summer before, leading up to the December period. That was, I think, a response to try to bring the management of that risk together. Was there a specific person allocated to the border risk? I am not aware of that.

Q329. The Chairman: So, in terms of that risk ownership, whoever owned the COVID Response Team owned the border risk? I am just trying to piece together the different parts. As you say, it was a complex picture, and obviously the best thing to do, in terms of command and control of a complex picture, is to simplify it and put someone in charge of it, and that did not seem to happen. Do you think that that was an opportunity missed?

Mr Hind: No. I think that was happening via Gold Teams in terms of the broader COVID management, and I think that seems a reasonable way to want to manage it, and also through to the Council of Ministers, who were regularly reviewing the borders situation and having, at times, as I would understand it, daily reports and meetings in relation to the management of that.

Q330. The Chairman: And you said that that happened in Gold Team. Have you seen evidence as to how the borders were managed in Gold Team?

Mr Hind: No.

Q331. The Chairman: So how do you know that it happened in Gold Team?

Mr Hind: I have been saying that the management of COVID *risk* was being managed proactively through …

Q332. The Chairman: I am trying to pinpoint now on the borders. We have asked for all documentation, as I think you did at the start of your inquiry, and we have had nothing from Gold, Silver, or Bronze, so we can only assume, from that, that the borders just were not discussed at Gold, Silver or Bronze level.

Mr Hind: But members of that team were reporting through to Council on a regular basis.

Q333. The Chairman: But we do not know about that. Again, in terms of Council of Ministers' meetings and in terms of the evidence you presented in your report, there are not an awful lot of Council minutes referred to in there about the borders issue either.

Mr Hind: That was coming, I guess, from interviews that I had throughout the course of my report and investigation, in terms of that, in my review.

The Chairman: Okay, but of course we do not have access to the interviews. It is just that they were not specifically referenced.

Mr Hooper.

Q334. Mr Hooper: Just on that point, then, you say that CoMin discussed these issues and had oversight of it, but like the Chairman has already said, there is not any evidence of that provided in the report.

Was it something of a surprise to you that it was not until August 2020 that the Director of Public Health first actually mentioned to the Steam Packet that Manx crew should be self-isolating when not on duty, when they were a high-risk contact? Actually, that is the first point I think you have identified in the timeline, that they were told that. Would you not have expected to see some kind of decision making made earlier? If CoMin were the risk owners, should there not be some evidence that they had considered the risk and made a determination around what they thought the correct mitigation procedure should have been, rather than leaving it up to the company?

Mr Hind: Perhaps in hindsight a dedicated borders strategy and management of that and the issues –

Q335. Mr Hooper: I agree with you, but I am not talking about it needing a whole strategy. I am talking about the Council of Ministers making a decision and saying, 'We know the borders are a risk. We know the Steam Packet is a high-risk area because of the type of work they do. We also know they are a lifeline.' You cannot turn the boat off, so I would have expected CoMin to say, 'Right, how are we going to mitigate this risk?' and for them, as the risk owners, to make that decision on the basis of best advice from various parties. But, from what I can tell in your report, no evidence seems to have been provided that supports that process, other than, as you say, the interviews you had, where you are taking them almost at their word that yes, they did these things, but there is no record of a minute, there is no paper, there is nothing that actually says this complex problem that you have already identified yourself as a complex problem was dealt with without any kind of documentation or formal sign off.

Mr Hind: Certainly on the documentation that I was provided with, that was the earliest point at which it was being addressed professionally or for advice, and that was on response from the Steam Packet actually querying to Government and senior crew members in the Steam Packet making that specific query, in terms of how crew-to-crew risks should be managed as well as crew-to-public risk.

Q336. Mr Hooper: Just for clarity, then, you say that all the documentation you were provided with … I am assuming you do not have any concerns that there is documentation out there that you were not provided with; it is just that you have not seen it yourself, so you do not know for sure.

Mr Hind: At this point it would be unreasonable of me to assume that I have not been provided with the information that I asked for.

Q337. The Chairman: The evidence we had from the Chief Minister was that having identified that the borders were a risk, it was left to officers. Does that chime?

Mr Hind: Yes, I think so, but if you look at the statutory reflection of that, that is where the risk is being managed. I know there is an element of Council of Ministers' responsibility in the statute, but primarily the named parties are the Chief Secretary, the Director of Public Health, the Department of Infrastructure Chief Executive in terms of critical national infrastructure, and the Department of Health and Social Care Chief Executives. So, it is very much, even in the statute and the regulatory framework, being delegated down to an officer level for statutory responsibility and management of that risk, but I would say the Council of Ministers have an overriding management responsibility in terms of that.

Q338. The Chairman: Thank you. Before I hand over to someone else, could I ask, then, what evidence you saw of any political oversight of this?

Mr Hind: In terms of?

The Chairman: Orders.

Mr Hind: Just from those …?

Q339. The Chairman: Any politician providing any oversight over the borders question at all.

Mr Hind: I have not seen specific evidence in relation to that.

Q340. The Chairman: Any evidence at all that there was any political oversight over the borders issue?

Mr Hind: In relation to the issues coming out of the borders issue, then if it came out in terms of interviews it was discussed in relation to the outbreak in February, which is obviously related to that. That, to be fair, was the primary focus. My review was around the outbreak in February, and that was certainly discussed and evidenced at least verbally that it was being discussed at Council of Ministers.

The Chairman: Mr Robertshaw.

Mr Hind: And corroborated by several parties in relation to that.

Q341. Mr Robertshaw: You quite rightly said this was a fast-moving situation, and in private discussions the Committee has likened it to a war. In this case, it is a war between human beings and a fast-moving virus. In your report, from 2.2.3 onwards you identify the particular risk that exists and existed between UK members of crew and Isle of Man members of crew. It came to a serious head when our enemy, the virus, converted from whatever transmission levels it had before to the Kent variant, which was an acceleration of the transmission.

It was very clear from an operational perspective that the Steam Packet operators knew full well that there was an increased risk. How was it, in your opinion, that this was so completely missed by Government in terms of not putting two and two together and making four, because not only were we hearing …? And remember, we did not, at this particular stage, as early as November and December, necessarily know how that transmission was working better. We now know that it went from droplets to aerosol transmission. But there was conversation going on at that time, right across the media in the UK and here, that this was a possibility, so the risk was seriously growing. The Steam Packet management raised this question from November onwards and fairly consistently thereafter, and it fell completely on deaf ears. What do you attribute that to?

You hardly mention the concept of vaccination as a risk reducer in your report. I was amazed by that, Stephen. How could that have happened?

Mr Hind: Which bit? My not mentioning vaccinations in my report, or the lead up?

Mr Robertshaw: Both.

Mr Hind: In terms of the vaccination aspect in my report, I do cite the delays in responding to vaccinations in relation to that as being a criticism in the response of Government in prioritisation

and capturing it. At the end of the day, that was a lesson learnt. By the time it came to my report, the decision had already been made in relation to crew vaccinations.

In relation to further lessons to be learnt from that, I think the problem … I think, in particular, in trying to write a report on fast-moving sands, which they continued to be … is making recommendations that are going to be valid going forward, as opposed to in a specific situation. Certainly on the vaccination issue the lesson had been learnt and that action had been implemented, in terms of the evidence that I was seeing.

Q342. Mr Robertshaw: But the criticism addressed to the Steam Packet at political level at the time failed completely to take that into account.

Mr Hind: And in terms of the management, where you started, it is the management of that crew-to-crew risk which I actually highlight as a key aspect and a key issue that needed to be managed.

I think it is a bit unfair to say that at that point, certainly from November-December, it was not being taken seriously by Government. Some of the issues around the statutory documentation being issued was challenges back to the Steam Packet in relation to the risk assessment framework that they were putting in place in relation to the management of that risk, and I would certainly consider from –

Q343. Mr Robertshaw: Can I talk over you? Are you suggesting that the managed risk within the Steam Packet outwith vaccination was going to be successful? Surely you are not suggesting that.

Mr Hind: I would say that is a public health expertise, in terms of the actual managed risk in relation to the impact of vaccination and contamination.

Mr Robertshaw: Yes, but what I am trying to do is –

Mr Hind: It is beyond my specialism and I would suggest you pose that question to the relevant expertise.

Q344. Mr Robertshaw: Yes, but you were invited to find out what went wrong. You have very kindly indicated at the beginning of your report the limitations within your personal expertise, but surely we cannot ignore this absolutely core issue, which was that the enemy, the virus, was changing its tactics. We missed it completely for months, because we did not actually finally vaccinate the last member of crew until – I cannot be absolutely sure of the date – either late March or early April. That is no response to an enemy, is it, which is the virus, and no regulation, surely, Stephen, is going to sort that out. Surely you would accept the fact that there are issues beyond that, in terms of communication and leadership, that should ensure that we focus on the right things at the right time. And let's be honest: the next thing that may happen could be outwith any regulations already prewritten.

Mr Hind: Absolutely, which is certainly why one of the key recommendations I have included in the report is that regular multi-agency meeting with particularly the Steam Packet, which is the area I was asked to look at, to make sure the issues are being discussed, the risks are being discussed and responded to. And certainly the generic recommendation around prioritisation and making sure that there is a proper issues management framework around this high-risk area I think is crucial to that continually shifting dynamic, let's say, when recommendations cannot …

The regulations, as I understand it, were amended fairly quickly at the end of December to account for the increased risks.

Q345. Mr Robertshaw: We did not need a regulation, surely, just to vaccinate the crew. Why did we need regulation or a set of rules around that?

Mr Hind: I am not saying that you needed a set.

Q346. Mr Robertshaw: But that would have been the action, wouldn't it?

What do you think went wrong? Why do you think the crew were not vaccinated when they should have been, when judgement and assessment of the degree of risk, bearing in mind what we were becoming aware of, would have been the right thing to do? Why do you think that did not happen?

Mr Hind: Well, as I said, it was a shifting risk framework and, in particular, I would suggest that is very much a public health expertise in clinical risk, in terms of the risk.

Q347. Mr Robertshaw: Did you speak to Public Health about it?

Mr Hind: At times, yes.

Q348. Mr Robertshaw: And what did Public Health say to you?

Mr Hind: They said that it was a shifting risk framework.

Mr Robertshaw: Thank you.

Q349. The Chairman: Can I just go back? A little earlier – just sticking with vaccination for a second – you said that that was a lesson that was learnt. What do you believe the lesson was that was learnt with regard to vaccination?

Mr Hind: The prioritisation of critical infrastructure key workers.

Q350. The Chairman: In other words, the slavish adherence to the JCVI formula in the UK was not working?

Mr Hind: I think a Manx-based solution was warranted, absolutely.

The Chairman: Thank you very much.

Ms Edge, you wanted to …?

Q351. Ms Edge: Just following on from that, with regard to gaps in the evidence that you have gathered, particularly from Gold Command, and talking about vaccination, surely recommendations would have gone up through the command structure. You have not seen any documentation – do you not think you should have delved a little bit deeper on that? It appears from the report that you have only gone down to a certain level and I am hearing you say a lot today that it was down to interviews that you have had with individuals.

Mr Hind: I do not think it is fair to say it was just interviews. In terms of the framework that we applied, I applied a similar framework almost to how actually the Committee would approach it, which is a call for documentary evidence, then a series of interviews and any clarification questions coming out of that.

I would accept that there are bound to be omissions in terms of the evidence that I had. I had no formal powers to obtain evidence in relation to that.

Q352. Ms Edge: Did you not think to ask for the full powers?

Mr Hind: Well, I was just going to come to it. Throughout the whole process I think what I was trying to do in relation to my own report risk was to balance my own risks in terms of expediency and needing to do this. It was very high profile. There was a requirement to get a report out. It was a very complex area – I think far more complex than I went into it thinking, in a lot of areas.

There was a substantial amount of documentary evidence as well as statutory framework that was being reviewed. I was very fortunate to be supported by a professional investigations team within Audit Advisory at the time, who, like myself, have experience and have training in relation to undertaking investigations up to a criminal level and for court reporting and providing expert witnesses. We did create a full evidence log of the written evidence and submissions that we had. There were over 200 items in that; some of that is going to be multi-pages. I guess there is a balance between expediency … All the way through, we were doing a triage in relation to where were the risks in relation to what we were needing to report on, back to the terms of reference, and I was having to make a call in relation to 'I think we need to focus on these key areas in relation to the lessons learnt, in particular going forward,' which was the overriding remit of the report – 'Yes, there are causes there; however, what are the key lessons to be learnt going forward?'

Q353. Ms Edge: You have admitted that you did not necessarily have the answers on vaccination, but with regard to the *vires* and time bound, as an audit professional did you not think at a point in time it would have been appropriate for you to go back and say, 'I cannot deliver on this at this time, and I have not got the *vires*'?

Mr Hind: I was content, in relation to the terms of reference, that I had sufficient *vires.* In relation to the instruction for people to co-operate, at no point did I feel that there was a resistance to co-operate with my report. Everyone I was dealing with dealt with it professionally. The issue around *vires* I think was an interesting one, in particular around third-party evidence, and obviously the Isle of Man Steam Packet is a third party to Government. However, they were very co-operative. At no point, in my view, did I feel I was not being provided with evidence, apart from when I felt it was reasonable in relation to the restrictions that the actual statutory framework would be putting on anyone in relation to direct evidence provided in terms of personal data and on what –

Q354. The Chairman: You are talking about contact tracing, though, there, aren't you?

Mr Hind: I am talking about any evidence that is collected under the Public Health regulations and predecessors. My reading of those regulations was it was not specific to contact tracing, albeit I did, during my course of my review, for my own professional approach and assurance, try to get an independent assurance in relation to the process of contact tracing and an independent review on that, and those regulations were preventing access into that data.

The Chairman: Mr Hooper.

Q355. Mr Hooper: It seems that we are touching on the terms of reference. You said there that one of the key outcomes of the terms of reference was to identify lessons learnt, but actually one of the key parts of the terms of reference was to identify the timeline of events and the root causes as well. You have got your root cause diagrams in there, but I am not sure the report really addresses the root causes of the cluster.

There is a specific part of the terms of reference that requires you to report on whether there are any shortcomings in the process and the documentation issued, which you have covered, I think, quite well in the report, but also to report on any shortcomings in the advice given. I think that bit does not come through very clearly from the report, whereas we can see from reading

through the report that actually the advice itself that was given to the Steam Packet was inadequate – it is quite clear there – and that there was a lot of confusion on the Government side as to what they should have been doing and who should have been responsible, which I think, like you have said, comes back to that risk ownership. So, in terms of that particular part of the report, in terms of shortcoming of advice, I have read that as really reporting on shortcomings of the mitigation measures that were in place, because obviously you cannot force people to do things – at the end of the day it is, 'We can tell you what you should do,' and if that happens, great.

But is it fair to say, really, that the ultimate root cause of that outbreak was that there was no body that had visibility across the piste of the risk and the mitigations that were being put in place to manage that risk, and that that body also did not have any understanding of whether those mitigations were appropriate to manage the risk that had been identified?

Mr Hind: There is a lot in there!

Mr Robertshaw: That is another report.

Mr Hind: Yes, absolutely.

In relation to addressing the advice issue, I certainly did endeavour to pick that up as a key part and look at what I thought would be the root causes in relation to that. There is an element of limitation in relation to where that advice is in relation to public health as a clinical expertise, which is inevitably going to be a key area around here. And equally, as I highlight in my report, there is a significant complexity. This is going into international maritime regulations. There is a significant specialism in relation to –

Q356. Mr Hooper: As you have said already, the regulations never changed, so the maritime regulations actually have not changed throughout. You made that point earlier.

Mr Hind: Yes, the guidance was, but in terms of the responsibilities and the general management of health and safety, there is a whole framework in terms of management of maritime health and safety in terms of safer management systems.

Mr Hooper: I accept all of that.

Mr Hind: So, in terms of quality of advice, I would say there are significant limitations in relation to my own specialism, and I absolutely accept that.

I think I do address some of the key issues in the advice, which is about the delays in responding to that, which I think is a lack of prioritisation at times from Government. Absolutely, I think it is highlighted in the report and some of the clear aspects of that are delays in responding to the vaccination issue, delays even in responding to that crew-to-crew risk issue. So, delays in the professionals giving that advice or Government taking action. I think I have picked up the best I can, within the context.

Q357. Mr Hooper: That is in the context of the advice given to the Steam Packet. (***Mr Hind:*** Yes.) The bit that really is missing is the Public Health piece as to what advice was being given in terms of the mitigation measures that were necessary to mitigate the risks. Part of this report is saying we have identified what the risk was, and it was the intra-crew risk and then the risk of the virus spreading, and like you quite rightly say, the intra-crew risk is quite complicated because of all the international flavour and everything that is going on. But then the second risk, how do you stop the virus spreading from the Steam Packet on to the Island – that is clearly identified in your report as a second risk – is very much a local management issue, it is how we address it on the Island, and I cannot see in your report anywhere where you have talked about that. I know one aspect of it is the vaccination potential, but also it is around things like testing or checking on the

crew. You have talked to the contact tracing team, for example. At this point in our borders strategy, we were checking on every single person coming through the borders, apart from the Steam Packet crew, but you do not seem to mention that in the report. We were also starting to test people coming back on Island, and again you do not mention that in your report either, about actually what advice was provided by the public health professionals on what mitigation measures should be in place to address this risk and whether or not that advice was listened to and acted on. That is almost entirely absent.

Mr Hind: Yes, I would accept that there is a potential omission in relation to that specific aspect. Partly it was because the lessons had been learnt. Again, not only had vaccination been implemented by the time I did my report, but also that regular testing and the testing framework. I did have detailed discussions with the Steam Packet in relation to how those risks were being managed now. Again, it may not seem it in what I appreciate became quite a lengthy report. It was focusing on what the lessons were still to be learnt.

The primary lesson out of all of this for me, and that comes back to an issue that you were talking about, was the prioritisation and making sure that there was an appropriate consolidated framework to manage this as a risk. For me, I was not specifically talking about the borders as a risk; I was talking about, per my terms of reference, that interaction with the Steam Packet as a part of that borders framework, but in terms of the idea of there being one multi-agency dialogue and regular dialogue in terms of the multifaceted risk framework which is being managed by both the Steam Packet and themselves. And certainly some of the issue was they were coming at this very much from a maritime perspective and Government was coming very much from a general public health perspective. There was certainly evidence that that caused friction, from my perspective, in terms of just the different language and dialogue around the management of the risk. As I say, I think the multi-agency meeting that was held in February was a very positive move in terms of addressing it. It was just that the time was unfortunate. Some of the movement to address this was before the outbreak, but it did not completely get finalised until post the outbreak.

Q358. Mr Hooper: The question I have on that is, as part of the root cause analysis – you were asked to investigate the root cause of the cluster, not just what happened on board the Steam Packet – would you accept that one of the key root causes of the cluster was that we had inadequate mitigations in place to stop that spread from the boat to the Island?

Mr Hind: And one of the key recommendations I make is around the contact tracing reaction to that, and note that I did not see any evidence to say that they did not adhere to protocols etc. and do a professional job. I think, for me, what came out of that is he management of that risk, once it is materialising, the idea of actually having a dedicated and specific risk response once that risk is being materialised, and that was certainly the intention of that recommendation – but for Public Health, which is where contact tracing sits, to consider the outbreak management plan specifically around that.

Q359. Mr Hooper: So, again, outbreak management is dealing with something after it has happened, which is coming across quite clearly here. You have said that in February there was lots of discussion around this, but that is, again, after the fact. What I am more interested in are preventative mitigation measures. For example, at this point, the mantra from Government was still very much test, test, test, and yet at no point does it seem anyone had considered even testing the Steam Packet crew on a regular basis, because they were mixing – even the Director of Public Health's advice back in August, which you have summarised in your report, as she was under the impression that they should be isolating. That is not quite correct, because of advice in August.

Mr Hind: High-risk contacts.

Q360. Mr Hooper: It is high-risk contacts only. So, that is another issue that really is not touched on in your report: where were these preventative mitigation measures? Not on the boat, necessarily, because that starts to get covered by things like mask wearing and social distancing – it is inconsistent, but it starts to appear from August onwards. But still no one is talking about on-Island mitigations or other things that could be put in place. Is that something you did not cover?

Mr Hind: No, I think it is because at that point the Public Health understanding, as I was understanding it, was that the high risk would be mitigated via self-isolation, and that was then further challenged in terms of trying to get the documentation right and the process right and the risk assessments.

Q361. Mr Hooper: But we knew that was never the case, because we knew at no point did anyone issue any requirement for crew to self-isolate. That did not happen. Even today, there is no firm requirement on that. I think your report is quite clear that –

***Mr Hind*:** Yes, there is a self-modification, and if they do not adhere to the –

Q362. Mr Hooper: Yes, but now the Government has implemented regular testing for the Steam Packet crews. So, again, after the fact these mitigations are all considered appropriate, but when the Steam Packet was asking for these measures prior to the outbreak –

Mr Hind: Again, I think the risk which I have identified is one of prioritisation and issue management around those prioritisations to make sure that these things are collected in a single place for risk management and can be escalated as appropriate and chased up in terms of what action is being taken to manage them. That, for me, was the key lesson learnt. There are myriad risk factors there, and that was the key. The key aspect was prioritisation and issue management, I think.

Q363. The Chairman: So, from what you have seen, do you believe that Public Health understood the risks and limitations of ferry operations sufficiently to understand and regulate the risk?

Mr Hind: I think there is a difference in dialogue in terms of maritime regulation, and one of the issues that I have highlighted in my report is that at no point was anyone talking to the regulator of maritime in this area, which happens to be on Island in terms of the Ship Registry. That was a specific question that I certainly asked the Public Health team, contact tracing and the COVID Response Team, in terms of was there at any time interaction with the maritime side to get an independent insight in terms of how those risks should be managed.

My understanding from talking to the Steam Packet is there is an element of balancing of risk for them, in terms that obviously they have to manage the COVID risk into crew risks. However, they are in a very complex health and safety environment; hence, full safety management systems and regulations around standards of health and safety. Certainly one of my views was that that early interaction and a memorandum of understanding with parties like the Ship Registry would certainly assist where roles and responsibilities are and where advice would be obtained.

Q364. The Chairman: I think here your concern is that the Steam Packet was sending risk assessments and mitigation proposals through – they were going to Public Health. Public Health, from what we have gathered here, did not really seem to understand what were the peculiarities of … and there was no real effort on behalf of Government in the wider sense to ensure that there was that meeting of minds, whether that was with the regulator or Public Health and with the Steam Packet –

Mr Hind: I think that is a fair comment until that multi-agency, multi-party meeting that happened in February –

Q365. The Chairman: Which was 11 months later.

Mr Hind: Yes, but in terms of lessons learnt and managing the risk going forward, the key lesson learnt out of that was that that seemed to work, getting everyone around the table to actually have that discussion.

Q366. The Chairman: And that begs the question: why wasn't that identified? Why did it take 11 months to realise that everyone needed to sit round a table? There were warning signs all through this as to misunderstandings and lack of clarification, and it took 11 months to get people round the table. Do you think that it was a lack of single controller or risk owner that meant that it took that long to realise that there was a problem?

Mr Hind: The statute lays out different responsibilities in relation to that, and actually prevents there being a single owner. And would that help? Certainly, I think a single owner, a single point of accountability, is always a good thing in terms of management of risk.

I would just remind us all, in terms of that context, it is very difficult to say what that root cause is when you are not aware of the actual noise level and activity level of everything else that is happening around that point.

Certainly, I would hope a recommendation would assist in that specific … let's call it a professional peer review in terms of Public Health, looking at that Public Health resourcing, and I make a recommendation in relation to Public Health clinical resourcing to provide (1) continuity for what is a critically named statutory position and (2) an element of professional peer review in terms of decisions and advice being given.

The Chairman: Okay. Mrs Barber.

Q367. Mrs Barber: You have touched on the multi-agency meetings. I think we all agree that the meeting that did eventually happen was a positive. But neither in the recommendation or anywhere else is there specific context around the recording of outcomes of meetings, which appears to be a huge gap certainly around Gold, Silver and Bronze. I wonder what your comment would be on that, because actually the failure to have anything clearly documented means there is no accountability for follow-up.

Mr Hind: Yes, as we highlighted earlier, I have not seen the documentation from Gold, Silver and Bronze, so I actually cannot comment on whether the documentation is there or not, or decisions have been recorded or how they have been managed.

Q368. Mrs Barber: Okay. On the multi-agency meeting, though, I think we took evidence where there were no formal minutes taken, which means that when concerns were raised there was a missed opportunity again. And yet, even in the recommendation it says that there should be regular meetings, but there is no comment about whether they should be minuted, and one would assume –

Mr Hind: I would hope my earlier recommendation in relation to issues management and priority management of issues is all about documentation of the ongoing issues and tracking the progress to resolution. So, my hope in terms of that would be particularly where issues are tracked, managed and escalated in relation to that. That, for me, is the key risk.

Q369. Mrs Barber: I think it is good to spell it out. (***Mr Hind:*** Perhaps.)

And then, just following on from your earlier comments, you talked about the need for expediency in the report, and I just wonder whether you feel that there was any compromise even, potentially, with the scope or the outcomes of the report by virtue of that need for expediency that you recognised.

Mr Hind: I do not feel professionally compromised in the report. We are talking about risk. I took a risk view throughout the process, a professional risk view and assessment of what was important and what was not. It was – a term that is referred to frequently in a crisis – a 'balancing of risk' for my own purpose, but I still, even now, do not feel I was significantly or materially compromised in relation to that report and the content of it and the professionalism that we put into undertaking it and the rigour we put in documenting our own work and managing that. If I was left to do this solo, I would be far more concerned. As I said, I was very lucky to have a strong support team around me and to provide my own internal professional peer review in terms of how we were reporting and what were the key issues, and to have that voice in the ear saying, 'We need to consider this, this is important, don't forget that.'

Q370. Mrs Barber: I wonder also whether you feel there is a limitation within the report. The report was, as we understand, specifically in relation to the Isle of Man Steam Packet Company, and I think we all understand the reasons why, but actually there is a transferability issue. Are there potentially other risks that simply we just got lucky on, that have never been properly articulated, identified, owned and managed?

Mr Hind: Quite possibly. As I said, I have not seen the general minutes in relation to seeing how that broader picture was being managed.

The Chairman: Supplementary question, Mr Robertshaw.

Q371. Mr Robertshaw: Thank you, Chairman.

Could you just walk us through recommendation 8, Stephen? I will read it out, so that perhaps those listening might be aware of it. It says:

> The Cabinet Office should undertake a review of clinical Public Health resourcing options and implement the most appropriate option to ensure continuity of clinical advice and if feasible, expansion of clinical expertise.

Could you expand on what exactly you mean by that?

Mr Hind: Yes, I guess there are multiple parts to it. I guess the starting point is the gap I have identified, or an opportunity I have identified is to … At the moment, there is one qualified person in relation to the statutory responsibilities and expertise around public health, which is a clinical specialism. There is a statutory role there, so there is obviously a key continuity issue; we have a key person risk in relation to that. So, that is the starting point of it. I think I am saying the Cabinet Office should review resourcing options because, particularly in the current environment, I imagine obtaining public health expertise or recruiting public health expertise is going to be fairly competitive, shall we say, so then I am suggesting that they look at the options in relation to how they can fill that gap, which may be varied in relation to the actual recruitment of a full or part-time position, actual contractual relationships with other third parties, with a specialist in this area.

In relation to the expansion of clinical expertise, I think the Director of Public Health … and certainly my discussions with Dr Ewart highlighted the fact that actually there are specialisms within public health, and infectious diseases is obviously a very pertinent specialism in relation to the risks that we are currently trying to manage. There is a sub-specialism in relation to that, and

if we could expand the clinical expertise in relation to that aspect I think it would be an improvement in our risk understanding and risk management going forward.

Q372. Mr Robertshaw: You are not suggesting that a response to this would have retrospectively sorted out the observation necessary to see a particular risk growing and respond to it at the time we should have done, and did not?

Mr Hind: I think any expertise, and clinical expertise particularly around infectious diseases and how they should be managed, has got to be about benefit to any approach to risk management of an infection.

Q373. Mr Robertshaw: So, your answer to this is just to grow Government again, really, isn't it? Look, I know nothing. I am a member of the public and I have been preoccupied for months about ventilation, and it seemed to me sensible, common sense. There was a ventilation problem on the Steam Packet, where you had two sets of crew capable of transmitting a more transmissible virus. How much expertise and staff do you need in Government to observe and respond to that risk, when the directors of the Steam Packet are telling you there is a problem there? How does growing Government get us much further?

Mr Hind: I think this is growing a specific statutory responsibility, which is an individual's responsibility within Government, and making sure you have appropriate contingency. As I say in my recommendations, it is not about growing Government, it is about sourcing options to fulfil that skill and continuity gap.

Mr Robertshaw: Thank you.

The Chairman: Mrs Poole-Wilson.

Q374. Mrs Poole-Wilson: Thank you.

Just picking up on the overall conclusion that you reach, which is that the safe continuity of the Steam Packet services should be a priority for all the relevant parties involved, I suppose my questions are … First of all, you have mentioned how much noise there was and the variety of things that were going on, but given your overall conclusion of how vital this service was – and, I suppose, also in the light of one of the aspects of the increased level of risk was Government's requirement that there was a continued twice-daily sailing operated by the Steam Packet – my question is where do you conclude this should have sat, in terms of Government's overall prioritisation of the risks it should have been managing effectively?

Mr Hind: I think that was sitting with the Council of Ministers because there was –

Q375. Mrs Poole-Wilson: Sorry, not where, but where in the priority order – how important was this risk to be addressed and managed?

Mr Hind: I would say very, very important. It is a critical risk. As I have highlighted, it is a critical risk in terms of the maintenance of critical infrastructure, it is accepted as a critical infrastructure, and it has also got this added flavour, as we have spoken about, in terms of border risk and being in exposure to that. That is why I think I have called a critical COVID risk point in relation to this, and it is twofold. It is absolutely critical infrastructure. Certainly at the outset of the outbreak and why it is multi-agency is at that point – and I know actions have been taken to resolve it – it was critical from a health perspective, in terms of obtaining oxygen supplies on to the Island, so in terms of maintaining that same sailings continuity. The risk to the crew is a risk to that sailings continuity as well, in terms of, obviously, what we are dealing with. So, the continuity of services

is very critical, and like we say, as a border risk, as we have identified from this, I think it was very critical, so doubly critical in terms of maintenance of that service. And those issues were discussed, as I understand it, at Council of Ministers, in terms of interviews I had intended in terms of why was that sailing schedule … where was it discussed, and it was discussed and decided at the Council of Ministers.

Q376. Mr Hooper: Could you advise when those things were discussed by the Council of Ministers?

Mr Hind: I think early on in the outbreak. Apologies, I would have to revert to the detailed evidence file of my own to actually track that down, or spend 10 minutes going through the timeline in my report.

Q377. The Chairman: Given the importance you have attached to this priority of risk, I think that – to me, anyway – adds emphasis that there should be a single risk owner. What you have described is that there is no one person, no one Department even; it is the Council of Ministers, which is obviously a group of people that owns this risk. You have not made a recommendation about a single risk owner. Is that something that perhaps you would reconsider? And if you would, who do you think the risk owner should be?

Mr Hind: I have not made a recommendation about a single risk owner, in particular because of the statutory framework as it currently is, and there is inevitably a split ownership of that risk.

The Chairman: Mrs Poole-Wilson.

Q378. Mrs Poole-Wilson: I suppose my question following on from that is: whilst there may be responsibilities within statute, what is there that would prevent Government organising itself in such a way as to make sure there is a single point that is overseeing that those people with statutory responsibility are acting in accordance with their statutory responsibilities?

Mr Hind: Yes, I would consider that that could be a valid option going forward.

Q379. Mrs Poole-Wilson: And I suppose just moving on and particularly picking up the point that Mrs Barber raised before, in terms of the risks we have not yet realised and documented how they are being mitigated, one of the things that leapt out at me from your report is on page 51, where you highlight that multiple red flags were raised and did not trigger appropriate escalation. I do not think any of us would probably disagree with the multi-agency framework you are suggesting, but there does seem to be a further issue, in that there is a lack of escalation of red flags. So, even if you create a multi-agency approach, what do you believe is the cause for red flags not being appropriately escalated and getting to decision makers?

Mr Hind: I think that comes down to my first recommendation, which is around issue management. I specifically highlighted that whilst my review was in relation to the Isle of Man Steam Packet Company, and that was the scope of the terms of reference, I specifically added in 'and other high-risk clients' to try and say actually there are going to be further risk-management issues in relation to this. I considered it was beyond the scope of my report to actually look at the whole management of COVID and how that should be undertaken, but that is certainly my saying the Steam Packet was absolutely a high-risk risk client in terms of this, but this approach could be replicated or amalgamated into a high-risk issue management to ensure appropriate escalation.

Q380. Mrs Poole-Wilson: I suppose my wider question there is does this speak to something broader in a cultural sense across Isle of Man Government?

Mr Hind: That is beyond the scope of my report, I would suggest, at the moment. I am no longer in a position to do an audit on that.

Q381. The Chairman: But you do have a significant amount of experience across all levels of all Departments. Is that something you recognise?

Mr Hind: There are aspects, I think, for improvement across Government, and Government is vastly varied, as we know, in the services delivered. With that, comes a massive variation in the cultures associated with that. The framework is standard for there to be a departmental management of that risk. As we know, the statutory responsibilities in Departments start with an individual called the Minister, and those risks are managed via departmental meetings. I know, in different guises, I have discussed with the Committee before that governance framework around the management of risk, and even that is varied across Government, in that you have some entities, like the Post Office, Manx Utilities and the FSA, that have a quite commercial board approach to the management of risk and they have formal audit and risk committees, so they are very proactive. That, as it currently stands, is not a governance structure that is replicated across departmental entities, I would suggest. In terms of best practice, how you square that circle in the complexity that is Government I think is a challenge.

Q382. The Chairman: So, in this particular context around the relationship of the Steam Packet and the borders, the key players were the Travel Notification Service, the COVID Response Team and Public Health. All of these fall under the Cabinet Office and the person responsible, therefore – the Minister responsible, therefore – is the Chief Minister.

Mr Hind: Yes.

Q383. The Chairman: Okay, so I suppose if there were to be a single political risk owner within the Council Ministers, it could be argued that is who it would be.

Mr Hind: Sorry to interrupt, but I think it is important to also recognise that the Steam Packet as an entity has a risk responsibility in this area, and directly, and a separate … As I said, in terms of the complexity of the regulatory framework, it is not to the Cabinet Office, it is actually to their maritime regulator, which happens, in this instance, to be the Isle of Man Ship Registry, but they could be a foreign-flagged vessel, I would assume. And the Ship Registry obviously has international responsibilities in terms of its shipping vessels.

The Chairman: Mr Hooper, then Mr Robertshaw.

Q384. Mr Hooper: Just in terms of that statutory responsibility, the Ship Registry was not the body issuing the direction notices, was not the body issuing the Coronavirus Regulations; all of that did sit elsewhere.

Mr Hind: I fully accept there is a Cabinet Office responsibility.

Q385. Mr Hooper: The question I have for you is you mentioned before about the twice-daily sailings and the risk that that presented. We know the Steam Packet later on have advised that they thought that was a risk too far, but you said the Council of Ministers considered that very early on in the pandemic – and I think that is probably fair to say, it was right at the start. Do you think that right at the start of the pandemic the Council of Ministers could have fully appreciated the risks around the decision they made at that point? And do you find it surprising that at no point did they revisit that decision during the pandemic as the risks became better known, even after these things had been flagged up by the Steam Packet?

Mr Hind: I cannot comment on whether they revisited that risk and how that was … As I said, I have not seen a reviewed full Council of Ministers.

Q386. Mr Hooper: It did not come up in it?

Mr Hind: It did not come in up in my review or interviews, absolutely, but as I said, I have not seen a full set of minutes over the period, so I do not know if they did or did not periodically review that.

Forgive me, what was the other part of the question?

Q387. Mr Hooper: Was that a surprise to you, that it was not revisited even after the Steam Packet flagged up that this was a risk?

Mr Hind: I am coming back to this idea of issue management being absolutely the key part here. Part of issue management is saying, 'Here is a decision that has been made – do we need to review it?' and putting review periods on it and having appropriate escalation and reporting around it.

Q388. Mr Hooper: That is exactly the point I am making, really.

Mr Hind: I would say, yes, in terms that I think one of the things you were raising was is it surprising that they did not understand the risk profile at that point – I find it not surprising at all, considering the vast complexity of what was happening in terms of context. Context is everything, in terms of what people should or should not be doing.

Q389. Mr Hooper: That is the question I am asking, really. It is that lack of issue management at the Council of Ministers level. They are the decision-makers. They are the ones who really should have made that decision to say, 'We have made a decision today. Let's revisit this in a month or two months, as things change,' whatever it is, but you did not see any evidence of that being provided to you?

Mr Hind: I did not see any evidence of that. That does not mean there was not any evidence for it.

Q390. Mr Hooper: But you did ask for all the evidence in relation to these issues, so you would have expected to have been provided with it, if it existed?

Mr Hind: In reference to the terms of reference –

Q391. Mr Hooper: For the Steam Packet specifically?

Mr Hind: Yes. I quoted the terms of reference areas and said, 'Please provide me with that documentation.'

Q392. Mr Hooper: So, the second question on that, specifically about the Steam Packet: again, we know there was a decision made quite early on about putting some mitigation measures in place – you are quite clear about that in your report – but again, the mitigation of those issues, it does not appear that it is raised again until February and the outbreak happens, and that is the point when it starts to get discussed again. Is that accurate, or did you see evidence of that being reviewed?

Mr Hind: Actually, as I stated earlier, I think that risk was being challenged with the Steam Packet as part of the updates to the statutory documentation that was being issued, and that is why I think you see the extension. That was from December onwards, in terms of the challenge to those risk mitigation measures that were being posed by the Steam Packet.

Q393. Mr Hooper: So, between March and December there was no evidence?

Mr Hind: Again, I said there is a delay in the management of this, and that is evidence of –

Q394. Mr Hooper: The question I am trying to get underneath here is those challenges were happening off the back of … The Steam Packet was querying things and then a response would come in. The question I am trying to get to is the people who actually made these decisions, the people who are the ones saying, 'You do not need to go away and do this, Chief Secretary, go away and do this deal,' or 'I go away and do the Steam Packet' – was there any challenge from that group, the decision-making body, to say, 'Are you actually doing the thing I have asked you to go away and do?'

Mr Hind: I have not seen the evidence to … It does not mean there was no evidence.

The Chairman: Mr Robertshaw.

Q395. Mr Robertshaw: Thank you, Chair. I just want to talk to recommendation 6, which again I will read:

> The Steam Packet should ensure that its future internal audit programme includes an internal audit of its Coronavirus risk management mitigations.

The point I want to make here is that your long experience, and the team that supported you in this endeavour have very much been involved in you could almost say steady-state risk environments, in other words looking at situations that are fairly predictable. What you have said yourself here is that we are dealing with an incredibly volatile and fast-moving situation, and therefore how could the Isle of Man Steam Packet, in isolation of knowledge about the fast-moving risk, manage internally and in isolation its risk management?

Mr Hind: I think, as far as the evidence I have seen, one of the core aspects, and hopefully added value in terms of where there might be gaps, was we undertook a full comparison and gap analysis in relation to what guidance was in place at that point.

In terms of the management, the Steam Packet has its own risk in this area. As I was saying, it is responsible for its own management of risk, notwithstanding the Government's part in the management of the whole situation, so the Steam Packet, as is identified, was proactively identifying this as a key risk for their own continuity of service and the health and safety of their crew members. I would expect that they would be looking for their own internal assurance as to the management of that risk. I accept that they are already working within a fairly regulated framework, and from a health and safety viewpoint in terms that, as I have mentioned before, the safety management system is a thing that is audited. This is certainly something I challenged the Steam Packet on, saying, 'What work have you specifically done in relation to the management of this specific risk?' So, if nothing else, the report back, in relation to that gap analysis, for example, that we did in terms of best practice fit, which is all they could do at that point, best practice fit in the maritime environment and whether they were complying with any regulations that had been issued – as I say, my research was there was not, but in terms of best practice guidance that had been issued by the maritime specialists and the International Maritime Organisation.

Q396. Mr Robertshaw: Yes, but the maritime people could no more keep up, it would seem to me from what I have listened to and observed, than anybody else. You cannot expect the maritime regulating bodies to keep up any faster than our own Director of Public Health, and –

Mr Hind: But I would expect an entity working within a regulatory framework to be reviewing their compliance with that framework, even in a fast-moving –

Q397. Mr Robertshaw: But that framework could not possibly respond fast enough to the virus changes, so it would not capture it, Stephen.

Mr Hind: Or be making its own recommendations, in turn, into how it could better manage that risk.

Q398. Mr Robertshaw: But it did recognise how it wanted to manage the risk and it sought support and did not get it. That is my point.

To what degree should a maritime operating company be capable of assessing fast-moving virus changes, which should belong to Public Health and its knowledge, surely?

Mr Hind: The risk is always going to remain with the organisation, in terms of health and safety. You cannot abrogate it.

Q399. Mr Robertshaw: No, it is not. It is virus transmission. It is an enemy changing by the week and therefore requires the absolute direct and immediate input from Public Health and a response to that organisation saying, 'We think that, in the light of what we understand the situation to be, there is a risk.' With the greatest of respect, I do not see how recommendation 6 could solve that fast-moving situation which you opened your comments with.

Mr Hind: The idea of recommendation 6 is that it is in relation to the Steam Packet's own responsibility to manage their risk, and they cannot abrogate that fully to external parties.

Q400. Mr Robertshaw: But they had to here, because it was vaccination that was required. The Steam Packet could not vaccinate their own crew, could they? Are you suggesting that they should have?

Mr Hind: But there are further mitigations they could be putting in place. In particular, one of the key concerns that was coming out was how the wearing of PPE was … in terms of managing that in –

Q401. Mr Robertshaw: Stephen, let me stop you. PPE makes no difference when you have got aerosol transmission in a constrained area, which was the issue here.

Mr Hind: I cannot comment on that, because I am not a public health expert, and that is back to that –

Q402. Mr Robertshaw: But that is where the risk of transmission occurred, which caused the cluster, which was the whole point of your investigation, surely?

Mr Hind: I disagree. The point of my investigation was outlined in the terms of reference, and I am happy and confident that –

Q403. Mr Robertshaw: The cluster occurred because the virus changed – it became aerosol transmissible, it transmitted in closed, constrained areas and then got out – and that cannot be

dealt with by recommendation 6. It surely is dealt with by a much closer relationship between Public Health, where the knowledge should have been, and an understanding of what the risk inside the Steam Packet was, which was articulated repetitively by the Steam Packet to Public Health and other governmental bodies. That is the point, isn't it?

Mr Hind: I think, to be fair to my report, taking a recommendation completely out of context and relying on that solely for the mitigation of this risk –

Mr Robertshaw: I understand that.

Mr Hind: – is not a fair comment. And the other issues and recommendations that we have spoken about are a package to manage this in the case that there is a risk.

Mr Robertshaw: Chairman, I have completed my points.

The Chairman: Thank you.
Ms Edge.

Q404. Ms Edge: We have talked about your issue management and review periods with regard to everything, really, with review. Who do you think is carrying those reviews out now, in this ongoing situation? (***Mr Hind:*** Sorry?) Who do you think will be carrying out those reviews, because there is not one lead?

Mr Hind: In relation to …?

Ms Edge: You have recommended that there should be reviews in issue management. You have handed your report over. Who do you think has taken responsibility?

Mr Hind: I have put the responsible party for that to be the Cabinet Office in my recommendations/actions table.

Q405. Ms Edge: And when would you expect that first review to take place?

Mr Hind: This is in terms of the issue management and responsibility?

Ms Edge: Policy and process, yes.

Mr Hind: I would be expecting that to be happening now, absolutely. My understanding is there is a specific project looking at how have things move forward, and I would hope they would be considering the recommendations I have made.

Ms Edge: Thank you.

The Chairman: Mrs Barber.

Q406. Mrs Barber: In 3.1.7 in the overall conclusions, you talk about recommendations about mitigating risk should another outbreak occur again, and I almost think it misses the prevention of another outbreak, which then ties into that recommendation 1 with the issue management, because you talk about the other high-risk clients. It goes back to that point about identification of who those high-risk clients are, and I wonder if you have had any engagement with the Cabinet Office, who you have said you have submitted this to, to try and maybe even suggest that there

should be further work in terms of this, in terms of looking into … The issue management is only as good as the issues that are identified.

Mr Hind: No, I have not had any further contact with the Cabinet Office subsequent to the issuing of my report. My understanding is there is a dedicated project team set up to look at how these risks broader are managed going forward and it is being resourced within the Cabinet Office.

Q407. Mrs Barber: I know you talked about a challenge and the *vires* under Public Health, but some of the stuff that came up, that is contained within the appendices, talks about things that in your gap analysis you would have expected to have been incorporated within the risk assessment from the Steam Packet. And yet, interestingly, we certainly have seen correspondence from the Director of Public Health, who said that their risk assessment initially went too far, and suggested it was more akin to what you would expect on a cruise ship than what you would expect on a ferry. And yet some of those items that you have identified in the gap analysis are things that appear, from the correspondence we have seen, to have been told directly to the Steam Packet from Public Health should be removed from their risk assessment. I wonder if you picked up on that in your report at all, or in the peripheral reading and conversations you had.

Mr Hind: Yes, I think I touched on it earlier, in terms of this difference between risk language and risk frameworks in terms that obviously Public Health were coming from public health language and this understanding of what the maritime requirements were, and I think the Committee itself has just highlighted the potential for a gap in terms of that understanding, in terms of the specialist environment that the Steam Packet were having to work within.

Q408. Mrs Barber: Just to tie it all together for me, do you believe that implementation of your recommendations as they currently stand would have changed outcomes significantly?

Mr Hind: In terms of as they stand now, yes, if they were in place. That is the idea of the recommendations. It is trying to forward guess, if something similar, with a variant of concern which at worst case is not covered by a vaccination strategy … what would help proactively manage that risk down.

Q409. Mrs Barber: But recognising that the limitation is that that is only in the area affecting the Steam Packet Company, rather than all of the other elements of potential risk not identified?

Mr Hind: Yes, absolutely. The scope is very focused on this.

Q410. Mrs Barber: Do you think the focus was too much based on one specific issue, rather than something that would have perhaps been more of benefit, which would have been to have looked at the broader risk management, risk ownership and risk accountability, I suppose, across the COVID piece?

Mr Hind: The scope of the review I was asked to undertake was not in my remit, and I think it is probably not appropriate for me to comment in terms of what other reviews may or may not be required in relation to that.

Q411. The Chairman: Just to pick up on a few issues that we danced around, but just to ask on them directly, in your view, would you have expected a walk-through audit or verification of the arrangements that had been agreed between the Steam Packet and Public Health, and the direction notices, to ensure that there was a mutual understanding of how it was supposed to work?

Mr Hind: Yes, I think that would have helped. Certainly my understanding from talking to both parties at the lower levels is that there were good communications. At the lower levels in particular, the Steam Packet certainly said they felt they had a good relationship with TNS, for example, in relation to that, as an ongoing communications relationship. There did not seem to be, at officer-to-officer level, any reticence in communications going in both directions. Certainly looking at the correspondence and documentary evidence, and in the interviews that we had, it seemed to be, at that level, quite a good discussion. Would a more formal approach, in terms of working through that …? Yes, lockdowns being permitted, obviously, but I think that would help.

Q412. The Chairman: And yet there were still some pretty fundamental misunderstandings.

Mr Hind: Yes, I think there were, but they were misunderstandings in relation to how the documentation should be issued in relation to the statute and how it applied. So, it was not just between Government and the third party, the Steam Packet. As my review has highlighted, there were issues in relation to what I think Government thought at that time it was putting in place and actually what I think was actually in place.

Q413. The Chairman: Because when people did end up sitting round the table, that was when it was realised there was quite a big difference in terms of what, on the one hand, Government thought it was getting them to do, and what was going. Is there not a danger that if you put in regulation, especially in a specialist area, without walking it through or checking or auditing its actual impact, you are on a hiding to nothing?

Mr Hind: Yes. As I said, a lot of this was at pace and the number of regulatory changes that were happening I think demonstrate that there were a lot of things happening in trying to get this right from the start.

Q414. The Chairman: That is true, but this is at any point in the nine months following the initial lockdown. There was no walk through, there was no –

Mr Hind: I think, just to clarify in terms of that, this is a critical COVID risk point. This absolutely would have warranted a more detailed management of that risk to make sure that all parties were understanding. Hence, the similar recommendation about regular multi-party meetings to have that conversation and make sure that all parties are understanding of what the situation is or is intended to be.

Q415. The Chairman: I suppose, yes, what I am asking is not just in terms of getting that mutual understanding at the design stage, but also in terms of implementation – someone actually walking it through and seeing that what you think is happening is actually happening on the ground. Again, that was not a recommendation that you put out there. Is that something that …?

Mr Hind: I could have made a recommendation in relation to that. As I said, my primary recommendation is about that multi-agency meeting, and that would identify where those risks or issues require more specific addressing – and there are bound to be myriad such issues where that could be. Actions would be required to address them. I think the macro approach to it is to have that multi-agency meeting and an issues register to make sure things are being appropriately triaged, properly understood and escalated as appropriate if action is not being taken.

The Chairman: I am assuming that the three hands that have gone up are in relation to supplementaries for this particular bit, rather than starting a whole new topic.

Mr Hooper.

Q416. Mr Hooper: Yes, in terms of that, again coming back to that issue management, nobody was checking on any of this stuff at any point. So, someone – the Council of Ministers at the start – had said, 'Go away and sort the borders out,' and they left it. The officers then, in various teams, went and did their individual bits, but no one at any point decided to check that what they thought was happening was happening.

What I am a bit unclear on myself is why Government thought what it thought. The position that Government took was that the Manx crew should have been isolating, all of them, but actually I cannot find anywhere in your evidence that backs that up, because the documentation from TNS did not suggest that, and the advice from Public Health was not that broad, it was more specific about who should be isolating. Did you find out at any point why Government thought …? In any part of Government? They all thought different things, but none of them thought the Steam Packet crew should have been isolating. Did you find out why that statement was made and why they said they thought that, when clearly none of them did?

Mr Hind: In terms of those statements that were made post outbreak, I believe that was outside the scope, in terms of my review.

Q417. Mr Hooper: But the context of this is about the issues management.

Mr Hind: But in terms of who was understanding what, the Director of Public Health certainly felt that she was being clear about self-isolation. My interpretation, from actually reading the e-mails, is that that was, as we mentioned earlier, about high-risk contacts, and that was certainly not reflected in a joined-up way in terms of the documentation that was being issued.

Q418. Mr Hooper: But my point is it was not reflected in an individual way. It is not like one of the parties had explicitly told the Steam Packet, 'This is what you should do.' All the parties were telling them something different, but actually none of those different messages were, 'or your crew should be isolating'. That is my question.

Mr Hind: That was certainly my interpretation.

Q419. The Chairman: Could I just ask why you felt that those comments afterwards were outside of your terms of reference? It does speak to me of an inconsistency of advice, which is one of your findings, and it does also speak to a failure in the communications links as well.

Mr Hind: I viewed the scope of my report as the items leading up to and the management of the outbreak itself. Obviously there was an element post outbreak which I looked at, because it was resolving some of the issues that I was identifying as leading up to the outbreak, like the statutory documentation issue, and contact tracing was specifically mentioned, which is a post-outbreak issue. But from my perspective professionally, I had to draw a line round the scope of what I was looking at, not least balancing expediency with rigour.

Q420. The Chairman: But from your review of documentation and correspondence in terms of who knew what and when, is it your view that on 18th February both the Chief Minister and the Director of Public Health probably should have known that Manx crews were not required to self-isolate?

Mr Hind: From the documentation that I have had presented to me, there was no requirement for them to self-isolate. I do not know what the communications were up to that point or at that point.

Q421. The Chairman: It is all in the bundle that you have had, in terms of documents between the Steam Packet and the Director of Public Health and others. Is it the case that the Director of Public Health and the Chief Minister should reasonably have known that there was no requirement?

Mr Hind: As I have said, I have considered that as being outside the scope of the review and the work that I have undertaken, and I do not think it would be appropriate for me to comment.

Q422. The Chairman: Okay, well, that is … You have taken the view it is not appropriate to comment. Obviously, what is in your report is what is in your report, but you have examined the evidence that would lead you to the conclusion.

Mr Hind: As I said, my report makes it clear that there was no requirement for self-isolation.

Q423. Mr Hooper: Just picking up on that issue of, again, the level of communication and some of the recommendations you are making, one of the recommendations that you have talked about already is this requirement to do a review and have an escalation process in place, but you are placing that responsibility squarely in the area of officers, saying that actually at an operational level there should be these kind of reviews, which I think no one can disagree with. Operationally, they should be checking that what they think is implemented is being implemented and escalating issues in the right way. Do you not also think, though, that there is a strategic responsibility on the strategic risk owners to also be undertaking those kinds of reviews, not across the board, perhaps, but especially when you are talking about a critical risk area like this? Would you not expect that actually those people you have identified own this risk, the Council of Ministers, would also have some form of regular update and reporting, so that they themselves were aware of the changing landscape and things that were happening and making sure that their policy was being implemented?

Mr Hind: I would expect that that management and exception reporting of current status of critical risk factors has an escalation framework, and I would expect part of that escalation framework would be as necessary and as deemed appropriate by the Council of Ministers to include reporting to them on an exception basis –

Mr Hooper: And just to confirm again, for –

Mr Hind: But in relation to whether that is happening or not, I am not in a position to comment because I have not seen the evidence of the Council minutes. It may well be happening.

Q424. Mr Hooper: But if there was evidence, you would have expected to have been provided with it, as you did ask for copies of everything?

The Chairman: Ms Edge.

Q425. Ms Edge: Just with regard to the issue management section and the recommendation, I am really surprised, from a good practice point of view, that you did not really comment with regard to end dates on the direction notices, which would have helped in the Steam Packet situation for Government to know by 18th February that they were not self-isolating, and here today we still are without direction notices with an end date on them. Do you not think, from a good practice point of view, when you recommend and review, an end date, on something of such significance as a direction notice to an individual, would have been helpful to recommend?

Mr Hind: Yes, I accept that there may be benefit in that. The earlier direction notices, as you are aware, were corporate, and they had an effective end date in terms of end of the emergency period as declared. When they were trying to rectify the situation, they absolutely started putting end dates on. I think that helped, but it was also confusing that they remained at the same start date, so it became an extended certificate as opposed to a fresh certificate, which I think, from my perspective, might have been a cleaner way to do it in relation to end dates.

I think, again, there is a balancing of risk in terms that there is an administration overhead in relation to the renewal certificates, and so I would say that would need to be considered in terms of the balancing of that risk, in terms of what would be the opportunity cost of introducing a process such as you state. There would be a way to balance that with a quarterly review etc., or a six-monthly review, if that was the risk of not putting an end date on, but there is that balancing of risk in terms of opportunity costs and admin, and the rest of it.

Q426. The Chairman: Mrs Poole-Wilson.

Q427. Mrs Poole-Wilson: Yes, so, just building on what was touched on before, in terms of the walk-through audits and why that did not happen, at 2.1.5 of your report you do say:

> Some of the core issues and concerns arising had been identified and discussions on their resolution initially commenced in August 2020, however it was not until the key parties met immediately prior to the February 2021 outbreak, that potential solutions were identified …

Your recommendation is to log issues and have meetings, and yet you say at 2.1.5 that issues had been identified and discussions were ongoing. What was it that stopped this effectively happening? At that point, in August 2020 and into the autumn, we were not in lockdown, so what was it, do you think, that got in the way of something you have recommended should happen, but you actually say it was happening, perhaps informally? What do you think are the real root causes of why these things were not adequately addressed at that point in a preventative way?

Mr Hind: I think part of the issue, of course, in the context of this, is the borders situation. If we are in full lockdown, then there is minimal movement over the borders and there is minimal movement of individuals requiring documentation etc. from TNS in relation to this. That context, in terms of that balance of workload, I think is fairly important to this. The trigger date in terms of why this was identified … As per my understanding, as I highlight in the report, there was a shift in the regulatory framework, which was meant to be just discussed, in relation to … The new certificates would be, per my understanding, required to be issued on an individual basis for Manx residents in particular; however, there was still an ongoing corporate certificate, which I think people felt was managing the risk up until the end of that coronavirus emergency period, and so the trigger really started to become a priority when that coronavirus period was coming to an end.

Q428. Mrs Poole-Wilson: That is all a level of detail and I understand that that preoccupies officers day to day, but I suppose the issue is going back to how critical this risk was. Is it a lack of understanding within appropriate levels in our officer cohort of what risk is and how to approach it? That type of detailed ongoing work will always be there, whether we are dealing with a crisis or whether we are doing business as usual, so the risk that people get preoccupied with some level of detail and do not lift their eyes up to see the bigger risk and address what is critical and strategic is what concerns me, I suppose. I would just be interested in your view and whether you have any insight or evidence from your review on that.

Mr Hind: In terms of that bottom-line risk assessment, yes, the evidence there, in terms of the manifestation of that risk, is that whatever they were doing risk-management wise was working. There was no outbreak amongst Manx crew and there were no concerns about that, and certainly

from discussions with both the Steam Packet and the Government side, there was a consideration … The Kent virus, as we said, was a game changer, as per my understanding, and that is the horizon scanning piece that I think I would agree with in terms of what would be the impact of this change in virulence on the risk profile and what should we be doing now about that.

I am pro-risk risk management, in terms of identifying … Risk is all about uncertainty and the future. You have to risk assess that and what the priority is in that, not least because the management of an uncertain future is taking away from the management issues that are happening right now. That is constantly the balance. Certainly without the scope of the review is the full context of that decision-making, in terms of what might be pulling people, operationally, away from …

Q429. The Chairman: Do you think the Steam Packet directors acted with sufficient persistence in raising their concerns? Should these perhaps have been raised via the shareholder sooner in resolving the systematic issues that had been identified?

Mr Hind: I think that the Steam Packet management were fairly vigorous in terms of trying to manage this risk and get a response, and I have not seen … Certainly no evidence was presented to me in the course of this that that was not the case or that there are any issues in relation to governance from that side of things.

Q430. The Chairman: Okay, thank you.

I suppose, to sweep the whole thing up – unless anyone has any themes, and I will give an opportunity for everyone just to go round the table again – do you think that there are now adequate processes in place to identify, capture and embed learning as we go? You have said about a few lessons learnt along the way, but do we think that, as a result of it – whether in regard to the specific inquiry, or perhaps in a broader sense, if you are able to answer that – we really have the processes in place to identify, capture and embed learning as we go?

Mr Hind: I think, in terms of the broad answer to that as a broad question, the broader comfort that I took from the review that was taken and the interviews I was having was the creation – as I understood it at the time, and I do not know what the position is now – of a six-month project within the Cabinet Office to specifically look at how this is going to be managed and how it will be managed in the future, the coronavirus risk management. I have not got the full scope of that as a review, but certainly as a headline, as a way forward to look at lessons learnt, and I would hope lessons learnt not just in relation to this but across the board, we are at risk in relation to … Obviously, there are political elections coming up. There is key person risk around individuals who have been involved in this. There are lessons learnt, I think, that can be captured as a part of that project. Any change is a project to get from how we do things now to how we do things in the future, and that change needs resource and focus, and it appeared to me, at least at that albeit fairly superficial level, that the Cabinet Office were absolutely putting in place a framework to learn the lessons and make appropriate changes going forward, or to review what those changes should be going forward.

The Chairman: Mr Hooper.

Q431. Mr Hooper: You keep saying the Cabinet Office, but I assume you mean the Gold, Bronze and Silver Command structure, because that is the structure that has been dealing with all of this since day one.

Mr Hind: In terms that this is a project, my understanding is that this is a separate project structure being implemented in the Cabinet Office to do this as a 'from point A to point B' type transition and review.

The Chairman: From the face there, it looks like that is a surprise to the member of the Cabinet Office! *(Laughter)*

Mr Hooper: Well, that is the point, really. The question that I wanted to ask.

Mr Hind: As I say, I have only had a superficial inquiry at the end of my review, in terms of that.

Q432. The Chairman: The question I was going to ask, actually, is, just to try and sum this up: the Chief Minister, when he presented your report to the House of Keys and to Tynwald, said something along the lines that there were failings on both sides of this piece of work, and it was very much presented as if those failings were equally weighted. Would that be your interpretation of events? Obviously, we do accept that no one is perfect, but would your interpretation be that whilst there were failings on both sides, both sides are equally responsible for where we are?

Mr Hind: I would certainly agree that there were potential failings on both sides. I think the balance of the recommendations probably clearly indicates where I have … Obviously, that is the lessons learnt going forward, but some of the statutory issues in terms of advice, I think … But, to be fair, the terms of reference were very focused on the Government side of things. There were three aspects there, which were how was Government reacting to this, and one in particular which was about –

Q433. Mr Hooper: You say that, but actually quite a lot of the questions this Committee has asked you this afternoon about, for example, on-Island mitigations, vaccinations, testing – all of those were considered by you to be outside the scope of your inquiry. So, whilst you are saying the focus was on Government actions, the focus was really on mitigations on board the Steam Packet vessel. You did not really focus on some of the other mitigations that really should have been in place around that.

Mr Hind: I think the terms of reference and what I reported on was broader than just the on board. Obviously, there was a whole terms of reference aspect about contact tracing, on which I raised the issues in relation to how effective that –

Q434. Mr Hooper: But I am talking again about preventative mitigations, where really you have not talked about any of those broader preventative mitigations that I think everybody would have expected to have been in place, not just with hindsight but at the time as well.

Mr Hind: I think the question is whether some of those issues identified are applicable broader, in terms of the documentation issued and how that was … Obviously, I focused, in relation to the regulations, on the Steam Packet. Absolutely that was the scope of the … Some of those issues raised may have broader application – I accept that – out of scope, in terms of the focus of my report.

The Chairman: Ms Edge.

Q435. Ms Edge: With regard to the letter you sent to the Committee on 21st May and the queries the Committee had about the independence of the review, you have stated that you felt you did it with the necessary professional rigour and in accordance with the parameters of the terms of reference. Do you feel that you did it in accordance with the Government Internal Audit standards, and particularly with reference to 'you shall not participate in any activity or relationship that may impair or be presumed to impair that unbiased assessment'? I am sure you know the rest of the contents of that.

Mr Hind: Yes, in terms of my independence and professional integrity, I have no doubt at all that I was absolutely, professionally, not compromised in my independence in undertaking this review, and I would absolutely state that.

Q436. Ms Edge: In accordance with the Government Internal Audit standards?

Mr Hind: It is an absolutely standard part of my relationship with Government. The terms of reference specifically say this is in relation to the Cabinet Office. I have no operational role in the Cabinet Office. I have no service function in relation to the Cabinet Office. I am an employee – albeit of the Public Service Commission, I am an officer of the Treasury. My management reporting line is, through the Treasury directly, through to the Public Service Commission ultimately. So, operationally, whilst this was not an internal audit, in relation to the actual scope of work undertaken I am absolutely happy …

Q437. Ms Edge: Would the Internal Audit department carry out audits of all of these Departments?

Mr Hind: Yes.

Q438. Ms Edge: You still felt it was appropriate to go ahead?

Mr Hind: Yes, absolutely.

Q439. The Chairman: Do you feel that the terms of reference you were given meant that you were not able to look into the political environment on this?

Mr Hind: I certainly was looking at the Government interaction with the Steam Packet directly at the officer level. So, rightly or wrongly, that was the focus of my report.

Q440. The Chairman: So you felt that you were …? Did you feel included?

Mr Hind: I would not say I was prevented. I would say that part of the terms of reference, albeit I accept that it broadens out in places, is very much in relation to contact tracing, which is a specific role within the statute – not political, it is in relation to the risk management on Steam Packet vessels, which again is non-political; it is about the issuing of statutory processes, which again was officer driven. So, I would not say it prevented me, but the focus of it was absolutely on –

Q441. The Chairman: So, that was a limiting factor you imposed on yourself?

Mr Hind: No, I think that was the scope of the terms of reference, in terms of the approach that was laid out there.

Q442. The Chairman: In terms of not looking at the political environment, that was something that you limited yourself?

Mr Hind: I was not limited, in terms that I asked for Council of Ministers' minutes in relation to some of the aspects that have been discussed, and I was given access to them, so there was no limitation in terms of that as a political environment.

As highlighted in my report, I did meet with the Chief Minister and I have met with the Treasury Minister as being key political aspects. I queried in relation to how some of those discussions were handled at the Council of Ministers. So, I think I was not prevented, and I didn't not include an element of political environment.

The Chairman: Mrs Barber.

Q443. Mrs Barber: Just picking up on one of the comments you made earlier, and highlighted in section 5.3 of the report, where you say that the notices were not enforceable in terms of self-isolation requirements, and then just tying that back in with the statement of the Chief Minister on 19th February, where he clearly stated that they were enforceable and then in fact there had been incorrect action taken by crew, was the inference from his comments. I wonder whether you recognise the potential damage that that caused, both to the Isle of Man Steam Packet Company but also to the crew of those vessels, who were operating appropriately and responsibly in accordance with the terms and conditions being presented to them. There is no commentary in the report except to say that that risk has been now resolved and just to move on, but actually would it not be almost a failure to recognise that one of the key issues that has presented within this whole scenario is the incredible pressure that a small group of people, doing their best to serve the Island at an incredibly difficult time, have been put under?

Mr Hind: I considered that I met fully the terms of reference, and that is what the report is focused upon. The issues that you are talking about I do not think were relevant to the terms of reference and the scope of the report I was required to produce.

Q444. The Chairman: It seems that communications to the wider public, and especially in the political environment, do not seem to have fallen within your terms of reference. I think they are areas that the Committee might have a view on, rather than your report.

Q445. Mrs Barber: Just to follow up, you would say that the Chief Minister was incorrect in his assertions at that time?

Mr Hind: I have not reviewed the assertions that the Chief Minister was making at that time, but my assertion is that there was no requirement for self-isolation in place at the time of the outbreak.

The Chairman: Mrs Poole-Wilson?

Mrs Poole-Wilson: No, I am fine, thank you.

The Chairman: Mr Robertshaw.

Q446. Mr Robertshaw: Thank you, Chairman.

It is appropriate, I think, to conclude my final question with your two final paragraphs in your overall conclusion. Paragraph 3.1.8 talks about new variants of concern and 3.1.9, your very final statement, says:

> However it is my view that the current position for the management of these risks has already been significantly improved, when compared to the position at the time of the February outbreak.

We have all, today, identified the speed of these changes and the uncertainty that surrounds them. Are you satisfied that the uncertainty that will exist in any new emergence will be satisfactorily dealt with between, in this instance, the company and Public Health, and that we will not end up deferring back to UK guidelines and will adopt decisions and actions appropriate to our specific Island needs?

Mr Hind: I would firstly caveat the part you have quoted, in that obviously that was my statement at 18th May and that is the only time … I can state that at that point I was certainly satisfied that the risks were being managed down.

In relation to the position now, I do not know. I have made my recommendations in terms of how I think this situation in further outbreaks would be improved, in what we have all conceded is a fast-changing environment – and, as we can see in what is happening in the UK, equally so.

1465 **The Chairman:** Mr Hind, thank you very much for joining us this afternoon and answering our questions about your report. It has been most enlightening. On behalf of the Committee, thank you.

The Committee will now sit in private.

The Committee sat in private at 4.18 p.m.