Te Tira Ārai Urutā

Royal Commission of Inquiry into COVID-19 Lessons Learned

Official Transcript of Interview: Rt. Hon. Dame Jacinda Ardern

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NL	All right. So recording has begun. Welcome, everybody. Welcome, Dame Jacinda, Mr. Finlayson. From the Commission is Nicolette Levy, I'm legal counsel, Danielle Kelly, and Commissioner Hill who will introduce himself.
AH	Good morning. So I'm Anthony Hill. I'm one of the commissioners, and again, thank you so much for your time and we look forward to the conversation, Dame Jacinda, thank you.
JA	Thank you, Commissioner.
NL	So perhaps just for the record, Chris, if you could introduce yourself and your client can introduce herself.
CF	Good. Chris Finlayson, counsel for Jacinda Ardern, and I want to express my thanks to the Commission for facilitating this session at eight o'clock on a Wednesday night. And thank the Commissioner. I repeat what I said at the meeting the other night. We are very pleased that a Commissioner is present. We would have liked three, but we're very pleased Mr. Hill is here and thank him for giving up his time.
AH	It's a pleasure, thank you.
NL	Thank you. And organising Teams meetings is one of the things the Commission does the best. So that's no problem. So Dame Jacinda, just for the record, if you could introduce yourself.
JA	Jacinda Ardern, former Prime Minister of New Zealand. Thank you for your time. Thank you for accommodating the time difference that we have. I do just want to add on my end, do not let that feel like a constraint to you. Feel free to ask as many questions as you would like. I have no time constraints on my end, although noting it's late in the evening for all of

	you. So thank you for the time and thank you for the opportunity. Looking forward to the conversation.
NL	Great. Thank you very much. Just for the record also, we are recording this meeting. There'll be a transcript and we can make available the recording and the transcript or both to you.
JA	Thank you.
NL	[redacted] So first, the heading then is strategy in a pandemic, and as you know, initially there was the elimination strategy. Then during the later period of time that this Commission is considering, it shifted to a minimization and protection strategy. The pandemic strategy is important context to the key decisions that were made really in 2021, and we'd like to understand that better. Can you explain, as you remember, how the private sector and the NGOs and community organisations had input into strategy development and implementation, if they did?
JA	Sure. Sure. And the one thing I'll just give a little disclaimer over. You just mentioned provisions over confidentiality or sensitivity. Rather than me for each answer where it's relevant giving the caveat of cabinet collective responsibility or cabinet confidentiality, I'm just going to speak openly, but just if I can put out a general provision here that I would just like that to sit over the top of this conversation. So whilst I'll speak openly here, there may be things that I give comment on where that may generally apply. Look, I think it's important when we talk about the strategy generally that we had during COVID that rather than arbitrarily start at 2021, of course, the COVID strategy and its evolution really began in 2020. And to give you a sense of the way that we tried to approach the development of strategy I'll give you an insight into that very beginning.
NL	Sure.
JA	The pace obviously at that early stage was rapid and you would see through all of the transcripts and the media commentary and the press conferences that we were giving, that there was quite a fast-paced evolution in the beginning. Initially internationally, we've seen that most countries obviously were adopting the approach of flattening the curve, which is essentially a suppression strategy. And initially that had been our intention too, and we spoke very openly and publicly about our view that that is how New Zealand would approach COVID when it reached our shores. Very early on though and through the frequent advice that we were receiving through particularly the chief science advisor and the international network that she belonged to, alongside her connection with modellers, and those weren't just modellers that sat

	centrally reporting to government but modellers that sat outside of government, TPM being one of them. There were others that were sharing their modelling data. Rodney... the surname I'm having a mind blank on, is someone who frequently communicated via our Chief Science Advisor. Now these were pieces of information that over time, but also rapidly, we established that a suppression strategy would overwhelm our hospitals.
NL	Right.
JA	And that had been one of the objectives that we had as a government was that if we're able to maintain the ability of our hospitals to cope with the impact of COVID, that meant that we would not see preventable loss of life. And so that early modelling suggested over 200,000 hospitalisations and the loss of over 60,000 lives. That was the early modelling. That was the point at which we pivoted. Now in the background, and these are some of the things that may not have been recorded. In the background, of course, you would've seen very publicly, and if it was public then we were privy to it too. There was input from the private sector on their view of what needed to happen. There were those in the education sector, very early on a lot of pressure around school closures for fear of the fact that schools would become unsafe environments. And so very early on you saw the input coming in from those different sectors. So sometimes that was formally organised, sometimes it's just informally. One quick example of the engagement of the private sector. Before we went into a lockdown and announced the alert level system, I was aware that there were a number of high-profile business individuals who had a view on New Zealand strategy. We had a call, myself, Minister Robertson and our Chief Science Advisor held a call with those individuals who expressed their view at that time that we needed to move to what essentially was an elimination strategy and the use of lockdowns. And so that was one of our earliest, an example of those early engagements as we developed that elimination strategy. That led directly to Rob Fyfe then becoming an interface for us between government and the private sector.
NL	Right.
JA	This is all within the space of weeks, sometimes days. So because of how rapidly it was moving at that point, the ability to formalise some of those inputs was a little more limited, but it developed over time. So let me then fast-forward to the COVID Protection Framework because that sits a little more neatly into the strategy that you are looking at within the time frames that you have per your terms of reference. And you can see in the cabinet paper there for the

	development of the COVID Protection Framework reference to engagement with treaty partners, health and disability sector, supermarkets and retail. We engaged with supermarkets a lot because of their sitting at the core as an essential provider. Hospitality and events, sports, places of worship, education entities, unions and workplaces. So sometimes that would be via departments, but oftentimes by this point, ministers had very direct engagement with these sectors. You had the likes of Minister Sepuloni talking directly with the community and voluntary sector. Minister Robertson, both doing finance but also directly connecting with sports. Individual codes. I remember a very deep engagement at one point with [inaudible 00:10:27] entities. Minister Faafoi directly into hospitality. So ministers built very clear direct relationships with each and would report on those, not just through a formal written paper, but often would give verbal reports during cabinet meetings or cabinet committee meetings on what they were hearing directly from the sectors they were relevant to. Keep in mind, also, we then had a number of groups that are being established by that point. We had a border reference group where CEs were linking in directly with our airports, with maritime. We had a CEs reference, CEs meeting almost daily when we were in a period of lockdown. And of course, that's on top of our existing cabinet committees. So a range of engagement. How lengthy that engagement was would depend on which strategy we were working on and the pace at which we needed to move.
NL	You've mentioned jumping in at COVID Protection Framework[redacted]. Where did the idea come from to move out of the alert level strategy and into the COVID Protection Framework?
JA	Yeah. And this is one of the things that I picked up a bit from the line of questioning. The sense that I got from the line of questioning from the Commission is almost this assumption that we leaned into lockdowns and that elimination was 'the' COVID strategy. Without factoring in that we always recognised we would need to shift and transition and intended to shift and transition when we had additional public health tools. Lockdowns and that set of public health tools that sat around that were in the absence of any other form of protection for New Zealanders, in the absence of an individual armour. If you don't have vaccines, how do you protect people from COVID-19? And so we had a suite of protections that existed that were all captured by an alert level framework until we had a vaccine that would enable us to transition away from what were extraordinary measures, that meant the loss of people's individual liberties.
NL	Yeah.

JA	So that was always the ambition. At the beginning of 2021, you see us talk about, "This is the year of the vaccine. This is the year that New Zealand can transition." And throughout that year, you can see us engaging with experts to support the development of a transition plan. The issue was the complication of trying to transition in the middle of an outbreak with the worst variant of COVID that we had.
NL	Yeah.
JA	So whilst we always had a plan to transition away from alert levels into a reliance on the vaccine, the overlay of having Delta come into the country, unable to deal with it in the way that we had before so it was circulating whilst we were trying to then shift to reliance on the vaccine. That was the complication. So I guess the short version is we were always transitioning. 2021 became the year that we intended to do that. It became very difficult because of Delta.
NL	Yeah. Yeah. Okay. Do you have anything arising out of that Commissioner Hill, Anthony?
AH	Dame Jacinda, during that period of 2021, and you mentioned the challenge of needing the public health tools in order to move and as the array of (you didn't say this) but as the array of tools grew, the ability to adapt grew because you had more choices, you had more things in the toolbox. So RATs came later, the ability to test and get quick results came later, saliva testing appeared. But during that 2021 period, did you ever have a sense that the system was struggling to get new technology fast enough or did you reach a point, as you were thinking very clearly about transitioning to the COVID Protection Framework and you needed those other tools, did you ever have a sense that maybe the system could have been moved a little bit quicker? Occasionally we'd see a frustration from a minister saying, Ministry of Health, you need to be moving faster, or we'd hear from the private sector we'd really like to see these tools accessed more quickly. Do you have any... And I'm just talking broadly as you mentioned that broad strategic move. Can you comment on that?
JA	Yeah. So look, I think, for instance, one example that I know the Commission are interested in is the vaccine passes and the electronic availability of vaccine passes. Yes we wanted to move quickly on those because we wanted to be ready for the transition to the COVID Protection Framework. It is not the case that we would've moved more quickly had those been available earlier. In fact, the vaccine, the electronic availability of vaccine passes were two weeks in advance of the transition to the COVID Protection Framework. But it is the case that we wanted to be ready. We wanted to have those available because of course it was a very dynamic

	environment. We would've wanted to transition as soon as we felt comfortable to do so. But it would not be fair to say that the technology, the implementation held us back from moving to a different operating model had we been able to. One of the points that I think is worth making here though is that when a technology was available, the assumption was that we should sometimes move at pace towards it without necessarily factoring whether or not it was the right tool for the right time. RATs is a really good example of that. Rapid testing, because we had an elimination strategy and because understanding what your requirements might be was based around testing, people wanted to be tested. They wanted to be tested quickly. They wanted to understand the requirements placed upon them as a result of the testing. PCRs were extremely accurate, but they were slower in that regard. So RATs, people placed an equivalency in their minds, RATs will be able to tell me whether I have COVID or not, and they'll be able to tell me quickly. Unfortunately, RATs did not have nearly the same accuracy. And when you have an elimination strategy, accuracy is key. So there was a lot of pressure to race towards RATs. While we had Delta, it would not have been the right approach to use RATs in place of where PCR testing was important. But with Omicron, great time to start rolling out RATs and using them more liberally. Great time to open up access. There were certain parts of the strategy where those tools would be useful, but not necessarily in all parts of it. So that was one example. Another, we really early on had the suggestion that WhatsApp channels would be really useful for COVID management. Rob Fyfe tried to chase that down for us. Turned out to be not that useful. We had another member of the business community who was extremely attracted and I would say persistent around the use of a contact tracing style card. So basically something that automatically was able to register where you were. They placed a lot of... There was a lot of advocacy and lobbying of government to adopt this approach. We did chase it down. We worked with them and put funding into looking at a pilot for this in Rotorua. It turned out not to be nearly as useful and user-friendly as was predicted. So I do remember a lot of different tools were put to us as being a technological solution. Sometimes they weren't quite what they appeared.
AH	Can I just ask a follow-up about the changing risk tolerance? That's an oversimplification of what was going on, but just if we're talking thematically about strategy change, so evolution from elimination into suppression and living with, we've gone through Delta, we've gone through Omicron. There was a very strong public health priority in protecting public health, protecting lives, protecting the capacity of the health system. And at the same time there was thinking about social licence and compliance.

	We'll get more into that as we talk about lockdowns later. But can you just talk us through, again, at a thematic level about how you were thinking about the different risk tolerance that was applied as we moved from Delta into Omicron and we were able to live differently because the risk profile started to look a little different and we had different tools. Can you talk about that?
JA	What do you mean by risk tolerance?
AH	I guess picking up that idea that in the beginning, no vaccine, we picked an elimination strategy correctly because that was how we would protect people, protect the health system, save lives. Then vaccines arrived, then we had to think about opening up the borders. And I'm just interested in how we thought about what levels of risk we were prepared to live within the community as we started to open borders, as we started to change into the COVID Protection Framework. Did that change the way you were thinking about choices?
JA	Yeah. I mean, look, I think the important point to make really early on as well is that there seems to be an assumption that we chose public health, and therefore wore the cost, the economic cost or the social cost or the cohesion cost, when actually our very strong view, and we said it openly at the time, was having analysed and observed what was happening internationally, our very strong view was that to choose to lean into an approach that focused on the preservation of life and to avoid preventable death, that actually was backed up by analysis, the best economic approach we could take and the best social approach we could take. And so we saw that in its totality, and I think the UK really bears this out because there does seem to be an assumption that if you chose not to take an approach focused on the prevention of the loss of life, that you therefore were choosing an approach of a liberal approach where you leaned into prioritising freedoms, and therefore somehow a lower economic cost. That proved not to be the case in the UK. The point where we were, of course, had adopted elimination, we're opening back up, very little loss of life, and we of course then had a much more liberal… our life back home at various points was as close to normal barring the border controls. In the UK, at that point the decline in GDP was roughly around 9% and they'd lost 40,000 lives and they were in lockdown. So I think that's just a general point that I wanted to make. In our view, we were choosing all, to lean into all three - the lowest economic cost, the lowest social cost, the lowest health, loss of life. Of course-
	[redacted]

JA	I was going to say, of course though, the strategy wasn't to live forever more in an existence of lockdowns. Of course, the strategy always was at the point that we have supplementary tools that individuals are able to take up and use as an individual armour, we would take them, and that then allows us to lean less on a collective action such as lockdowns and more into an armour that is then provided us for the long term, because it was not the case that we saw that it was sustainable to maintain a elimination strategy in the long term, we knew that. I remember at one point talking to my Chief Science Adviser in 2020 over the phone and asking her, "How long do you think vaccines will take?" Because we knew that was our exit strategy. She said to me, "If everything goes right, five years." And I remember collapsing into my chair because I knew it was... We all knew that it would not be possible to maintain an elimination strategy if you're having to use lockdowns frequently. Keep in mind, of course, we were trying to use them as little as possible. It would be very hard to maintain that long term. So when you say risk tolerance, I think the implication I take is that there's an assumption that we wanted to use lockdowns, that lockdowns were... where you had the lowest risk tolerance, and I think that's just a little bit simplistic.
NL	Yeah.
JA	We used them because we had no other tools. If you were going to use them and use them to ensure that you didn't have the downsides of them, you had to use them the way we did, short, sharp, get rid of it, and then go back to normality. So it ended up being one of those options that by default, if it was going to work well, you had to have very little tolerance for COVID within it. But it was never a long-term strategy.
NL	I was just going to say, I think our questions under strategy at number two tend to suggest that there was a tension between social and economic outcomes and public health outcomes. But what you're telling me is that from your perspective, the social and economic outcomes followed, good social and economic outcomes followed the public health choice.
JA	Indeed. Indeed. Absolutely. And the second point that I'm trying to make is that actually, if you want to run that strategy well, unfortunately, you can't have much tolerance for COVID within it. But the second point, and this is relevant to the period of time that you're really interested in the transition was the difficult part. The movement from reliance on public health into leaning into the vaccine was the difficult part. And when you talk about specifically risk tolerance in that period, what immediately springs to mind there is how much tolerance did we have for letting Delta get away on us in that

	period, in that transition? So there's a very specific, I think, question about the decisions that we made in there, but the overall kind of, how much risk tolerance did you have? That's where it feels simplistic, but if you dive in a little bit more into some of those decisions. Yeah. We faced some interesting questions, but most of them at that point were how do we ensure that we're not still seeing preventable loss of life because we jump a bit too early in that transition? But we're talking really about a 12-week period over the course of the pandemic where that dismount was very tricky and difficult.
NL	Yeah. So it was planning the jump.
JA	The transition, really hard.
NL	Yeah. Now one of our questions here is did you ever consider that you or cabinet had a different risk tolerance than members of the public? Is that something that came through or was that [inaudible 00:27:00]
JA	Yeah. I mean here really, if I was being crude, I would characterise the feedback we were getting through this period into two different camps. Those who believed that if we moved too early or if we managed that dismount incorrectly, we would be committing genocide. And I don't use that word lightly because it was used in that period of time. That we would be making a decision where we were knowingly accepting preventative loss of life.
NL	Yeah.
JA	There were others who believed that we were carrying on an elimination strategy or through the transition for too long, and that we therefore were unnecessarily restricting their freedoms. And where it got tricky during that period was actually some of the people making that argument were already vaccinated. And we were very, very aware of the fact that some people had gone out and done the thing that we'd asked in order for us to transition into a new strategy. But because not enough people had done it yet, we weren't able to move at the pace we wanted. Now those individuals had a very valid point that they were making but so too was the point that unless we had a large enough cohort, we might be affecting the immune compromise. We might be affecting those who might experience vaccine hesitancy and needed a bit more time. So there were very valid arguments being made on all sides, and I heard all of them. I talked very openly about this being one of the most difficult periods because we understood the fatigue. We were aware of the tension around social cohesion, and many of our responses were built around that.

	To give you two examples, the step-downs that we used, which we were criticised for for them being a confusing strategy, were actually put in place to try and help people during a prolonged lockdown, give them more social freedoms, maintain a strategy a little bit longer without the same mental health impacts. So knowingly, we knew we would be criticised for it, but we wanted to prioritise people's wellbeing while we were trying to manage the transition. The second thing was vaccine passes. I know we'll come to that, but there often there's an argument that we weren't acknowledging social cohesion, when in fact our response to the fact that we saw people getting very angry at those who had not been vaccinated and it became a way that we could allow people who were vaccinated to get out and about. And so we thought [inaudible 00:29:54] the tension out.
NL	Yeah.
[redacted]	
NL	Our next question under this heading is that in a recent media interview, you referred to two options, being attacked for doing too little or doing too much. I think your answer is that you'd rather do too much.
JA	Yes. I saw that. Do you mind though, just because I'm aware that in the first question you had around people inputting into the strategy, this will be relevant later on. I actually went back and looked, so before we just move on from this section. I went back and looked at all of the engagement through this period that I had with external groups. Keeping in mind, I've already referenced the groups that ministers engaged with, the number of oversights, the expert advisory groups we had. We had Skegg, we had Roche, we had five leading external groups. But I thought it might be useful to share with you some of my direct engagements because all of it was relevant to the decision making we were making at that time. Just to put it on record. We ended up going into that lockdown in 2021, in the middle of August. In that period, of course I found myself tied to Wellington a little more than I would've liked, but we were careful about trying to follow the rules and restrictions we'd put in place ourselves. From then, 19 August the National Zoom Fono with the Ministry of Pacific Peoples and invited guests. 25th of August, Business New Zealand and the network executives, chambers, all the business chambers from around New Zealand. On the 1st of September, I met with Local Government New Zealand members. On the 3rd of September, Samoan Assemblies of God church leaders, because of course that's where one of our significant outbreaks affecting that community. On the 8th of September, I met with Brian Roche, who was part of our improvement and advice group. 10th of September, the farm leadership groups so the like of the farmers and our primary industry leaders. 14th of

	September, Fyfe, Roche and Gerrard. 21st of September, Business New Zealand and the Council of Trade Unions, of course, trying to work through some of the packages and support we continued to provide. 22nd of September, the Cook Islands community. 23rd September, Auckland DHB. Then the next day I had DHB meetings with Northland, Taranaki, Lakes, Bay of Plenty, and Tairāwhiti. Big focus on vaccine rollout at that point. Sir David Skegg on the 27th. The 29th Fonterra, really wanting to understand some of the impacts for them, including exports. Same day, the Border Reconnecting Sprint Group, that was Adrian Littlewood in particular, the CEO of Auckland Airport was on that call and Brian Roche. The mayor of Auckland on the 30th of September. 6th, the Chief Medical Officer, Andrew Connolly. The 7th, this is when we started going out. Then I started a road show. I visited Rotorua, Murupara and vaccination clinics. Then Hastings, Wairoa and Gisborne. I did an online vaccination chat with members of the Chinese community, talked to the Chief Medical Officer again, Andrew Connolly. Then David Skegg on the 12th. Then I went to New Plymouth. We had a Vaxathon on the 16th. I did an interview with a kids group, Auckland and Northland DHBs on the 19th of October. The CTU, Council Trade Unions again on the 20th. Then visited Wairarapa, met with the DHB CEs again. Then the Future Borders Sprint again on the 21st. The children's Commissioner, met with them several times to try and get feedback. They were engaging directly with children's groups, but also kids themselves. Went to Northland on the 2nd, then Whanganui on the 3rd, met with Iwi leaders there as well. Now, it wasn't until the 10th that I ended up back in Auckland. I met with Mayor Goff, business groups, Pacific vaccination centres. I met with a Pacific youth group. Met with David Skegg, Rob Fyfe. Brian Roche later that week. Business New Zealand and Auckland business leaders, again on the 17th. Went to Gisborne then to Christchurch, met with business representatives. I remember that business round table in Christchurch to talk about impacts on them. Iwi chairs, the 19th. Hugo Group, the 20th. Local Government again on the 24th. Went back to Auckland, did a social sector round table and another Auckland business leaders group meeting them. I went to see Hamilton business leaders because of course they were greatly affected as well. Then back to Auckland again on the first. I met with hospitality then as a significantly impacted group. We made the Auckland Reactivation announcement then, specifically focused on business. Then we start coming into Christmas so things start easing up. I will email you that list but I just wanted to give you a sense again of the, from outside cabinet processes, the ways that I continued to try and engage and get feedback from different groups. Now, sorry to your question, I'll dance forward your question now.

NL	Just before you do that, is it fair to say that you would've received a huge range of different opinions on everything from those groups?
JA	You can imagine, yes. But I wanted to share that because there was an implication in some of the areas of interest from the inquiry that I've seen around the first within cabinet papers on public health. That's very much because at those points, we're making very often very specific decisions on lockdowns, on how to exit them so they're naturally inclined to analyse the public… you know, what's happening from a health perspective and public health ramifications of moving in, moving out, and so on. But the idea that there may not have been the engagement with other groups is wrong. You can see from that, that alongside often daily Zoom calls that I was having with public health on the ground to see if we were any closer to getting out of lockdown, I was also engaging with those affected by it. I just wanted to share that.
NL	That's really helpful. Thank you. I think that just comes back to the comment about doing too little or doing too much, which-
JA	Yeah. I think my point that I'm actually trying to make here is that looking internationally, I don't know that I've ever seen a place where the overwhelming commentary, and I say commentary because I think actually the public view, it's very hard to capture that sometimes. Where the overwhelming commentary is perfect response, bang on, right down the middle. Perfect balance between the preservation of liberty and life. That I think is the point that I'm making, is that you either end up a one or other group. In the UK, very much the perception at least, the inquiries that you see publicly there lend themselves to not enough was done to prevent the loss of life. As I say, very early on 2020, 9.7% decline in GDP, 40,000 people have passed away. And so there, it's what more should have been done. It just so happens that in New Zealand, the line of questioning seems to be, could we have achieved the same outcome in terms of the preservation or the prevention of preventable loss of life without having had to have used some of the public health tools that we did, or using them for the length of time that we did. The point that I'm making is that, if I was having to choose from two, because I don't think it's realistic to say that there was ever some perfect flawless approach, my preference would be having that conversation, because we are not having that conversation with a long list of people grieving family members that they believe could have been saved.
NL	All right. I think something that we don't see in the cabinet papers, but which we've been looking at in the last couple of days are the graphs that you were receiving as you made the lockdown decisions and the modelling and then the actual, what was actually happening, which was sometimes a little more scary than it was in-

JA	Yeah and I talk very openly about that. Of course we will never know how realistic some of that modelling was or not. But at the time, of course, with what we knew and what we were seeing internationally, you think about New York, Italy, some of those areas where we were seeing not only a number of people losing their lives, but completely overwhelmed health systems. And as much as there was a discussion around, can we just better prepare the health system, what was clear that even the most sophisticated health systems in the world were being overwhelmed, because there was no way to simply control it to a point that you had enough resource. It implied a level of control over this infection that no one had. Once it got away, it was away. And so those graphs, I think were an illustration of that and I talk a lot about that graph. But at the same time, what I also had in mind was that GDP was projected to take a hit of between 13 and 33%. Unemployment, between 13 and 26%. We would lose people and we would also see a collapse of our economic well-being as well. Now, some people say, well, because that never happened, therefore they were all over estimates rather than, in my view, they didn't happen because we took a different approach. We took an approach to try and prevent those things from happening.
	[redacted]
NL	[redacted]. I think we've dealt too with the commonly used phrase that a strong health response was the best economic response. Did that ever change, that policy?
JA	Well, the strategy of course changed as the illness changed and the tools changed. But it was still our view that actually, and you see this later on, that the proper management of COVID was a way to give people confidence to engage with the economy. And, for instance, to even engage in education. One of the things that we saw when we opened our schools back up is that sometimes people didn't go back. Now, yes, we need to take into account that there are a number of issues that already existed in our community that COVID exacerbated and that's one of the findings. It's one of the things that Principals' Federation keep talking about, but we were also hearing reports that sometimes people lacked confidence to go back. That was with us believing that we were doing so in a really responsible and timely way at a point that it was safe. I absolutely believe that had we not properly managed, for instance, the transition into vaccines, had we not been really thoughtful about health impacts and so on, people would not have seen it safe necessarily to go back out and fully engage in the economy again. And we may have seen more hesitancy around workers to return to the workplace. It's fascinating to me was in many economies to get people back into the workplace in a way that yes, people enjoyed flexible working in New Zealand, but I don't see nearly the same difficulty back in New Zealand as I saw in other places.

NL	All right. We've got a general question at the end of that strategy section. On reflection with hindsight, are there changes to the strategy that you look back and think could have been made or should have been made sooner?
JA	Yeah. I mean, one of the reasons that as a government we established the Royal Commission was because we were sure there would be, but the question for me was who's best place to tell us that? And it felt to me that there was a certain futility in having those of us who were in the midst of it, be the ones to try and cast back. We need the benefit of foresight, rather than perhaps sometimes the futility of hindsight. So that group was really important to us because we want to be able to look at those decisions. But one of the things I think politicians of the day, will always struggle with is we can remember the competing pressures. We can remember the absolutely diametrically opposed positions people were taking and with the best intent in the world, there will be things that could have been much, much better. But I prefer to lean on the independence of Royal Commissions as we did with round one to do that and they have produced a helpful report for future pandemic planning, which I do not disagree with. I accept and support their findings. So really, I guess here in answering this question, I would say, please refer above to Royal Commission one.
NL	All right. Thank you. We'll move on then to the particular lockdowns. This is the national lockdown in August and September and the extended lockdown in Auckland and Northland in September 2021, which we interpret as and beyond because when those lockdowns were… they were in lockdown on their own and then going forward on their own.
JA	Nicolette, before we jump, one extra point I wanted to make. You asked about whether or not we had the right strategy at the right time. We did ask others for advice on this so I just thought I would make a reference to that. Particularly David Skegg's group, we asked about taking the use of different strategies through that period of transition. When we asked him, he did point out, for instance in June that in light of vaccination, we should still though maintain elimination until we were highly vaccinated. It does not mean zero COVID, but stamping out clusters and they suggested regular reviews. So I just wanted to make the point. We did have some formality around testing the strategy with experts as we went. Sorry, let's project on. Let's move forward on to lockdown.
NL	No, no, that’s a very helpful point. All right. Lockdowns. We see from the documentation that the initial belief was that the outbreak in August 2021 would be quashed within a short timeframe by the level four restrictions. When did you realise that that was not going to be the case?

JA	And that with every lockdown was always the ambition, but you'd notice that actually we tended to use three more than four when we had outbreaks. We used four in this case, my recollection, for two reasons. Delta, we knew Delta was highly infectious. We saw, for instance, in India, they were reporting their highest daily tallies when they had Delta and their highest losses of life during Delta. So that was to us an indication of, and of course, we had the modelling of the R value of Delta versus others so we were on high alert for when Delta arrived. So, level four, because (a) Delta, (b), we are making these decisions, keep in mind, within hours. I was in Auckland visiting Auckland University when I got the notification by Minister Hipkins that we had a case. The first things I always looked for in those initial hours when we make a decision around whether or not we're going to lockdown, a decision I always dreaded, I loathed, loathed having to put New Zealand restrictions on New Zealanders. When making that decision was do we have any sense of how this person may have been infected? If there were any initial indications, I remember someone who we found had a case initially it was questionable if we connect them to the border. It worked out that they worked in laundry for airlines. And so when you've got a clue like that, you could have some level of confidence that you would be able to find the chain and therefore build a bubble around that chain and not take away any liberties of any additional people more than you needed in order to stop the spread. This individual, there was nothing that gave us a clue, nothing. In fact, we never found out how this person came to be infected with COVID. Those initial clues suggested to us that four was required, and whilst of course we hoped that we would have the same outcome we always did, which is to eventually squash that cluster, you never know necessarily. Now, just to give you a little bit of a sense, early September, the Ministry of Health believed it had peaked in August. So by early September, the Ministry of Health had a belief that maybe we'd seen the worst of it, that did not hold. By late September cases started increasing, including the number that we couldn't epi-link. Now that was because by that point, COVID had moved into a community of rough sleepers. It had also moved into a community of those that I would loosely describe as being gang affiliated. As you can imagine, contact tracing with individuals in those two communities was extraordinarily difficult. We went to extraordinary lengths to try and create an environment where we could sufficiently contact trace, but it was incredibly difficult. At no point do I remember anyone saying formally we will never manage to eliminate this cluster. I don't remember that advice formally ever being given, but I'd been around these clusters long enough to see that we were in a very difficult spot. At that point, the Ministry of Health continued the strategy, but also looked at, what do we start thinking about if we're unable to do that with Delta? So you saw these two parts of consideration

	starting and I believe that that was in September that we started doing that, but there was never a black and white piece of advice on this.
NL	I think the question, why do you think the Auckland lockdown failed to successfully repress the outbreak? I think that's really a question for a scientist. I think that's a bit unfair.
JA	Yeah. Well, I've also given some indications. If you can't epi-link it, then you can't contact trace it properly. Then all of the things we relied upon don't work so well. The one thing I think I will add here is that Australia had the same problem with Delta. And so really, Delta made everything more difficult. And so perhaps if it hadn't moved into those more difficult communities, it may have been possible. However, another country found the same issue. It had probably moved into those communities because of its level of infectivity. I think the final interesting point to make is that actually we did eliminate Delta. It was in January that eventually it was gone. Now, one point that I don't think gets made a lot, had we not managed Delta down during that period, it wasn't a futile exercise. Our first real experience of COVID in our community was with Omicron. Had our first real experience of COVID in the community been with Delta, who knows what would've happened then. And so the fact that the country, through its efforts, managed to suppress Delta to the point that actually it was not the dominant variant of COVID and the testing, we were testing variants all the way through and in January, I remember they believed that Delta had essentially been eliminated, we would've had a very different experience.
NL	Just thinking about where your information was coming from, obviously a lot of places, did the cabinet papers contain information that you didn't already have or were they just bringing together what you already knew?
JA	Because of the pace of cabinet papers, of course we would see drafts that gave us an indication of the advice from the Ministry of Health, but it was very dynamic. It might be the case that you'd see a draft might be circulated to departments and of course, I'd be aware of those drafts and I might see the initial thinking from the Ministry of Health, but their view may shift by the time the final draft came through. Of course, feedback from other ministries would often lean into the nature of the advice that was coming through from the ministry and the options that were being presented. And so that might mean their position may change or may be more dynamic as well. The pace meant that sometimes yes, a final cabinet paper may contain information that I may not have otherwise received. I do not remember ever being surprised and that's in part because of the constant dialogue, daily calls with senior officials, the advice that I would receive from the advisory group I had in DPMC, or just really understanding the position of different groups that might be represented by departments. I very rarely felt surprised.

NL	Your chief science advisor was involved in these discussions that you were having?
JA	The discussions that I would have with Dr. Juliet Gerrard were continual. Of course, we would often give voice to what her advice may be, but in the cabinet process, of course there's a chain of inputs that are very heavily departmental focussed. But certainly I made sure that people were aware of her advice, be it written or verbal, as we were going. The importance of Dr. Juliet Gerrard can't be overstated. She was a link not only to the chief science advisors in each department, including Dr. Ian Town, who had particular knowledge of respiratory illness, that was his specialty area. She also had a network of international science advisors. She was linked into the international community in a way that with a speed and pace that we just otherwise would never have been able to have reached into. Those networks were rapidly responding. They had access to some of the information around the databases that were being kept on variants. She could test what we might be hearing in the media or on international reporting. She was very aware of the progress of vaccine development. She was incredibly important for all those reasons.
NL	Where's the record of her advice? Was that...
JA	Again, as I say, cabinet papers have a degree to which they have a pro forma way of capturing advice. They have a process that allows that advice to be formally captured and fed into a cabinet paper. That does not mean those are the only forms of advice that you receive here or take account of. My recollection, you'll forgive me for doing this based on recall, is that she will be referenced in papers, memos and briefings, but the templates for cabinet advice, which of course include departmental, equity impacts, Treasury's view, the templates do not an area for the Chief Science Advisor and that's in part because different governments have utilised them differently. Not every government even employs chief of science advisors, let alone regards their advice highly enough to place them in cabinet papers. Templates don't have that little spot. My recollection is she was referenced. What I can certainly tell you without having to go back to any of those written records is that I would often give a verbal briefing on the advice I had received from the Chief Science Advisor. One of the reasons that might be verbal is because it was such a dynamic environment that I may have received it within hours of the cabinet committee.
NL	I have the question here. What non-government sources of information and advice were drawn upon in informing decisions about changes to alert levels? This is, I think, a reference not so much to the, this is what I want to happen, but this is what should happen from a scientific perspective.
JA	From non-governmental advice?
NL	Yeah.

JA	Well, actually this is where, and I think this is one of the strengths of the New Zealand response, is that many of those external non-governmental science advisors, scientists, epidemiologists, modellers were also speaking frequently in the media. For instance, to give you an example, of course, Rodney Jones is a modeller who was doing a lot of work, was actually fairly accurate. Even though early on there wasn't that formal connection, I observed the accuracy of the work that he was doing. And so during 2020, his was some of the modelling that… I've talked before about how I maintained a very close watch on our hospitalizations, our testing numbers, and our number of cases. I plotted that against the modelling of Rodney Jones because I could see the accuracy of what he was presenting. He sometimes was within five to 10 cases of being bang on accurate for where we might be, given the public health measures we were using. TPM, so some of those informal groups that came together over time and may have then been contracted once they established themselves. There were a number of epidemiologists. Some were engaged eventually. At that time, actually, Ayesha Verrall was an epidemiologist that we eventually brought in to do some work on contact tracing for us. Shaun Hendy, of course, endless epidemiologists who would commentate. They would commentate, we would hear them. Sometimes we'd bring them into some of our advisory groups as well. There was formality, but there was also informality in those periods.
NL	Okay, great. Great. Just moving on then in lockdowns for something completely different, did you feel that you had an evidence-based understanding of the on-the-ground impacts in Auckland?
NL	And I think you've probably answered that question in the list that you gave us before.
JA	The one thing I would just add, of course you need more than anecdata, obviously, when you're in government and you're making decisions. But it is difficult to find measures for these impacts. Just because it's difficult to find measures does not mean that we weren't acutely aware of them. Keep in mind, our ministers were in lockdown. So our Auckland-based ministers were living the same lives as other Aucklanders whilst continuing to work remotely. And even though I wasn't there, it's my home. It's where my family is.
NL	I'm sure you knew a few people there.
JA	So I think you never want a government governing by anecdata, but let's not discount the awareness that you build from the fact that the people that you are working with are there, and that your connections and community are there. And you see it in some of the decisions and the way that we were operating. Let's track back to the 2020 Labour New Zealand First government. In that 2020 period, we put a dedicated channel on TV with education programmes. We sent out modems, and we sent out education packs. We were

	acutely aware of the burden on parents of trying to be at-home educators. I start doing [inaudible 01:01:26] weekly, I think it was event where I do a little webinar with experts on mental health and wellbeing, parenting. We created a mental health strategy for COVID-19, and I'd be really interested in diving into that in a little bit more detail because often, you don't see conversation about the extra funding we put into helplines, apps and so on. We were very aware. In fact, when I was confronted in 2020 before we went into lockdown, confronted by the business group I spoke of who had a call with me before that level four lockdown urging me to race into lockdown, the point I made to them was, as a government, we have to worry about our rough sleepers. We have to worry about families in domestic violence situations, children who rely on school to access food, stability and protection. We have to worry about the job losses, small businesses who won't be able to operate, access to essential services, those who have a completely isolated otherwise other than the very small contact they have with essential services, the elderly, the isolated. We had to worry about all of those groups, and in a very short space of time, putting contingency for them. That awareness never went away. The entire time, we thought about the impacts on those groups, the cumulative impact of lockdowns, and people's mental health and wellbeing, as well as the economic impacts. And so I think every single decision that we made, you could ask me about the steps that we took, the step-downs, the CPF work, I will show you in every single one of those decisions, an attempt to mitigate in some way the impacts of public health measures. So yeah, just thought I'd make that general point.
NL	Okay. Thank you. Just give me a moment, I'll just talk very briefly to Commissioner Hill.
	[redacted]
NL	Question 12, we think has been covered by answers that have already been given. But question 13, Jacinda, what economic or social impacts were you most concerned about in regard to the lockdowns?
JA	Yeah, you can see the social impacts I was particularly worried about in the last question. And again, coming back, you can see some of the decisions we made, that bearing out. So for instance, the social isolation. We made a decision that when we talked about bubbles, that if you were someone who lived on your own, that you could join someone else. Constantly, every rule and provision, we were thinking about how to mitigate some other aspect of well-being. If I were to fast-forward to 2021, the step-down, some people asked, "Why did you alter the simplicity of the alert level framework to allow 10 people to gather in a park in the middle of an outbreak?" We could feel how difficult that period of time was for those in Auckland, Northland, who had been in the lockdown for a long period. We were looking at ways to provide release,

	connection, to try and improve well-being in very difficult circumstances. We looked for the ways that would be least impactful or risky in terms of public health. So allowing people to gather in parks and outdoor spaces, because again, and I knew when we made those decisions, that we'd be criticised, but I did not think it was sustainable to ask people to continue on without that social connection. Early childhood education centres, we brought them back early in that step-down. And again, people ask that question. But we looked at the relative risk that we saw to that age group, and the well-being issue, the ability for parents to continue to manage without those supports and made that decision. So you can see some of that. On the financial side of things, wage subsidy, income relief payment, leave support scheme, rent arrears assistance, the doubling of the winter energy payment, reactivation plan, all of those based around our attempts to mitigate the deep concern we had of the economic impacts of these public health measures. They were significant, the plans we put in place. And so there was deep awareness and there were significant attempts to try and mitigate. If I could jump back also to some of the initiatives on the social side, there was the care in the community and community connectors. We were worried about those who we were asking to isolate if they had COVID, even when we weren't in lockdowns. We used community connectors to make sure that MSD was providing the support that people required. Put in critical food support. We put in additional mental health funding for services like, as I said, apps and call centres. There was even specific Māori mental health support funding provided. There was, in 2020, a psycho-social and mental health well-being plan specifically for COVID. There was a youth plan that focused on mitigating the effects of COVID put out by the Ministry of Youth Development. Ministry of Pacific Peoples had a recovery plan that also included a Pacific Education Innovation Fund acknowledging the impacts on Pacific education. The Office for Senior Citizens looked at how specifically they could support seniors. So basically, you name a sector of society we should have been worried about during COVID and there will have been some work done. We were very aware that this was not costless.
NL	I think that takes us to the question 15 about did you feel well-informed, just looking at that list, after it was over, were there any of those topics where you looked back and thought, oh, we didn't know enough about that?
JA	We always wanted to try and model everything. So probably it was at a micro level that I actually would've wanted more than sometimes we had. For instance, can you tell me whether or not it makes any difference to have a gathering limit of a hundred versus 200, because I want to give the maximum capacity I can? Will it make a marked difference?

	The problem was those things were very, very hard to model. They were very hard, and you all were having to make decisions around them. Other examples might be that we might make a decision, and then its implementation. I might not be aware that it wasn't being implemented appropriately. And sometimes, I saw that on the vaccine rollout. I certainly believe that was the case with the exemptions around vaccine mandates. We might make a legal decision and then the implementation might not be what we would like. So I would've wanted to know if that was the case and didn't always. That's why you see us starting to have those conversations directly with DHBs, particularly on vaccine rollout, but then modelling the micro decisions. It was very hard to know. If we move to the CPF framework a week earlier, what kind of difference is that going to make? That was what I would've loved to have known, but it was not easy to get that information, or to be able to rely on it.
NL	All right. So it wasn't that there weren't the people to ask, it's just that the answers were too complicated?
JA	Or unable to be accurately modelled. There was no shortage of either formally commissioned advice or advice that was not commissioned. Feeling like you had the accurate information to be able to make the decisions was sometimes difficult. So no shortage. The only other thing I would say that sometimes, and I think the Royal Commission One brought this out, the transition strategies were hard. Sometimes we saw additional work to be done whilst maintaining. You might be managing an outbreak, and you're saying, "Hey, we are still seeking to eliminate, but we need an alternative transition strategy if we're unable to." There wasn't always the capacity in the system to do that work well. So the COVID Protection Framework was an example. Yes, it was developed, it was consulted on, but it wasn't necessarily the case that it was worked up in a traditional way by a department and then consulted on over a number of weeks because capacity was so constrained, timeframes were limited. And so look, that's probably an area where you'd want to see some improvement, maintaining the legacy knowledge that was in departments when people were moving around a lot, people were burning out, maintaining that consistent level of advice with some [inaudible] strategic thinking. But that's something that the Royal Commission One really dived into.
NL	Yeah. Okay. So moving on then to the CPF, do you think you have explained fully the motivations for changing from the alert levels to the CPF?
JA	Yeah. Essentially, as I say, when we were talking January 2021, we talked about the year of the vaccine. Even March 2021, we talked about phase two, the reconnection now with other countries. At that point, the view was that we could start reconnecting with other

	countries while we built our individual armour. So lots of early indications that we were changing up our strategy, signalling that we would change up our strategy, but heavy reliance on the vaccine. In an ideal world, we probably had envisioned successful use of the elimination strategy, let's paint the picture of the ideal world, successful use of elimination strategy. Vaccines come along, we roll them out, and then we're able to just flip to a strategy where everyone's vaccinated to a high level. And when you have COVID roll in, you might then just assess how much COVID was in the community and the effect it was having on hospitalizations and cases and if it's starting to look a bit niggly, you might use things like, as we did in the CPF, gathering limits or social distancing, or even just some extra requirements just to try and prevent the scale of its spread. And then you get rid of the alert level system. That's probably your ideal scenario, and I'd say probably was what was in our minds, a smooth transition. But because we were in a lockdown and we tried to transition out of a lockdown into a CPF, into the COVID Protection Framework, and we had a highly infectious version of COVID circulating during that transition, that was difficult. But yes, the transition was always on the cards. And we would've ended up with some version of a CPF.
NL	So I think that answer probably fits into and answers our question about your advice on scenario planning.
JA	Yeah. I know you were also interested in why not just play around with the alert level framework? If we always knew we were going to transition, why not transition within the existing frame we had? One of the reasons was there was a simplicity to the alert level framework that we would've had to have retrofitted on the way that you use vaccines in that framework. So it fundamentally would've altered it. So the advice from David Skegg, for instance, we asked these questions directly of experts. Their view was maintain it as it is, transition to a new strategy. One school of thought was we might need it again, who knows when. And if we've altered it too dramatically, it becomes very confused. And again, fundamentally, it didn't have vaccines embedded in it. So it just wasn't fit for purpose.
NL	All right. Okay.
JA	Yeah, because I know that you're interested in this idea of scenario planning and did they include exiting the elimination strategy? I think I probably covered off the fact that there was always the intention to move that strategy. And as I say, we went to the likes of David Skegg and asked this question of, "When do we transition and how?"
NL	So the 90% of eligible Aucklanders and 90% of the rest of New Zealand being fully vaccinated, where did the 90% come from? Was there any magic in that number?

JA	I think if you go through some of the media commentary, we were very hesitant to name a number in that for a long time. And I'm pleased that we didn't for a long time because the advice changed. Initially, and you'll see this internationally, that some countries went with 70% because initially there was a view that you'd reached the level of the protective factor that you'd want for a community as a whole once you got to 70 plus. That was early on, and it proved to be wrong. COVID was changing, we were starting to see the real world impact of the vaccine, and also the longevity of the protective factor of the vaccines. And so again, once again, we benefited from having a bit of extra time and started to see the difference in some of the modelling that was being presented to us between 70% and 90%. And it ended up being something like a 30% difference in the impact of COVID from having 70% versus a 90%. The first time it was talked about openly, I believe was Ashley Bloomfield mentioning it in a media interview. Behind the scenes, we were having lots of conversations about whether or not we had a target. I think my recollection was the Ministry of Health weren't that keen to have a target, they wanted the highest number possible, but actually talked about 90%. The next day, I believe, the Herald started its 90% campaign. And then we started digging a little bit deeper into, okay, if you have 90% as a target, what's the distribution of that? Because the advice we had of course was even if you have 90%, if 90% sits in one corner of your community, they hit 95% in West Auckland, but you end up with something more like 70 in central Auckland, you've still got a problem. And so I know you've got this question around to what degree was my office making suggestions around this? It's fair to say everyone coalesced around the 90, and then it became a question of what's the best way to then manage the distribution so that you get an equitable outcome. The Ministry of Health talked about age, had a couple of concerns about that, and a number of people did. Again, doing age bands, was that the right way to ensure an equitable outcome? If you had, for instance, a particular age band that hit 90%, but actually some of that age band still only hit 60% in say, south Auckland, then we've still got a problem. So it struck me that actually it was the geographic spread we needed. And there were a number of benefits to doing it via DHB. There are a number of additional benefits that just didn't carry when you did age bands, including the ability of the DHBs themselves to really motivate communities and focus their attentions on where they needed to lift in a way you didn't get if you had an age cohort approach. The final thought, in vaccine distribution and targets, I was constantly aware of not seeing any portion of our community blamed for not being vaccinated and therefore holding the region back and keeping them in lockdown. So one of the pressures we had at this point was whether or not we should have ethnically based targets. And people advocated for that for very good reason. We knew Pacific and Māori communities were much more gravely affected by

	COVID than others. There was a reason we needed to ensure that those communities were highly vaccinated. So we targeted our spending towards trying to lift vaccination in those cohorts. But I was very careful about explicit targets that might be over and above the rest of the country, and saying if we don't get to 95% amongst Māori, we won't move. What does that do? What kind of pressure would that place on those communities? So I was very aware of that, including in the way we prioritised the vaccine rollout. So you'll see a lot of funding going into those groups, a lot of focus by DHBs into those groups, but care taken around the publicly communicated targets.
NL	Yeah. Okay. That's very helpful. Do you remember a time being reached when the 90% target was ultimately rescinded, or was that more that you were satisfied with some areas?
JA	It was mostly that we were satisfied with the projections. So one of the things, the timing of this was incredibly difficult. We were so mindful that here we are, we've got this, so was looking at some of the timelines for these decisions. So when we're in the CPF, so we've said to the Auckland, "Okay, we want you to reach 90%," making those decisions in October, 18th of October. We're also aware though, and we agreed to move to the COVID Protection Framework, we announced that on the 22nd of November, we agreed to move to it on the 2nd of December. Now at that point, officially needing to rescind, it was much more the case. It was not the case that we'd given up on the importance of 90% or a high level of vaccination, but we'd received data that told us that we were projected to reach 90% by the end of the year. If we'd said, "We will only move once we reach that 90%," we would've been doing that smack bang in the middle of holidays, smack bang at a time when people wanted to reunite with loved ones, smack bang at the time when the number of people that we would need to be able to operationalize the transition would not be available to us. And we would not have the capacity to iron out any issues that we may see with the transition to an entirely new operating structure. So the decision, I remember, being very pragmatic. We projected to get there, the goal we have we will achieve. But if we move this forward by just a few weeks, it's not likely to have a huge impact on the public health outcomes, but it enables us to smoothly manage a transition, and to allow people to be together over Christmas. So we could see that the public health costs at that point were manageable, but it was incredibly important to give that certainty. So that's my recollection of the reason for that decision. And you could see that we did hit those targets essentially, within weeks.
NL	Were there downsides to having targets or public believing that you had targets?

JA	Look, we debated those continuously because there was a lot of pressure for us to have one, a lot. So we had a lot of discussion behind the scenes. And the pros was it's a rallying point, it gets people motivated. The cons, what if the data changes? And so that was very clear if we'd gone with 70, we would've had to change the target. You might hit 90, but it might be a bit of a false layer of protection because again, if you don't have that good geographic spread, some [talking over].
NL	Ethnic distribution, yeah.
JA	Distribution matters. And actually, you also see that after, and we didn't have this modelling at the time, but there was also some modelling that the last Royal Commission brought out, which demonstrated that actually the waning effectiveness of the vaccine, and not to often take into account these kinds of things. I think in the end, a target probably helped because one of the things on reflection, it was so hard. We knew this at the time, it was so hard. It felt never ending for people. They needed to know what the off-ramp was, and they needed to know how they could contribute to it. And the vaccine and the target helped with that. There were some who said that the target should have been a date.
NL	The target should have been?
JA	A date, not a number.
NL	Okay.
JA	So the vaccine, it is now universally available across the country for every age bracket. Go out and get vaccinated. We open up on X date. So if you choose not to be vaccinated, you bear the risk. There were some who believed that should have been the target. And whilst I understand the sentiment, it did not take into account that there were some people who carried hesitancy. And this has long been an issue in New Zealand. Yes, there's a small core group of people who don't believe in vaccines, but there are some people who actually just need time. They need access to experts and people they trust. So we wanted to create an environment where that was available. And it also didn't take into account the immunocompromised who needed a high level of vaccination to protect them because they couldn't protect themselves. So there were a number of trade-offs we would've been making if the date was simply the target.
DK	Way back at the beginning, you talked about a level, in this period particularly, of hearing some, I think you used the word “hate” towards people that were unvaccinated because that was stopping coming out. And I wonder if the target fed that. Do you think using vaccination target as a way to get out fed a bit of hate towards some of those people that might've been hesitant for various reasons?

JA	Well, I think this is one of the reasons that we decided also to use passes, which is really interesting to me because they've been framed in a very different way. And I will get into passes a little bit. So if we know that actually the vaccine is a methodology of getting out from the other restrictions it's only going to be helpful if we reach a certain point. It's very hard to avoid a number. And we tried for a period of time. It was very hard. If you say as many people as possible, then people, they know that fundamentally vaccine is your exit. So I think that exists regardless of whether there's a number on it or not. People know that they need to be highly vaccinated to get the benefit from it. So I don't know if we could have prevented that. But we saw that tension because people were saying, "Well, I went out and got vaccinated." Even when it was 70%, people were saying that. "Well, I went out and got vaccinated. Why can't I get out?" So regardless of the overall numbers, that still existed. So vaccine passes was one of the things that we started thinking about. And we socialised the idea of vaccine passes well before we even flipped into the COVID Protection Framework because there's another way to say, "Yes, and we will acknowledge that. We will acknowledge the fact that you've gone out and been vaccinated. And we will have this extra set of things we're able to do in the transition because you have been vaccinated." And even though I'm jumping ahead, I really want to make this point. I spoke openly against vaccine passes. We had a number of ministers who spoke openly against the idea of mandates. And whilst there now is a view that we used them when people were against them, actually we used them when we were against them because of the amount of pressure that started coming from those who wanted to see their individual actions acknowledged, and wanted a way out of other measures that were curtailing their liberties. We were so mindful though of the fact that this had the potential to disrupt social cohesion, that when you look at the COVID Protection Framework, you can see that we were trying to still provide means of access to services for those who were not vaccinated. And I remember going through every scenario and going, okay, what about those who aren't vaccinated? How are we still ensuring their access?
JA	So on this COVID Protection Framework up in the corner, "Some places won't be able to introduce vaccine requirements to ensure everyone can access basic services, including supermarkets and pharmacies." So I remember being very clear you cannot put vaccination passes in place for those places that we need people to be able to access service, and that we explicitly mentioned because of the pressure that started coming to bear to allow businesses to implement vaccine passes wherever they wanted and mandates wherever they wanted. And I want to reference this in the media at the time, because I think it's important to remember the environment that we were in where actually, we were trying to manage

	them not being used too liberally, rather than the other way around. So on the 8th of October, when we were working on the CPF and vaccine passes, David Seymour, now obviously our deputy prime minister, called for changes to health and safety laws to make it clear that business owners could require workers and customers to be vaccinated without facing litigation. In the same article, Judith Collins said she supports business owners imposing vaccination requirements on their premises, regardless of whether they are an essential service. David Seymour went on to say that government should be able to decide which public sector employees need to be vaccinated, while private sector employees should decide for their workforce and clients. So there was a general view that, actually, we should give very liberal access to both mandates and vaccination passes. We did not believe that that was right, so we put out guidelines and a checklist for businesses when using mandates, to curtail them being used too liberally. It's now viewed that, actually, it was about trying to broaden it. Our initial view was it was a curtailment. And now, Royal Commission One has found that, actually, sometimes those mandates were used more liberally than they should have, and I don't disagree with that, but it's really interesting to me now that the view seems to be that we were taking a liberal approach, as opposed to actually putting some constraints around where they were used. Back to the COVID Protection Framework, at every level, you'll see us trying to accommodate the unvaccinated. Orange, if vaccination certificates are not used, so therefore you're providing service for anyone, you could still access hospitality, we just asked it to be contactless. So coffees to go, meals to go, but still able to operate. We still were allowing gatherings, but just with a lower limit. You could still have a gathering, you could still have a wedding. Even at red, at the point at which action is needed to protect the health system because it's facing unsustainable number of hospitalizations, we still said, "Okay, if you've got unvaccinated people, you can have a gathering, just the numbers are small." We still allowed contactless access to hospitality, because at every level, we knew that a vaccine pass was saying that if you're unvaccinated, you wouldn't be able to go in and sit down at a restaurant. We didn't want it to mean that you couldn’t access anything. I accept that that nuance was lost, I accept that people saw vaccine passes creating that separation. However, the alternative was that you would've had much more broadly-applied limitations, and people were starting to see that as being unfair, given they had gone out and taken on the armour we asked them to take on.
	[redacted]
CF	We're now on to vaccine mandates, are we?

NL	Well, we've made a bit of a start into the vaccine mandate questions, and some of them I think you've answered as we've gone along.
JA	One supplementary piece of information. I'm loath to exclude any one political group in my references to where everyone's positioning was during the period that we were considering vaccine passes and so on. And I thought it was worth just acknowledging, as we come into this next part of the conversation, that my recollection at the end of 2021 was not so much around the amplification of those who took a view against vaccines, but more amplification of those who took a view against the use of lockdowns. You know, we had some protest action in Auckland around that, people who of course were seeking their freedoms, and so vaccines I think were looked upon very broadly by all political parties as a call for freedom. In fact, I think that was the language that was used by the leader of New Zealand First, Winston Peters, at that time in November was extensive, because of course at that time he was no longer in government, but was still placing extensive messaging online that his view was that we needed to vaccinate as a sort... I think his words were that vaccination was on the side of freedom, and so he was calling for widespread vaccination as a tool for no longer having to use other forms of public health measures. So very, very pro-vaccine.
NL	So the political heat was coming on the issue of lockdowns, rather than vaccinations?
JA	Well, the political heat was hasten vaccines, and try and encourage people towards vaccination and a range of different measures. So you have ACT calling for employers being able to use vaccine mandates liberally and vaccine certificates liberally. You had National saying the same thing. You also had, I believe that Chris Luxon at the time even referenced a “no jab, no dole” policy, so he wanted to restrict access to benefits if you were not vaccinated. And so there were a number of areas where we chose not to go as far as some were advocating, and it's very interesting to me now those same groups now advocate that we went too far. Just a point I wanted to make, and I think it's shown great restraint to not make that point until we're one hour and 45 minutes into the hearing.
NL	Can I just... I'm going to say this at the end, but you have made more points in the one hour and 35 minutes I think that you've been talking, many more points than you made in the stand-ups over the course of COVID, and with so much more nuance and detail than the public ever saw, that this is why we think that public hearings will give the public confidence in what we're doing, is if they can hear that sort of nuance from the people that were making the decisions.
JA	Well, respectfully I disagree, so-
CF	Well, I've told you I'm coming back to you on that, so...

NL	No, no, I'm…
JA	It's probably is born out actually as well by the comments from at the time. So I think the bit that I disagree about is not the point about public hearings, but whether or not I had nuance at the time. I think that's the point I would disagree with. I think, over the initial phase of COVID, I think I did something like 51 press conferences. They were at least almost an hour each. I was very, very aware in each of those that the way to build trust and confidence was to share what we knew, what we didn't know, what we had absolute knowledge on, and what we did have uncertainty around and what we didn't. And so there have been some questions, and let's dive into those, that I think present as if we spoke in absolutes, when I don't believe we did. I believe the transcripts bear that out, and I've gone back to those, and I really appreciate the ability to draw on those. I believe that we presented with the nuance that was in front of us, rather than absolutes, and the strategy bears that out, the shifts we had to make bear that out. We took one view on face masks, then we took another. We took a view on vaccine passes, and then we took another. Mandates, we shifted on, suppression versus elimination, because we always acknowledged that we were in a changing environment. So let's get into the examples that you want to get into, because my belief is that I did have nuance, where perhaps you seem to be implying I didn't.
NL	I think that's a very fair point that you make about the 50 hours of press conferences and-
JA	Yeah, yeah.
NL	... and I don't think that the transcripts of the press conferences are something that we have looked at, and maybe the answer is that the nuance of those 50 hours of press conferences, if the people that listened to them at the time were... I don't think anybody would've listened to the full 50 hours, perhaps except maybe people at the press gallery, but people have forgotten. If there was nuance at the time, people have forgotten it.
JA	I think one of the points that I would make, though, is that for those who wish to take a view, those who wish to take a view in absolute terms are likely to take it, and those who wish to view vaccines in a particular way will view vaccines in a particular way. And one of my experiences very early on was, although we all operate in an environment where, if presented with new information, you've got a willingness and ability to pivot your view, there are some for which that is not the case. And I can tell you that if we're seeking to try... And I think I understand the hope to build greater cohesion, based on perhaps through this Inquiry as a tool, perhaps that is the ambition for some. There are a certain group for which I do not believe that that will be possible via my words, but I-

NL	I don't…
JA	...make that point not as a statement of argument about the methodology that you choose to adopt or otherwise, rather than just an observation, just an observation. But let's dive into the examples you wanted to get into.
NL	All right. Well, let's just have a quick talk then about the occupational mandates.
JA	Yeah.
NL	I think you've made it pretty clear that you were getting advice about everything that you felt you needed to have advice about before making the occupational mandates. But do you know why government border workers were mandated early on, but private sector border workers were not mandated until November 2021?
JA	Yeah. So now, this is, again, I'm going on my recollection here, so when we were talking, of course the border, on the face of it, you are thinking about customs workers and so on, but when you get into ports and the like, you really are getting into people who work beyond just the state sector, who sit outside of Crown employment, who are often highly specialised. So not only is it more difficult to have a rollout that dips beyond your Crown employees, there's extra considerations there, you also have a group that, if they have a very tight timeline, they choose not to be vaccinated, and you've got a legal requirement that they can't operate, then that for some smaller ports, that might mean that the port ceases to operate. And so time was required to work carefully through those issues and ensure that you had no disruption of service. That's my recollection around the timelines that applied there.
NL	And what do you remember being the most important human rights impact that you were concerned with in the mandate discussions?
JA	Essentially, the idea of anything being mandated is an imposition on someone's rights. And so there, it was very important that we went through a process that brought to bear the advice of the Ministry or the Attorney-General, to ensure that we were appropriately weighing up the curtailment of someone's individual rights against the rights of the collective and the impact on the collective. And so there, if I'm to crudely articulate it, that's why you saw a weighting towards the use of mandates in areas where people were exposed or working directly with the highly vulnerable, because then you would weight the rights of the collective, because the collective may have been more vulnerable than other than otherwise, aged care, health, those who worked in health and disability sector. When you're on that spectrum, though, there was a call for us to mandate social workers, for the same argument, they're working with vulnerable people. But actually, that's where

	we thought actually the tension point there, we thought moving too far down the spectrum and away from those considerations. And so even though the argument existed and could be broadly applied, we didn't broadly apply it. I remember a real discussion around that. Where you were emergency services, fire and emergency for instance were called out to medical emergencies often, so there was some crossover there. Where do we draw the line? So that's why you see the likes of fire and emergency in there. In some rural areas, they might be first to scene on… with critically ill individuals. Police was a difficult one, and I would like to draw the Commission's attention to that one. Some asked why we were slower to mandate, that's because we were hesitant to mandate. But the Police Commissioner asked us to mandate, in fact asked us to mandate very broadly. Not only were we delayed in making that decision because we believed that it might not meet our thresholds. I called the Commissioner [inaudible 01:53:00] question, if this was something he really wanted for his workforce, and he confirmed he did. We subsequently put that mandate in place, but not to the degree they wanted. They wanted all police employees, and we didn't allow it for everyone within the police's charge, for non-sworn, for instance, is my recollection. So for every single... You name one area the Crown mandated, I will give you the rationale and some of the discussion that sat around it. We tried to be very thoughtful, and we did not respond to every call that existed for us to mandate. It's interesting to me that some of the mandates that often are challenged are those that were applied via the process of the private sector, not always just the Crown mandates.
NL	Yeah, I suppose that's a related question, is that the effect of the rules of the COVID Protection Framework meant that …
JA	Oh, the vaccine passes?
NL	Yeah, meant that workers in hospitality, for example, had to be vaccinated or their employers determined that they had to be vaccinated.
JA	Yeah, and you know, and I do remember coming across hospitality who chose, said that they didn't want to do that, and so they worked in a contactless way for a period of time. So you know, there was a curtailment there. But at green, for instance, if we were in a green space, you didn't have to use vaccine passes. You could have 100 people on site, so we tried to factor that in. We tried to factor in that there'd be some who, maybe on principle, for their own personal reasons or because of their staff, didn't want to use them, and we tried to give some ability to operate within that, yes though, there was some imposition there. But we equally wanted to keep in mind that, actually, there'd be many operators who might know that their customers may choose not to come if there weren't vaccine certificates in

	use as well. It's very hard that some hospitality might call for them, because how else do they signal to their customers that it's a safe environment for them to come into during that period? So we tried to weigh that up. I know Royal Commission One found that they believe that that was… you know, was it considered unreasonable? They did raise whether or not mandates were used too liberally in some areas, and I thought that was a fair point for them and recommendation for them to make.
AH	Can I ask?
NL	Yeah.
AH	Dame Jacinda, can I ask you? I've asked several people who we've talked to over the period, both in public and private sector, and employee union representatives and business owners, and I've asked the question, in the next pandemic, do people think that mandates are a tool that needs to be in the toolbox? I'm a health guy, I start with, "Well, it would probably need to be there," but there's an array of views about that. Just given your experience and seeing the impact of mandates and the question of the uplift that was necessary in certain high-risk areas, what's your kind of reflection on that? Would you see mandates as necessary in the toolbox, at least to be accessible at need in the future?
JA	Of course, in ideal world, wouldn't it be good if we weren't even asking that question, that you had a health workforce that recognised the importance of vaccine for protecting the vulnerable, protecting immunocompromised, and believed in the importance of vaccines? I'd love an ideal word where we didn't have to use the tool of that nature.
AH	Sorry, can you say that again?
JA	So I would love for us to live in a scenario where it was understood and appreciated, particularly in the health and disability sector, of how important vaccines were to protect clients, and the immunocompromised, and also to build trust and confidence in vaccines. It was more complicated than that, obviously, and so in an ideal world, you wouldn't, but we don't operate in an ideal world. And I remember particularly a real view from those in the disability sector, in particular, about ensuring that they could feel confident that the health professionals they were interacting with had taken measures to try and protect them. That included vaccines, and for instance, the use of face masks. And so we had to hear from them what role we could play to give that assurance as well. Now, there are some in the health sector who supported mandates or at least supported the universal uptake of vaccines, and there are some who did not, but I still think it was important to try and give that confidence to people. Question is how long do they last for? Interestingly, mandates weren't actually, from the final point where people were required to have their second shot, and when they lifted, it was not a particularly long period of

	time. When you look at some of the dates, and I was going through them, I mean, sometimes it was less than six months in some cases, depending on those where we removed them earlier. I think the longest were for healthcare workers in the end. So for instance, where we had mandates for healthcare workers, deadlines to be fully vaccinated was the 1st of December 2021. By September 2022, it was revoked, so less than a year. Education workers were required to be fully vaccinated by 1 January 2022. It was revoked in April, so several months, a term. The issue was, even though it was relatively short that they were in place or told, they may have had a perception of being a long-term tool because we weren't in the position to be able to tell people, "We have a mandate here," whilst we're ensuring that we have enough saturation of people who are vaccinated and that we're protecting the highly vulnerable, particularly in that first wave. We weren't able to really tell people when we'd get over the top of that, when we'd be through it and at a point where we could have a bit more of a tolerance towards COVID in our community, because we'd built up our resistance and we had seen the impacts of that first wave. It ended up being probably quite a bit shorter than people would've anticipated, but we couldn't tell them that. We couldn't say, "Well, if you choose not to be vaccinated, this is how long you may not be able to be in your usual place of work." So I think that with hindsight, it would've been great to be able to give people that sense of the timeframes, but at the same time have enough grace to know it wasn't really advice we were receiving. So we lifted when we received the advice, which was from David Skegg. My recollection is around March we started getting some of that advice.
NL	Thank you.
NL	Do you remember when the advice began to include the fact that the vaccine was not going to be so effective against transmission?
JA	That modelling, I only remember seeing well after. So I don't recall. If we were presented with it, I don't remember it being underscored.
NL	Yeah.
JA	I did make some notes around this. It certainly was never the case, we never ever received anything that said vaccines don't make a difference. Definitely not.
NL	No, no, but they obviously…
JA	And so there was... Yeah. What we were getting was, with Omicron, we are seeing different levels of long-term effectiveness and waning immunity. So we got things like that. But of course, that was through Omicron, and we lifted some of those requirements after the first peak. So I'd like to think that was factored in by our expert advice as well. I made a note - early 2022 was when we started receiving some mention of reduced protection against

	transmission, early 2022. So after you had things like the CPF framework and some of those things in place. That was January and by March, we were moving out of them.
NL	Okay.
DK	I think we've been directed to, or pointed to an article earlier than that, in October 2021, which was suggesting reduced or no effect on transmission, even for Delta, of vaccination or no difference in transmission between vaccinated and unvaccinated for Delta in October 2021. But you're saying you weren't even aware of that?
JA	Sorry, I didn't…
CF	What article is that?
JA	Whose advice is that?
DK	It was a Lancet article, and I'm probably summarising it not quite accurately.
JA	I never received advice that it had no impact.
DK	That's just in your timeframe. Yeah.
JA	I don't believe, and nor do I believe that there would be a scientific basis to argue that it had no effect on severity.
NL	No, no, it's not to do with severity, it's…
JA	I'm interested in the Lancet article because I did read the science weekly, almost every week. So I tried to stay across... So it's not the case... I do want to underscore this here. It's not the case that we didn't see the change. We knew that the vaccine, I mean as I've already referenced, initially, people were saying 70% is enough, then to 90%. So we knew that with each variant it altered. We knew that the vaccine had a different... even the different vaccines were having different impacts. We'd very, very clearly targeted certain vaccines knowing that there were differences between the vaccines and transmission and severity and the level of effectiveness. So we were always aware that this was not an absolute science, but at no point did anyone say vaccination was of no value. And I don't believe anyone says that now.
NL	No, no, they don't. They don't. I think we're distinguishing between-
AH	They definitely don't.
NL	We're distinguishing between the public health benefit of people being vaccinated so much less likely to get COVID, so much less likely to overwhelm the health system, and the situation where if they do get COVID... I think it was believed in the community, as I

	understand it, that a person with COVID, if they were vaccinated, they were much less likely to pass it to another person than a person with COVID who wasn't vaccinated.
JA	Yes. And I remember the debate and discussion over the variants on this. And this is again, I would add it to the number of lists of things where the information was fast moving, the research was fast moving, the modelling. But I think I refer back to Royal Commission One, where overall, the view is that the vaccination saved over 6,000 lives and prevented tens of thousands of hospital admissions. Your question is, "did it have any effect on transmissibility?" I do not remember receiving something that said, if you're vaccinated, it makes no difference to whether or not you're likely to pass on COVID to others. I don't remember receiving advice of that nature.
NL	I don't think it was ever absolute like that, but it was raised as a question. And it just-
JA	If it wasn't absolute, then every time it's a judgement call, isn't it?
NL	Yeah. Yeah. Yeah.
JA	And these things are linked. Of course, if it reduces your level of severity, then you can assume it reduces your, how symptomatic you are, which again impacts transmission. So whilst I recall the discussion around the role of vaccines, because actually it was one of the reasons you saw targets increase, I do remember these were judgement calls. And as I say, that would be another reason why the advice we received was actually that only several months after requiring someone to be fully vaccinated, we were lifting them. If you think about it, it was March. For many, [speaking over] longer, that is true, that was 'til September, but that again was based on advice, which we sought regularly. I'm happy to go back and look through some of what we were provided though. I certainly don't want to… I don't want to recall incorrectly, so happy to go back through.
NL	No, no, that's alright. Yeah, it's… just let me… can I just have a look at that email from I [inaudible 02:06:46]
JA	I think the Royal Commission I think traversed this, the first one, this question, and I don't disagree with where they landed on it. There was, I believe, some modelling that was included in that report that we didn't receive, and understandably because of how movable it was. But yeah, I don't think this is a new debate is all I'll say.
DK	I'm just going back to what you said. The question with mandates was how long? I wonder if you have a thought on if there's also a question about how flexible they can be. And I think there's obvious trade-offs there, but some people... I think we've had even a disability, because you mentioned disability, people calling for it. And we had some, at the last public hearing actually, talk about losing... People who need in-home care and losing

	their carer, and wanting to keep that carer because of the connection, people with autistic children. And so saying that they have supported the mandates absolutely, but would've liked a bit of flexibility there. So that's just one tangible example, but I just wonder if you have thoughts on whether that's even possible.
JA	Yeah, I do. We had an exemptions regime, and that's coming back to one of the points I made around were there areas where I didn't feel we had advice, or where I would've liked to have seen things happen differently, implementation of some policies. And this is no blame intended here. This happens in government. You make a decision, you have an intent behind that decision and then the execution of it moves away from the intent. We had an exemptions regime. I remember being asked questions in the House where different examples were raised, and it was clear to me that actually the implementation of that exemption regime was not as we intended. One of the concerns had been that it was too liberal, and so it was tightened up and centralised and I think there were people who should have been granted exemptions who were not. I'll give you one example. I met someone after COVID had long passed and mandates had been lifted who experienced an incident of myocarditis and did not get an exemption for their second dose. They, of course, should've received an exemption. That was the intent of the regime. But because, she advised me, or at least her perspective was that because there was a question on the exemption form, which of course we wouldn't design, on the form that asked, “are there alternative vaccines that may be used in this case?” And so, if someone had a view that you had Pfizer and you could have had AstraZeneca, then they may feasibly not grant the exemption. That would not have been our intention for someone who had an experience of adverse outcome. So there's one example. I do not believe the exemption regime was operationalised appropriately, no blame, but an observation.
DK	I guess I'm also interested in whether you think that it's even consistent with the idea of having mandates to have flexibility beyond things like medical exemptions. So that autism example is accepting that someone might just not want to have the vaccine, but they wanted to prioritise keeping that relationship rather than have the person not be able to work with them, and they wanted to take that risk themselves.
JA	I would say that that's less of an issue around the exemptions regime and more around the nuance of the mandate.
DK	Yes, that's what I mean, with the mandates is there more flexibility possible or not?
JA	So obviously it applied across the health and disability sector, and I think it's fair to say that the prevailing view was that there was good reason for that. You've raised an example of someone whose perception around vulnerabilities is very particular. And so it's like is it the

	case that we should've had a carve out for those who work in the health and disability sector who may work for a different particular part of the sector? I'm sure the Commissioner, with experience in this area, could cite a number of examples where there would've been those, for instance, in the sector who, for a number of reasons, may not have wanted to take that risk and would've wanted some way to encourage their care workers to be vaccinated that didn't place pressure on the individual. If we had a regime where it, for instance, it came down to an individual making the decision over whether they were worried about their carer being vaccinated or not, that also creates a really difficult dynamic. When you are trying to create national policies, you will have these situations. We tried to create a regime to allow for them. It did not work as we intended. Can I give you an individual response to each example that will be brought to you? Not effectively, but we were mindful of them and we tried to create a general regime that would work for as many people as possible.
NL	Jacinda, is there anything else on vaccines or vaccine passes that you think you can contribute to our review?
JA	Yeah. There was some discussion around the use of vaccine passes, whether they were useful given some of the later evidence in 2021 around, just generally the role of vaccine passes within the CPF framework for one, and whether or not it actually had any benefit in lifting vaccination rates as well. Because of course by the time we moved into the CPF framework, we were broadly speaking at 90%. The point I just wanted to make there was even though it was operationalized late in the piece, it was signalled in October, so people knew about the use of them. So it is I think, quite difficult to say what impact they had on encouraging vaccination. I think it's very hard to say what difference they would've made, but I just thought it was useful to point that out. It was also the view of the Ministry of Health that they reduced the likelihood of super-spreader events as well once they were in use. So even though then we had a high vaccination rate, if you had someone that was with COVID, because the view was it would have an impact on the likelihood of having COVID, obviously, their view still has been that it reduced the role of super-spreader events as we transitioned as well. Just thought it was worth making those points.
NL	All right. Can we move to the communications topic? And I think it's impossible to ask you these questions without thinking about what you've said about your 50 hours of press conferences, but thinking about where that got to. So the first question is that the public-facing communication was often conveyed by and alongside ministers. And we've heard from some people that this may have politicised health messaging. What's your comment and reaction to that?

JA	Well, I think on the flip side, if we think about a scenario, therefore, where we weren't then present for any health messaging, there are some who might argue that it demonstrated a lack of confidence in the measures or a lack of support or a lack of consistency. So I personally don't agree with the view. In my mind, if anything, actually the ideal scenario is that you try and depoliticize crisis communications as much as possible and a pandemic response, I would argue, is part of that. But if we had had absented ourselves from some of those press conferences, would that have raised the question of whether or not we supported them? Would it have led to greater contradictions and less consistency of messaging? There are a number of concerns I think had we not taken that approach. I do draw an important distinction though. We were always very clear that we were not the ones making medical decisions. And so I was going back over some of the press conferences, including when we were about to receive advice on whether or not vaccines should be extended to a younger cohort. A lot of questions about trying to draw out what the decision might be, and pushing back very clearly it's not a decision for cabinet. We receive advice and we have to lean into that advice. We are not health practitioners. We do not have the expertise. We have to build faith in those decisions by taking in the advice of clinicians. And so I'd like to think that we made those distinctions frequently.
NL	So a question about the messaging around the vaccine being safe and effective, which is what's being said. And the alternative way of phrasing that would be that the vaccine meets safety standards and the benefits outweigh the risks. Now, undoubtedly, the second version was said, but that the vaccine was safe is what has been heard. How do you balance the need for explaining the uncertainty that's inherent in some aspects of the vaccine with the need for clarity and with the explanation of the benefits and the risks?
JA	I mean, I think one of the difficulties here is I can't control what people hear. I can only control what I say. And so going back to, I went back to the press conference, for instance, where... Excuse me, I'll just close the window because there's a little bit of construction noise. I went back to the post-conference where, very sadly, on the 30th of August where the confirmation of a death related to myocarditis. And my statement then was, “The first is this is a known very rare side effect with the Pfizer vaccines, and we had- Medsafe had put out an alert over a month ago, and in fact I pointed everyone to that in one of my stand-ups. The risk of myocarditis after the vaccine is a lot lower than the risk of myocarditis after being infected with COVID-19, so that's another point I'd make. And the other key point, and the reason we have put this out there is to make people aware that this has happened, but also to make sure that people being vaccinated and our health professionals are aware that if someone does present with chest pain or shortness of breath or palpitations and they have recently been vaccinated, they should look into it.”

	And so you can see there, and I don't think that this comes across as the conveyance of new information, but again, highlighting the adverse effects, the smaller risks as they are that exist. So that would not have been my first time. I thought it was also worth pointing out that we ran an adverse effects survey. So if you were vaccinated, you may have received this yourself, you'd receive between the 27th of August and the 5th of October. We ran a reaction survey where if you were vaccinated, you'd get a text, and I got this, a text message that asked you, "Did you experience any symptoms after your vaccine?" and 147,000 people responded to this. It was one of the most comprehensive post-vaccine surveys and it was run very, very openly. And so I do think that we were talking about the adverse effects. I do think that we had the nuance, but again, unfortunately sometimes that takes a little more long form in your conversation as well. I don't think reference to the vaccine as "safe and effective" precludes the fact, precludes the notion of adverse effects either. I think I've made that point. So it seems to be that there's this binary view that if you say "safe and effective," you're not taking into account adverse effects. And I'm not sure that I would take that view, but...
NL	It's certainly been one of the things that we have heard an awful lot about. And-
JA	Sorry, that they felt that there wasn't enough nuance in the communication?
NL	No. That they felt that a vaccine with these possible adverse side effects, no matter how rare, should not be described as "safe and effective." And I mean, we can't know exactly where all those people are coming from that have said that, but there is a real theme to it. And even just thinking back on the answer that you just gave-
JA	I think as we make the point, "safe and effective" relative to "being unvaccinated and experiencing COVID" because that's the alternative, I guess. You have this or you have the effects of COVID. And as I made the point in that stand up, the likelihood of myocarditis was greater with post-viral infection of course, with COVID. And we were seeing incidences of children manifesting with myocarditis in some countries, for instance, post-COVID. There was also the long-term, Long COVID effects that were poorly understood and under researched. I remember seeing that we had an increase in Kawasaki disease amongst children. The long-term impacts of COVID were poorly understood. And so in every comms, obviously there's the idea of vaccination versus exposure to COVID and long-term effects. And obviously that was the view of those who were strong advocates of vaccination. But yes, ultimately when we have Medsafe and others tell us that it's considered to be a safe and effective vaccine, then I will repeat the messaging I receive from clinicians.
NL	All right, thank you. You've certainly spoken a lot about your messaging and the question, which I think is now 32, was challenges about consistency in messaging. But I think your

	point is that when things changed, it was important to be flexible enough to respond to that, and so consistency was not always the goal. Is that fair?
JA	Yeah. I mean I think if you're being transparent about what you do and you don't know, people understand that there will be changes, and we were very open that we were learning about the illness and we were sharing everything that we learnt. Face masks were a really good example. I remember through 2020 the Deputy Prime Minister at the time, Winston Peters, being very, very rigorous in his advocacy for face masks and their use. At that point though we hadn't received… the health advice wasn't as strong on it. I do remember really questioning health advisors on that, because it seemed internationally they were really being picked up. And of course, all of the evidence was suggesting that droplets were really problematic and that certain masks when consistently worn was making a difference. And that was something eventually there was a change in position based on health advice and research. But I don't think we would want the case where politicians, they are often in a political environment, which again, I think there's benefit to try and remove the politics of public health measures, but if you change position, it's seen as weakness or flip-flopping. That's the way that changes of heart in politics are often characterised. In a health response, you've got to be able to move with the evidence that's presented to you. And so I felt like we did that, even if we operated in an environment where that's very rarely rewarded.
NL	So were you satisfied that you gave effect to the goal of keeping New Zealanders up to date with the most up-to-date information that you had?
JA	Yes. If anything, we were very present in people's lives. Obviously, people had built a very strong association between me and COVID as a result of that. But I still think that that was important to try and build trust and confidence in the response. So yes, I think we did that. That doesn't mean it was perfect. When you're giving, in round one of the response, over fifty-something press conferences, mistakes are going to be made. And there's one example I know that gets pulled up a bit, and had I known it would be a statement around being a “source of truth,” had I known it would be interpreted in that way, of course I would not have expressed that in that way. But I think that's simply the price you pay for spending a lot of time being very open and frequent in your communication.
NL	Yeah. Do you have a view on the policy of not countering deliberate disinformation, but rather focusing on putting forward the positive, the information that you do know and encouraging people to vaccinate?
JA	It certainly was the advice that we'd been receiving, was that you shouldn't repeat the disinformation least you elevate it. And I think that is based on research and evidence.

	Certainly the analysis dating back to the 1970s around the illusory effect, that if someone is exposed to a false piece of information repeatedly, regardless of the nature of the way that's presented to you, even if it's not presented as fact, the mere continual exposure to it leaves a psychological imprint that perhaps there is truth in it. And so I think that there it's warranted, that idea of not repeating disinformation but rather debunking it or without the repeat, that was evidence-based. And so I think the point that I would make is, we were concerned about disinformation, we were very worried about its impact, but we tried to use an evidence-based approach in the way that we addressed it.
NL	Are there any-?
JA	That research may evolve over time, but I can understand the basis for it.
NL	Yeah. Okay. All right. So we're up to lessons learned.
JA	Oh, one more thing, if you wouldn't mind. I was going back again over some of the press conferences and one example of where we were trying... Very early on, we were aware of disinformation and rather than referencing any specifics, that was where, and this was very early on in 2020, that was where I said, "I want to send a clear message to the New Zealand public. We will share with you the most up-to-date information daily. You can trust us as a source of that information. You can also trust the Director-General of Health and the Ministry of Health for their information. Do feel free to visit at any time to clarify any rumour you may hear COVID-19.govt.nz. Otherwise, dismiss anything else." And that's when I use the frame, "We will continue to be your single source of truth. We'll provide information frequently, we'll share everything we can." So in context, you can see what I was trying to convey. It's not the case though, that we wanted to diminish other experts in the field because, actually, we leaned on them heavily, particularly when it came to vaccines.
JA	We acknowledged that there were those who had a poor experience with the Crown who held long-standing mistrust of the Crown, and I was a representation of that. So we needed to lean into other experts to convey messaging on the vaccine. My statement there was not intended to undermine that in any way. So that's an example of something over the course of 50 hours may have been poorly expressed, but in implementation, you would've seen that we tried very hard to use those alternate and additional sources of advice that were trusted within different communities.
NL	Anything else on the communication issues?
JA	One thing that I think is really important that governments look into was the evidence that demonstrates New Zealand's consumption of disinformation was higher than those we

	would usually compare ourselves to. So Microsoft's analysis is that our consumption was 30% higher in New Zealand than Australia or the USA and that it peaked during the occupation. I'm interested in why New Zealand consumed disinformation and often it was even credited as being specifically Russian disinformation, at a higher level. I think it might be a distraction to look at why New Zealand was targeted because I'm not sure that Russian foreign policy would target specifically New Zealand as opposed to a general approach of chaos and disruption. So I'm not thinking it's fair to say that we were specifically targeted, but why were New Zealanders consuming at a higher rate, and what are the protective factors we can build in in the future? The example we're dealing with right now is COVID. There will be future examples, and I think it would be to our benefit to understand specifically what happened for us in that experience so that we can address it in the future.
NL	Anything further on those communication issues?
AH	Nothing from me, thank you.
NL	No. All right. What else have you got in those press releases?
JA	Well, you give me a subject and I'm sure I could go back and find something. Yeah, my memory's still there on it. That happens with trauma.
NL	Where are they now? They're not on the COVID website, are they?
JA	Anything that's publicly available you'll find often in... So all of the transcripts of my press conferences are all publicly available. Scoop would provide the transcripts. Scoop continue to hold a number of all the press statements. My recollection is that the Beehive, yes, you can search through the Beehive website.
CF	You can go through the Beehive records, yes.
JA	Yeah, the Beehive website.
CF	Mine are still there. I think mine is still there. But Nicolette, if you want to send me a list of what you would like, I'll coordinate an answer for you.
JA	Yeah. And even if it's just this particular statement, we can provide the wider transcript that sits around it because often, as is the case with all of these things, sometimes the context makes a difference.
NL	Yeah, yeah. All right. So I think you've covered some lessons learned as we've gone along. What were the things that went the most right in your opinion?

JA	I always see COVID in two phases. And I think as difficult as it was, and I think some commentary may forget how difficult it was, phase one, I think, is generally viewed as most people seem to coalesce around that as being a relatively successful approach. Phase two, the transition when we dealt with the most difficult variant was, as I've said, difficult. But again, I don't think anywhere in the world found... even if their transition was easier, it was because they'd lost so many vulnerable people. Their phase one was characterised by long-term lockdowns, children missing a year of school and the loss of hundreds of thousands of lives. And so as much as we may be comparing our phase two to what other countries were experiencing at that time, but having come through a much more difficult phase one than we were doing. Lessons. The other point, the reflection I'd make is the context in which we make decisions might not be the context in which those decisions are then reflected upon. So I think hopefully I've made the point that whilst there's a lot of focus on vaccination and the rollout, there's not often a reflection on where the mindset was at that time and the extraordinary pressure that existed. Of course, it's up to any government of the day to make a decision regardless of the pressure based on evidence and advice. And I'd like to think that we did that, but I just think it's important to note that context at that time because it's very different to the context in which now it's been judged. My other reflection I think was around just the implementation and what's on paper and then the way it's operationalised. We saw that a bit with MIQ as well. I know that's slightly out of scope of what you're doing, but the best laid plans can still be difficult on execution. Those are, I think, some of the... Otherwise, again, as I say, Royal Commission One spent a lot of time digging into some of the more detailed sections and I don't disagree with where they landed. Final thought, I've said this a few times before that we had two goals. One was, of course, to save people's lives and lessen the impacts of COVID economically, socially as much as possible. But the other was to keep people together. It was in the criteria we had when we were making decisions. Social cohesion was a factor we thought about all the way through and it was incredibly difficult. But one of the reflections that I have is that social cohesion still applies a degree where we're able to have debate and dialogue. And for some of those, some who have taken a very adverse view on what wasn't a perfect approach by any means, but an adverse view on the government's response, some have a view of COVID that is not based on evidence, that is not based on research, not based on generally a shared understanding. Some believe COVID didn't take lives. Some believe COVID was a hoax. Some believe that the vaccine took more lives than COVID did.

	Some believe the vaccines were part of a grand government conspiracy. So there is a diversity of views in those who take a view against the government response. And so I find that one of the difficulties in the aftermath is trying to really reflect back on the things that could or should have been done differently whilst acknowledging there are some for whom that engagement will never be satisfactory, because the position that they've taken on the pandemic is so vastly different than the remainder of the population. So yes, I wanted social cohesion, but were the foundations of it there to be able to sustain it? I don't know. Don't know. When vaccines are the answer, is complete social cohesion an impossible goal? Because New Zealand has experienced splits and divisions on vaccines before. And I remember the 1990s, I was in the cohort that was brought in for the refresher of the MMR. I remember the autism debate, I remember children being excluded from the rollout of that vaccine. I remember it being vicious and difficult and that never was resolved, and that still existed when it came to the vaccines that were rolled out during COVID. And so when vaccines are at play, when you have the ability of information and disinformation to spread rapidly, when you have existing distrust in government, is social cohesion possible? I don't know.
NL	One of the groups that we have spoken to is a woman who has collected reports of adverse vaccine reactions and she doesn't scan them for validity or anything like that, but she's got more than 100,000 people on her list. And her message is that these were people who did trust but have suffered what they believe to be vaccine injuries. Is there a way to talk to those people today?
JA	Yeah, I'm sure. You make an important point that obviously maybe let's take it as a general question as opposed to having to apportion a number to it. But of course there should be. I think the importance is how do we have that conversation without the absolutes that might be prescribed by others? So there's an assumption that we never took into account... I spoke in press conferences about myocarditis. I remember equally having to dispel a vicious disinformation piece that started around a young girl who lost her life and it was causing extreme distress to her family that there was a claim it was based on the COVID vaccine. So the difficulty is, of course, that communicators during that period were having to talk about the Medsafe advice, encourage vaccination, dispel disinformation all in the one piece. So it was very complex. I think a reasonable effort was made. But for all those who were trying to report adverse events, and we were seeking that as I expressed with the text and trying to get that information, our regular reporting on the vaccine rollout included adverse events. I would see every day someone who reported an

	adverse event and oftentimes you were getting things around myocarditis being of course, one of the most adverse, but otherwise dizziness. So we saw that reported, but we also had people claiming that it was taking hundreds of lives, which was not true. So when you're in an environment where even in this line of questioning, you're asking me, "Did you do enough to dispel that whilst at the same time not talk in absolutes?" I believe we tried to walk that line. I believe we tried to acknowledge adverse effects without overstating adverse effects as some others who stood against vaccines may have tried to do. So it was a fine line and a hard one to walk.
CF	I must say Jacinda's answered that question, which was very broad, as best she can, but you haven't put any particular material to her or given us an opportunity to assess the accuracy of the methodology of this lady or anything like that. So I just note that.
NL	No, I understand that.
CF	It may well be based on her own obsessions or her having anecdotes around the place. We just don't know. But Jacinda's answered that question as best she can, given the generality and the vagueness of it.
DK	I think Nicolette mentioned this woman didn't have any methodology. She accepts people's claims.
CF	Oh, there you are. That just adds to what I've just said.
DK	Yeah. I think the question was can we talk to these people who are attributing those things to the vaccine now rather than-
JA	My point is that we were actively, at the time, seeking that information. I remember someone, a practitioner at the time, saying never before have we sought out the degree of information and collated that degree of information in a vaccine rollout as we did with COVID. I think the question you may be implying is were we too dismissive? I'd like to think we weren't, at the same time remembering there was an environment though where, just one example, it was during the vaccine rollout and I was doing a groundbreaking event in Hamilton where there was a group of people who'd gathered outside that event, and for 30 minutes straight chanted “Murderer.” So we were trying to operate in the middle, and that is where that woman is asking us to have operated, in the middle. But at the same time, we're on the extreme and we were having to try and send some clear and consistent information in that environment as well. So that’s very, very difficult.
	[redacted]

JA	So the government decision-making. Yes.
NL	Were you satisfied with the institutional and advice arrangements during ’21 and ‘22?
JA	Yeah, the fact that you saw the arrangements and the infrastructure altered demonstrates that we, of course, saw room for improvement. And so was I satisfied? I was satisfied that people were working to the best of their ability to meet the expectations. They weren't always being met and the alternate arrangements were formed as a result. But I think it's probably quite well-traversed in the Royal Commission round one.
NL	And the division of roles and responsibilities between DPMC and Ministry of Health?
JA	Yeah. Initially, not quite right because the Ministry of Health became the lead agency. And as you have demonstrated, and as I've tried to demonstrate, there are a range of factors we were needing to take into account. They were the most important when it came to providing information around the public health implications of lockdown decisions and so on, hospitalizations, all of those health-based consequences. But we needed to factor in a range of issues in our COVID response. And so DPMC were best placed to help provide that all-of-government approach. And of course, we moved to an all-of-government institutional arrangement to better cater for that over time.
NL	Did you receive and respond to alternative perspectives on managing the pandemic? You've explained that business was very keen for the immediate lockdown. Were you approached by groups that said, "No lockdown, just let this thing run"?
JA	Oh, you could see that obviously there were those who would've held that view certainly, and I was aware of every public debate that was being had at that time. The view of those who believe that all of our elderly people should be placed onto an island. There was, of course, those who believed that we should take the Swedish approach. So any international approach would often be put to us as an alternative. Should we be like Sweden? Should we be like the UK? Then of course there was often references to whether or not we were more or less like Hong Kong or Singapore. So the full ambit of approaches would be put to us at various points. So even if you don't see it traversed in the final formal cabinet paper, we were very aware of alternate approaches. We saw the modelling of different approaches. If you didn't have a lockdown at this point, this is what your R value would look like. So we knew the impact of the alternatives. And so I do believe that meant that broadly speaking, we were always considering, if not this, what would New Zealand look like? The one thing to keep in mind is no one could exactly... Sweden would never be an accurate reflection of how that same approach would work in New Zealand.

	We have a different demographic, a different demographic profile, a different age profile, different comorbidities more present in our different communities and different obligations from a treaty perspective as well.
NL	Yeah. Okay. Look, that has been so helpful. Do you have any additional questions?
AH	No. Look, thank you, Dame Jacinda. It's been just so profoundly helpful to the inquiry. And let me assure you, we do have a completely open mind. Our questions aren't designed to elicit or propose a position, they're not, we're just asking questions. We're very much focused on learnings and New Zealand did an extraordinary job through that time. Some things went incredibly well, some things could be done better, but it was a phenomenally complex environment and many of the population are extraordinarily grateful for how well we did. And this is a good thing, and we are very keen to learn as we look ahead and that is very much our focus.
JA	Absolutely. Yeah. And in that vein, look, after this, of course, if you go away and there's anything else, you've got more questions, please don't hesitate. I don't consider this to be a one and only opportunity for us to engage. I want to be helpful because I want New Zealand to be as best placed for any future challenges as we possibly can be. And we've got to reflect on our own experience if we're going to do that. So I want to be as helpful as I can in that regard.
AH	Thank you. Appreciate it.
JA	Thank you very much. [inaudible 02:55:00].
NL	We've lost you there. Luckily for the first time, we can't hear you.
JA	Thank you. I won't say that it's ever been that enjoyable to talk about COVID but I appreciate your time. I was just going to say I appreciate your time.
CF	Thank you. Good night.
NL	And we very much appreciate yours. Thank you very much.
AH	Thank you very much indeed.
NL	Goodbye.
JA	Thank you.
End of interview	