# Evidence Pack Edition No. 4 The Position in Northern Ireland

### **Ethical Approach UK - November 2025**

## **Executive Summary**

This Evidence Pack examines the conduct of the Northern Ireland Department of Health (DoH NI), the Police Service of Northern Ireland (PSNI) and related oversight bodies during the Covid-19 pandemic. It reveals systemic failures in relation to vaccine safety reporting, end-of-life care pathways, informed consent and institutional accountability.

## Key findings include:

The DoH NI received official data from the MHRA showing confirmed vaccine deaths and thousands of serious adverse reactions, but failed to share this with clinicians or the public.

The GMC confirmed in 2024 that it had never received this information from DoH NI, leaving doctors unable to comply with their legal duties on informed consent.

The PSNI, when presented with this evidence, refused to investigate, citing "national directions" from Operation Talla.

Senior officials gave sworn testimony to the UK Covid-19 Inquiry in 2025 denying blanket DNACPRs and use of NG163 in Northern Ireland, despite Assembly findings (2021) and FOI releases (2025) confirming otherwise.

Oversight bodies, including the Policing Board and Ombudsman, failed to act when alerted.

These failures raise questions of perjury, misfeasance and breach of statutory obligations under Article 2 of the ECHR.

## 1. Background

From 2020 onwards, NICE Guideline NG163 was applied across the UK to guide Covid-19 treatment and care. In Northern Ireland, this meant DNACPR decisions and end-of-life protocols using midazolam and morphine were put in place. Concerns were raised by MLAs and documented by the Assembly in January 2021.

By 2022 to 2023, FOI responses from the MHRA confirmed vaccine-related harms in Northern Ireland. Citizens reported these to DoH NI and the PSNI, but both institutions refused to act.

#### 2. DoH NI Failure to Inform

On 7 November 2022, Kathy Gray emailed the CMO, CPO and CNO attaching an MHRA FOI response showing 48 vaccine deaths and over 5,000 serious adverse reactions. She warned that failing to share this data with GPs, nurses and pharmacists would breach the law of informed consent. No reply was received.

A follow-up request in January 2023 to MP Jim Shannon confirmed that DoH NI had still not responded.

# 3. PSNI Non-Investigation

On 8 November 2022, Kathy Gray hand-delivered the MHRA evidence to PSNI HQ.

On 9 November 2022, PSNI (via ACC Todd) replied that no investigation would be conducted, citing "voluntary participation" in vaccination.

On 17 November 2022, PSNI Justice Secretariat was notified that failure to inform the public breached the law and an urgent investigation was requested.

On 29 November 2022, solicitor Michael Brentnall confirmed that Rabone Article 2 duties to protect life and investigate deaths were engaged.

Despite this, PSNI refused to act.

## 4. Assembly Findings (2021)

The NI Assembly report of January 2021 referenced NG163 as guiding care planning, raised concerns about DNACPR practice and warned of Article 2 and 8 ECHR breaches.

This shows NG163 was referenced in NI policy by January 2021 and per DoH NI's 2025 FOI, implemented from April 2020 to March 2021, thus contradicting later denials.

#### 5. Evidence Timeline

- 7 Nov 2022 (K. Gray email): Sent MHRA FOI data to CMO, CPO, CNO showing 48 deaths and 5,000+ ADRs. Warned that failing to cascade to clinicians breached informed consent law. No response.
- 8 Nov 2022: Evidence hand-delivered to PSNI HQ.
- 9 Nov 2022: PSNI response no investigation.
- 17 Nov 2022: PSNI Justice Secretariat notified urgent investigation demanded.
- 29 Nov 2022: Solicitor confirmed Article 2 duties.
- Jan 2023: MP Jim Shannon asked to press DoH NI for answers.
- 2024: GMC confirmed it had never received vaccine safety data from DoH NI.
- 2025: DoH NI FOI confirmed NG163 was applied April 2020 to March 2021.

#### 6. GMC Position

In July 2024, the GMC confirmed:

- It had not received the MHRA/DoH NI evidence.
- Its communication channels (website, newsletters, events) are the sole means by which doctors are updated.
- Doctors remain bound by consent guidance (2020).

GMC consent guidance (2020) could not be met in practice because material risks were not transmitted to registrants.

## 7. Contradictions at the Inquiry

- At the Covid-19 Inquiry (2025):
   DNACPR/End-of-life: Swann and McBride denied
   blanket approaches. Assembly 2021 recorded NG163
   and DNACPR concerns.
- NG163 application: Denied by officials. DoH FOI 2025 confirmed it was applied April 2020 to March 2021.
- Awareness of risks: Claimed ignorance. Documented correspondence (2022 23) proves otherwise.
- Human rights: Not acknowledged in testimony.
   Assembly 2021 identified Article 2 and 8 risks.

Commentary: These contradictions may amount to misleading a statutory Inquiry, potential perjury under the Perjury (Northern Ireland) Order 1979 and misfeasance in public office.

## 8. Comparative Evidence

Public FOI material in Scotland (the "Speirs Directive") records an instruction to reject vaccine complaints on NPCC/Gold Command advice. This mirrors the PSNI position.

## 9. Legal Analysis

- Fraud: Failure to disclose known risks before obtaining consent may engage Fraud Act 2006, s.2.
- Offences Against the Person: Administering treatment without informed consent may engage offences under the OAPA 1861.
- Article 2 (ECHR): Failure to investigate deaths and protect life engages positive obligations.
- Misfeasance in Public Office: Officials who knowingly suppressed or denied evidence may be liable.

## 10. Oversight Failures

The Policing Board, the Police Ombudsman and Assembly members were repeatedly informed. None acted decisively. This permitted suppression of evidence and non-investigation to continue unchecked.

# 11. Appendices

All evidential documentation is in the possession of Ethical Approach UK and will be placed into the public domain at an appropriate point, in due course.

NI Assembly Health Committee Report (Jan 2021)

NICE Guideline NG163 (2020)

MHRA FOI data (2022)

Email correspondence: Kathy Gray to DoH NI (2022)

Email correspondence: Kathy Gray to PSNI HQ/Justice Secretariat (2022)

Email correspondence: Solicitor to PSNI (2022)

Email correspondence: Kathy Gray to MP Jim Shannon (2023)

GMC FOI response (2024)

DoH NI FOI confirming NG163 (2025)

#### 12. Conclusion

The evidence demonstrates:

- DoH NI failed in its duty of transparency.
- PSNI failed in its duty to investigate.
- Oversight bodies failed to hold them to account.
- Inquiry testimony conflicted with established facts.

Northern Ireland therefore represents not only local failure but also a critical test of whether UK institutions obey their own laws when under pressure.