An Roinn Sláinte
Department of Health
Office of the Chief Medical Officer

Mr. Stephen Donnelly TD,
Minister for Health,
Department of Health,
Miesian Plaza,
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Dublin 2

17th February 2022

Dear Minister,
I write further to today's meeting of the COVID-19 National Public Health Emergency Team (NPHET). The NPHET reviewed the latest epidemiological data, and the following key points were noted:

Epidemiological update

- A total of 34,460 confirmed PCR cases have been reported in the 7 days to 16th February 2022 (cases notified to midnight 15th February 2022), which is an 8% decrease from last week when 37,383 PCR positive cases were reported in the 7 days to 9th February.
- Data on the number of positive antigen test results uploaded to the HSE portal the previous day are reported daily. There were 29,309 positive antigen test results reported in the 7 days to 16th February 2022 (positive antigen test results uploaded to HSE portal in the week to 15th February 2022), which is a 20% decrease from last week when 36,615 positive antigen test results were reported in the 7 days to 9th February.
- As of 16th February 2022, the 14-day incidence rate (PCR) per 100,000 population is 1,509; this compares with 1,497 a week ago, a 1% increase. Incidence rates are likely to be underestimates.
- Nationally, the 7-day incidence (PCR) per 100,000 population as a proportion of 14-day incidence (PCR) per 100,000 population is 48%, demonstrating that there have been fewer cases identified through PCR testing in laboratories in the last 7 days, compared with the preceding 7 days.
- The 5-day rolling average of daily reported cases (PCR) is 4,439 as of 16th February, an 8% decrease from that reported on 9th February (4,803).
- The test positivity rate in public health laboratories (>40%) remains high. The positivity rate in hospital laboratories (11.7%) is high, and unstable, reflecting a high and fluctuating prevalence in the population.
- From 9th February – 15th February, there have been approximately 111,959 laboratory tests reported in community, private, and acute laboratories, which is down 43% from 196,661 at the last NPHET meeting (20th January). The 7-day test positivity rate in the community has significantly decreased from 55.2% at the last NPHET meeting to 47.5%.
- Antigen test kits booked through the HSE Antigen Portal have decreased by 5% in the latest reporting week, in comparison to the previous week. There were 259,948 test kits booked during the week to 15th February, compared to 275,046 in the previous week (2nd February to 8th February 2022).
- According to the Contact Management Programme (CMP), from 6th February – 13th February 2022, the total number of close contacts managed was 92,219, a decrease of 21% on 116,535 in the previous week. The average number of cases managed per day decreased from 16,648 to 13,174, a decrease of 21% over the same time period.
- There were 639 confirmed COVID-19 cases in hospital this morning, compared with 595 last week on 10th February, and 896 at the last NPHET meeting on 20th January. There have been 120 newly confirmed cases in hospital in the 24 hours preceding this morning.

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- As of 15th February, 52% of hospitalised cases were categorised as hospitalised for COVID-19, with the remaining 48% categorised as asymptomatic COVID-19 cases and potentially infectious. Of hospitalised cases aged 0-14 years old (N=33), 70% were categorised as hospitalised for COVID-19, with the remaining 30% categorised as asymptomatic COVID-19 cases and potentially infectious.
- As of 15th February 2022, age breakdown of hospitalised cases: 260 (36%) aged 80 and older, 206 (28%) aged 65-79, 110 (15%) aged 50-64, 120 (16%) aged 15-49, and 33 (5%) aged 0-14 years old.
- According to the latest HSE data on hospitalisations and vaccinations, as of 15th February, 37% of hospitalised COVID-19 cases were boosted, 28% of hospitalised COVID-19 cases had completed their primary vaccination course and 35% of hospitalised COVID-19 cases had not completed their primary vaccination course.
- There are currently 58 confirmed cases in critical care as of this morning, compared with 63 a week ago (10th February 2022). There were 2 new admissions to critical care in the 24 hours preceding this morning. Of the 58 cases in critical care this morning, 32 were invasively ventilated.
- There has been a reduction in the absolute number of patients whose primary reason for admission to ICU was COVID-19, from a peak of 126 on 23rd November 2021, to 47 as of 15th February 2022. Of the 20 COVID-19 cases aged 0-18 years old admitted to ICU between 1st January 2022-16th February 2022, the primary reason for admission to ICU was not related to COVID-19 for 10 cases.
- According to HSE data as of 15th February 2022, where vaccination status was known, 43% of COVID-19 cases in ICU were unvaccinated and 56% were fully vaccinated, of whom 41% were recorded as having received a booster/additional dose.
- As of 14th February, 180 patients were in receipt of non-invasive ventilation/Continuous Positive Airway Pressure (CPAP) or High-Flow Oxygen in non-critical care settings, of whom 42 patients were COVID-19 cases.
- As of this morning (17th February), there were 10 COVID-19 patients in the three hospitals of the Children's Hospital Group (Children's Health Ireland). This compares with 15 a week ago (10th February), and a peak of 26 on 10th January.
- There continues to be a significant number of cases of hospital acquired infection (note this is based on data to the week ending 6th February 2022). There were 153 hospital acquired COVID-19 infections in the week ending 6th February 2022, compared to 137 in the week ending 30th January, and 182 in the week ending 23rd January.
- The proportion of cases that are Omicron variant, based on the sample prevalence of S-gene target failure (SGTF) on the TaqPath assay, accounted for approximately 50% of infections by 17 December 2021, and 90% by 25th December 2021. The prevalence of SGTF has recently been reducing in the context of the growth of the BA.2 lineage (Omicron). In total, approximately 60% of current infections are S-gene target negative, suggesting approximately 40% of current infections are BA.2. This is growing at 9.7% (7.5-12%) per day and may be dominant by the last week in February 2022.
- According to the latest whole genome sequencing data in relation to B.1.1.529 (Omicron), as of 16th February, 5,322 BA.1 (Omicron), 1,320 B.A.1.1 (Omicron), 78 BA.2 (Omicron), and 2 BA.3 (Omicron) cases had been confirmed in Ireland.
- Thirty-seven laboratory confirmed influenza cases were notified in week 6 2022 (7th-13th February 2022), an increase from 13 in the previous week. There were 13 laboratory confirmed hospitalised influenza cases notified in week 6, compared with 2 in the previous week. In the 2021/2022 season to week 6 2022, notified laboratory confirmed influenza hospitalised cases have been predominately influenza A (not subtyped)/influenza A(H3), with the remainder influenza B.
- Respiratory Syncytial Virus (RSV) notifications in week 5 2022 (to 6th February): 25 RSV cases (52% aged 0-4 years; 16% aged ≥65 years) were notified during week 5 2022; 13 of these cases were reported as hospital inpatients (62% aged 0-4 years; 8% aged ≥65 years). As of week 5 2022,

rhinovirus/enterovirus and other respiratory viruses continue to circulate, with coinfections of respiratory viruses reported.

- The SARS-CoV-2 positivity rate from sentinel GP COVID-19 referral specimens tested by NVRL decreased from 61.6% in week 1 2022 to 35.3% in week 5 2022. In week 6 2022, the positivity rate increased to 40.0%.
- As of 13th February 2022, approximately 60% of the population aged 35-44 years, 50% of those aged 25-34 years, and 43% of those aged 16-24 years have received a booster/additional vaccine dose.
- As of 17th February 2022, 72% of children aged 12-15 have received their primary course of vaccination. Of those aged 5-11, 23% have received one dose of their primary course of vaccination.

Outbreaks for week 6 (6th – 12th February) are based on those reported up to midnight on 12th February 2022.

In week 6 there were a total of 96 COVID-19 outbreaks notified. Regional departments of public health are currently prioritising the investigation and reporting of outbreaks in settings that would benefit most from Public Health and clinical intervention. Therefore, the number of outbreaks reported in some settings is underestimated.

<u>Healthcare setting outbreaks:</u>

- There were 20 new nursing home and 4 new community hospital/long-stay unit outbreaks created in week 6. The case range of these outbreaks was 2-27 cases.
- There were 15 new acute hospital outbreaks created in week 6, with a range of 1-23 cases.
- There were 25 new outbreaks reported in residential institution settings in week 6 (16 in centres for disabilities, 2 in prisons, 2 in children's/TUSLA residential centres, 1 in direct provision centres, 1 in a mental health facility, 1 in a centre for older people, 1 in a homeless facility and 1 in a 'not specified' facility), with a range of 1-30 cases.
- There were 8 new outbreaks in 'other healthcare services' in week 6 (5 in day services for people with disabilities, 1 among clients of mental health facilities and 2 in other healthcare services), with a range of 2-5 cases.

<u>Outbreaks associated with school children and childcare facilities:</u>

- There were 9 new outbreaks associated with schools notified in week 6 (1 in a primary school and 8 in special education schools), with a range of 2-13 cases.

<u>Outbreaks among vulnerable groups:</u>

- There were 10 new outbreaks among Irish Travellers notified in week 6, with a range of 2-14 cases.
- There was 1 new outbreak in the Roma Community.

The current epidemiological profile of COVID-19 continues to provide a broadly stable and positive outlook.

Following a recent moderate increase, particularly amongst young adults, the number of infections detected per day (based on PCR and self-reported antigen tests) remains high but has stabilised, and may be starting to decrease. The number of detected infections in those aged 0-11 years is reducing, and is stable in those aged 12-15 years. The November 2021 Delta wave was associated with higher incidence in children compared to vaccinated adults. Given that vaccines offer more limited protection against infection with Omicron, the risk of infection is now more evenly distributed across the population under 50 years of age, with higher incidence currently in the 19–24-year-old cohort.

Demand for testing is reducing. Test positivity in public health laboratories remains high (>40%). Test positivity in hospital laboratories is high, and unstable, likely reflecting a high and fluctuating prevalence in the population. TaqPath assay data suggest that the prevalence of S gene target failure has reduced in recent weeks, from over 95% to approximately 60%, indicating that approximately 40% of recent infections are due to the BA.2 lineage.

The total number of confirmed cases in acute hospitals and the number of admissions and newly confirmed cases per day remain stable. The numbers of confirmed cases in ICU, cases requiring invasive ventilation and ICU admissions have decreased. The number of people requiring advanced respiratory support for COVID-19 in hospital settings outside ICU continues to reduce.

The Omicron wave has been associated with an increase in the number of people hospitalised with, and for, COVID-19, including increased hospitalisations in children. This is in the context of high levels of transmission across the population. The weekly number of children hospitalised with COVID-19 peaked at approximately 150 in early January 2022 and is decreasing. The increase in COVID-19 hospitalisation amongst children during the Omicron wave has not been disproportionate compared to the number of adult cases hospitalised. The proportion of cases hospitalised accounted for by children is marginally higher than during comparable periods in 2021. Data provided by the HSE also indicates that a proportion of recently hospitalised paediatric cases are asymptomatic and receiving care primarily for reasons other than COVID-19. While severe COVID-19 disease requiring hospital care can be experienced in paediatric cohorts, data continue to indicate that this remains uncommon. The Omicron wave has been associated with a small cluster of ICU admissions of children. Since 1st January 2022, of cases aged 18 years old and younger admitted to ICU, half had a primary reason for admission that was not related to COVID-19.

Evidence continues to emerge internationally on COVID-19 hospitalisations in children in the context of Omicron. International evidence generally indicates a relatively increased level of paediatric COVID-19 hospitalisation during the Omicron surge, particularly amongst younger children. However, the overall risk of hospitalisation in children remains low, with admissions that do occur generally short and illness experienced typically not severe.

The number of hospital-acquired infections in Ireland remains significant, though the clinical impression continues to be that many cases are not severe or are asymptomatic. There continues to be a significant number of outbreaks reported in settings with vulnerable populations. COVID-19 mortality has remained relatively stable and may be starting to reduce.

Long COVID

The NPHET received an update from the HSE on a national approach to Long COVID and noted developments in relation to the resourcing and development of an Interim Model of Care (MoC), aimed at addressing the emerging needs of those with prolonged symptoms following infection with COVID-19. The MoC provides a framework for the provision of services spanning General Practice, Community Services, Acute Hospitals and Mental Health Services.

Mandatory Vaccination

The NPHET discussed a paper on mandatory vaccination, in particular the complex ethical and human rights considerations pertaining to this public health policy. Mandatory vaccination policies represent a considerable interference with individuals' liberties and autonomy and as such require strong justification and supporting evidence that the measure will achieve the intended goal, is proportionate to the intended benefit and that no less restrictive measure would be effective. It was recognised that

the successes Ireland has already achieved in relation to COVID-19 have been largely based upon trust and transparency rather than penalties and enforcement. On balance, in the context of the current epidemiological situation and given the high levels of immunity in the population as a result of vaccination and natural infection, and in light of vaccine waning and vaccine escape in the context of Omicron, the NPHET:

- does not recommend a population wide vaccine mandate on the basis of necessity or proportionality. It is vital that continued efforts be made to engage, listen with respect, communicate effectively, and offer practical and targeted support to those who have yet to be vaccinated.
- does not recommend a vaccine mandate for Healthcare Workers (HCWs) and considers the current "intervention ladder" approach as sufficient and proportionate. The NPHET recognises the particular ethical and professional duties of healthcare workers to do no harm and advises that any change in vaccination policy for this cohort would have to be informed by a more complete understanding of COVID-19 vaccine uptake in HCWs, both in health and social care settings. Less intrusive measures must first be shown to be ineffective before more intrusive measures are considered.

NPHET Advice on Remaining Public Health Measures

Following its last meeting on 20th January, the NPHET advised that the prevailing profile of the disease in Ireland and the available evidence and experience of Omicron internationally allowed for a fundamental change in the management of COVID-19. It advised that this should entail a transition, in broad terms, from a focus on regulation and population wide restrictions to a focus on public health advice, personal judgement and personal protective behaviours.

Specifically, the NPHET advised that there was no longer a continuing public health rationale for the majority of the public health measures that were in place at that time and advised that a range of measures could be removed. It, however, advised that a small number of mandatory requirements should be retained until 28th February, at which point all children between the ages of 5 and 11 years would have had the opportunity to complete their primary course of vaccination. The NPHET today gave further consideration to these measures and concluded that there is no longer a continuing public health rationale for retaining them and advised that the following measures could be removed with effect from 28th February as planned:

- Mandatory mask wearing in areas where it is currently regulated for, including: public transport, taxis, retail and other indoor public settings, and staff in hospitality settings.
- Public health measures in early learning settings, school-aged childcare, primary and secondary schools, including physical distancing measures such as pods, and mask wearing.

In making this recommendation, the NPHET emphasised that the following advice will continue to be important as these measures are removed:

- The NPHET gave particular attention to the wearing of masks on public transport. This is a setting where physical distancing can be difficult and where those who are more vulnerable to the severe impacts of COVID-19 do not always have a discretion to avoid. For these reasons, the NPHET recommends that the wearing of masks on public transport should continue to be advised.
- The NPHET recommended the continuation of mask wearing in healthcare settings in line with evolving national guidance.
- The NPHET noted the importance of continuing infection prevention and control measures in early learning settings, school-aged childcare, primary and secondary schools, including in relation to

ventilation, hygiene measures and advice to stay at home if symptomatic. These measures are important for mitigating the spread of COVID-19 but also for mitigating the spread of other viral infections. The NPHET recognised that there will be some children who will wish to continue wearing masks and that no child who wishes to do so should be discouraged.

It is important to note that as part of its considerations, the NPHET gave specific consideration to the results of consultation exercises with children, parents and teachers in relation to the requirement for mask wearing in the 9 to 12 age cohort. It was also noted that the approach being advised by NPHET is similar to the general trend in approach across EU countries.

The NPHET also noted that those who remain unvaccinated are susceptible to severe illness with Omicron and efforts should continue to encourage everyone to complete their primary and booster programme of vaccination, including amongst those aged 5-11 years, in whom uptake to date has been less than 25%. Vaccination against infection remains important to protect children from severe disease, the consequences that can follow infection e.g., multisystem inflammatory syndrome in children (MISC), long COVID, psychosocial and developmental impacts.

More broadly, the NPHET reiterated its advice from 20th January that the COVID-19 pandemic is not over, levels of infection remain high, a cohort of the population still remain vulnerable to more severe infection and the emergence of new variants with increased levels of transmissibility, immune escape and/or virulence remains a risk both nationally and globally. For these reasons, the following must remain critical components of our collective response and ongoing communication in relation to COVID-19 and all will need to be retained and reviewed on a periodic basis:

- Clear guidance and communication with the public on the evolving disease profile and a cultural shift towards embedding individual and collective personal behaviours to mitigate against COVID-19 and other respiratory infections;
- A renewed and sustained focus on the importance of rapid self-isolation if symptomatic (even if fully vaccinated/boosted) or if diagnosed with COVID-19;
- Continued promotion of vaccination against COVID-19 in line with evolving national strategy and seasonal influenza vaccination;
- Continued wearing of masks, practicing of physical distancing and avoidance of crowded environments based on individual risk assessment and with a continuing focus on protecting others, and adherence to basic hand and respiratory hygiene;
- Sector specific measures, based on risk assessments by individual sectors, to ensure a safe environment including in relation to the promotion of rapid self-isolation when symptomatic, hand and respiratory hygiene, ventilation, signage, and use of face masks and physical distancing if appropriate;
- Continuing engagement with and support for global vaccination and surveillance initiatives;
- The impact of the pandemic on the health system has been significant. It is important that a continued focus on health service resilience is maintained, including in particular:
    - ongoing strengthening of health system capacity across the spectrum of public health and community and hospital services, to ensure the system is adequately prepared for future challenges. This includes critical care and isolation capacities, and the continuation of appropriate support for non-COVID care in a COVID environment.
    - a continued focus on infection prevention and control measures in healthcare settings, including appropriate mask wearing and physical distancing requirements based on national guidance and local risk assessment and advice from IPC teams, given the ongoing requirement to provide care for both COVID and non-COVID patients and the need to protect both patients and staff.

At its meeting on 20th January, the NPHET advised on the need for ongoing robust public health surveillance and response capacities including testing, contact tracing, surveillance and sequencing capacities for COVID-19. You will have received separate advice in relation to the future of the COVID-19 testing, tracing and surveillance programme. This advice, the key elements of which were outlined to the NPHET today, proposes that it is now appropriate to transition from a response based on extensive case finding and tracing of infection to reduce transmission towards a response focused on mitigation of the severe impacts of COVID-19, with a continuing requirement to protect those most vulnerable to the severe effects of the disease and those with risk factors for severe disease who may benefit from specific interventions. During this transition phase;

- Anyone who has symptoms of COVID-19 or other viral respiratory tract infection should self-isolate until 48 hours after symptoms have substantially or fully resolved.

- While nothing should replace or constrain clinical judgement that a test is required on a particular person in a particular clinical context, henceforth public health indications for testing will differentiate between those at high risk of severe disease who may benefit from early treatment and other people. As such, testing will no longer be needed for clinical or public health purposes for otherwise healthy younger people (<55 years) with symptoms. However, it is recognised that some people may require a test for other reasons for example to support a claim of social welfare payments associated with absence from work. Through a transition period, HSE will support access to antigen testing for those in this group.

- PCR testing is recommended (through the HSE portal) for the following people with symptoms:
    - Those who have not had booster vaccination and are aged 55 years and older
    - Those with a high-risk medical condition
    - Those who are immunocompromised
    - Those who live in the same household as a person who is immunocompromised
    - Those who provide care or support for person they know to be immunocompromised
    - Those who are pregnant

- Anyone diagnosed with COVID-19 should follow current guidance (self-isolate for 7 days from date of onset of symptoms, or if asymptomatic, date of first positive test. Exit from self-isolation after day 7 on basis that symptoms have substantially or fully resolved for the final two of those seven days. Anyone exiting at day 7 should continue to adhere to other public health protective measures, including appropriate use of masks, until at least day 10).

- Asymptomatic close contacts do not need to restrict movements; if they develop symptoms, they should self-isolate. Asymptomatic people including close contacts, other than healthcare workers, do not need to have PCR or antigen testing. It is recognised that some asymptomatic individuals may choose to use rapid antigen tests. Any asymptomatic individual who has a positive antigen test result should consider this result definitive and self-isolate. This advice will be reviewed during the transition phase should prevalence decrease.

- For healthcare workers, repeat antigen testing is required if identified as a household close contact, unless they have recovered from COVID-19 in the previous three months.

- Serial Testing in residential care facilities for older people will continue to be offered to these facilities through the transition period until such time as a facility meets set criteria.

- Admission testing of *unscheduled* adult admissions to hospital by laboratory or laboratory supervised near-patient testing. Admission testing of scheduled admissions and transfers to

hospital and residential care facilities based on current national IPC guidance and institutional risk assessment.

- Contact tracing will be limited to those contacts readily identifiable as at risk based on individual characteristics or context, public health risk assessment and settings where further transmission is likely and could have serious impact.

- There will be a requirement to expand and strengthen surveillance programmes including the GP sentinel and SARI programmes and the HSE will develop a comprehensive proposal for a population infection survey.

- Existing sequencing capacity will be strengthened as part of the development of the ECDC supported programme and work will progress to improve turn-around time and integration of sequencing data with epidemiological data.

- A sustainable, permanent Biostatistical Modelling Unit will be established at the HPSC, to enable a smooth transition of knowledge, methodologies, and skills from the IEMAG to the HPSC.

The NPHET acknowledged that, over the coming period, people will perceive the risk of COVID-19 infection in different ways, depending on their individual medical history and experience of the pandemic to date. For many, the further easing of measures as recommended today will lead to some uncertainty with regard to the adoption of protective behaviours. It will be important that people's individual choices with regard to physical distancing, use of facemasks and other protective measures are respected over the coming period. A programme of public health communications should be considered in this regard.

At its meeting on 20th January 2022, the NPHET reiterated its previous advice that, while accepting that there will be broader operational and staffing considerations, and noting that everyone who accesses healthcare facilities, including nursing homes, should adhere to directions on essential infection prevention and control practices, there is a clear need to make rapid progress on resuming social activity within residential centres and outings for residents, given that there are no longer any public health reasons for not doing so. There is a need for reasonable access for family and friends in all healthcare settings including acute hospitals. National guidance on infection prevention and control and on access and visiting represents a balanced approach, respecting the need for a degree of caution. Acknowledging the progress made by many hospitals, nursing homes and residential care facilities in this regard, significant concern was expressed by members today that some healthcare facilities continue to apply onerous restrictions that are in excess of national guidance and of any reasonable requirements at this stage. This is impacting negatively on the wellbeing and the rights of patients and residents to share in the resumption of normal social and family life that the wider society is benefiting from. As such, it is recommended that:

- Nursing homes and residential care facilities should move as quickly as possible to restore the activities and social life that provide a stimulating environment within the home for residents.
- In acute hospitals, nursing homes and residential care facilities, visiting restrictions that are more restrictive than those specified in national guidelines are not indicated unless there is specific written advice from a Public Health doctor or other appropriate expertise that additional restrictions are required in a specific context for a defined period of time and based on a risk assessment that is reviewed regularly and is publicly available.
- As appropriate, regulators should maintain a focus on ensuring visiting arrangements are in place in line with existing legal frameworks and guidance and should report to the Department on concerns of a systemic nature if they are identified.

- In all circumstances, including during outbreaks, there must be flexibility to meet the needs of residents and take account of the will and preferences of the residents in the application of limitations on access.
- While healthcare facilities will find it necessary to refuse access to people who show evidence of infection or those who will not cooperate with infection prevention and control requirements, this should be very exceptional as most people are happy to work with the facility to keep everyone safe.

As set out above and in previous NPHET advice, the pandemic is not over and the future trajectory of COVID-19 remains uncertain. New SARS-CoV-2 variants will continue to emerge, and it is possible that these will include variants that are less susceptible to current vaccines, resistant to antivirals, or are associated with altered disease severity. As such, there will be an ongoing requirement to be able to scale up appropriate responses quickly should they be required and key areas of focus in Ireland over the coming months will likely include:

- Surveillance and monitoring of the epidemiological position nationally and internationally, including in relation to current and new variants;
- Modelling of likely disease trajectories and impact;
- Ongoing assessment and advice on emergent issues in relation to SARS-CoV-2 and other respiratory viruses.

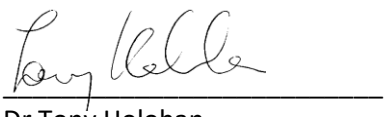
Notwithstanding the need for continued vigilance in these areas in particular, we are now entering a transition phase of the pandemic response. This transition will entail a shift from the emergency type processes and measures of the last two years while also necessitating the maintenance of high levels of readiness for COVID-19 outbreaks and the emergence of new variants of concern, with significant strengthening of existing disease surveillance systems.

As discussed at the NPHET today, as we move out of the emergency phase of the pandemic and given the significant mainstreaming of the COVID-19 response, the continuing impact of the vaccination programme, and the programme of work already completed by the NPHET, it is now deemed timely to conclude the work of the NPHET. My Office will continue to closely monitor the epidemiological profile of the disease and I have today sent you a specific proposal on the appropriate structure and processes for this.

My Office, of course, remains available to provide any further advice and recommendations that may be of assistance to you and Government in relation to ongoing decision-making processes in respect of the COVID-19 pandemic.

As always, I would be happy to discuss further, should you wish.

Yours sincerely,



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Chair of the COVID-19 National Public Health Emergency Team

cc. Ms Elizabeth Canavan, Department of the Taoiseach and Chair of the Senior Officials Group for COVID-19