Friday, 10 May 2024

(10.00 am)

LADY HALLETT: Ms Dobbin.

MS DOBBIN: My Lady, may I call the first witness, please, for today, Professor Sir Michael McBride.

PROFESSOR SIR MICHAEL McBRIDE (sworn)

Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 2C

MS DOBBIN: Can I ask you to give your full name to the Inquiry, please.

A. Professor Sir Michael McBride.

Q. I think that you ought to have before you, Sir Michael, three statements. The first statement which you made, I think you signed on 24 July 2023; is that correct?

A. That's correct.

Q. And I think that you've signed that statement at page 88. Yes?

A. I don't have the page in front of me, but I accept that I did.

Q. You probably recall you signed it there.

A. Yes.

Q. I think it's in front of you now. Are you content that that witness statement is true to the best of your knowledge and belief?

A. Yes, I'm content that that's a full and accurate statement.

Q. Then I think the next statement that you made is dated 6 March 2024, and that's a statement that comes to 366 pages, and I think again you signed it on that date. Again, are you content that that statement is true to the best of your knowledge and belief as well?

A. I am content to affirm that, yes.

Q. Then you signed a third witness statement on 22 March 2024. Again, may I check that you're content that that witness statement is true to the best of your knowledge and belief?

A. Yes, I can confirm that.

Q. Sir Michael, in terms of your career, if I may start there, I think that you first of all qualified as a medical doctor in 1986; is that correct?

A. That is correct.

Q. That you developed a specialisation in research into and the treatment of HIV; is that correct?

A. That is correct.

Q. And I think that you worked for some time at St Mary's Hospital in London; is that right?

A. That is correct, yes.

Q. Then you returned to Northern Ireland and practised in that field from 1994 until 2006?

A. That is correct, yes.

Q. Thereafter, you led and co-ordinated the response to the

H1N1 pandemic in Northern Ireland?

A. That is correct as well.

Q. And then I think after that point, you then -- your career perhaps took a different path in that in 2002 you were appointed the medical director of the Royal Group of Hospitals; is that correct?

A. That is correct.

Q. Thereafter, in 2006, you became the Chief Medical Officer for Northern Ireland.

A. That is correct, yes.

Q. Then from March to August 2009, you were the permanent secretary to the Department of Health in Northern Ireland?

A. That is correct as well, yes.

Q. And also, you were the chief executive to the Northern Ireland Health and Social Care. Is that trust or board?

A. Trust. It was the Health and Social Care Trust. It was the Belfast Trust.

Q. All right. Is that an arm's length body of the Department of Health?

A. It is a provider or organisation delivering health and social care, which is an arm's length body from the department.

Q. Then I think that from November 2014 to February 2017,

you were the chief executive. Is that of the Belfast Health and Social Care Trust?

A. Yes.

Q. Then I think in July 2021, you were made an honorary professor of practice at Queen's University Belfast; is that correct?

A. That's correct.

Q. I just want to come back and understand, if I may, a bit more about your role as the Chief Medical Officer to Northern Ireland and how it compares to the UK CMO, Professor Sir Chris Whitty.

In terms of his role, first of all, he acts as an adviser to the UK Government, doesn't he, as opposed to just the Department of Health and Social Care in the United Kingdom?

A. That is correct, yes.

Q. I think that it's also right that his position is an independent position at permanent secretary level; is that your understanding?

A. That is correct. That is my understanding, yes.

Q. I think it's right that, by contrast, your position is not an independent one within the government in Northern Ireland; is that correct?

A. There are two aspects to that. In terms of my policy responsibilities, which is where it differs, I am not

independent in terms of policy responsibility; I'm accountable for that to the perm sec in the department.

In relation to my professional advisory role, it would be akin to that of Professor Whitty in providing independent advice. My advice as Chief Medical Officer is directly to the minister, to the perm sec, so it is independent and independent of -- shall we say it's given freely, without an -- unfettered in terms of professional advice, so it's similar to the situation with Professor Sir Chris Whitty in that respect.

Q. Can I see if I can understand that a bit more?

A. Yes, sure.

Q. Because, in fact, you are and you were at the time of the pandemic a member of the senior management team within the Department of Health in Northern Ireland. So in terms of your functional independence, you're not functionally independent of the Department of Health, are you?

A. No. In terms that, I don't have a separate office per se, and I am part of the managerial arrangements within the department. So I'm a member of the senior management team, which in the department is referred to as the top management group. I'm a member of the departmental board, but separately I also have a professional advisory role and responsibilities, and

within that, my group, I have also the Chief Dental Officer, Chief Pharmaceutical Officer, the Chief Environmental Health Officer, and we provide independent professional advice, not just to the department, but also we provide independent professional advice with the agreement of the minister to other departments when that's requested.

So there is a separation, and that -- you know, when I'm providing professional advice, I'm very clear, and others are very clear, I'm providing independent, professional advice.

Q. It might be thought very simply that you can't provide independent advice to a department or organisation that you are part and parcel of.

A. I can understand that perception. I can assure you that over the years I've not -- as I said earlier, I've not felt that in any way my professional advice has been compromised or has been in any way filtered. And I give my advice, my professional advice, freely and directly to the minister.

But I understand the perception and that conflation of policy responsibility and accountability, and then separately the professional roles and responsibilities. And I'm conscious it almost seems like I'm trying to wear two hats, you know, both at the same time, but I'm

very clear in my mind, the department's very clear, and I'm giving professional advice. I'm giving independent professional advice.

Q. I want to examine that, if I may, in a little bit more detail --

A. Sure.

Q. -- and look perhaps in a bit more detail at your role and the advice that you gave.

But just, again, trying to understand where you fit in, in terms of the management structure, to whom were you accountable within that structure?

A. I'm accountable to the permanent secretary in the department. I'm also ultimately accountable to the minister in the department, whoever that minister might be at the particular point in time.

Q. In terms of who you had management responsibility for within that structure, who reported to you, or who were you the line manager of?

A. In terms of policy roles and responsibilities, those have evolved and changed, and they continually change within the department, but the time of the relevance to the Inquiry, I had policy responsibility for all aspects of public health, so that would have included health protection, health improvement. I also had policy responsibility for quality and safety and policy, so as

that pertained to, for instance, serious adverse incidences, investigation processes and policy, complaints policy. I also had policy responsibility for research within health and social care and was supported very ably by the Chief Scientific Adviser who you heard from recently.

So those would be the main areas of policy responsibility. And I also had a number of other roles within that, including sponsorship responsibilities on behalf of the department which I exercised in relation to the Public Health Agency, which is the public health --

Q. I'm just going to ask you to slow down slightly --

A. Okay.

Q. -- because you're speaking quite quickly.

So I think what you've -- you've delineated your responsibilities --

A. Sure.

Q. -- in terms of the areas that you had direct oversight of within the Department of Health, the issues or the areas that you've just gone through, and I think you're separately then saying that you had sponsorship responsibility --

A. Yes.

Q. -- and I think that was for the Public Health Agency in

Northern Ireland and the RQIA as well; is that correct?
A. That's correct.
Q. And I think we'll touch upon the RQIA in due course, but that's the body that has oversight of, I think, or is the regulator of health and social care services in Northern Ireland; correct?
A. Correct.
Q. And also has -- exercises those functions in respect of care homes and nursing homes as well.
A. That's one aspect of the work, but yes.
Q. We'll come back to that. I just want to focus and continue to focus on your role within the Department of Health.

Can you help me as to whether or not the advice that you provided to the department during the pandemic, or indeed generally, whether that advice is shared with the minister and the permanent secretary, or cleared by the Department of Health or the minister before it is shared with the Executive Office?
A. As I say, I -- my role is not a cross-government role, and that's where it differs from -- you mentioned Professor Sir Chris Whitty. It is a role within the department. The advice that I'd be providing is health advice. Normally what happens within Northern Ireland Government is that a minister would write to another

minister in another department and seek input from officials within their department. So I would provide my advice. It's not cleared by the minister, but the minister would be aware that I would be providing advice to another department, and, as I say, that advice is provided and it's not filtered or cleared as such, but in that it is health advice, the minister would have an awareness that I was providing that advice.
Q. All right. I'll come back and look at that again in a bit, we'll go to some specific --
A. Sure.
Q. -- documents and perhaps examine that.

When Sir Chris Whitty gave evidence to the Inquiry, he referred to the fact that his independence was a prized aspect of his role and gave evidence about the Office of the Chief Medical Officer in the UK, and this characteristic of its independence going back to the 1860s.

Was it not regarded as perhaps anachronistic in Northern Ireland that the CMO should both -- not just be within the Department of Health but actually an intrinsic part of the management of that department as well?
A. I mean, that's the structure that I was appointed into. It wasn't a structure of my design, and I think that

it -- probably also relates to the relative size of Northern Ireland. We often have individuals covering multiple roles because essentially we are a very, very small department, and we don't have the numbers of individuals to separately cover a range of issues. And, I mean, that became a material issue in terms of resilience during the pandemic response itself.
Q. But in terms of the suggestion, I think, that you're making that you could effectively decouple your role into a non-independent one and an independent one, is that not obviously problematic in a number of respects?
A. I mean, I can see from the outside looking in, I absolutely accept the point that you're making. From myself, working in the role over many years, that was a distinction that I was very clear in my own mind in terms of my policy responsibilities and lead role, and my responsibilities, my professional responsibilities as Chief Medical Officer.

I mean, if I could expand to make your point, there are some inconsistencies with that, for instance. So if I take one of my areas of policy responsibility, which is health improvement, addressing health inequalities, I have passionately spoken about health improvement and health inequalities over many, many years, and the disparities that there are in terms of health outcomes,

healthy life expectancy, depending on where people live, you know, the circumstances in which they are born, they live, they grow up and they're educated. But at the same time, the policy responsibility for health improvement sits in my group of which I am the head. So, I mean, I think that's -- just illustrates, I think, the point that you're making.
Q. Yes.
A. However, I was always clear in my own mind when I said we need to do more professionally to address health inequalities, to improve people's life chances. I spoke freely and again unfettered when I was speaking professionally about the need to do more, not just within Health, but to do more across government, collectively, to deliver improvements in the health and wellbeing of the population, and to address health inequalities.
Q. I'm just going to look at this, if I may, through the lens of the pandemic --
A. Sure.
Q. -- and why it might be regarded as potentially problematic that you were a part of the Department of Health.

It may be very obvious, but, I mean, obviously there's the objective perception, perhaps, on the part

of others, and perhaps most importantly on the part of other ministers, that they would regard you as speaking for the department as opposed to giving them independent advice. Do you agree that that's something that was potentially problematic and indeed may have become problematic during the course of the pandemic? So that's two questions.

A. I can accept that there is a perception. I mean, two of the ministers I'd previously served as health ministers, who were part of the Executive, so they would have known -- you know, the deputy First Minister would have known that clear separation. The then minister for DAERA was also a previous health minister. I think that the -- but obviously ministers will be better able to speak to this.

My understanding throughout the pandemic was they regarded the advice that I and the Chief Scientific Adviser were providing was provided independently, and I say that -- I mean, I can understand that when -- perhaps some of the more challenging periods that there may have been a perception that somehow or other that there was a conflict in the role. But certainly that was never a conflict that ... I mean, I gave advice, professional advice, and obviously I had a close working relationship with whoever was the health minister, but

equally I had good relationships with other Executive ministers who I would have known over -- over many years.

So I -- my sense, but, as I say, others will be better able to comment, was that the independence of the advice that myself and the Chief Scientific Adviser was providing was both understood and was respected.

Q. I think that those might be different things, though, and, I mean, I think -- I mean --

A. Sure.

Q. -- we may hear more evidence about this from the First Minister and the deputy First Minister, but I think we've maybe had a flavour of it from some other witnesses, and I'm thinking of Sir Peter Weir, who gave evidence about the power wielded by the Department of Health, and appeared to encompass you and the CSA, the Chief Scientific Adviser, within that sort of block.

Is that something that you recognise or perceived at the time?

A. No. I mean, the power and authority is vested in ministers. Ministers are the decision-makers. They determine policy, which is right and appropriate. My role and the role of the Chief Scientific Adviser was to provide advice. We provided that advice, but the medical and scientific advice was only but one aspect of

the many other factors that ministers needed to consider, and the Executive needed to consider before arriving at a decision.

I mean, I was very clear at every stage that ultimately the decisions were decisions for ministers. And I have to say I'm somewhat surprised if there was any perception to the contrary.

Q. All right. Well, we'll come to look at that. But again, just focusing on the reasons why it might potentially be problematic that you were not independent of the Department of Health, isn't it extremely difficult, and human, to -- that you would be able to, as it were, decouple your professional advice from the operational concerns that the Department of Health had and would have during a pandemic? So, for example, the sorts of operational concerns about which we've seen a great deal of evidence would inexorably colour the advice that you were going to give to ministers?

A. I think that that proximity and awareness of some of the operational issues, some of the consequences of the pandemic across health and social care, the pressures on the health service, the outbreaks in care homes, I think that was an advantage in terms of in shaping and informing the advice. I don't see it as disadvantageous. I think it ensured -- as a very small

system we have very close lines of communication, and therefore there's a high level of awareness of what the pressures in the system are, and I think that was of benefit in informing the advice that I was providing, and its relevance. I don't see that as a disadvantage at all.

Q. Moving on in terms of this Inquiry and the work that was done for this Inquiry on the part of the Department of Health, obviously you've provided your statements and put in a huge amount of work into providing the Inquiry with those. But did you also have a role in the preparation of the departmental corporate witness statement?

A. Only insofar as it related to my areas of policy responsibility, not in matters of opinion or views. So, take an example, where it came to input on departmental policy in relation to health inequalities, yes, I would have provided input into that. But the corporate statement is a corporate statement and covers many, many other policy areas across the department for which I didn't have policy responsibility, and covers the responsibility of not just myself but other professional colleagues within the department.

Q. I think, again, I just want to be clear about this, I think the answer is yes, then, that you have

contributed to and informed the corporate statement on behalf of --

A. Well, I think the answer is a qualified yes. It's qualified to the extent that, where it was relevant and appropriate. I mean, was I signing off and clearing the corporate statement? No, I wasn't. I was providing input, given my policy responsibility, in the same way that other professional and policy colleagues would have provided input to the corporate statement. I wasn't holding the pen on the corporate statement.

Q. All right. And did you have a role in the preparation in the same way in any of the other witness statements that were provided to the Inquiry on behalf of the Department of Health? So, for example, Mr Pengelly.

A. I -- no, I didn't provide any input at all into Mr Pengelly's statement.

Q. So is it just the corporate witness statement then?

A. The corporate witness statement in relation to my policy areas of responsibility.

Q. So I think in terms of the Department of Health response to this Inquiry, and your response, there isn't a clear line either, that distinction is somewhat blurred in that regard?

A. Well, I mean, I think the -- I mean, I think I've clarified the relevance of the input that I provided.

Now, I would add that the input was provided by my team, you know, so it would have been policy colleagues within health protection, policy colleagues within health improvement, you know, policy colleagues within the vaccination programme. And they report to me, but, you know, they were doing the detail input. You know, I just wouldn't have the capacity to provide the input. But, I mean, they do report to me, and I think that, you know, I've been clear that there was appropriate input, I would suggest, in relation to those areas for which I ultimately had policy responsibility.

Q. I'm going to move on, if I may, and deal with a different topic, which is the absence of the Chief Scientific Adviser. Perhaps if I start with an email, please.

If I could bring this document up on screen, it's INQ000047559. I think if we could go to page 4 of this document, please.

And I think it's -- yes, it's the document of 25 January 2020, Sir Michael. We can see that it's from you. And I think it's sent to the UK CMO group; is that correct?

A. Yes, I can confirm that's correct, yes.

Q. I think we've seen this, or we've certainly referred to this email before, but at the final paragraph you say:

"... a massive thank you to Chris [I think that's obviously Sir Chris Whitty], Jonathan [I assume that's Professor Van-Tam], DHSC and PHE colleagues. As ever you are/will be doing a lot of the heavy lifting for us and providing much appreciated expert advice."

Thank you, that can come down.

Does that email capture the relationship between Northern Ireland, or you, and Professor Sir Chris Whitty at the start of the pandemic, or was that generally the relationship, that the United Kingdom experts, as it were, would be doing the heavy lifting for Northern Ireland?

A. I think the latter. I mean, I can expand on that if it's helpful. What I was referring to there was the fact that Northern Ireland does not have an equivalent of the -- of SAGE. I mean, it wouldn't be technically or scientifically feasible for us to replicate the expertise within SAGE, nor would it be operationally necessary.

So as part of the UK we are critically dependent and plug into SAGE, its subgroups, including NERVTAG, for expert professional advice, and, as I say, we would not be able to replicate that in Northern Ireland. And I think the same would apply to other jurisdictions, to a greater or lesser extent. You know, Northern Ireland

is relatively small, and to ensure that we have the best available scientific advice it's important that we make best use of those established networks.

Q. Although nonetheless you did have a Chief Scientific Adviser, but the Inquiry understands he wasn't called on at all at the outset of the pandemic until he came back. I should be clear about this, he went on leave in the middle of February. But he wasn't called upon to be part of the response in Northern Ireland at all at that point?

A. I wouldn't be inclined to read too much into that, and maybe I could explain the context.

As the situation was evolving, as all new pathogens as they emerge the initial response is a public health response, so on an ongoing basis there's active surveillance globally for the emergence of anything that potentially could become a threat to human health. That arrangement, UK is plugged into European arrangements and WHO arrangements.

At this stage, this was, you know, a watching brief on a new and emerging pathogen. The primary focus was the public health focus on it. So in England that was being co-ordinated by what was then Public Health England, in liaison with the public health bodies in each of the jurisdictions in the UK.

What subsequently evolved then was the stand-up of what we refer to as an incident management team. So this is basically the public health organisations and professionals watching, seeing the picture as it emerges, determining what, if any, steps need to be taken.

So it was being managed initially, in the very early days, through that lens. And it was only then, once this became a -- recognised as a potentially greater threat, that we, as chief medical officers, became involved. And then only later, again, when the science started to emerge that -- you know, because in those very early days we knew very, very little about this virus, there was very likely scientific data available to us.

So incrementally science and the, sort of, public health response became very much integral, because understanding the science was key to understanding the virus, which was key to the public health response.

Q. When you say -- sorry, I didn't mean to cut across you. When you say that "in the early days", what period are you talking about?

A. I mean, it's hard now to cast one's mind back, but certainly my recollection is that, you know, I first received emails about this novel pathogen somewhere

either late December or early January. I recall there was -- a press statement went out from Public Health England I think around maybe the start of the second week in January about travellers to China in relation to this novel virus, and also in relation to avian influenza at that time, of which there was also concern. So it's probably in that initial period around early January, in the first couple of weeks in January, from recollection.

Q. Yes, but by 24 January, the UK Government had convened COBR --

A. Yeah.

Q. -- and, at that stage, obviously, that was gathering together a much broader spectrum of people from across government --

A. Indeed.

Q. -- including the Chief Scientific Adviser to the government. So why, at that stage, did that not prompt the thought: we could do with having people in Northern Ireland and more people than me involved in this in Northern Ireland in terms of that --

A. Well, I mean, just to answer your question --

Q. -- advisory role?

A. Just to answer your question, it wasn't just me. I mean, I was very ably supported by, at that time, two

deputy chief medical officers, both of whom were publicly health trained, both of whom were trained in clinical epidemiology. I also had two senior medical officers who similarly were public health consultants and were trained in clinical epidemiology and had experience in managing a significant number of outbreaks of various infections over the years. So it wasn't that there was an absence of scientific input or advice to me; it was basically -- at those early days, it was primarily from a public health perspective because, again, what we were seeking to ascertain at that time was what the public health implications of this might be.

Now, I think that I would say that, on reflection, and I genuinely now don't recall whether I did have conversations with the Chief Scientific Adviser at that time, but on reflection, if I didn't, it does now seem a bit of a gap, I would agree. I didn't feel it was a gap at that time. I felt significantly comfortable in the information that I was being provided with, my ability to interpret that information, and the support that I was receiving from my team in interpreting that information.

I think it also goes to the point -- one of the points I made earlier which is that -- one of

resilience. The Chief Scientific Adviser role in the department is a part-time role, and, you know, he is -- works three times a week in the department but has other responsibilities. And you alluded to -- maybe I'm getting ahead of the question, but he was absent then for a period, and his absence was both unpredictable and sadly unavoidable at that time. So I certainly welcomed his return, and certainly that was a great source of scientific advice and support, in terms of the advice that I was providing and over the course of the next couple of years.

Q. But just focusing on that, we've already heard evidence from him that there was no modelling capacity until he returned and you asked him to undertake that work, and that there was no independent advisory body to Northern Ireland, and to you, in order to inform the advice to the health minister until -- I think it was 27 April that that met for the first time.

Sorry, just in terms of the question, then, it might seem surprising that what might be thought as fairly fundamental parts of the response to the pandemic were contingent upon an individual coming back from leave and that there wasn't a system response but rather an individual response?

A. I'm not sure that's a fair characterisation, if I might

say so. I mean, I think that in relation to the scientific advice, we were and were receiving -- you know, from 24 January, we had -- and I think you showed it in that email chain -- we had regular four UK CMO meetings from 24 January, and they were specifically on the emerging threat of Covid.

Those meetings were happening three times a week in 2020, and indeed over the period of this Inquiry, there were 274 of such meetings. So there was regular engagement, and we were receiving and discussing all of the relevant science and public health -- and considering the public health implications on an ongoing basis.

In terms of modelling, in those days -- in those early days, the problem was absence of hard data to do specific modelling, and as no doubt we will maybe come on to later, what we were essentially using was reasonable worst-case scenario planning from seasonal flu and using that to project the potential impact for planning purposes and for modelling purposes in terms of -- you know, at a UK level.

I mean, in those early days we didn't even have, and SAGE did not -- SAGE and SPI-M, which was the modelling subgroup of SAGE, was not able to do regional specific modelling for Scotland or Northern Ireland; it was

actually doing UK-wide modelling.

Q. Okay. Can I --

A. There's an important point, if I may, on the modelling --

Q. Of course.

A. -- because we had no cases in Northern Ireland, so we had no hard data to do any Northern Ireland specific modelling at that time.

Now, the Chief Medical -- or the Chief Scientific Adviser returned at exactly the right time when we did have local data, and therefore we could do local modelling. So I think that is a crucially important point.

And the other point I would make is: there was modelling capacity within the PHA, but it wasn't to the sufficient extent that we could scale it up quickly enough, particularly given the other demands that were emerging on the Public Health Agency.

Q. I will come back and touch upon the demands on the Public Health Agency, but I wanted to focus on the structures in Northern Ireland --

A. Okay.

Q. -- if I may, just for a moment. And coming back to my question, which was whether or not the response was driven by individuals rather than by a system response.

I think it's right that Northern Ireland didn't have any membership of SAGE at that point.

A. That's correct.

Q. It didn't have any membership of SAGE until the Chief Scientific Adviser came back; is that correct?

A. It --

Q. And he was the person who became a member.

A. Well, I mean, if I could clarify, and I'm conscious we didn't get to answer -- the second part of your first series of questions was about the scientific advisory group in Northern Ireland --

Q. Yes --

A. -- so maybe we'll come back to that.

We did have observer status on SAGE, as did other jurisdictions. You're absolutely correct, we didn't have membership. I do think that was a disadvantage in the early days of the pandemic because it is one thing being present and listening to the discussion and debate; it's quite another thing interjecting and contributing to that debate. So I think that was a disadvantage in the early days. And certainly on the Chief -- or the Chief Scientific Adviser's return, we did have a discussion, and we agreed that full membership of SAGE was crucially important, and that was agreed to by the SAGE secretariat. I think that was

certainly an advantage and remained so throughout the pandemic.

Q. But in terms even of observing what was happening at SAGE, I think it's right that there was no Northern Ireland observer or -- that no one's certainly been able to confirm -- that anyone observed the first five meetings; is that right?

A. Well, we weren't invited to the first five meetings, which is a different point again --

Q. Yes --

A. -- and maybe you want to return to that. We were only invited to -- we received invitations from 7 February, which was after the fifth meeting of SAGE. Now, I would qualify that again by saying that, as the four UK CMOs, we had been meeting from 24 January, so there wasn't any sense that what was emerging, in terms of the concerns or the consensus or recommendations from SAGE wasn't being relayed by Professor Sir Chris Whitty to the other four CMOs.

However, I think it is correct that we were not hearing that discussion and that debate in real time.

Q. I think that -- and I want to be fair about this, because I think the Department of Health has confirmed that a trainee medical adviser did observe some of the SAGE meetings, and you did as well, but not all of them.

A. Well, if I could bring you back to -- I mean, I think it's now impossible for me to convey fully the pace, the momentum, the multiple demands, the competing demands and diary pressures that there were, and in a department the size of the health department in Northern Ireland, those were extreme. And particularly in that early period, and certainly I can confirm and I think we have confirmed with the Inquiry, that in the period in February through to March, the Chief Scientific Adviser's return, I personally attended eight of the 14 SAGE meetings, and Northern Ireland was represented as observer on ten of the 14, and it may well have been more; it's only our records are not complete, and we cannot confirm with certainty. But what we have confirmed is those meetings where we can assure you that there was someone in attendance.

Q. But does it come back to the point, Sir Michael, in terms of it being very heavily dependent on you as an individual, obviously under enormous strain at this point in time, and is there not a proper point about your ability as one individual to synthesise a very considerable body of expert advice and opinion that was being generated at that time?

A. Well, as I've said earlier, I mean, it wasn't just me. I was very ably supported by two deputy chief medical

officers who were experts in this area and two senior medical officers who were both public health consultants who were also expert in this area.

I think there is a wider point which I mentioned earlier, which is: we are a very, very small professional team within the department. I think at the time, there were six of us -- myself and two deputies and a number of senior medical officers, and some of those were not full-time, although became so because, you know, everyone was absolutely committed from the outset to managing the emerging situation.

So I think in terms of -- and I've covered this in my witness statements, both of them -- the learning point for me is certainly the resilience within my office, within my team. And I think that in all small jurisdictions, one of the problems is you have too many single critical points of failure potentially, and I think that is something that needs to be considered in terms of learning for the future.

Q. All right. I'm going to move on because I want to ask you about some of the challenges that Northern Ireland faced at that time, particularly as regards its health services. I want to begin with a point that you've made in your witness statement. I don't think I need to take you to it because I think it's something that you're

very familiar with. But just starting with the profile of health in Northern Ireland, I think that your opinion is that, broadly speaking, the population of Northern Ireland compares to most other parts of the United Kingdom, save for -- and I'll come back to this -- the prevalence of mental ill health.

A. Yes.

Q. I think it's also right that in terms of health inequalities in Northern Ireland, perhaps the most significant one -- but please say if I'm putting this too broadly -- relates essentially to poverty. Is that an accurate way of putting it? Or social disadvantage.

A. I think it's the latter. I think it's broader based, you know, sort of a -- sort of straightforward way of describing it is the circumstances in which people are born, they live, they grow up, they work, they age. And it's all of those economic, societal, environmental factors, and also the underpinning behavioural factors which contribute to the stark differences in life expectancy, healthy life expectancy, which frankly are not unique to Northern Ireland, sadly, but remain stubbornly difficult to address.

Q. I think again, just for the purposes of comparison to the other parts of the United Kingdom, is that inequality in Northern Ireland again broadly similar to

other parts of the United Kingdom?

A. It is. And, I mean, I've covered this, and I don't know if you wish me to go into any further detail on it, but it is broadly similar, and I think if -- and depending the measurement that you take, but if you look at life expectancy, generally women live longer than men in Northern Ireland, we generally compare more favourably to Wales and Scotland, less favourably to England in terms of life expectancy, although we have seen a stalling and fall in life expectancy across all the four nations. That has been greater in England than here, so the gap between ourselves and England has somewhat narrowed over the last four years.

Q. All right. Just returning then to the particular prevalence of mental ill health in Northern Ireland and that being a distinguishing feature perhaps from the rest of the United Kingdom, I think that that relates to the fact that there are many more people diagnosed with a mental health condition in Northern Ireland, is that correct, as compared to other parts of the UK?

A. Yes, and I think I did reference some research that had been carried out by Professor Siobhan O'Neill and Professor Nichola Rooney in relation to that differential and why that might be, and amongst their conclusions was that in a society coming out of

conflict, which sadly we were a society that was in conflict for many, many years, that the root cause of much of that was that conflict. And, again, we've had research from Queen's University which -- looking at the prescription of anti-depressants and those individuals who live in interface areas close to so-called peace walls, we see a higher rate of prescription of anti-depressants, so there is no doubt that there has been an enduring and lasting consequence of what we euphemistically refer to as the Troubles in Northern Ireland.

Q. All right. I'll come back, because obviously that might be something that's relevant in terms of the considerations that needed to be taken into account in terms of the consequences of some of the --

A. Sure.

Q. -- restrictions, so that's why I wanted to ask you about that, before moving on, then, to some of the other perhaps distinct challenges that Northern Ireland faced.

Specifically I wanted to ask you your opinion about the absence of ministers between 2017 and 2020, and the extent to which that absence or void of ministerial decision-making in that period affected health services in Northern Ireland in a way that conditioned the response to the pandemic specifically.

A. Yes, I've thought about this a lot in formulating my response in my statement, and -- I have a view that is not a professional or technical view, so therefore I'm somewhat hesitant to share it. Others may have different views, and those views may be much more valid than mine.

I think that it is absolutely preferable to have a government in Northern Ireland and to have ministers in place, and I think we were fortunate during the pandemic that we did have ministers in place and a government in place, and I've also said so in my statement.

I think that that period between 2017 for the three years until three weeks before the pandemic started was a difficult period, certainly from a health, from a departmental perspective and from my role as Chief Medical Officer, we were not able to advance significant policy decisions or take forward legislation underpinning those policy decisions. That was problematic. And I know some of this was covered by the then perm sec in his evidence, so I'll not go over that ground again, in terms of the limitations and constraints under which permanent secretaries operated.

I think that, as I've said in my statement, the health system in Northern Ireland was long overdue for

structural change and reform. We'd had a succession of reports and reviews, and it wasn't the absence of reports and reviews or future policy determination, but it was one of implementation. Because obviously major restructuring requires ministers to agree to those major changes, and we didn't have ministers to agree to those major changes.

Now, that said, we were fortunate in that we had -- and we may come on to this -- the publication of the Bengoa report, *"Systems, not structures",* in the October of 2016. So that gave us a roadmap or a blueprint of a future direction of travel for how health and social care in Northern Ireland might be transformed.

So during that period, in the absence of ministers, there was a lot of preparatory work, there was a lot of public engagement, and that preparatory work and public engagement would have needed to occur whether ministers were in post or ministers were not in post. And indeed many of those new models that we were designing, we used to good effect during the pandemic, to make sure that we minimised the impact from the downturn in routine services that we had. But we could not make decisions about the end point and final decisions around what that new structure would look like and how those services would be redesigned.

Now, that was one half of the problem. The other half of the problem was the budgetary situation, which is well outwith my remit but, you know, as you say, I was a perm sec at a point in time as well, so maybe I have some insight into that.

In Northern Ireland, there has been a situation where we've had -- and the minister I think sums this up quite well in his statement -- a hand-to-mouth existence where we had one-year budget cycles as opposed to a three or five-year budget, and therefore -- and we were dependent on what's referred to as in-year monetary returns, so there's a slippage in spend in other departments which would go back to the centre and then would be given out to other departments, and we benefited from that, but you can't plan strategically, you can't employ staff on a recurrent basis on non-recurring money.

So we had that, if I might say, double hit of not being able to implement the change and actually not having the budgetary certainty either, which meant that many decisions were short-term decisions as opposed to longer-term strategic decisions, which only ministers can make.

Q. But just coming back to the focus of Module 2C and whether or not the difficulties that health services

faced as at January 2020 and -- whether they conditioned the response or created strictures in terms of the response, what's your opinion on that specifically?

A. I mean, I think as the Chair will note, I mean, I was asked this question in Module 1, and my view was that the health system in Northern Ireland was less resilient at the start of this pandemic than it was in 2009, which -- with the H1N1 pandemic, which by comparison was a -- you know, did not have anywhere near the same impact.

So we headed into this pandemic with a less resilient health and social care system, budgetary uncertainty, significant workforce challenges and vacancies, a system that was long overdue for change. A decision had been made in 2015 to close the Health and Social Care Board, which was one of the major commissioning bodies of services, but obviously in the absence of ministers that decision could not be enacted until April 2022. So you had staff within a really important key body uncertain of their future, and we lost some very experienced staff.

And similarly within the Public Health Agency, because of the voluntary exit scheme from 2014 -- and I know other witnesses have referred to the impact that had on the Civil Service -- we also were losing

experienced staff from the Public Health Agency, and also, I might say, the department.

So as we headed into this pandemic, I mean, I certainly can -- my assessment would be that we were not in as good a place as we were in 2009.

Q. All right. We'll come back to, perhaps, how some of those concerns fed into the advice that was given. But I think we can proceed on the basis, then, that, pandemic to one side, health services in general were in quite a precarious position.

I'm going to move on to something quite different and ask you then about Northern Ireland's pandemic flu plan, and I think -- was that something that you had corporate responsibility for within the Department of Health as part of --

A. Well, I mean, the department, and ultimately the perm sec in the department, has corporate responsibility. I had policy responsibility. So the corporate responsibility is for the health element of it.

Now, we need to also be aware that the pandemic flu policy transcends many parts of government, and I think this is something which came up, you know, yesterday in terms of, you know, who holds the -- who holds the ring when there's a pandemic. Because pandemics, as we,

you know, can see from the response to this pandemic, cut across the policy responsibility of many departments.

But to answer your question, I had policy responsibility for it, supported by my team, but it was a corporate departmental responsibility. And equally, there were responsibilities under CCG(NI), Civil Contingencies Group or other departments in relation to elements of that, for instance, the Department of Justice, in relation to any excess deaths, and the Executive Office, in terms of cross-sectoral resilience in actually other areas outside of health. So, you know, Health does the health bit.

Q. Yes.

A. Other departments need to do the other bits.

Q. I think you're probably coming on to a fundamental issue about the nexus between the Department of Health --

A. Sure.

Q. -- and other departments as part of the response, and I'm going to move on to deal with that, and with the --

A. Sure.

Q. -- contingency arrangements.

I just wanted to deal with the flu plan and what happened in respect of that. I think that what you say in your statement, and it's at -- this is your second

statement, at paragraph 155, I don't think we need to go to it.

A. No, no.

Q. "The extant position at the end of January 2020 was that existing pandemic flu plans would/could have been adapted to address a novel pathogen other than influenza. In actual fact the extant pandemic influenza plan in respect of specific elements of the response was not of material benefit as it was clearly written following the experience of the H5N1 pandemic and not for a pandemic as severe as as Covid-19 with the extensive measures and interventions required including the 'lockdown' and the scale up in diagnostic testing and contact tracing."

So I just wanted to examine and understand whether or not in January those plans were revisited then in light of the information that was coming to light about the development of the pandemic?

A. Well, we certainly were using elements of those plans, and the arrangements that fell out from those plans. So in terms of the assessment of what the impact would be, we were, up until 27 February, when SAGE changed its recommendations in relation to reasonable worst-case scenario, when it had some hard data on the virus, and then that was accepted by the Cabinet Office, we were

using the reasonable worst-case scenario for pandemic flu to inform our planning and preparation.

Now, that was useful, and indeed, you know, when this was declared a public health emergency of international concern by the WHO on 30 December, as the four UK CMOs, we said, you know, prepare for --

Q. 30 January, I think.

A. Sorry, did I not say that?

Q. You said December.

A. Oh, sorry, apologies, 30 January. We said: use the reasonable worst-case scenario for pandemic flu without a vaccine as a basis for planning and preparation, which is what we did.

Now, so that initial modelling was helpful in terms of pointing to the potential impact of what was beginning to emerge or potentially emerge, so that was useful. But in any scenario, including the reasonable worst-case scenario for pandemic flu, which we were then using, or, subsequently, the reasonable worst-case scenario which was more specific to Covid, the health service would not have been able to cope.

I think that what was extremely helpful, and I think -- I would hope the Inquiry, when it reflects on these arrangements, in terms of how we're better prepared in the future, considers the role of the

emergency planning arrangements that we have in place. Because those are agnostic; it doesn't really matter what the pathogen is. The arrangements in terms of the gold, the silver and the bronze arrangements served us very well in the initial response in terms of the health department responding to the pandemic, and all of that was informed by and developed from our exercises and training in terms of how we would respond to a pandemic flu. And those -- I would say that those structures served us well.

Now, we did need to modify them, because they weren't designed for what was -- turned out to be a long-term response and -- you know, to the pandemic. We had never used them to that extent before, and the 2009 pandemic was the last occasion that they had been used.

Where the pandemic flu plans were less helpful, and I think this is an important learning point, if I could finish on that, where they were less helpful was that they had not anticipated or planned for the sort of pandemic that we had in 1918, or indeed in 1958 or 1967, which were more severe pandemics, and I think that even if you look back on those pandemics, whilst there were some limited NPIs used during 1918, we had never before ever used NPIs to the extent that we used in this

pandemic or had to use in this pandemic.

We had, similarly, never tested to the extent that we had test -- we ultimately were testing in this pandemic, and we had never before had contact tracing at the scale that we were contact tracing. It had never been envisaged. And I think therein is an important learning point: it had never been envisaged.

And I think the point I want to come back to and finally close on, that I -- I mean, I was present during the 2009 pandemic, I was involved in the development of the 2011 -- it was published here in 2013 -- pandemic plan, and we looked, as we always do, to your last experience of the last pandemic, and that's a mistake. Because looking back -- and it's important to look back to establish the learning about what you might do different -- the next pandemic will not be the same.

And I think from the Inquiry's perspective, it's about what are the -- if I might respectfully suggest, it's: what are the core elements of a response to any pandemic which are generic? What are the core elements of any response that you need to be able to scale at pace and with agility? And then to think around a range of scenarios of potential new pathogens which may lead to a pandemic, and then begin to think: what are the specific elements that we might need to inform

a response to those range of pathogens?

So, for instance, you know, with climate change, are we prepared for a vector-borne pandemic? Now, sorry, I shouldn't be asking you the question, but I think those are the sort of questions that we need to be asking in our planning and preparation, and I think that is just a really vitally important point that I hope the Inquiry will be able to make some recommendations on.

Q. All right, well, I just want to focus, if I may --

A. Sorry.

Q. -- on what actually happened in response to the pandemic in Northern Ireland in these early stages in 2020, and I was asking you about the pandemic flu plan, because, when he gave evidence to Module 2 of the Inquiry, Professor Sir Chris Whitty said that at around the time when evidence was accumulating about how serious and severe the pandemic might be, he said that it was pretty clear to him that the pandemic flu plan in the UK "wasn't going to give us any particular help, frankly", is what he said, and he went on to say:

"So my view was we didn't have a plan that was going to be useful from a prevention or management point of view. It had a large number of useful components within it, there wasn't nothing helpful there, but the idea

there was a respiratory pandemic plan for the kind of pandemic this was going to be, if it was going to be a problem, that we could just take off the shelf and follow the playbook, was optimistic at best."

The question for you is whether or not you, similarly, approached the pandemic flu plans in Northern Ireland on the basis that they weren't actually going to be very much help at all?

A. I mean, I didn't take down the pandemic flu plan and look at it and say "This is a playbook for how we respond to this pandemic", no. So, to that extent, you know, my comments in my statement concur with those of Professor Sir Chris Whitty.

Q. Forgive me, I didn't mean to cut across you, I think he was making a different point, he wasn't saying that it was treated as a playbook, he was saying that he realised that there wasn't a plan that was particularly useful --

A. No.

Q. -- that he -- realisation crystallised. And I'm asking you if similarly you had that realisation?

A. Yeah, I mean, I'm not certain -- please correct me if I'm wrong, but I think we're saying the same thing. The pandemic flu plan, to my mind, as I've said, was not of huge use. There were elements, there were building

blocks within it, and I've given an example of the emergency response arrangements, I've given the example of the reasonable worst-case scenario planning, how we used that, but in more general terms, given the severity of this pandemic, it was not of huge use. So I would absolutely agree with it.

And again, just coming back to the final point and the reference to "there wasn't a plan I could take off the shelf", there will never be a plan you can take off a shelf, because the next pandemic will be something that we were not expecting. That is the nature of pandemics. And I think just to reiterate the point that I've just made, and that's the need to ensure that what we identify are those core elements that will require a generic response to a pandemic and then the specific elements, depending what the pathogen is, how it's transmitted.

Q. Okay. I'm just going to go back to early 2020 if I may --

LADY HALLETT: Just before you do, I'm sorry to interrupt.

Sir Michael, you talked about the importance of the role of emergency planning and the gold, silver --

A. Yeah.

LADY HALLETT: -- command structure. Isn't that separate from the pandemic influenza plan?

A. Oh, sorry --

LADY HALLETT: That's normal -- if you can have a normal emergency -- that's your standard emergency planning.

A. No, I think that's a very valid point, Chair. I think the point that I was seeking to make is that in terms of pandemic flu planning and preparedness, most of the major exercises that we've deployed have tested those arrangements, our emergency planning arrangements. So every time, for instance in 2016 -- I know we covered this in Module 1 -- Exercise Cygnus, we reviewed our emergency plan and developed it further.

So, I mean, they are absolutely discrete. One is generic, one is more specific. I think what I was seeking to make -- the point is that there is a link.

LADY HALLETT: I understand that. The reason I ask is that I did hear evidence in Module 2 to the effect that the UK Government certainly virtually abandoned the pandemic influenza plan because it really wasn't much use for the kind of pandemic we faced.

A. I think that we -- I think you're correct. I think what we -- the approach that we are taking now is talking about and planning for, you know, pandemic capabilities that are pathogen-neutral. You know, it may well be that within that we envisage different scenarios. I mean, we will always have to be prepared for

a pandemic flu, you know. It is and always has been on the highest level of the National Risk Register. But I think we need to take a broader, more holistic approach, otherwise we get caught out by something like coronavirus which, you know, we were not expecting.

And I think that's the point I was trying to make, that -- pandemic capabilities, and then consider certain scenarios in terms of how certain pathogens might emerge and how they might be transmitted.

LADY HALLETT: Sorry to interrupt.

MS DOBBIN: Just going back to the specific planning, did the plan in Northern Ireland then become the 3 March plan, the United Kingdom-wide plan?

A. It was, I mean, I think that's -- sorry, a shorter answer: yes.

Q. Yes, and obviously the Inquiry heard quite stringent criticism of that plan in Module 2, and for example it being referred to as resembling more a communications plan than any sort of substantive plan for a pandemic.

A. I --

Q. Was that view shared in Northern Ireland?

A. No. I think that, you know, it 1was a reasonable plan. And, you know, I've had lots of experience with major incidents and, you know, now have lived through two pandemics, and all I would say -- and again, it's back

to the point I made earlier -- no plan, in my experience, survives the first engagement with a new -- a virus or a new variant of a virus, and every time you have to change and modify and adapt.

And that's -- you know, so we had the building blocks that were within the pandemic flu plan, but we significantly adopted those and changed those, because every virus is different, and the response to the coronavirus was hugely different from anything that we'd envisaged with pandemic flu.

So coming back to the coronavirus plan, I think it was a good plan in terms of its various elements, in terms of contain, delay, research and mitigate. I think it was, as you described, and other witnesses have described, it was publicly accessible, and I think that was a real strength. I mean, it was readable. I think it explained in clear terms the government's response, UK Government's response and the devolved administrations. And I think in general we worked our way through that.

And if we want to look back at what we did in the contain phase and mitigation phase, what we did in terms of research to inform our understanding of the virus, to develop new drugs and vaccines, and then the mitigation phase, I think we broadly followed the key elements of

the plan. But, as I say, there is no such thing as a plan that doesn't need to change and adapt.

I mean, I remember saying at the time in interviews, the virus doesn't have a plan and it doesn't read our plan. And it will be the same with the next pandemic. And that's why the really important elements is to be able to have that agility, as I've said in my statement and the ability to rapidly adapt and innovate and change to whatever the emerging issues are.

MS DOBBIN: I'm going to come back and look at the information that you had at the start and the planning that took place in respect of the specific information, but I think we've probably come to our morning break.

LADY HALLETT: Certainly. I shall return at 11.30.

(11.15 am)

(A short break)

(11.30 am)

LADY HALLETT: Ms Dobbin.

MS DOBBIN: Thank you.

Sir Michael, I just wanted to return, then, to the facts about information that was being provided to you in January 2020 --

A. Okay.

Q. -- if I may, and I wanted to start with the information that was provided by Professor Woolhouse in Scotland on

25 January 2020. The Inquiry has already heard about that. I can take you to that if you would like, but it's probably information, I imagine, that you recall, or an email that you recall, when he set out the concerns or set out the predictions about what, on the basis of the work Scotland had done, they thought might happen in terms of their health system and set out the view or the concern that the Scottish health system would be completely overwhelmed. You recollect the email that I'm talking about; yes?

A. I do, and, you know, it may be helpful to pull it up. It did flag that point, but I think it also --

Q. Sorry, would you like to see it?

A. No, it's there on the screen, but I think what it also points to is a huge uncertainty that there was at that time, and the fact that it would take some time.

You know, if we look at the penultimate paragraph:

"There are [some] very good reasons to suppose it might not be as bad as that but we need additional evidence (not currently available ...)"

Et cetera, et cetera.

So I think that there was concern of the potential impact, but I think that there was very significant uncertainty at that stage, and that's what --

Q. Can I just -- sorry, forgive me.

A. Sorry.

Q. I didn't mean to cut across you, but if we look at the final paragraph in this email, it says:

"It is still possible that this outbreak can be contained and that Scotland and the rest of the UK escapes relatively lightly. But I and others consider this more of a hope than an expectation at this stage."

So that doesn't speak so much of uncertainty, does it?

A. Well, I think this has to be put in the context of -- that there was a range of scientific views at that time, and even if we fast forward, and I don't know whether you -- I think it was probably the SAGE meeting of 28 February, there was again discussion, you know, at that meeting about whether or not there was even established transmission within the UK and/or how likely that was.

So I think that there were a range of scientific views at that time, and certainly this was one potential scenario, and it was a concerning scenario, but at least at that stage there was still, you know, this potential that the virus would be contained in early January within China.

The other scenario was that it wouldn't be, and obviously then that would have wider consequences.

I think the other point I would make is that, if there was, as we were discussing at that time, the potential for spill-over into the UK, that still at that stage did not mean that we would see sustained human-to-human transmission and an outbreak. And again, if I, you know, give an example, we had -- back in 2003, we had SARS, another coronavirus, a higher mortality which caused a significant number of deaths in parts of the world where there were outbreaks, and then it disappeared. Why it disappeared, we don't know.

So I think that all I would say is that I think it's very important when you're looking back at events that we avoid falling into the: well, surely you should have known because of what's happened subsequently? We knew what we knew at a point in time, and at that time, there was still a high degree of uncertainty as to how this might develop or indeed if it would develop.

Q. All right. So if it would develop, we'll come on to examine that.

But at this point in time, obviously there had been a COBR. This sort of information is coming from counterparts in Scotland. Where was your antennae in terms of potential concern or, I mean, how worried, I suppose, were you by this point in time that this might in fact become something very serious?

A. It's hard now to reflect back with any degree of certainty. I had a high level of certain, I think as we all did at that stage, and I think we were proceeding on that precautionary principle that this may be very significant. Still at that time it had the potential not to be so significant, and I think that, you know, planning and preparing in uncertainty is extremely difficult.

I think that -- I do recall after the COBR meeting on 29 January, I was concerned. I was very concerned. But then again, I suppose I -- my responsibility and role is to look forward as to what might happen, and then to map my way back from there in terms of, well, I'm planning for a range of different scenarios, which I think is what we were doing at that time and in that period from January and into February.

Q. In terms of the risk posed to Northern Ireland, it wasn't theoretical, was it, in terms of China being on the other side of the world, because the Inquiry has seen that on exactly the same day there were tourists from Wuhan in China who entered the -- who entered Northern Ireland, and, in fact, we've seen some messages about that.

A. Yes, and, you know -- I mean, I can't recall the exact detail at that stage. I mean, Wuhan had gone into

lockdown, and I can't recall the exact timing of when those tourists left Wuhan, but China had -- was in a "no stay" at that time, closing airports from Wuhan.

I think that -- you know, it's interesting now, because I saw those WhatsApps, and it's interesting how others interpret your degree of concern or otherwise. There was an extensive exercise undertaken with those --

Q. Can I just ask you to pause to ask why you say that. I think we've seen in one of those messages, and this may be what you're alluding to. The message said:

"Tourists from Wuhan were actually known to have arrived in Northern Ireland. Nothing to stop them. CMO is not concerned."

Is that what you were referring to?

A. Yes, which I think is -- you know, I think we're all now very familiar with the dangers of WhatsApps, but I think that that abbreviated version of events belies the significant risk assessment that was undertaken at that time.

So this was a group of tourists who had travelled into England and had travelled through England, had travelled into Scotland, and then into Northern Ireland. Now, they had -- one of the party had developed respiratory symptoms, had presented and been tested in Scotland and had been confirmed as having flu, seasonal

flu, had been tested negative for Covid, and all of the other travellers were asymptomatic. So they had been risk assessed in Scotland. They travelled into Northern Ireland. The time that we saw them, all were asymptomatic. Our Public Health Agency made contact with them immediately on their arrival. Prior to their departure, I was in contact with the Chief Medical Officer in Scotland. I contacted the Chief Medical Officer in the Republic of Ireland to advise of their onward travel, and public health agencies in Scotland, Northern Ireland and the Republic of Ireland were in close liaison.

So I think that to suggest that -- and I think the WhatsApp summary sort of belies the significant amount of risk assessment and ongoing work that was undertaken at that time.

Q. I'm not clear as to the risk assessment that took place in Northern Ireland because I think, as the Inquiry understands the information, because there was only one individual who had respiratory symptoms, there wasn't anything anyone could do, and the tourists were allowed to proceed into Northern Ireland. So, I mean, they weren't tested or anything or --

A. Well, they had been tested in Scotland, and they were asymptomatic, and I think, you know, let's bear in mind

what our approach was at that particular time. So this was well in advance of some of the other measures that were taken across the UK in terms of people returning from China. So the risk assessment was taken, carried out by experts in public health, both in Scotland and in Northern Ireland, and we passed on the relevant information to public health colleagues in the Republic of Ireland.

So I think that -- you know, I mean, from my professional assessment of the action that was carried out, the risk assessment that was made, the testing that was carried out, I was satisfied with those -- those arrangements, as were the authorities in Scotland and the authorities in the Republic of Ireland.

Q. Can I just check, were all of those individuals tested in Scotland?

A. I don't have that detail --

Q. I thought that perhaps was what you were suggesting. I don't --

A. No. I was --

Q. -- think we've seen any evidence --

A. I wasn't suggesting anything of that nature. There was one individual who was symptomatic who was tested. The others were not symptomatic. I suspect in that they were not symptomatic, they were not tested, but again,

I don't have that detail.

LADY HALLETT: Can you remind me, when was the date of this?

MS DOBBIN: 25 January.

LADY HALLETT: Right. I'm trying to remember when the first tests in Scotland started.

MS DOBBIN: I don't have information about Scotland to hand --

LADY HALLETT: No. I'm not surprised because you weren't in 2A, but I was.

A. It was much later. It was in February.

MS DOBBIN: Yes.

A. I think there's a wider point, if it --

LADY HALLETT: Sorry, before you go on to the wider point.

If the tests in Scotland didn't start till February, how was a member of the tourist group tested in January --

A. Well, that's the information I have, so --

LADY HALLETT: -- in Scotland?

A. Yeah. I mean, I think that there probably wasn't widespread testing. I mean, certainly we had -- we started testing in Northern Ireland, had the capacity to test from 10 February, in terms of -- at scale, at some scale. But again, I mean, that was the information that was relayed to us. So, I mean, I -- obviously, I cannot speak for the authorities in Scotland.

I think, if I may, there's maybe a wider point which I think is maybe helpful here which is that the measures that were subsequently introduced by the Chinese authorities and were introduced in terms of returning travellers from China, and then we expanded that to include travellers from other parts of the world, other parts of Asia, subsequently Italy, we now know but didn't know at the time that those measures were actually effective. The route of seeding of infection into the UK was not from China; it actually came from Europe and from European countries -- from Italy, from Spain, from France. We didn't know that at the time, but we now know that from genomic sequencing, so --

MS DOBBIN: I am going to come on to Italy and some involvement you had, I think, in giving advice, or certainly steering direction of travel in Northern Ireland about travel to northern Italy.

But if I may just take it chronologically, and then we can return to that, and then obviously --

A. Sure.

Q. -- you'll be able to provide evidence about that.

But just coming back to this period of time, I mean, did you understand, Sir Michael, there to be a significant shift in understanding between 22 and 24 January in terms of transmission of Covid-19 --

sorry, in terms of human-to-human transmission being sustained?

A. Well, we certainly -- again, I can't now recall the exact date, but certainly in that period, we certainly were able to confirm that there was human-to-human transmission. Now, there's a difference between human-to-human transmission and sustained human-to-human transmission. We certainly saw that there was human-to-human transmission within China, and we were around that period -- I think late January -- I think that the WHO I think had confirmed that, and we had evidence which was consistent with that.

However, you know, back to the SARS example, we didn't yet know whether that human-to-human transmission would be sustained and therefore potentially could lead to a pandemic.

Q. All right. The Imperial College report number 3, I think, reported on 23 January, hadn't it, that human-to-human transmission was the only plausible explanation for the size of the outbreak; is that correct?

A. But I think we're talking about two separate issues here. One is human-to-human transmission, which I absolutely accept there was evidence of. Sustained human-to-human transmission is quite another thing. You

can get human-to-human transmission because of close proximity, but that depends on how infectious the agent is.

So, for instance, if you're in very close proximity or you're living with someone who has the infection and in very close contact, then you will see human-to-human transmission. However, that does not necessarily mean that you're going to see wider community transmission, particularly if the infectiousness of the virus is different in other environments. So, for instance, in more open spaces or in the environment more generally.

So I think there's a really, really important distinction there to be made, which is an important one.

Q. All right. But in terms of, again, just coming back to the sort of antennae of concern at about this period in time, nonetheless, did that shift in understanding about human-to-human transmission, as it were, make you more concerned and more worried at this point?

A. I think it raised a level of concern, yes.

Q. All right. Then I think that, in terms of chronologically, what happened next or what might be relevant to you is -- we've seen reference to this, and again I can bring it up if needs be -- Professor Sir Chris Whitty's email of 28 January where he essentially said that the way things might go was effectively

binary: either China would have a large outbreak but would contain it, or it would have a large outbreak and it wouldn't be able to contain it. And it appears from the email that he sent that that was a position he had arrived at having discussed the position with the other UK CMOs. Is that correct?

A. That's correct. We had a call on 24 January where we discussed this, to the best of my memory.

Q. All right. And again, can the Inquiry presume, then, that was the basis upon which you were working as well, that --

A. Yes.

Q. -- it was a dichotomous position and that there wasn't, as it were, any middle ground or fudge, so to speak?

A. It would have been unwise to assume there was some middle ground.

Q. And in terms of your state of understanding or knowledge, again at around this time -- perhaps if we could bring this up. This is INQ000282744. And I think it's on page 2, please. Thank you.

So I believe that this is the WhatsApp group for the UK CMOs.

A. That's correct, yes.

Q. And I think it appears from this that on 28 January, you were setting out to your peers or to your counterparts

that:

"Having considered the EWRS notification as reported appears to be consistent with asymptomatic transmission during the incubation period."

Correct?

A. Yeah, it's correct that that's my WhatsApp, yes --

Q. Yes, but I --

A. -- elaborate my thinking, if that's the question, but yes.

Q. Well, it was about your thinking, yes.

A. Okay. I think that, you know, the -- as I mentioned earlier, the important thing in all of this is to have a precautionary approach. And you mentioned about antennae, and we were very alert to: this was a new virus about which we knew absolutely nothing at that point in time, and it was therefore important that we kept an open mind about the potential consequences. And you mentioned that dichotomous position, so that was our view.

But also what we were very alert to was the transmission dynamics: how infectious was this virus? Were we going to see sustained human-to-human transmission? To what extent would we see that? Had it the potential to become a pandemic, or was it going to be like the SARS outbreak in 2003 where we didn't see

sustained human-to-human transmission and the virus disappeared?

I mean, this, as I -- I recall receiving this report, and this was related to a cluster of cases in Germany at the time, and as I recall related to someone who had returned from China. And we had incomplete details, and I simply was raising a question. And obviously, I think quite correctly, Chris -- sorry, Professor Sir Chris Whitty was, you know, agreeing that it raised the question, but not conclusive, and we really needed to await the NERVTAG assessment.

Q. I think the next message down, which if we're able to go to it, it may be on the next page, yes, so whoever the owner of the cell phone is, and I'm afraid I don't know that, says: but we should now assume that it's happening, or may be happening --

A. I think that is Chris -- sorry, Professor Sir Chris Whitty's response to me.

Q. All right. So we should assume it may be happening?

A. I think that, you know, from -- and I think this is another important point. In January and February, we were alert to the possibility, and that was as far as, you know -- and it was important that we were alert to that possibility. We didn't know. There was no evidence to suggest it. We were actively seeking to

understand whether there was asymptomatic transmission or not, but what we needed was evidence.

And as I recall, it wasn't even until probably towards the end of March, and I do recall a read-out from a NERVTAG meeting on about 15 May when we actually had definitive evidence of asymptomatic infection.

So had we known what we now know, then things may have been very different, but we did not know then and we did not have the evidence, but we were alert to that possibility in January and February, and it was right that we asked the question.

Q. May I ask you a number of points about that.

First of all, you said in your reply that we should take, or that there had to be a precautionary approach --

A. Yeah.

Q. -- and I wasn't clear as to what you meant by "precautionary" in that context.

A. It wasn't in relation to this. I don't think I was talking about a precautionary approach in terms of planning and preparing for what might happen in relation to the potential or otherwise for a pandemic.

Q. Do you mean precautionary in the sense of the worst might happen?

A. Yes.

Q. Plan on that basis, as opposed to the opposite to that, which is precautionary: we don't know how this is going to play out, so let's not --

A. I mean --

Q. -- plan too definitively or --

A. No, absolutely not. I mean, I think that, you know, there was no -- you know, sitting and waiting was not an option here. We had to plan and prepare for what potentially might happen. I mean, it would have been irresponsible to sit and wait to see how things pan out. And therefore what we started to do then was gear up for what potentially might happen, even though we didn't know -- we weren't certain at that stage how things might develop.

Now, I mean, it's always difficult when you look back at, well, you know, at what point were you clearer? What point were you more certain? I think we proceeded on the basis of what might happen because if you wait and waited until it actually happened, it would be too late --

Q. Yes, quite.

A. -- to do any preparation.

Q. But I think just coming back to your point that there wasn't evidence of asymptomatic transmission until the end of March, the final message here is that you should

proceed on the assumption that it may be happening; correct?

A. Well, I mean, again, you know, we proceed on the basis of the expert advice from NERVTAG and SAGE. I mean, this is an informal WhatsApp chat between chief medical officers. What would happen and what did happen is, all of that information in relation to that particular case would have been considered by UK leading experts in terms of: do we have evidence here of asymptomatic infection?

You know, I would defer to those who were more expert than I in this area and to the scientific experts within NERVTAG who are examining that, and at all stages as UK CMOs we were informed by the considered views of NERVTAG, which fed into SAGE. So I'm raising a question which I think needs to be asked. The answer to that question I don't then know.

Q. Well, the answer from Sir Chris Whitty does appear to be clear, but can I ask --

A. No, sorry, I really don't accept that characterisation. I mean, I think what he's saying -- compatible, probable, but not conclusive, and then goes on, you know, NERVTAG, you know. So, I mean, I think what that is essentially saying is: NERVTAG need to consider this. So, you know, I think I wouldn't -- you know,

maybe I'm dancing on the head of a pin here, but I think it is an important distinction to make. There was no certainty at that point. We -- I posed the question, and it was right and proper that NERVTAG looked and formed a considered view based on the scientific evidence.

Q. I'm certainly not trying to engage in a semantic argument.

A. No.

Q. I just read his last message as making a very different point to the one he was making in the message above, which is that: notwithstanding the uncertainty, nonetheless, you should proceed on the basis that it may be happening. In other words, you should plan. You should --

A. Well, I mean, I think there's a distinction there. I mean, I think that, again, what we needed to do was ascertain whether that was the case.

I mean, there is a very different response required for planning for and responding to a pandemic which has asymptomatic transmission.

For instance, the critically important point to know is how much asymptomatic transmission there is. Is asymptomatic transmission as great a risk as symptomatic transmission? So why that's relevant is if you ask, as

we did on 12 March, everyone with symptoms to self-isolate, if there are asymptomatic individuals, is the power of transmission sufficient to maintain transmission in the community? So it's a really, really important point, and it has major implications.

At this point in time, we did not know, we didn't have the evidence, but I think we were asking the right question as to whether or not there was or there wasn't. But it would have been at that stage premature to assume, until we had the evidence to suggest -- I mean, why this was at the back of our minds is that we did know that asymptomatic transmission can occur with other coronaviruses. We know, for instance, with SARS that infection and symptoms largely coincide. So most people who had SARS really became infectious to others with the onset of the symptoms, when they were coughing and sneezing, but we knew that there was a possibility slightly before that, but perhaps within 24 hours. We didn't know with this particular virus because, you know, there were -- whilst there was a 80% similarity between this virus and SARS, they weren't the same viruses. And the problem with all of this is that we just didn't understand the basic science about this virus, its transmissibility, how infectious it was, whether there was asymptomatic infection or not, and we

were planning in huge uncertainty.

And, you know, looking back now, with all we know about this virus, I think it's important that we bear in mind throughout that we knew so little then. Our planning was based on what we knew about other coronaviruses because we didn't have the scientific data about this particular virus.

Q. Can I just cut through and ask: what would have been wrong, or what would the problem have been, assuming you didn't work on the assumption that asymptomatic transmission might be happening? What was the difficulty in proceeding on that basis in your planning?

A. I mean, I think the approach that -- I mean, the approach that we'd take, and I think was the right approach, was to be informed by the evidence and the science in all of this.

You know, at this stage, there was a high level of uncertainty, and I think it would have been not appropriate to proceed on the basis of what we think. And at all times the advice that we provided, I provided, was informed by the best scientific advice that was available to me. And at this point in time, NERVTAG, SAGE were not saying that there is asymptomatic transmission. But we were alert to the fact that we needed to keep this under review and see if there was or

there wasn't.

Q. Okay. I'll come back to perhaps when one starts to plan on the basis of the imperfect picture.

But just going back to the chronology, it seems clear that it was well understood within government in Northern Ireland from around 5 February -- and I say "government". It appears that civil servants who were not in the Department of Health understood from 5 February that the United Kingdom Government's position was that China had lost control of the pandemic. So, in other words, that the -- in terms of the dichotomous position set out by Sir Chris Whitty, the direction of travel was towards the worst-case scenario that he had set out in his email; correct?

A. I think that's the correct timescale, without looking at the record, yes.

Q. All right. And in terms of then what happened in Northern Ireland after that point in time, what was -- and the premise of the question is, again, this must have raised the alert and the concern even more. What was the strategic response to that that you advised?

A. Well, I mean, our strategic response had kicked in much earlier on the basis of my advice, so we had already at that stage stood up our response, or operational response arrangements, you know, referred to as

"silver", which is the Public Health Agency Health and Social Care Board. In the department, we had stood up our gold health arrangements, which is on 27 January. There were daily calls between health silver and gold, so we were processing emerging information that was coming from UK Government, and we were relaying that -- that information was coming in to us. And certainly from early February, there was a lot of planning going on. At that stage in early February, there were daily four-nation calls at departmental level. There were daily calls between what was then Public Health England and the public health bodies in the other nations, including the Public Health Agency. The Public Health Agency was -- you know, even in that first week in February was developing plans for dealing with our first potential case. We were dealing with protocols to -- and we may come on to this -- about the transfer of patients, either to a high-consequence infectious disease unit in England or to the regional infectious disease unit in Belfast. We were developing guidance for general practice. We were engaging in relation to communicating out to health professionals about what the potential symptoms might be, and there's a number of circulars to that effect. Providing advice about returning travellers, and that changed very frequently

as more and more countries were beginning to identify cases, advising those individuals returning to self-isolate. We were ramping up testing capacity in our regional virus laboratory. So we were -- you know, on 10 January, we had -- at that stage knew what the genetic make-up of the virus was, and on 10 February, we were one of 12 centres across the UK who began testing for Covid-19, although we only had 40 tests a day capacity.

We were developing and working at pace to develop legislation, in terms of the Coronavirus Act. We were working with the Department of Justice, the Department of Education in developing all of those clauses.

We also were developing legislation to make Covid a notifiable disease so that we could track cases in the community as they arose.

Similarly, I was -- the colleagues in the PHA were ramping up their health protection capacity to deal with any potential outbreaks, including looking at their arrangements for contact tracing.

I met with colleagues in the Health and Social Care Board on 11 February and asked them to develop surge plans for health and social care and followed that up in a letter on 17 February.

So there are many, many other things we were doing

in terms of also -- the minister was briefing the Executive, having attended COBR, and he did so on the 3rd, the 10th, the 17th and 24 February. We were briefing senior officials across all government departments, up to and including the head of the Civil Service, in terms of what might lay ahead and the impact across government.

So what we were doing in Health was getting ready and flagging to others: you need to get ready; this could be potentially a very significant problem. But, I mean -- and, again, that's just a snapshot of some of the activity at that time and doesn't reflect the totality of it.

Q. No, and I'm going to, if I may, just examine some of the aspects of that.

I wanted, though, first of all, to just pick up and ask -- and obviously it's appreciated that you were the Chief Medical Officer within the Department of Health, but in terms of flagging to broader government in Northern Ireland at that time how potentially serious the position had become, where -- what was the channel by which that was being communicated by you or by the Department of Health? Or what was the principal channel by which that was being communicated?

A. Well, I mean, at that stage, as you pointed out, COBR

meetings had been occurring. The minister had been nominated by the Executive, by the Executive Office, to represent the Northern Ireland Executive at the COBR meetings. I supported the minister at those meetings. Executive Office officials attended those meetings. The Executive Office was receiving papers, COBR ministerial meeting papers, and also was attending COBR official meetings from early February. So they were receiving all of the information themselves. In addition to that --

LADY HALLETT: I think the question was -- sorry to interrupt. I think the question, you may have misunderstood, was: how did you pass it on? What was the main channel for passing it on?

MS DOBBIN: Yes, and what was --

A. I think -- I was trying to make the point that the information was coming directly into the Executive Office, but in addition to that, what we were doing was we requested a meeting of CCG (NI), the Civil Contingencies Group. We presented at that the emerging picture of one of my deputy chief medical officers --

Q. That came much later, didn't it? That was on 20 February.

A. That was on 20 February.

Q. Yes. I'm really just focusing on -- and I'm taking this

chronologically -- trying to understand what alarm bells were being sounded by you, if any, to wider government in Northern Ireland about quite how serious the position was, given the centrality of your role and the information being provided to you --

A. Well, okay --

Q. -- by dint of, for example, you being in the UK-wide CMO group and --

A. Yeah. Well, as I say, the information was going in directly into the Executive Office, and officials were attending the relevant meetings.

In addition to that, back in, you know, the -- as I recall, the COBR meeting of 5 February, there was an action that all departments across governments, including the DAs, should consider their business continuity arrangements and planning for a reasonable worst-case scenario for flu. The then head of Population Health flagged that in a written memo to the head of -- and TEO.

I mean, I think you did look at this previously, but I think it's important that --

Q. Are you talking about the 6 February communication?

A. Yes.

Q. I'm going to come to that. I'm taking this in stages.

A. Okay.

Q. I'm going to -- I'll go to some of what happened before that, and I'll go to some of the correspondence around it --
A. Okay.
Q. -- and then you'll have an opportunity to address it.
A. Okay. Well, all I would say is, you know, things were moving very quickly at that point in time, and, you know, it was pace and momentum, and, you know, there certainly -- you know, the ... you know, if you look back on this, and I think it is important that we do look back on this, that at this time, we had raised UK CMOs on the basis of the emerging picture. So let's go back a little bit and look at that earlier period on 30 September -- sorry, 30 January. The World Health Organisation said this is a public health emergency --
Q. Yes.
A. -- of national concern. As UK CMOs, we met and agreed to raise the alert level to moderate. Now, we did so to send a signal to all of government and all governments to begin to plan and prepare, and that means, you know, all eventualities. You know, it's -- I mean, I appreciate that, to the layperson, "moderate" sounds pretty benign, but, I mean, I think those of us who are familiar with that terminology, "moderate" means: prepare for all eventualities, and preparing for all

eventualities meant, you know, using the reasonable worst-case scenario for pandemic flu without a vaccine.
Q. I think maybe if we just look, then, at some of the specific communications --
A. Okay.
Q. -- around this time to try and understand that.

If I could start, please, with INQ000201813, and page 1, please. I think the Inquiry has seen this already. It's an email from a Ms Rooney to Mr Stewart, so individuals within the TEO. So this is following that COBR meeting at the end of January. We can see that the minister, Minister Swann, asked if the First Minister and the deputy First Minister had been briefed on the issue, and we assume that's the evidence that was coming to light about Covid-19. We can see there she says:

"I haven't seen any papers going through so I am not clear on what [the] First Minister and deputy First Minister have been informed to date.

"It is anticipated it will become a global pandemic over the next three weeks.

"Agreed: ..."

And it would appear that Ms Rooney is reporting back what had been agreed at the meeting.

"... it would be prudent to planning for

a reasonable worst [it says "vase" but I assume that means "case"] case scenario. Possible that it will be similar to the flu pandemic experience of 2018."

I'm going to come to the next chain in this, and then I'm going to ask you some questions about it.

And I think we can see that the reply given from Mr Stewart at the start:

"That is a stark assessment, and we should brief First Minister and deputy First Minister - please seek input from the Department of Health."

Then if we go, please, to the next document, which is INQ000469468, and page 1, please. It appears that -- and this is -- sorry, I should say -- an email from you to Ms Rooney, saying:

"Bernie, please confirm this paper has been updated as per my email ... today.

"Given the professional and technical nature of these papers as CMO I will wish to clear all future Executive papers while DoH remains the lead government department."

So just pausing there, Sir Michael. This was officials from the Executive Office who were, it would appear, simply seeking to update the First Minister and the deputy First Minister about the outcome of COBR. I won't go back to the notes of 24 January, but that --

sorry, 29 January. But like the COBRs before, it was attended, wasn't it, by a wide range of ministers from across government --
A. That's correct.
Q. -- in Northern -- sorry, in the United Kingdom. So not just a meeting of health officials or health ministers.

Looking at that email and the language you use, you as CMO are saying that you want to clear Executive papers. So, I mean, on the face of it, not medical advice going to the First Minister and the deputy First Minister, but clearing papers from within their own department, updating them about COBR meetings.
A. I think --
Q. Can you explain -- sorry, forgive me for cutting across you. That might be thought or might appear to the outside eye to be a clear example of overreach into the Executive Office on your part.
A. I mean, I accept the interpretation that you've placed upon it, but I think the qualification is professional and technical.

What I was referring to is that any professional advice or technical advice into the paper, absolutely, I would have expected to have cleared that, given the significance and importance of that.

I mean, I think it's one thing someone sitting in

a room -- and maybe we'll come back to the first email as you've suggested. One thing someone sitting in a room forming an interpretation of what they've heard, particularly if an individual doesn't have a professional or a technical background, and then providing an interpretation of that.

In something of such nature and importance, I absolutely felt it was important that, in terms of that professional input into the paper, irrespective of what else it said, that I needed to be sighted on that and needed to agree that.

I accept, as it's written there, you know, your interpretation is another interpretation of it, but that's not what was meant by that.

Q. I don't think it's a question of interpretation. I mean, I think it's a question of you as CMO inserting yourself into the processes of the Executive Office so that the officials couldn't provide an update without, as you say, wishing to clear -- and it's not just this -- clearing all future Executive papers whilst the Department of Health remains the lead government department --

A. Well --

Q. -- and, sorry, forgive me. The Executive was a separate department to yours.

A. Yeah. I mean, I go back to the point I'm making -- is that at this point in time, we were clearly the lead government department, this was professional, technical advice to which I was referring, and I think it was entirely appropriate that I was assured of the completeness of professional and technical advice to the First Minister and deputy First Minister.

What I was referring to was -- and, again, I appreciate it's not well worded, but I was referring to clearing the advice that we were providing. As I recall, and subsequently found out, the advice had actually been provided by the Deputy Chief Medical Officer, so there wasn't an issue. But I wasn't aware of that at the time, such was the pace of events. But certainly that's what I intended by that email, and certainly, you know, I stand by it, that I absolutely needed to clear professional and technical advice to inform any Executive papers to the First Minister and deputy First Minister.

Q. It says:

"... I ... wish to clear all future Executive papers while the Department of Health remains the lead government department."

It doesn't say "I wish to clear". I mean, you wouldn't need to say "I wish to clear my own advice"

because you would be providing it.

A. Well, look, let's be -- you know, let's be clear. I do not, never have done, clear Executive papers, and the officials in TEO would know that. It's badly framed and worded there, I accept, but I have no rule -- I have no rule -- role in clearing Executive papers. Those are considered and approved by the First Minister and deputy First Minister. And as you saw throughout the pandemic, our role was simply -- my role was to provide professional and technical advice into those papers.

That's what I meant by it. I appreciate there could be a different interpretation put on it, but that is not a correct interpretation.

Q. I mean, the impression that's given is, I think, again, the centrality perhaps of your role, and that, as I've said, even within the Executive Office, officials don't seem to have been able to simply provide papers about COBR, for example, without you having sight and -- I mean, it says in terms -- clearing them.

A. I mean, I -- what I -- I mean, I make this point again and we can ... but I -- what I was -- I mean, I'm certain in my own mind, I remember sending this email, I was simply referring to professional and technical matters. I needed to be sighted on those.

I became aware a paper had gone. I didn't know what

and who had contributed to or cleared the professional, technical input into it. I subsequently found out that it had been provided by the Deputy Chief Medical Officer. At that time I didn't know -- I knew a paper had gone and I was concerned that perhaps it didn't fully reflect the concerns at that time and the risks at that time. I think I would have been in dereliction of my responsibilities as Chief Medical Officer were I not to assure myself of the accuracy of the information that was being provided on the professional and technical aspects of that.

I have no role in clearing Executive papers, none, and never have had, and did not have throughout the -- throughout the pandemic. And that would have been understood. I understood that, and officials in TEO would have understood that.

Q. I'm going to bookmark the lead department and come back to that in a second, but perhaps just to deal with that shortly, there wasn't any doubt, was there, or uncertainty, that the Department of Health was the lead department for the purposes of this emergency?

A. At that stage, yes.

Q. Right. We'll come back and I will take you to the protocol, the 2016 protocol about that.

A. Can we -- you mentioned earlier we'd come back to the

email of the 29th, which we didn't do.
Q. We can certainly do that. Was there a point that you wanted to make about it?
A. Yes, which I think is an important point.
Q. I think it's INQ000201813.
A. I think it's before that. I think it's just over the page, the earlier page, if I might, please.
Okay, and I think this makes the point helpfully, the third line down:
"It is anticipated [that this] will become a global pandemic over the next 3 weeks."
That wasn't what was said at the COBR meeting. I was at that COBR meeting, the update was provided by Professor Sir Chris Whitty and the minutes will reflect what he said, which he said this -- you know, I paraphrase it, and he was referring to the fact that this would be either contained within China or not, but we won't know that for the next three weeks.
So the reference here that this would become a global pandemic over the next three weeks is an interpretation of what an individual, without professional or technical background, made of that. Now, that's not a criticism, it's just a statement of fact.
So I think that if we link that then back to the

email we've just discussed, what was crucially important in my mind was that I would -- was confident of the advice that -- professional and technical advice that was provided to ministers on what we then knew about the pandemic and the potential risks.
Q. Ms Rooney was someone who was involved in civil contingencies, so she did have a distinct role within that sphere within the Executive Office, so one might have thought that she would be entitled to brief ministers or to provide that information, or at least, if this was an issue of real concern to her, that she would be able to communicate that.
A. No, it's not that, that's not -- sorry, it's not the point I'm making. The point I'm making is that that reflects a less than full understanding of what was discussed at that COBR meeting. It's absolutely not a criticism whatsoever, it's just --
Q. I think --
A. -- it's just a statement of fact.
Q. I think what that would suggest was that the officials were alarmed by what they had heard at the COBR meeting and wanted to brief ministers to that effect.
A. Which is entirely appropriate, and which is why the then -- the health minister asked if the First Minister and deputy First Minister had been briefed.

Q. Just moving on then, to, as you've referred to before, the COBR meeting on 5 February that had some officials from the TEO added. I won't bring up the notes, I don't think we will need to, because I think you know this, you've referred to it, that COBR on 5 February agreed that:
"All departments to rapidly advance planning for reasonable worst case scenario, centrally co-ordinated by Civil Contingencies Secretariat."
Correct?
A. Correct.
Q. I think -- well, you may tell me this is not the case, but is that what prompted the letter from Liz Redmond of the Department of Health on 6 February?
A. I can't now be certain, but -- and I'm conscious what I'm doing is piecing information to -- almost together, but I think -- in terms of the timeline, I think that's most likely the case.
Q. I think so, because I think we look at correspondence from you at the same time that demonstrates this.
A. Yes.
Q. Perhaps if we could just look briefly at that letter, it's INQ000218471, and it's page 2.
So, again -- and I'm just drawing attention to this. Sorry, I was going to look at the second paragraph very

briefly, because again it obviously makes the point that Health is the lead government department.
A. Yeah.
Q. So, again, no lack of clarity about that.
A. No.
Q. Then if we may just go down a couple of paragraphs, please, and we see -- and we've seen this a number of times -- Sir Michael, the advice that appears to be given:
"I do not consider it necessary to activate NICCMA arrangements at this time, unless and until the infection appears in [Northern Ireland] and impacts are experienced here."
Was that advice that you had provided or that you were party to at this point in time?
A. With the passage of time, I don't have a clear recollection of that being discussed with me. Although I would say, given where we were at that point in time, I felt that was not an unreasonable position, and I wouldn't have disagreed with that, even -- well, at the time I wouldn't have disagreed with that assessment, where we were at that point in time.
Q. I mean, that might seem a surprising answer, I mean, given that it's advice that you don't need to activate civil contingencies until the virus is actually

a reality in Northern Ireland. So it seems to obviate the fact that contingency arrangements might play a vital part in planning for that.

A. I'm happy to elaborate on that, but I think it wasn't -- what it was saying -- what it wasn't saying was "Don't do anything". I think if we move done a little bit -- sorry, no, it was on that paragraph, apologies.

Yeah, so:

"In order to provide assurances should an escalation of events be required ... [Document read] ... request to implement NICCMA, it would be helpful if you would consider convening a multi-agency meeting in order to ensure/inform an assessment of sectoral resilience, preparedness, capacity and capabilities across Northern Ireland departments ... [Document read] ... emergency services ..."

So I think what we were signalling there is the department's assessment at this time is: not just yet, but you need to get ready, you need to prepare. And, you know, I think that that also, and we may -- I hope I'm not jumping ahead, we may come on to this, the update that was provided by the perm sec then to the perm secs group, where he said this is a very fluid situation, a rapidly evolving situation, and urging perm sec colleagues to consider the business continuity

plans and to plan on the basis of pandemic flu reasonable worst-case scenario.

So I think we were clearly signalling: there is a problem coming our way and we need to prepare for it, not just Health, but other departments need to prepare for this.

Q. The suggestion "it would be helpful if you would consider convening a multi-agency meeting" hardly sounds alarm bells, does it?

A. Erm --

Q. I mean, it's --

A. It's how civil servants write to each other. I -- you know, I agree -- you know, we would not be putting in writing a memo to the lead official in TEO, which -- and in -- this also included a letter from myself. I don't send many letters to departments saying "You need to plan and prepare on the basis of reasonable case worst scenario for pandemic flu, to check preparedness and readiness".

So, I mean, for those who know, we were clearly signalling that there is a problem, a potential problem here, and we need to be assured of our preparedness and our readiness across government and sector resilience across Northern Ireland.

So I appreciate the wording, but, you know, I would

say to you the interpretation of that and what we were doing would be clearly understood by those who needed to understand.

Q. You mean that the officials in the TEO --

A. Yes.

Q. -- to whom this was addressed, who aren't medical professionals, they would understand from this that actually what you were saying was: the situation is incredibly serious and all departments in Northern Ireland really need to start thinking about the fact that there's a global pandemic on the way?

A. There is a potential. Because don't forget, at this stage -- you know, the global pandemic wasn't declared by WHO until 11 March, so we're in, you know, very, very early weeks here.

The other point you made there in terms of not professional or technical staff, it's back to the earlier point that you made, they were still individuals who were in civil contingencies branch and therefore would have been familiar with the language and the request and what we were asking for. So it didn't require a professional or technical background to understand this request. This request wasn't being made by me in a professional, technical capacity, it was basically being made in relation to being prepared to

stand up our civil contingency arrangements.

LADY HALLETT: Sir Michael, could I just ask you to use hindsight for a minute, and I appreciate the number of people in your position who don't want me to use hindsight. But, using plain English, wouldn't it be better if that had said "We urge you as a matter of urgency to convene a multi-agency meeting" as opposed to "It would be helpful if"? Wouldn't that have got across a sense of urgency?

A. You know, with the benefit of hindsight -- you know, it's a wonderful thing. I didn't write the letter. I accept the point that you're making. I think we -- you know, and I know we're not -- we're taking this chronologically, but certainly I used that language at a meeting of the perm secs which I attended on 28 February, but I appreciate that's a later time period.

I mean, I think that it's the language that you would use within government. I do accept your point that it could have been more direct, it could have been more action orientated, but again it comes back to the point that in Health, you know ... you know, perhaps it was unduly deferential, is I think the point you're making, and perhaps it might have been more helpful to have said, you know, "We now advise that you should".

LADY HALLETT: You see, I find it difficult to accept that in a time of emergency you would use that language just because that's the way you normally do things.

In an emergency you don't do things in a normal way, you get on with it, and I'm afraid that language doesn't give any sense of urgency.

A. As I say, I wasn't the author of the letter, but, I mean, I do accept the point that you're making, but I think if we put it in the context of the attendance of TEO officials at COBR meetings, I mean, it wasn't that this letter was coming, you know, completely out of any other context. At that stage TEO officials were attending COBR meetings, they were attending COBR (O) meetings, official COBR meetings, so the letter came in a context where there was already a knowledge within TEO of the wider aspects, and we alluded to earlier the email from -- you know, exchange in TEO between officials about their level of concern. So I think that contextual point is important, but I accept the point you're making about the use of language.

LADY HALLETT: Thank you.

MS DOBBIN: Could I move on to the letter that you did send that day and which is annexed to this letter. That's at INQ000218470. Sorry, forgive me, that was that letter. It's INQ000254430.

So, first of all, Sir Michael, we can see that if we look in the left-hand corner of the top of this letter, that this was being sent to all Northern Ireland departments through the Civil Contingencies Group for onward distribution to all public authorities.

If we could, please, just scan -- I don't want to take this out of context, Sir Michael, but we can see that you've explained, first of all, at paragraph 1, what the purpose of the letter is.

A. Yeah.

Q. "... to respond to any and all potential eventualities ..."

Maybe I'll come back to that language, but just to put this in context:

"It is essential that all Departments are assured that proportionate, appropriate and efficient arrangements in are place that are consistent with the key public health messages about novel coronavirus."

Thank you.

If we just scroll down a bit, there's an explanation about coronavirus. There's reference at paragraph 4 to the symptoms.

At paragraph 5, there's explanation that the cases have been -- have originated in Wuhan, and information about flights being suspended and so forth.

I don't think it mentions anything about people potentially coming by bus or anything like that into Northern Ireland. I think the focus there is on flights from other airports. I say that because it specifically draws out the fact that there are no direct flights between China and Northern Ireland or the Republic of Ireland.

If we could scroll down, please, a little bit more, then the key public health advice that you've suggested there ought to be consistency with, we can see that it's about travel from Wuhan, we see that at 7, and paragraph 9.

Thank you.

And I think paragraph 9 says the same thing.

Then paragraph 12 follows up on that. It's about travel from Wuhan.

If we could go down, please, and I think if we could go to paragraph 20.

Sorry, I don't want to, again, take this out of context, but I think the paragraphs 13 to 17 are about travel advice.

Then when we get to paragraph 20, there's reference to the fact that:

"The Department of Health ... and other ... Departments [had] received queries from a range of

public authorities and other sources about what action they should take in response to the [2019] outbreak. The Department of Health is closely monitoring the outbreak as it develops."

And the advice that's given is:

"... those public authorities that already have contingency plans for responding to infectious diseases, such as pandemic influenza, should ensure that all relevant staff are acquainted with those plans."

I just want to check, please, there's nothing more. Yes, so paragraph 21:

"No other action is recommended at this time to public authorities in general."

Again, Sir Michael, it would be thought that that's hardly sounding alarm bells for either Northern Ireland government departments or to all of the public authorities that they sponsored?

A. I mean, I think it's important to put this in context, and if we go back to the last letter, it was to facilitate and to enable a meeting where other cross-sectoral stakeholders were fully briefed and informed of the emerging threat.

I think if we link it back -- and I know we haven't got it up on-screen, but one of the action points arising out of the 5 February SAGE was that -- and

I can't recall the exact wording, but that trusted partners would be informed of the emerging situation, and there was a communications strategy in relation to how that communication would be relayed.

So all this was doing was scene setting for a meeting at which there would be a briefing in relation to trusted partners, as were referred to in the COBR meeting of 5 February, and that at that meeting assurances should be sought around contingency planning across the public sector and other organisations.

So this letter was not meant or intended to explain or set out the level of risk or the level of concern. It was an enabler to facilitate a meeting which had been suggested, which we've just covered, at which there would be an update provided.

Q. You're going to have to help me, because above paragraph 20 it says "Coronavirus: actions to be taken by public authorities", it doesn't say anything about "We're going to have a meeting and it's going to "... I mean, it is what it says.

A. No, I mean -- can we go back to the last exhibit, which was the letter from Liz Redmond? Because I think it clearly states in that -- or if it doesn't state in the letter, it states in the covering email that is associated with this -- that went, you know, "To assist

in the cross -- or this cross-sectoral meeting, I attach a letter from the Chief Medical Officer".

Maybe if we could go down the next page. Yeah. Penultimate paragraph:

"To assist with the wider government co-ordination here, the Chief Medical Officer has written a letter ... regarding health advice, to be shared ... I would be grateful if you could arrange for this to be shared as soon as possible."

So this was basically in the context of the meeting, and that was the purpose, as I recall, of the letter, and to ensure that those who attended were aware of the seriousness of the situation and that, as Chief Medical Officer, I was writing the letter and that they could be -- would be briefed at the meeting.

Q. The letter -- sorry, not this letter, the one that you sent, was to all Northern Ireland government departments and all public authorities --

A. No.

Q. -- that they, I think --

A. No, it wasn't. The letter was attached to this memo and it was distributed and it was attached to this to go to TEO to distribute to all government departments.

Q. Yes.

A. Because we were doing this under the context of civil

contingencies --

Q. Sorry, forgive me --

A. -- I think that's -- that is a distinction and I think it's an important distinction.

Q. Sorry, I'd like to understand the distinction. So it's to all Northern Ireland departments, through the Civil Contingencies Group, for onward distribution to all public authorities.

So this letter was -- you intended that this would go to all public authorities --

A. Yeah.

Q. -- in Northern Ireland; correct?

A. In the context of the civil contingencies arrangements.

So there's two points to that. The first is we were clearly signalling the importance and significance of this because we were rooting it and framing it in the civil contingencies arrangements, which obviously you only -- you stand up if there's a level 2 or level 3 incident, and therefore we were sending it out in that context, and we were sending it out in the context of the Executive Office responsibility for assurance around cross-sectoral preparedness and resilience, for which they are responsible.

So, you know, the -- as I recall this email, memo to the Executive Office, had as an attachment this letter.

The context was to have the meeting and this was to inform stakeholders in advance of that briefing session. I mean, that's my clear recollection of the sequence of events at the time.

Q. So in terms of the briefing session that you're referring to, I just want to be clear who that briefing -- what this was a meeting of. Are you referring to the Civil Contingencies Group or is that something else?

A. No, I mean, I think I -- you know, again, at this stage I had many and multiple demands on my time, so I -- you know, I'd assume, but I don't know and -- you know, in terms of what action TEO took on the back of it. There certainly was a CCG(NI) meeting, and I suspect that that CCG(NI) meeting was probably on foot of this correspondence.

Q. Okay, we'll come back to that meeting, because we do have the minutes of what was discussed at it. But we know, and I won't take you to it, but the advice that was given by Liz Redmond about not considering it necessary to stand up NICCMA, we know that that advice was repeated by -- well, certainly it was in his script or his speaking note -- Richard Pengelly at a meeting of permanent secretaries the next day.

It also appears that it was the message that was

being provided, I think, to ministers at the same time; is that right?
A. I mean -- I mean, I wasn't at the Executive meetings, and certainly didn't attend regularly until around 14 May, although I did attend an earlier Executive meeting on 2 March, but, as I say, said earlier, throughout February there were regular weekly updates to the Executive about the emerging situation, and the minister, I know, and certainly in his speaking note -- I can't vouch for the discussion at the Executive meeting, but I know at the meeting of 10 February he alluded to the fact that correspondence had been issued from the department to civil contingencies branch in relation to assurance around cross-sectoral preparedness and readiness.
So, I mean, that was certainly in the minister's briefing, but, as I say, I wasn't in attendance at the Executive meeting.
Q. Maybe we could look at that.
It's INQ000425517, please.
A. I hope I have the right date, but I can't be certain, I'm sorry.
Q. We'll check and see. This is --
A. That's the 14th, sorry.
Q. That's 14 February, so it's a little bit after this.

It's really just to understand the consistency of messaging. Have you got that?
A. I think it's INQ000425551.
Q. Sorry, we might be at cross-purposes from each other.
A. Sorry.
Q. I can ... so I think -- is this the document that you were referring to?
A. No, it's the -- I think it's 10 February, from memory, but, you know, I stand to be corrected, I don't --
Q. All right.
A. I can't be certain.
Q. If I could go back, please, to the document --
LADY HALLETT: The meeting was 10 February.
MS DOBBIN: Yes.
A. That's a point, it could be -- sorry, Chair, you might be absolutely correct. Sorry, apologies.
LADY HALLETT: It's all right.
A. Oh, sorry, you are right, apologies. Yes.
LADY HALLETT: So we've got there.
MS DOBBIN: We've got there. But it's not in fact the document I was going to.
A. Sorry.
MS DOBBIN: I don't know if I'm confusing everyone.
A. No.
LADY HALLETT: You're not, Ms Dobbin, and I shouldn't have

tried to help.
A. I think you were asking me about the understanding of the Executive was, and I was simply referring to the fact that the minister had briefed the Executive in relation to this communication to TEO and the letter from myself, and that's only the point I was trying to make, which is reflected in the briefing note here.
MS DOBBIN: I was making a slightly different point --
A. Sorry.
MS DOBBIN: -- which was about the message that was being conveyed to ministers. But perhaps that means that it's a good point at which to break for lunch and then I won't confuse anyone any more.
LADY HALLETT: Not at all.
I shall return at 1.45.
(12.45 pm)
(The short adjournment)
(1.45 pm)
LADY HALLETT: I think we got rid of all confusion, Ms Dobbin.
MS DOBBIN: I think we're on the straight and narrow.
Please may we go to document INQ000425517.
Sir Michael, this was the document that I was going to take you to before the short adjournment, and it's a briefing, it would appear, dated 14 February 2020, and

it's a briefing to you and Minister Swann; yes?
A. That's correct, sorry.
Q. I think if we go down, we can see that it was a briefing for an Executive meeting on 17 February, and perhaps you can help, was it usual that you and the minister would be briefed in the same way by this sort of submission for the purposes of Executive Committee meetings?
A. This wasn't a briefing for me, I mean, I wasn't attending Executive meetings at this stage. This was a briefing for the minister in advance of his attendance at the Executive meeting.
Q. So why are you one of the people to whom it's addressed, rather than just a copy?
A. It's protocol for clearing papers that go to a minister in terms of submission, so I would be -- you know, notwithstanding the other matters under consideration, I would have viewed the submission and approved it for the minister's consideration.
Q. Right. So this is an example, then --
A. Yes.
Q. -- of a clearing --
A. Yes.
Q. -- process that you were involved in --
A. That's correct.
Q. -- in order for advice to be given to Minister Swann; is

that right?
A. That's correct.
Q. And onwards to the Executive Committee --
A. Yes.
Q. -- correct?
I think if we please go to -- I'm going to try to cut through this document, but perhaps if we could go to page 5, paragraph 20. So I think this was the advice that was being provided.
So we see reference there to the letter of 6 February that was sent to the TEO, and, again, repetition of the point that multi-agency co-ordination is not needed yet, but "they might want to consider convening a multi-agency meeting through the Civil Contingencies Group"; yes?
A. Definitely.
Q. If we go on, please, to page 9, we can see that this is a "Speaking note and lines to take".
And if we go on, please, to page 11, and if you could highlight bullet 3.
And again, the same point in terms of the lines to be taken, that TEO "might want to consider convening a multi-agency meeting through the Civil Contingencies Group to assess sector resilience"; yes?
A. Yes, and I think in the context of the first bullet

point on that page, which is relevant as well.
Q. The first bullet point?
A. Yeah, the final paragraph -- or final sentence, sorry.
Q. Yes. So in terms of the message that is being provided to ministers, that might be thought of as being said with a forked tongue, so, on the one hand, clear that if we have sustained transmission and spread and a global pandemic, that the impact will be felt, on the one hand, but then, on the other, the continuation of the consistent message, to that date, that there wasn't any need to stand up civil contingencies arrangements and, rather, the suggestion that they might want to consider setting up a multi-agency meeting?
A. I mean, this is in the context, as I've mentioned, where there had been a series of updates, 3rd, 10th, the 17th and then 24 February, so the fact that this is a regular update to the Executive itself on this matter suggests a matter of importance.
I think that the final paragraph there as well I think is relevant in that context. You know, notwithstanding the sentences above, that there is no -- continues to be no room for complacency, and the minister indicating in the final sentence there that "we must plan [and prepare] to mitigate the potential consequences".

So I think that, you know -- I mean, I obviously wasn't at the meeting itself, I don't know how that was conveyed. To my reading of that, I think there was a conveying of a sense of potential significant consequences across government and certainly, potentially, for Health. And I think it's also important to put it in the context of the very small number of cases that this alludes to. I think the earlier page there had been nine cases detected in the UK. Those had all been travel-related. There was no -- as I recall at that stage, no community transmission that had been identified at least in the United Kingdom, no cases in Northern Ireland, and the WHO, you know, didn't declare the pandemic until 11 March. So I think -- it's just in that context, I think, that we need to view this at a point in time.
Q. So I'm just -- I want to understand what you're saying, that that's a point that obviously militates towards the suggestion that the situation isn't really -- or, I don't know if this is what you're suggesting, that it's not gotten that serious just yet, therefore "you might want to consider having a civil contingencies meeting", or are you saying that in fact you were trying to convey a sense of urgency and that you were trying to convey to government in Northern Ireland the gravity of

the situation?
A. I think what was being conveyed here, that there was an urgency about planning and preparation for a range of eventualities, and I think the key is earlier in terms of the raising of the alert level from low to moderate, and governments, all governments, as was relayed at the COBR meeting, to prepare for all eventualities.
So essentially what this was saying is that, you know: we just, at this point in time, don't know, but don't wait until we know because we need to begin to prepare now, and Health is already beginning to prepare, and all other governments under the umbrella of the civil contingencies arrangements need to do likewise.
So I hope that sort of answers the question, but, again, I think the important point is it was in the context of what we do at a particular point in time.
Q. All right. Well, let's see what the messaging was that followed this.
I think that the next development at this point in time was that there was a COBR meeting on 18 February.
And perhaps if we could just have that on screen, please, INQ000056227, and perhaps if we just go to page 7 of that.
I think we can see here that COBR was setting out "Planning for a Reasonable Worst Case Scenario (RWCS) -

next phase", and then we can see at paragraph 18 the various points that were being set out.

So, in other words, it seems that the planning was starting to contemplate, for example, going beyond government and going towards the voluntary sector; yes?

A. Yes, that's within my understanding of that, yes.

Q. I think if we go to the penultimate point, at page 11, we can see as well that:

"All departments and devolved administrations [were] to contribute possible future decision points to the Civil Contingencies Secretariat as part of the reasonable worst case planning."

Yes?

A. Yes, I can see that, yes.

Q. So, in other words, it does seem that COBR was contemplating that the devolved administrations become involved in terms of providing their, as it says, future decision points; correct? And what was that a reference to? What did you understand by that?

A. I mean, I think this is back to the earlier point on this, I think, which was back to the civil contingencies arrangements. I think that my understanding was that that was clearly within those civil contingencies planning arrangements, and that that's how that would be taken forward.

LADY HALLETT: What's a possible future decision point? I appreciate you didn't write the document. I believe in plain English, as I think I've made plain many times, and I've got no idea. A decision point, is it a point in time when the decision's going to be taken?

A. I suspect -- I don't know, I'm putting an interpretation on something which I'm, you know --

LADY HALLETT: You have a better idea than I have, probably.

A. Right, okay. Although I stand to be corrected and, as I say, I didn't write it, my sense was that this alluded to a range of eventualities should this evolve into a significant pandemic which required a response that would be a cross-government response consistent with the civil contingency arrangements. I think that's my interpretation of that.

I think your specific question is: how do you know you've reached the decision point? And I think that goes back to when we have identified cases of, you know, community transmission within the UK, and if it was, as was emerging, that this was a highly transmissible virus and there was sustained person-to-person transmission, then in all likelihood we were in an entirely different scenario.

But I think it probably reflects even then, even at that time there was a degree of uncertainty and a degree

of watchful waiting, but preparing and preparedness. And, you know, you look back on it now in terms of what subsequently happened, and you do ask the question as -- you know, could we, should we have been doing more or interpreting what we were seeing emerging more significantly?

But, as I say, it was based on the information we had at the time, what we knew at the time and what our understanding was it at the time.

LADY HALLETT: So did you understand -- I'm so sorry to interrupt, Ms Dobbin -- "future decision points" to mean, so, for example, "When we reach 1,000 cases we do X", or what -- is that what you understood it to mean?

A. If indeed we were seeing the impact -- if this became a pandemic and we started to see -- let me put it another way.

If it was highly probable that this was going to become a pandemic, and therefore was going to have impacts, as it did have, right across government, impacts on health, education, economy, et cetera -- so, I mean, I think that -- and, again, I can't recall clearly what my interpretation was at the time, but, I mean, that was my understanding of what was meant by that.

MS DOBBIN: Can I just ask you, the language you've just used of "highly probable", where does that come from in terms of planning at this point?

A. I said "if it became highly probable". I mean, I think it was just trying to illustrate the normal sequence of events where it comes forward -- you know, it develops from a situation whereby there's an emerging new virus, there's an assessment of the risk. You come to a point as to whether you need -- you obviously then need to establish the likelihood that this is -- is it or isn't it transmitting from person to person. Then the next question is: is there evidence that it's -- there's sustained person-to-person transmission? And then the next question is: what is the probability, likelihood that this actually may develop into a pandemic? Is that a possibility? Is it likely? Is it highly likely? Is it extremely probable?

And I suppose those are the range of options which, you know -- and considerations -- which were going through -- certainly going through my mind at the time, and certainly through CMO colleagues at the time. Obviously we feared the worst, but we weren't yet certain at that stage in terms of how things would develop.

Q. Were you planning for the worst, or were you planning

for the reasonable worst-case scenario, as COBR was suggesting --

A. Well, we -- well, certainly --

Q. -- ought to be done?

A. Certainly in Health, I know what we were doing, which was preparing for the reasonable worst-case scenario, and in turn we were communicating that to other departments in terms of to use that as a basis for their planning and preparation.

And there obviously comes a point -- and I think this is -- you know, this is probably an important point to observe, that sometimes it's -- you know, if you're in -- a major incident occurs, if there's a bomb blast, you go from being at point zero to basically standing everything up, and it's very clear that you need to stand everything up, the civil contingency arrangements, you know, COBR, whatever the emergency response arrangements are.

However, you know, this was a situation which was evolving and developing, and we sometimes refer to those as rising tide events, and it's sometimes not easy to determine when you're switching from one phase of the response, in terms of, you know, planning and preparing, into response mode. And I think that's -- you know, we were watching this developing, we were watching the

situation, we all were watching it on our televisions in terms of the situation in China, you know, and then -- and we're going to come on to this -- in other European countries, but there was still at that time a reasonable prospect that this could have been contained in China. And as the time went on, you know, as -- you know, back to Professor Woolhouse's email, it became clearer that that was more in hope than expectation --

Q. This was 19 February.

A. No, no, I know, but I'm just using -- I'm just trying to relate it back in terms of his earlier assessment --

Q. Forgive me, it was 14 February, I'm going to come on to 19 February, but, you know, we're some weeks past that email where he was expressing more hope than expectation.

A. No, sorry, I was just referring to the use of the language. I mean, I think that's the only point I was making.

Q. Can I come back -- I don't think it matters, but this -- what was being referred to at COBR on behalf of Northern Ireland in relation to the reasonable worst-case scenario planning was that there would be a Civil Contingencies Group meeting on 19 February which would discuss the response, and I think that's something to which --

A. Sure.

Q. -- you've already referred. Was that a meeting that you attended yourself?

A. No, I didn't attend that, no.

Q. All right, I'm going to go briefly to the minutes of that, if I may.

That's INQ000023220.

The Inquiry's already looked at this. It sets out the meeting, and in fact it ultimately I think took place on 20 February, although it had been referred to in COBR as taking place on the 19th.

As we can see, the priorities that were identified in Northern Ireland were the identification of isolation facilities, legislation, storage, and then just general readiness:

"... review business continuity plans in light of reasonable worst case parameters ..."

Again, this suggests, doesn't it, once again, that there's no sense of urgency across government in Northern Ireland, but ... I mean, there's no sense of any understanding from this document, if these are the priorities, of the sorts of planning that one might expect to have been going on in government at this time?

A. I mean, I think this is a very high-level note. It doesn't reflect the totality of the discussion as

I understand, and if I -- and I know you examined this, so I'm not suggesting we pull it up again, but if we look back to the detail of the presentation by the Deputy Chief Medical Officer at that meeting, I think he was very clear in terms of planning to the reasonable worst-case scenario. That was potentially meaning up to 50% of the population affected, 2 to 3% mortality.

Q. Yes.

A. And I think it's in that presentation where he refers to impacts across government, excess deaths, school closures, massive impact on the economy, et cetera, et cetera. So I don't think there could have been any doubt -- although I do accept that this is, you know, a very short summary of action points and priorities, there couldn't have been any doubt in term of the enormity of the potential consequences.

Now, I think the other point I would make in relation to this is the reference to the legislation. We were at that time very rapidly and, indeed, had just secured the agreement of the First Minister and deputy First Minister to proceed, to take forward emergency legislation, emergency legislation in the Coronavirus Act, to give us powers to implement some of the draconian restrictions that people experienced, to close schools, to close, you know, to ban mass

gatherings, some of the other facilitating, enabling legislation to allow retired health professionals to come back, doctors, nurses, pharmacists, some of the relaxations that were put in place to reduce the burden on frontline staff.

So, you know, there can be no doubt that, even taking that one example, in terms of legislation, we were planning across government. I mean, justice was involved in the various clauses into the Coronavirus Act, we were involved in that, the Department of Education in terms of school closures was involved in that.

So the seriousness, even if one looks at the powers that we were beginning to consider that were needed to respond to what lay ahead was very significant. And, you know, similarly, the other point I would make there is the reference to excess deaths. I mean, we were talking about something that was potentially very, very significant and impactful. I absolutely accept it's not necessarily captured in those very succinct priorities, but I think -- I think it's important to understand that -- the sort of subject matter that we -- sorry, that was being discussed at that meeting.

Q. So why, then, did it continue to be the position, on behalf of the Department of Health, and indeed the

advice that it provided, that it was still not necessary to activate the Northern Ireland central crisis management arrangements? Because we know that that was still the position and the advice being given on 21 February.

A. Yeah, I mean, I think that -- and obviously, you know -- and I know we've -- you know, this has been discussed with other witnesses and I don't wish to go through all that again unless you wish, but I think that at all times it was seeking to ensure a proportionate response to this. I mean, it was quite clear that -- and certainly the last reference point there in terms of readiness, in terms of business continuity plans, that was a big ask of departments, to ensure that their business continuity plans were in place.

There was also a request, and we referred to this, and this was referred to in the presentation by the Deputy Chief Medical Officer, about engaging with their sectoral partners, their ALBs, to ensure readiness. I think that there is a -- there is that point, and it's where you switch from preparing to responding.

And I think that whilst civil contingencies arrangements are primarily geared to responding, they are -- that is not at the exclusion of standing them up in the preparedness phase, particularly if standing them

up in that preparedness phase can add benefit in terms of greater cross-government co-ordination.

So I think the point I'm making there is I think it was a fine judgement call as to whether they were stood up at that point in time or not, because in standing them up, you then move into a situation where you're having daily meetings of CCG(NI), you have the daily situation reports from each department, that was a huge, huge commitment and undertaking, and I suppose the question was: was that time better spent in engaging with the respective sectors, ensuring business continuity plans were in place, doing the advance preparation, or would it have been better spent with finite resources standing up, you know, CCG(NI)?

Now, you know, I think these are judgement calls, and I think that had this been a, you know -- you know, a tripping of a switch in terms of a major incident, it would have been straightforward. I think the difficulty thing, this was something that was emerging, evolving and developing, and I think it takes judgement then to determine when you switch from one into the other, recognising that there are significant resourcing implications which may detract from the initial preparatory work.

I mean, I think that's the only point I would make.

Q. Do you accept that at this point in time it ought to have been made pellucidly clear to government in Northern Ireland about the gravity of the situation that it faced?

A. I -- I mean, I would contend that it had been made clear, and I am surprised if it wasn't understood, you know, particularly given the briefings that the minister was providing to the Executive, as I said earlier, throughout February on a weekly basis, the engagement that had been with other departments, the memo that had gone from the director of Population Health, who I alluded to earlier, the briefing that had been provided to perm sec colleagues by the then perm sec of the department.

I think that, you know, we were there in a situation where -- and I think this is important context. We were in the situation where the WHO had already declared that this was a public health emergency of international concern, COBR had been stood up -- COBR, you know, doesn't get stood up, you know, because of something that can be necessarily managed within one department. There were regular meetings of COBR. As I say, we were in attendance, TEO officials were in attendance at official meetings of COBR, papers were being circulated, and, you know, in that time all of us -- you know, you

turn on your television and we could see what was happening, tragically unfolding in China and elsewhere. So --

Q. Professor, sorry, I'm going to try and move this on a bit.

A. Okay.

Q. I assume that you accept, we might all and officials might have been able to watch this on the television, but you are the Chief Medical Officer to Northern Ireland, and one might expect you to have been the person giving the sort of clarion call that matters really had reached a point of --

A. Well.

Q. -- some significance?

A. Well, you know, I think -- I mean, and I was fulfilling that role within the department, I was directing and leading the departmental response, co-ordinating the planning, preparation for the public health response, the health service response, briefing the minister, supporting the minister at COBR meetings. I think it's not an unreasonable expectation that senior officials in other departments would brief their own ministers.

You know, I hadn't yet been invited to attend or update the Executive or the First Minister or deputy First Minister, and, you know, had I been afforded that

opportunity I would have -- you know, I would have updated the Executive consistent with the updates that were being provided to the minister to bring to the Executive meeting.

Q. All right. I'm going to move on, then, and there was -- the 13th SAGE meeting took place on 5 March, and I think because the Department of Health in Northern Ireland provided us with a list of dates that you attended it --

A. That's correct.

Q. -- yesterday, that in fact we know that you did attend that meeting.

I won't go to the document, but at page 3, and it's point 7 of the notes, SAGE said that:

"[Her Majesty's Government] should plan for the introduction of behavioural and social interventions within 1-2 weeks to contain and delay spread; precise timings depend on the progress of the epidemic."

A. Yeah.

Q. So I assume if you attended that meeting you were aware that that was the advice that SAGE was then providing; yes?

A. Yeah, I mean, I think that's correct, yeah.

Q. I think it was that, wasn't it, that then led to the Cabinet Secretary emailing across government and the devolved administrations about moving to the next phase

and seeking an assessment of each department's preparedness against the reasonable worst-case scenario; yes?

A. That's correct, is my recollection, yes.

Q. If we could go to that document, please, at INQ000309229, please. I think we have to start at page 9.

So I think we can see from this, Sir Michael, that this email -- and forgive me, we've come straight onto the second page of it, but it was sent from Cabinet Office to numerous people across government and across the devolved administrations.

If we go to page 9, please.

We can see that it was a "Commission -- Impacts of non-pharmaceutical interventions -- by 1300 [on] Sat 7 March". We can see:

"Please could all Departments provide a return by ... Saturday 7 March ..."

If we just scroll down a little, please, the measures that were being contemplated are the three set out.

If we just go down, thank you.

If we scroll down a little bit, please, it also said that -- it also asked:

"Are there specific implications for ... policy

areas and the Devolved Administrations?"

Sorry, that's just the penultimate point. Correct?

I think that we can see, if we go to page 6 -- yes, thank you -- we can see that the email that came from Mr Stewart, again to a number of -- I think that's permanent secretaries, and to Dr Chada -- who I think was your deputy?

A. That's correct, yes.

Q. And to other people in the TEO, "Brace [yourself]", and setting out what had been requested for, from the Cabinet Office, requesting information.

I think we've already seen this, and I'm sure you're familiar with it, at page 5, the education permanent secretary set out that he thought he would have difficulties in replying to this.

A. Yes, the first paragraph. Yes, I see that.

Q. At page 3 you replied, and we can see that, so 7 March, obviously in the early hours of the morning.

A. Yeah.

Q. Where you set out that Northern Ireland simply didn't have "modelling capability to replicate and provide such granularity".

Then we can see:

"Given the unrealistic timeframes it is not possible to provide any meaningful analysis."

That you were:

"... unclear as to why this ... [was] a 'must do' ... that this [was] a marathon not a sprint."

If we can just pause there, it was a sprint by this stage, wasn't it? I mean, there really was. The reason why government departments and devolved administrations were being asked to respond at such short notice was because of the urgency of the situation?

A. I mean, I think all I would add is that my concern was what we could reasonably provide that was meaningful, as the perm sec in education said, within that timeframe that was actually going to be of material use.

And you're correct, I mean, it was a sprint, but then also my team had been sprinting for seven weeks at that stage and working flat out, working 16, 18 hours a day, and there's a question of reasonableness of asks given the timeframe for the return.

Now, as I recall, this email -- because I do remember it -- it was an email that I picked up, as you say, late in the -- into the early hours. Prior to that I had phoned, when I received it, the head of the EOC, the emergency operation centre, asked that she check both what Wales and Scotland were doing with the request, because it was a pretty generic request.

She contacted me again at 12.30 to basically say

that she was working with colleagues in those jurisdictions who equally weren't certain in terms of whether they could provide anything of any value, and also whether that would be materially different in terms of the mitigations. You know, are there particular characteristics that would be different in the population in the respective jurisdictions. As I recall.

Now, this is for an official meeting of COBR on the Saturday, as I recall, hence the return by lunchtime, but the actual ministerial meeting wasn't until the Monday, and we worked Saturday and Sunday and did make the return on the Monday in advance of the COBR meeting.

So I think -- all I would say is that I think, irrespective of what is in the content of this, we responded to the request and worked complete -- throughout the weekend to ensure we got the return back.

Q. I'm just going to carry on with this --

A. Yes, yes, by all means --

Q. -- because in fact we have later emails that I think show that in fact Cabinet Office chased up and pushed for a return to be provided.

A. Well, that might be the case, but, as I say, we were already working on the response, but ...

Q. Just before this goes down, we can see -- it's the third

paragraph up --

A. Sure.

Q. -- that there was:

"... deeply troubling and significant community transmission in the [Republic of Ireland] which is ..."

It might be:

"... [without] other risk of wider community spread, we are ... some ... weeks behind."

Yes?

A. That's correct.

Q. We can see there you weren't saying "We might -- you know, give us a day", or whatever, you were saying "I suggest that we wait further modelling by SAGE, in which I participate"?

A. Well, just to add that we did actually get that further return from SAGE. And, I mean, it's not in this series of emails, that's in my evidence bundle, but I think around 8 o'clock, it may have been, that evening we did get additional material from SAGE and from DHSC to inform our population of this return. So I hadn't seen that at the time, but I have, you know, subsequently become aware of that.

So I -- you know, my assumption that we would get a further information was a correct assumption.

Q. I'm just going to ask, before -- I've got some questions

to ask about this, but just before the document goes down, I think if we could look, please, at page 4, and I think -- sorry, yes, I think this is the final part of the same message that we saw at the top, and what you say at the first paragraph is:

"Our priority across government is to ensure that we remain focused on our priorities at this time while still in the containment phase, recognising other parts of the UK are in a different place and preparing for 'surge' with plans to mitigate impacts on public services and wider society."

Then again:

"... in ... weeks we will be ... in the place. We have however some time -- not a great deal -- to fully and accurately consider and quantify the implications and any unique impacts in [Northern Ireland] as opposed to responding to unrealistic deadlines and risk providing less than fully informed analysis and information."

Then, again, reference, at the third paragraph, to there being a "soft stand up" of civil contingencies arrangements.

I think, before we leave this, we also see the reference -- because I do want to pick this up -- about Italy. Then I think your professional advice in respect

of that.

If I just deal with that before we go on to the next email:

"My professional advice will be in the context of the UK position that the responsibility for authoritative competent advice on the safety of travel remains with the FCO which has UK wide responsibility. To provide advice other than this has significant financial implications."

Then you go on to say that you do:

"... recognise the complexity and incongruity of current advice to schools in [Northern Ireland] and the [Republic of Ireland] ..."

So, just picking up on that point, that's because school trips were still going on --

A. That's correct.

Q. -- to Italy, and I think concerns had been raised in Northern Ireland that that was still the position, given that I think Italy was in fact in a lockdown at this stage?

A. Well, certainly significant parts of it, I mean, but 12.5 million people in northern Italy I think at this time were already in lockdown, and, you know, there was a period of -- well, significant inconsistency, as pointed out in that section, between the advice that the

Irish Government were providing in terms of not travelling to Italy and the Foreign and Commonwealth Office who provide and are responsible for providing travel advice. And obviously in Northern Ireland that's particularly problematic, as you can imagine.

Q. So just going, please, if we can, to page 2, to finish off on this document. So this is -- and I'm looking at the middle, mid-email from Chris Stewart:

"To be aware of Michael McBride's advice, which means that the analysis put to the COBR meeting on Monday will not include specific Northern Ireland material (hence no specific briefing from me)."

He:

"... will also sense Michael's irritation and caution on the prospect of departing from FCO advice:

"It might be prudent to advise [the] First Minister and [the] deputy First Minister to soft pedal any raising of differences between [the] UK and Irish advice."

I think if we could go to page 1, please, again. It's an email from Mr Stewart, and it starts:

"Carol."

I think -- is that -- is Ms Morrow from the --

A. She's from the Executive Office, yes.

Q. Thank you:

"Even that needs caution ..."

I think that related again to the position with Italy:

"... lest the deputy First Minister might appear to be at odds with (or ahead of) her CMO."

So just going back, then, in terms of all of those emails. I mean, what it suggests again is that you were inserting yourself into communications from the Cabinet Office to the Executive Office and effectively telling the Executive Office that it ought not to be responding to correspondence from the Cabinet Office that it had been asked for in terms.

A. I mean, that's not my interpretation of it. I think certainly what I was clearly saying, that I felt that it was extremely challenging and difficult to provide anything meaningful within that timeframe, and I stand by that.

We did, however, do the work, and we did provide the response, and that was in advance of the reminder from the Cabinet Offices. Indeed, we did participate in the COBR officials' call on the Sunday where this matter was discussed, and the Cabinet Office was informed that we were preparing the information that had been requested.

As I say, I wasn't -- I mean, I wasn't copied in to this chain of emails, and I wasn't aware that the

request had been stood down because of -- because, obviously, this was more than health. There was a request in relation to education. And had I been copied in, I would have said "Look, we are working on developing the information" which we did do over the weekend and did make the return and did participate in the COBR meeting.

I'll maybe pause there on that specific issue, but I know there's other matters in the email you want to cover.

Q. The position about Italy was obviously quite serious, wasn't it?

A. Yeah.

Q. Because there was obviously awareness, and in fact I think Mr Baker, who was the permanent secretary in the education department, I think had raised concerns about this idea that children were going to Italy. And what that email suggests was that even the deputy First Minister was -- you know, was being or was expected to hold a line so as not to depart from the position that you had taken, rather than it being the other way around.

A. No, I mean, I don't agree with that characterisation. I simply -- had I been asked as Chief Medical Officer: what is your professional advice to the public,

you know, professional medical advice? I would have advised them not to travel to Italy. But that wasn't the request. The request here was in relation to the advice by the Foreign and Commonwealth Office in relation to whether it's safe to travel.

Now, those are matters that were in the -- within the competence of the Foreign and Commonwealth Office. As Chief Medical Officer, I don't advise on that. It primarily relates to the ability -- you know, and particularly why the schools were concerned about this. One, they were concerned about the safety of their children, and indeed whether the children should be travelling and indeed their staff, but there was also a secondary issue which was about insurance and compensation for not travelling, and cancelled trips. And I think it was also a material issue for schools and why I agree there was, at that time, a mismatch between the advice that I would have provided, which I refer to in terms of professional advice, and the position of the Foreign and Commonwealth Office, which at that time was basically still saying: it's safe to travel.

And I think all I was saying was, I -- it's not for me to intervene and insert myself into the advice that's been provided by the Foreign and Commonwealth Office. That is not my role.

Q. You're the Chief Medical Officer. Your role is to provide independent advice, and that advice can be contrary -- if it's independent, it can obviously be contrary.

A. But I have no role or influence to the advice or decisions of the Foreign and Commonwealth Office. I mean, I think that is the point. All I was simply pointing out is, I can provide, as Chief Medical Officer, professional public health advice. Is it wise to travel? No, it is not.

I mean, that is very, very different from the advice from a government department which has responsibility to advise the public in relation to countries that are safe to travel to. Whether it's in the context of conflict, or whether it's in the context of a health threat, that is not within my role and responsibility. So those are two distinctly different things.

Q. Did you give that advice, then, in terms of your professional advice, that there shouldn't be travel to northern Italy --

A. I honestly can't now recall, but I have no doubt that -- I mean, it refers to explaining at a meeting, I presume -- I don't know what date this was, 7 March. I mean, that was the -- I mean, I can't now recall whether -- but I think that was the point I was making.

There's a distinction between official government advice around travel, which was FCO, or the counterpart in the Republic of Ireland. It's a very different matter in relation to professional health advice that I would be providing.

You know, if schools were to cancel -- you know, let me take this further forward. If schools were to cancel school trips on the basis of my advice, they would not be able to claim insurance or compensation for those cancelled trips, and I think that was why -- and, undoubtedly, that was entirely appropriate in those circumstances for the deputy First Minister to point out that incongruity, that how can it be, given the developing and emerging situation in Italy, that the Foreign and Commonwealth Office, at odds with the advice from the Republic of Ireland, is advising that citizens not to travel, and I think that was a very legitimate point to make. But it was not -- it was not an issue which I could insert myself into and resolve.

Q. I'm going to move on to a different topic, if I may, Sir Michael, because I'm conscious that time is pressing on.

The issue of large-scale events has arisen, I think, in every devolved administration, and I just want to understand the point. I think you have set out in your

witness statement issues around ensuring that there were powers -- and indeed you've just mentioned them -- powers to cancel large-scale events. But it's right, isn't it, that by 10 March in Northern Ireland, a number of large-scale events had been cancelled, and I think this includes the St Patrick's Day parades in Belfast, Newry, Downpatrick, Derry/Londonderry City and Strabane Council, the Royal Economic Society's annual conference, 600 delegates, had been cancelled, and I think tickets for a football match against Northern Ireland and Bosnia Herzegovina had also --

A. That's correct, yes.

Q. -- ticket sales had been cancelled. And all of those events were cancelled, I think, because the organisers decided that --

A. That's correct.

Q. -- they wouldn't go ahead. So if Northern Ireland was spared the consequences of superspreader events, it was because of the acuity of the people who organised them, rather than because of any advice that had been given not to -- not to hold them.

A. There are two points there. Firstly, you referred to superspreader events. I think that, you know, outdoor events, in general, are safer than indoor events, and it is a matter of fact, evidentially, that most

transmission happened in the home or in enclosed spaces. So the general rule is: outdoor spaces, and indeed even outdoor interaction, was always safer throughout the pandemic. Of course, that became clearer as our knowledge grew, and you're correct that there was not absolute certainty at that point in time.

But I think that we need to go back to what SAGE was advising at that time. The advice from SAGE, and again I've covered this in my witness statement, was that they did not see that mass events would make a significant contribution to the transmission of the virus at that time, and that was their assessment.

There was also the other very material and real concern that if mass events were cancelled, particularly those events that were scheduled to be outdoors, that people would respond in a way that they would come together indoors to mark those same events, and perhaps in indoor environments where there was less ventilation and there was closer contact.

I think that -- so the SAGE advice at that time, and I remember those discussions at the SAGE meeting, was that cancelling mass gatherings was one of the least effective interventions. And you mentioned earlier, in the email about the number of social distancing measures that were being considered, that cancelling of mass

gatherings was one of the singular less -- least effective interventions.

I think, as I've also mentioned in my statement, there is the wider point which is the fact that these events occurred created a sense of normality when there should have been no sense of normality. So I think that looking back on it now, there was probably not a full appreciation, even in the discussions at SAGE, about how that might influence public behaviour. And I think there probably -- I think it's fair to say there wasn't a full understanding of the fact it wasn't the events themselves but actually the interaction and the intermixing that goes on pre-event, post-event, travel to events and public transport, et cetera, all of which created environment.

But, as I say, at all times, my advice -- I mean, I did not at any time depart from the scientific advice, and I was very mindful of that. I provided the advice, and ministers made decisions.

I do recall in those -- in the run-up to those events that, at the request of Minister Hargey, I did engage with a number of local councils and met with them, who were considering cancelling their events, and that was the advice that I provided, ie the evidence is weak around this at this point in time, and --

Q. Sorry, I'm going to move on, but I think the bottom line is, Sir Michael, that Northern Ireland was probably fortunate that the organisers of these events decided to cancel them themselves without waiting for any advice from government or any --

A. I mean, if I might respectfully suggest, I think that's a conclusion to which we don't have the evidence base. I mean, I think that the evidence base that we have now is that mass events did not make such a significant contribution. It's actually the -- it's the, as I've mentioned, the mixing pre and post event and transport to. So, you know, I think that's a conclusion which was -- you know, it's easy to make that now, is all I would say. That is not the scientific advice that was available to us at the time.

Q. Yes. I'm going to move on to a message I think that you received on 23 June. If I could go to this, this is INQ000370538, and it's at page 6, thank you.

I think these are messages between you and the Chief Scientific Adviser, and I'm just looking at the message, I think it's about sixth down. It's a message of 23 June 2020, and you say:

"Ian would you be free for a short call in the morning? Edwin Poots connected ['with me', I assume that is] this evening. Peter Corry drive in concert:

wants to allow eating beside car 2m space all on same left side of vehicle. I have asked for details re numbers and toilets/cleaning etc."

So I think what this would tend to suggest was that Mr Poots was contacting you on 23 June about having or knowing someone that wanted to have a concert --

A. Yes.

Q. -- and eating beside it. I mean, was that usual, that ministers would contact you directly in order to see whether or not they could be allowed or whether these sorts of events could happen?

A. I mean, it was an unusual approach. It wasn't a typical approach. I mean, undoubtedly, you know -- I mean, ministers would have made contact about certain aspects during the pandemic. I think that was --

Q. This seems to be about allowing some sort of large-scale -- you know, it doesn't appear to be maybe a private gathering or -- I mean, this looks as though it's a sort of substantial undertaking that a minister's asking you --

A. I mean, certainly what I was referring to, and you can see I referred, and if you go down through this, we referred to the legislation. So essentially what I was referring to there was: is this permissible in the context of the legislation?

I mean, I think there was a lot of pressure at that time, because this was early June, and the Executive had just agreed indicative dates for a series of relaxations because the levels of transmission were low at that time.

I don't recall the exact legislative position, but I think, irrespective of the approach, as you can see from the responses and the exchange between Ian and I, we were basically affirming -- we needed to check -- we weren't saying "Let's make a special case or allowance for this". We were saying "What does the legislation say?"

So I think it was not unusual for us to -- you know, and, I think, looking back on this -- not this particular episode; the more general point -- that at times -- and we did produce from early June onwards, as I recall, guidance to the public about what the legislation meant for them in their everyday life, because it was often -- I think the public found it difficult --

Q. I'm going to just -- I hope you don't mind --

A. No, that's --

Q. -- I am going to cut across you because time is pressing on.

A. Okay.

Q. And this is not guidance to the public at large. This is something very different. And I think if we look at what the Chief Scientific Adviser replied, you know:

"Sounds okay on its own but would undoubtedly give rise to lots of other requests ... might also require a change in legislation."

I mean, you're there to give -- your role is to give medical advice. Are you suggesting that you're giving legal advice?

A. No, no. I mean, what I'm suggesting at the bottom in the very final -- in that chain, the legislative position, I'm basically asking policy colleagues to check what the legislation is. It's not for me to interpret legislation, change legislation. I can provide advice in terms of where I think the balance of risk is, in terms of relaxation of restrictions, which is what I did. But I think what I was double checking was: what was the legislative position vis-à-vis restrictions at that time? Was this permissible within the legislation and the restrictions that were then in place? I mean, I think the final -- the final text message signals that.

Q. Would you not have said "I'm terribly sorry. It's not my job to give that sort of advice to ministers. You should you look at the regulations yourself or take

advice from someone who's" --

A. I mean, there's always a balance in these matters in terms of, you know, relationships with ministers which are important, and particularly in a very difficult and challenging time. And obviously Minister Poots had previously been health minister, and I'd worked closely with him, and he obviously had my number from that time. So, I mean, I agree that it's unusual. I could have said "Sorry, I can't discuss this with you. Get one of your officials to check regulations". But, of course, one of his officials wouldn't necessarily have been in a position to check the regulations because he wasn't in the relevant department at the time.

So, I mean, I accept the point. And, you know, essentially what I was trying to root this back is to the legislation and an interpretation of what the legislation actually said.

Q. I'm going to move on to a different topic, which is the closure of schools.

The Inquiry's heard a lot of evidence that the Republic of Ireland moved to close its schools on 11 March. I'm going to bring up a document very briefly that the Inquiry has seen before, which is INQ000232525, and we can see it's dated 12 March. If we go over the page, please, yes. The meeting started -- you weren't

in the initial group of people, but the meeting started, and then we can see that you arrived with the health minister, Mr Pengelly. We can see that the First Minister said that:

"... there was an urgent need to decide on action for Northern Ireland."

And this is where we see Minister Swann saying:

"... that containment measures are working in Northern Ireland [that] following the Republic of Ireland position would crash the NHS and create unnecessary panic and fear. Complexities included grandparents being in [a] more vulnerable group [and therefore not able to look after children at school]."

And then we see Minister Swann referring to the:

"... need to follow the science. Closing schools will not stop the spread of Covid. Republic of Ireland approach not appropriate for Northern Ireland."

So I think it's clear that that was the advice and presumably your opinion at the time; correct?

A. I mean, I think the balance of the advice -- I mean, I think the minister's here talking about the immediate closure of schools and his concern around the consequences in terms of the health service, but there was a wider context, which he and I had discussed, which

he would have been aware of, around the relative contribution of schools being open to transmission and the damage that it would do to children if schools closed, and I'm happy to elaborate on that if it's helpful.

Q. I think that's understood. I think it's just understanding the chain of events and why that advice changed because the Inquiry has seen that there was an Executive Committee meeting on 16 March.

A. Yeah.

Q. And, again, the issue of whether or not schools should close came. There was a vote on that --

A. Yes.

Q. -- and the health minister did not support the closure of schools, and presumably that was on your advice; correct?

A. Yes, and I think I've covered that extensively in both of my statements.

I think the -- up until that point and at the meeting -- it may have been either 12 or 13 March -- there was a series of interventions, and we alluded to this earlier with the Cabinet Office request to look at a variety of social interventions. It had modelled and made an assessment of the impact that school closures would have on reducing the peak of infection, and its

conclusion on 12 March was that it may reduce pressures on the health service by about 20 to 30%, but on its own, it was one of the most -- least effective -- sorry, the least effective -- one of the most least effective interventions on its own.

Now, I think that that -- right at that time, what I was weighing up on my mind -- and that was based on an assumption, on the presumption that the transmission of schools was similar in children as seasonal influenza, which in actual fact it turned out not to be. And you mentioned about superspreaders, that, you know, children can act as superspreaders for flu.

So managing the situation in relation to schools open or closed was one of the most challenging issues during the pandemic because, undoubtedly, schools being opened did push up rates of transmission. How much, we didn't know. But what we did absolutely know is closing schools is damaging to children from an educational point of view, in terms of their social development, in terms of their mental and physical health, their life opportunities, and really important in terms of addressing health inequalities which we discussed earlier.

So those were not easy decisions, and the advice from SAGE at that time, resolved advice at that time

was: yes, school -- closure of schools may play a part, but not now -- and that was discussed and agreed at COBR on 12 March -- but maybe later. But if you are going to have to -- if you do decide, ministers, to close them, you're going to have to close them for a minimum of 12 weeks.

So I was, at that point in time, not satisfied that the evidence base around transmission, the benefits, in terms of reducing community transmission, outweighed the significant evidence that we had of damaged children --

Q. Yes, and --

A. -- and that's particularly a case in point in relation to children with learning disabilities, with special needs, which I also flagged at that time.

Q. So on 16 March, schools should not close; 18 March, schools should close.

A. Yeah.

Q. So what changed?

A. Well, you referred earlier to the meeting of 13 March, which was the SAGE meeting which was a really important meeting. It was signalled I think at the meeting of the 10th, and then the -- I think it was 13 March -- my dates may not be correct -- that we were actually further into the pandemic than we realised.

Q. But this was -- you were --

A. No --

Q. 16 March was the date that the meeting --

A. This is really important context.

In the run-up to that meeting of the 16th, SAGE realised that because of data capturing issues and very limited community testing, we were actually further along into the pandemic than we'd actually realised.

What was also increasingly apparent at that time, that there were huge pressures on the health service, and particularly in London, and the health service and intensive care beds were about to be overwhelmed.

So several things happened at that point. We realised we were further into the pandemic than we knew, because we weren't testing enough, because we hadn't got the capacity. That caused significant concern. And at the meeting of SAGE on 16 March, there was an agreement they would remodel the impact of schools, having previously said: don't close schools; not yet. And on 18 March, the SAGE meeting and the recommendation was close: schools as soon as possible.

So that reflects the speed with which the change in decision happened, and I reflected that in the advice I provided.

Q. All right. I'm going to look -- ask if we could look at a document, please. INQ000371378. And I think we have

to start at page 4, please.

Yes, it's the message of 17 March 2020. This is from Minister Swann to you:

"He has wind that [the] Scots are going to move independently and that Gavin Williamson is [going] to make a similar proposal to Boris on Easter ..."

I think this relates to Easter holidays and schools and potentially bringing them forward; is that right?

A. Yeah.

Q. "... and ground is already being laid."

If we look at the next message, you say -- I won't read all of it out, but one can see that you mention trailing this with CMO colleagues earlier in the week and today. Then you say:

"I'm afraid they don't quite get it. Everyone wants to take the lead now. Suggest you and the Executive do and steal a March if any planning to do so prior to Thursday advice from advice."

Then reference to the sort of statement that might be made.

Then if we go about five lines up from the bottom of this paragraph:

"This will now be a political rush to declare first and [Nicola] will want to lead the way."

Is that a reference to Ms Sturgeon?

so might be best if this is a political proposal when we meet tomorrow ..."

Then:

"Pending this suggest you take a tactical view from Richard as in my experience he is good as such things and may proffer some useful considerations for you as Minister."

Again, Sir Michael, this might be seen as a significant move away from the provision of medical advice to a minister and quite firmly entering the political realm.

A. I think my concern at that stage, as is reflected in those exchanges, I think we were losing the public narrative. I think there was a great source of public debate about this. I think that that was covered extensively in the media. I was under very significant pressure to change my advice, you know, one way or the other. It was an impossible position for me to find myself. I consistently kept the position in terms of the scientific advice that was provided by SAGE in terms of the impact on transmission, the harm that would be caused to children, and I did not want schools to close any earlier than was absolutely necessary. I accept the point. My concern is that this would become a public confidence issue at a very early stage in the

A. Yes.

Q. "Not optimistic on UK consensus on timing and perhaps in discussion ..."

I think that's reference to Lord Weir, Baroness Foster and Ms O'Neill:

"... we should steal a march and declare out intent. Schools closures are inevitable - we might as well be on the right side given we have held the line at cost."

I think that's probably supposed to be a reference to.

"Nicola may [seize] the moment."

Then a bit further down, it's at 23.49, you say:

"Minister, I have now departed from the realms of professional evidence based advice to you to anticipating further SAGE evidence. I am confident they will recommend school closures although probably not prior to Easter. You and Ministerial colleagues have held the UK line at cost in support of me. I need to now recognise the political reality and confusing public narrative. The experience of my CMO colleagues is just not there."

Then I think if we just go down a little bit more, please, to 23.59, then I think reference to whether or not it should be announced at the committee:

"Just to be aware I have not discussed with Richard

pandemic --

Q. Forgive me, you're advising your minister about Ms Sturgeon possibly stealing a march on a political announcement.

A. I --

Q. That is not medical advice, is it?

A. No, but I think that where it is material is in terms of wider public confidence. You know, I think the one thing that it was important, particularly at that early stage of the pandemic, that it was that we were getting consistent messages out to the public in terms of what we were asking them to do to minimise their risk. We were about to ask people to do almost unthinkable things, but with unthinkable consequences in terms of their everyday life, and this was a clear fracture point, and was a particularly clear fracture point in Northern Ireland, where you had decisions that had been implemented in the Republic of Ireland which hadn't been implemented in Northern Ireland, and there was a huge amount of debate and public concern. And parents were voting with their feet at that time in terms of some parents were taking children out of school. There was -- in my view, we risked losing the consistent messaging, and I think that equally would have applied across the UK. And that's why it was hugely important.

We eventually did get to a UK-wide agreed position, but I was really concerned that it was all going to unravel really, really early on.

Q. Those were all points that had been made on 16 March. The point about parents already taking their children out of school, that was a point that was already being made on behalf of -- or being made by some ministers.

A. Yeah.

Q. What shifted was the political landscape.

A. Well, there were two things that were shifting at that stage, and I alluded to one a short time ago, which was the decision by SAGE to look again at the modeling of the impact of school closures. I mean, that -- that decision was made on the 16th, and I don't -- I can't recall the timeframe between the Executive meeting on the 16th and the SAGE meeting, but SAGE said, as I say, on the 10th or 13th: we're further into this than we think we were, we're going to have to look to additional members. And as you recall, on the 16th the advice to households to isolate if someone in the household had symptoms.

So my sense, although I didn't yet know what the outcome of the SAGE modelling was -- but my sense was that we were in a rapidly escalating situation and my sense was that SAGE advice, as I've alluded to there,

was that the advice would change and they would recommend school closures, which in actual fact they did on 18 March.

So I think that's the context. And I was -- I was really anxious, I have to say, that we would lose the public when public trust and public confidence I knew was going to be absolutely crucial over the next period. And I accept the point you're making in terms of I was straying beyond providing professional, technical advice, yes.

Q. At the outset of your evidence I asked you about your independence from government and I asked you about the concept that the independence of the CMO is a prized characteristic of the office. It's very clear, isn't it, from the examples that we've seen, that your role wasn't one of independence and that you were on -- you did on occasions veer not just into directing or involving yourself in the work of the Executive Office, but we've seen here an example of something that's really overtly political?

A. I mean, I genuinely do not accept the characterisation about inserting myself into the role of the Executive Office and I feel I've adequately and fully addressed that and answered that. I think how others have interpreted my response, a response which I wasn't

copied into, is another matter.

I think in this case I don't -- I wouldn't underestimate the pressures that I was experiencing at that time to change my view, change my professional advice, and all I was doing was providing the professional advice, but I was increasingly aware and anxious that my professional advice had become a dividing line within the Executive, rightly or wrongly.

And you alluded to the Executive meeting on 16 March where there was a vote taken whether to follow my advice or not follow my advice, which is a nigh on impossible position for me -- to place me in, in my view, and what I was trying to do was to ensure that at a very early stage in this pandemic, with all that was ahead of us, that we continued to maintain the trust and confidence of the public, which I think I -- that is a genuine responsibility of mine in terms of my role in public messaging. I have a material role in public messaging, which I filled throughout the pandemic, and I was really, really concerned how this was playing out in the media at the time and creating confusion in the minds of the public, and I was genuinely concerned about the longer-term implications of that, because I knew that we had many, many more difficult asks of the public in the

months ahead.

MS DOBBIN: My Lady, I think that's probably --

LADY HALLETT: Certainly.

MS DOBBIN: -- an appropriate time for a break.

LADY HALLETT: I shall return at 3.15.

(3.00 pm)

(A short break)

(3.15 pm)

LADY HALLETT: Ms Dobbin.

MS DOBBIN: Thank you, my Lady.

Sir Michael, I just wanted to, as it were, round up on this period of time.

A. Sure.

Q. I think that the national lockdown was announced on 23 March 2020, and I don't think I need to take you to this, but in your statement I think you suggest that that was something that you had discussed with the other UK chief medical officers on 23 March; is that correct?

A. It was a busy day, 23 March, but yes, that's my recollection.

Q. But I think it's right that you hadn't given any advice prior to that to the Executive Committee that a lockdown -- that you advised that a lockdown was necessary at that stage, it was the UK Government who effectively --

A. That's my recollection. I can expand if it's helpful, but in the interests of time maybe it's not necessary.
Q. In terms of why you didn't think one was --
A. Well, I mean, I think we -- we collectively -- I mean, we met on 16 March, and in the days in the run-up to the 23rd, we certainly had noticed an impact of the measures that had been announced on the 16th.
Q. Yes.
A. But I think we collectively agreed that we would need to go further. Now, we did not have discussions about lockdown but we felt that more was needed, and then we did meet again on the morning of the 23rd. There was the SAGE meeting and then there was the COBR meeting later in the day. So it's hard now to piece it all together but things were moving very, very quickly then --
Q. Of course.
A. -- and I think we acknowledged that there needed to be more intervention.
Q. In terms of, and again I'm just rounding up on this stage of the pandemic, do you agree that Northern Ireland was perhaps fortunate compared to other parts of the United Kingdom, and particularly I think London and the South of England, that that lockdown was announced by the UK Government whilst the pandemic was

still not as at an advanced stage in Northern Ireland?
A. I think, relatively speaking, although we didn't know -- I mean, I think that part of the problem was, you know, when this information came from SAGE, we're further into this. We didn't yet, at that time, know how far in we were, because we weren't testing enough, but I agree we did benefit in that it was introduced at a relatively earlier time in Northern Ireland than certainly in parts of the UK, certainly than in London.
Q. In terms of what explains, then, the lower mortality rate in Northern Ireland during the first wave, do you attribute it to that rather than anything else that might be different about Northern Ireland or that might provide another or contribute, as it were, to the fact that there was a lower mortality rate?
A. I mean, I don't want to be seen not to answer the question. I think it was an important contributory factor, but there are other factors which I think we'd need to factor in in terms of, you know, issues in relation to population density, deprivation, et cetera. And obviously there is the risk -- you know, we did have benefits in the initial lockdown, and particularly removing people who were at risk, but obviously then you had more very many people who hadn't developed natural immunity through -- you know, through exposure, and

I think that partially explained why we had a more challenging second wave.

So, unfortunately, pandemics work that way, that the way out of it is hopefully through immunity, through vaccination, and the difficulty is the timing of those measures, because if they're too early you get all the harms with none of the benefits, and if they're too late well, they're too late and you're overwhelmed. So they're just finely balanced decisions. But I agree we did benefit. I think the reasons why we benefited are most probably related directly to the timing, but there may have been other factors.
Q. All right.

I want to move on to ask you more about the challenges that you faced in your role or perhaps the factors that made your role more complex, as the pandemic developed --
A. Sure.
Q. -- after the first wave, and the first thing that I wanted to ask you about was the funeral that took place on 30 June 2020 which was attended by the deputy First Minister and, I think, two other ministers.

Can you provide your view or opinion as to what impact that might have had at the time in terms of -- or if it did in any way complicate or make more complex

either the position in Northern Ireland or the position within government?
A. I suppose I'm not in a position to give any objective assessment of the impact that it had. I think my concern at the time -- and there were other high profile breaches of the guidance and the regulations at that time, right across the UK -- was that anything whereby those of us in a position of public profile and who were leading the response to the pandemic or contributing to leading the response, anything that suggested that there was one rule for us and a different rule for someone else I think was extremely problematic.

My concern was that that and the other incidents where this occurred created a great deal of hurt, anger, and also had the potential to undermine public confidence in what we were asking people to do, and the huge sacrifices that people had already made at a time where they had many, many more sacrifices to make.

So I was concerned about the discordance of those images and, indeed, other high profile individuals across the UK who had similarly not followed the advice, which was there for everyone and there for everyone to follow.
Q. All right.

I wanted to ask you then about how the pandemic

developed in late summer and into the autumn of 2020.
A. Yeah.
Q. I'm going to try to do this without reference to documents --
A. Sure.
Q. -- just because time is against us. But I hope these are just uncontroversial --
A. Sure.
Q. -- dates or general propositions.
I think that it's right in Northern Ireland initially had quite a decent period where transmission of the virus actually became very low indeed --
A. Yes.
Q. -- I think that was probably around the, maybe, end of June, start of July?
A. That's correct, yes.
Q. But that then quite quickly rates began to go up?
A. Yeah.
Q. I think first of all it's right that you had advised ministers at quite an early stage that once restrictions were lifted, that that would be quite a likely outcome. Forgive me if I've put it -- it wasn't put as high as that, but certainly I think you advised.
A. I mean, my advice was that it was inevitable. I mean, we had a population that we estimated less than 5% had

any immunity to this, we had no vaccine, it was highly transmissible. It is the nature of pandemics that they are growing or shrinking, and you only shrink them by reducing, sadly, the mixing of people and networks; and once you remove those restrictions it comes back. It doesn't go away, it was inevitable, and I think everyone understood that to be the case.
Q. All right. But I think the reality obviously was that the restrictions had to be lifted --
A. They did.
Q. -- and I think that you advised a calibrated approach --
A. Yes.
Q. -- to the lifting of restrictions that effectively allowed for restrictions to be lifted sequentially but allowed time to monitor the impact of lifting one before another was lifted; is that broadly correct?
A. That is absolutely correct. And that was in keeping with SAGE's advice at the time as well, yeah.
Q. In terms of what was initially driving the uptick in transmission in July 2020, I think it's also correct that it was primarily amongst younger people who were initially contracting the virus to begin with; is that also right?
A. Yes, and young people mix more. At that stage they had already made huge sacrifices in terms of their

education, schooling, university, so inexorably then, once you get a rise in younger people, it makes its way into older people, and therein was the risk.
Q. Yes, and I think that it took a little while for that to become the position and that older people started to get infected, but I think nonetheless the advice that was given by the chief medical officers of all of the --
A. Yeah.
Q. -- of all of the United Kingdom was that schools should re-open and they did re-open in Northern Ireland, obviously with safeguards such as there could be in place as well?
A. Yeah, we issued a four UK CMO letter because we felt it was so important that parents understood that it was better for children to be in school, teachers were confident that it was safe for them to be in school, and that we were really, really concerned about all the evidence that showed real harm to children from not being in school. So yes, we were -- you know, we wanted children back in school and that certainly was a priority for the Executive as well.
Q. I think very quickly then you also had to grapple with the reality of the transmission rates I think starting to go more seriously --
A. Yes.

Q. -- up --
A. Yes.
Q. -- in September and that that led to the advice that there should be localised restrictions, and I think they initially took effect on 11 September in Northern Ireland?
A. Around the 10th, and then we tightened them further, extended them further to Northern Ireland-wide on the 22nd. But before that, you know, I provided advice on the 18th, as I recall, that the Executive should begin to consider either local restrictions or Northern Ireland-wide restrictions, and we had and the Executive proposed and the Executive had agreed to, even in -- I think it was late August around 20 August to reduce the number of people who were meeting in a household --
Q. Yes.
A. -- and in private gardens, et cetera.
Q. So that was the "rule of six" that came in?
A. We never actually used the term in Northern Ireland but it was a term used in England and -- but it was the same approach basically.
Q. And I think it's right -- schools re-opened. I think, you -- and we've already seen this, so I won't take you through it, but that you and the Chief Scientific

Adviser also gave advice about opening pubs that didn't serve food and that that was something that was of particular concern to you. I think we've already seen the advice said it may not be possible to have schools open and pubs, these sorts of pubs, open at the same time. But I think it's right that pubs did re-open at a point in time in September as well. I think that was on 23 September.

A. I think it was around that time, yes.

Q. Again, I'm not going to go to the documents about this, because we've seen it before, but on 21 September SAGE gave advice, because rates were rising --

A. Yes.

Q. -- across the United Kingdom, and I think SAGE provided a menu of options --

A. They did indeed, yes.

Q. -- that were available, and I think it's also correct in fact that that was reflected in a paper that went to the Executive Committee on 24 September --

A. That's correct.

Q. -- which I think also set out those options to them.

I think it's also correct, if we move sort of past that point, and I think --

A. Yeah.

Q. -- when it became clear that those localised

restrictions hadn't been as effective as had been hoped, that you and the Chief Scientific Adviser were advocating a more robust intervention at that point; is that right?

A. That is correct.

Q. I think that's in and around 5 October?

A. It was around that 5th, and certainly over that -- the next few days, yes, over that weekend.

Q. I think that that also coincided, perhaps -- and I won't take you to this, but one can see it in some of the messages, perhaps, between you and the CSA, that -- and there is one that talks about, for example, that you and he both felt that you were being briefed against in the media by ministers. Do you --

A. I don't think we said ministers, I think --

Q. Sorry.

A. In fairness, I think what was happening at that stage was -- and I think it's been covered by the Inquiry already -- what was undermining decision-making in my view at the Executive, and undermining the advice that we were providing, was the -- almost in real time -- leaking of evidence into the media. I mean, you would be sitting in, at times in Executive meetings and the media would be reporting on something that had just been said in the Executive.

Now, that created a huge sense at times of distrust and, in my view, significantly impeded the timings of decisions. You know, the media coverage of that became a distraction.

I mean, ministers should be afforded the opportunity to discuss such important matters which impact on lives and livelihood confidentially, to robustly challenge the advice that they're providing, as is within their right, to ensure that they make the best situation -- the decision they can. Because there were no easy answers here, there were just a series of bad outcomes, and some were worse than others. So it was deeply, deeply undermining and I think we experienced that as well as ministers.

Q. Yes. We know, and again I won't go to this, but on 8 October there was an Executive Committee meeting, and we have already seen that it was a meeting that you said that you had never been more concerned --

A. Yeah.

Q. -- I think at that point in the course of the pandemic than you had been at that point. Is that correct?

A. That's correct.

Q. One of the ministers who gave evidence in the course of last week suggested that you had come to the meeting with that level of concern but hadn't offered any

recommendations to the meeting. I wonder if in fact that was correct, or whether or not the previous recommendations that had been made or the advice that had been given was still extant at that time?

A. I'm not sure the particular time period that we're referencing there, but --

Q. This was on 8 October, so she -- I think it was Minister Hargey, and I'll be corrected if --

A. Well, I think that we presented the situation to ministers and our concern. And I think -- as I recall, we had a series of meetings, I think one on the 11th I think, which might have been a Saturday or Sunday, to brief the First Minister and deputy First Minister further, and as I recall then there was an Executive meeting either at the 11th or 13th. So we were outlining the position, we were saying "We are in a very difficult position, this is what we foresee the consequences might be". In terms of pressures on the hospital system, very near to being overwhelmed. The consequences of the high levels of transmission not just on hospitals but when you have high levels of community transmission, you also have high levels of outbreaks in care homes. So we were clearly signalling the need for us to bring a further -- ministers to bring a further paper with our advice, to ensure that there was an

Executive decision-making.

So I think the paper of that period of the 5th was more a discussion paper of: this is the situation and we need to look -- think of what the options are.

That's my recollection but I would need to see the paper.

Q. Okay. I don't think we need worry about that, because I think matters moved apace --

A. They did.

Q. -- and that you did, in fact, recommend -- or you and the CSA, I think, jointly recommended that there be a six-week period --

A. That's correct.

Q. -- of restrictions, but that -- we've already seen this again, and I want take you to it -- but in fact the Executive Committee didn't accept that and instead enacted a four-week period of restrictions?

A. Well, I mean, our advice is advice. I mean, they certainly considered it, but, again, ministers at all times were weighing up not just the health and scientific advice but, you know, the impacts on society and economy and a range of other things. So, I -- you know, I know the words "did not accept" -- you know, it's up to ministers as to how they use the advice -- and I'm sorry, I'm dancing on the head of a pin about

the use of the word "accept", but, I mean, they -- we provided the advice and ministers made a decision.

Q. Yes, and they didn't take it, and I think we've seen there was a four-week period of restrictions which then failed to -- I think would have lapsed on Friday 12 November, and that precipitated the meetings about which the Inquiry has heard quite a lot that ran over the period of 9, 10, 11 and 12 November.

A. Yes.

Q. I think that it's -- you were obviously at that meeting -- or, well, if it can be characterised as one meeting, but I think it's clear from, certainly from the messages that you sent in and around this time that it was an extremely difficult meeting and that tensions at it were extremely high?

A. That's correct, yeah.

Q. And in fact what you went on to say, certainly on 10 November, I won't bring it up on screen, but you said that it was disgraceful and that they should all hang their heads in shame in respect of the ministers; is that right?

A. I mean, I think the second part of that WhatsApp is the relevant bit, which is putting it in the context of the consequences which I was reflecting, of, you know, a 40 -- I think -- 6 or 49-year old man saying goodbye

to his children on FaceTime.

Q. Yes.

A. So I think ...

LADY HALLETT: Take your time, Sir Michael.

MS DOBBIN: Yes.

A. My sense was the need to understand the consequences of decisions.

Q. Yes. So that people understand what it is that you're referring to, what you had said in your message was:

"How will history tell this story to the wife and two boys of a 49 year old who said goodbye to their father on Facebook on Friday ..."

A. Yeah.

Q. So I think what you were reflecting there was obviously the reality of the position that some people were in, in hospital, in Northern Ireland?

All right, I think we can see that that was obviously a very difficult meeting for you, and I think that it's right that in terms of what happened after that was that certainly when it came to the next meeting, when the decision had to be made about what to do --

A. Yes.

Q. -- that in fact Minister Swann didn't feel that he could make any recommendations to the Executive Committee for

fear of how ...

A. Yeah, and I think -- and I think -- I'm sure the minister will speak to this -- my assessment of it, which I've covered in my statement, was -- and the minister alluded to this, and it's in the paper -- that he regretted the fact that his paper had divided the Executive. And, you know -- and I know -- and one thing I would say is throughout that period the First Minister and deputy First Minister were working very hard to achieve consensus. That proved very difficult. And I think the minister's approach was to present a series of options to ministers so that, you know, ministers felt that there were options available to them and that there could be a consensus on a way through.

So there were a series, as -- I remember the paper clearly -- from A to H about different approaches as to how we might prevent the health service being overwhelmed, prevent and reduce the risk in care homes, et cetera, et cetera, and those were outlined, but there was no recommendation in the paper.

Q. Yes. I think it's quite difficult to work out the chronology, because --

A. Yes.

Q. -- obviously there were -- those restrictions did lapse. It appears that there was a period of about a week at

the -- from 23 November onwards when shops were open, and I think cafés were allowed to open as well?
A. There was, yes.
Q. And we've seen then I think that one of the consequences of that, certainly the Chief Scientific Adviser pointed to in his papers, was that even a short window at that time, again, did cause an impact again on transmission rates?
A. It did. I mean, things were on -- and I think we said this at the time -- were on a knife edge, and -- you know, we had a good impact from the four weeks but it wasn't enough and admissions were still at a high level, ICU admissions were high, the health service was running very hot, there were a lot of sick people in hospital, similarly numbers of outbreaks in care homes. And we needed more. And we did -- we did agree to a further two weeks. There was some amendments then -- there was a proposal to classify toy shops as essential retail and click and collect to open. And what we did see when we looked back on that, I think it's reflected in a later Executive paper, was the first week we got a good impact, and mobility figures in terms of population movement were down, and the second week less so.
But nonetheless, and I know we've shared this with

the Inquiry, the overall package of messages that the Executive put in place at that time compared extremely favourably with other parts of the UK and were more effective by comparison to the metric in Scotland, Wales or in England and as assessed by SAGE, so, yes, you know, it was a very difficult period, as, you know, the population experienced.
Q. I think we saw with Sir Brandon Lewis that, certainly in terms of the impact on healthcare workers in Northern Ireland and health services, that military aid was required in order to compensate for some --
A. Yeah, I mean, staff in hospitals and care homes were burnt out at that stage. You know, my own daughter was working in intensive care as an anaesthetist, so I've friends and family working in the health service and colleagues. It was an extremely difficult time.
Q. All right. I think that we're obviously into the decision-making that took place around Christmas as well, which was obviously pressing at that point in time, and there were difficulties, I think, in trying to arrive at arrangements --
A. There were.
Q. -- and I think those changed as well. But ultimately the position was arrived at that people would be allowed to meet for a short period over the Christmas holiday?

A. Yeah, I mean, you know, people had been eventually locked down for about 40 weeks at that stage. We were hugely concerned about the damage in terms of mental health and wellbeing. People hadn't been able to visit their elderly relatives, they hadn't been able to visit their elderly relatives in care homes. I mean, there was genuine concern at that stage about the impact, and again Minister Long I think mentioned at one of the Executive meetings around 8 October that her view was the public were beginning to lose hope. And I think that was the case. There was a sense of no way out of this.
So I think it was a very difficult time, undoubtedly for the population, everyone working in the health service, and I think there was a general sense: is there ever going to be an end to this?
Q. One of the things that I wanted to ask you, if I may, about that period as well, and again I won't go back over the meeting minutes --
A. Sure.
Q. -- but there may have been a sense on the part of some at the Executive Committee meetings, and possibly a concern shared by you, that there wasn't sufficiently robust policing at that time?
A. Yeah.

Q. Is that right? Or certainly -- am I correct that there was a concern about that?
A. I think that was a concern probably from August, and probably even earlier from the easement of restrictions, and I was fully supportive of the four Es approach of, you know, engage, inform, educate, I think it is, the third, and enforce. And I worked very closely with the then Assistant Chief Constable Alan Todd, we had regular calls. I think it was a very difficult ask for the PSNI on top of other competing demands, and I think we all knew that, you know, we couldn't -- you know, we couldn't police this virus into submission, and I think that ... I think the important part of the police's role was their role, in my view, in engaging and explaining; enforcement where there are egregious breaches, which there were in some instances, and fines were issued, but I think it was just about encouraging the public and reminding the public. And I think by and large my assessment was the police did a very good job in very challenging circumstances.
LADY HALLETT: Sir Michael, can I ask about the regulations.
A. Sure.
LADY HALLETT: Did you discuss -- I don't know if you know, but in Module 2 I saw some of the regulations, certainly ones drafted for England and, having done nearly

50 years in the criminal justice system, I couldn't have enforced them. So did you have that problem here?
A. We did indeed. And the PSNI raised it on a number of occasions that they found them at times impenetrable.
LADY HALLETT: Yes.
A. And the fact that they kept changing -- you know, we were reviewing the regulations initially every three weeks, then every four weeks. We reviewed them five times in wave 1, eight times in wave 2, ten times in wave 3. So they kept changing. And indeed it was even difficult for the public to keep up with what we were advising them to do. So I have absolutely every sympathy with the police's position.

I'm absolutely not an expert in the regulation at all, or the regulations, but I can only be but sympathetic how difficult and challenging it was for them.

Of course, you know, the Executive recognised that and the police were not the only organisation responsible for enforcement of regulations. The Executive did provide funding to local government to appoint Covid marshalls, and indeed local councils played a significant role in encouraging their own communities to abide by the guidance and follow the regulations.

But look, I think it was -- at times the PSNI were placed in a nigh on impossible position.
MS DOBBIN: All right.

I'm going to move on, if I may, to a different topic completely, which is the Republic of Ireland --
A. Sure.
Q. -- and co-operation with the Republic of Ireland --
A. Yeah.
Q. -- as part of the response.

The Inquiry has seen a paper that was prepared by the Civil Contingencies Group in the Executive Office that was, I think, provided in and around maybe 20 February, and one of the things that it said needed to be considered was civil contingency arrangements in relation to the Republic of Ireland. I think as well you also, certainly at the outset of the pandemic, I think possibly in a WhatsApp or an email exchange with the other UK CMOs, had said that modelling with the Republic of Ireland --
A. That's correct.
Q. -- would be very useful, and that was right at the outset.

I suppose the question is really this: whether or not you do consider that co-operation with the Republic of Ireland worked in a way that was optimal

perhaps to both jurisdictions during the pandemic, or whether you consider that perhaps more could have been done?
A. I think certainly at the professional level and policy level we had long established very close working relationships. I mean, Tony Holohan was the Chief Medical Officer for the Republic of Ireland. You know, the first contact we had I think was on 22 January and then again a phone call on the 24th, and we were, you know, in very regular contact throughout and we set up the regular meetings then following the signing of the MoU in May, as I recall.

I do not think that that professional co-operation could have been any better. Similarly, working with CMO colleagues across the UK.

I think there were some challenges as well, and I think it's only fair to say, and particularly around international travel and border and sharing of information. Now, we worked through those public health agencies professional to professional and found workarounds, but in terms of the passenger locator forms, we ran into all sorts of -- and apologies -- all sorts of legislative barriers about why information couldn't be shared for public health purposes, because it related to enforcement. So -- and respective

attorney generals got involved, et cetera, from memory. But we did get there and we did develop a workaround.

So it wasn't without its challenges, and during that time ministers, through a series of North South meetings or quad meetings involving the Secretary of State met on a very, very regular basis.
Q. So you say, I think from your answer, perhaps that you don't think there was a definite or that any further structures are required in order to -- if there were to be another pandemic, that might make cross-border --
A. No, I wouldn't say that, and I think I did say, Chair, in Module 1 that I think for the future what we need is a two-island, five-nation approach. You know, this sense that somehow or other that a border between Northern Ireland and the Republic of Ireland insulates approaches to how you respond to a pandemic is not based on any epidemiological basis.

You know, the island of Ireland behaved like a single epidemiological unit -- although there was variation at times; you know, the transmission rates in Dublin are not necessarily the same as in Belfast, and we often had hotspots in border areas. So the trajectory of the pandemic in Northern Ireland was more similar to the Republic of Ireland than it was to the rest of the UK.

But borders are controlled -- just one example, borders are national, so that would have required the UK Government and the Irish Government to work collaboratively, and particularly material implications for the Common Travel Area, for instance.

So -- and you referred to civil contingencies earlier. In my view there needs to be very close interconnection between civil contingency planning on these islands, full stop. And I would also argue that pandemics spread, and with global travel we need to also think about our connectedness to Europe.

You know, I think we just need to be more expansive in terms of our learning from this pandemic.

Trying to control the pandemic in the UK, in Northern Ireland or in the Republic of Ireland, does not work; you know, it has to be a global response. And it needs to be, certainly within our gift, in my view, co-ordinated across the Common Travel Area.

Q. May I just ask you on the subject of borders and the idea that -- the idea -- the reality that there were hotspots on the border. Was there any particular reason for that or is it just to do with the specific --

A. Yeah.

Q. -- locations or density of population or because people travelled backwards and forwards?

A. Well, I mean, I suppose borders are usually the same wherever you look. In Northern Ireland, in the Republic of Ireland, you know, you go over a bridge and you're in one country and then in another country. These populations are seamless. A farmer has a field in one jurisdiction and he takes his cows into a field in another jurisdiction. You know, these communities are very close. Many of them go to school -- I mean, back to the earlier discussion, many of them go to schools which are in respective jurisdictions.

So, I mean, those same issues pertain to parts of the UK, obviously, between Scotland and England and between England and Wales, but I think that we did see particular hotspots in Derry and Strabane and Donegal, for instance. We never quite understood why that was, at times, the feeling was it was transmission from the Republic of Ireland into Northern Ireland, at times we thought it was the other way around.

And I think -- then when there was different restrictions North and South, so the Republic of Ireland or Northern Ireland decides to open pubs and restaurants, the population travels across a 200-mile very porous border, and that, you know, is a significant factor.

So it was a challenge, and I think it does speak to

the need for greater policy alignment where that's possible, whilst absolutely respecting that there are two sovereign governments, the Irish Government, the British -- the UK Government, and there are Executives and assemblies in the other nations, and -- I mean, I don't know the political answer to that. I mean, that's a question for someone else.

Q. Okay. Thank you.

My Lady, I'm conscious that there are questions for Sir Michael, and I was going to, if I may, pause there. I think I've got a little bit more time than I thought. I'm just conscious that -- I think I do have ten more minutes. That's fine, I do have ten more minutes.

Sir Michael, I'm going to try to deal with one topic, then, and I'm going to -- I'll try my best not to deal with this in too superficial a manner, and you must stop me if I'm --

A. Sure.

Q. -- if I take this at too fast a pace, but it relates to the position in respect of care homes in Northern Ireland.

A. Yeah.

Q. We did touch upon this with Mr Pengelly, and I think understand something of the basic chronology in terms of what happened in care homes.

A. Yeah.

Q. I think what we have seen is some communications that took place -- for example, we see it in March, that there was a letter from Mr Pengelly to the chief executive of arm's length bodies, and in the Department of Health's summary Covid-19 plan from, I think it was, mid-March to mid-April, the advice or guidance given that trusts will work to maximise and utilise all spare capacity in residential, nursing and domiciliary home care, so I think reflecting the advice at that time, and we've seen other iterations of this as well and the way that it was put, that effectively -- I think the idea was that people should be moved from hospital where possible to live in care homes in order to provide space in hospitals.

So, I mean, first of all it is right, isn't it, that that was the policy that was initially adopted at the outset of the pandemic?

A. I mean, I think that -- I mean, I think the letter, I don't have it in front of me, but I think it actually indicates, you know, where it's clinically appropriate. I mean, there was never a policy direction to the health service to discharge people from hospital. I mean -- and it was made clear at all times that the decision to discharge an individual patient is a clinical one for

the clinical team. We historically have a problem, which is common across the UK, of delayed discharges because of the inadequacies of time, and it's not solely this, but of the adult social care system. And that's not a reflection of those working in it, it's simply a reflection of the resourcing and funding over quite a considerable period of time.

I think what the letter was indicating, I think appropriately, was the concern that there would be a significant number of people requiring hospital care and that we wouldn't be able to manage that demand, and indicating that trusts need to do everything they could to make sure when it was clinically appropriate to ensure the discharge of patients from hospital, whether to home or elsewhere.

I think that's how I would present it but, you know, I do accept, you know, it can be interpreted in a different way.

Q. I think -- I mean, regardless of how it's interpreted, I think the issue that arises is the testing of people before they were discharged from hospital into care homes.

A. Sure.

Q. And I think from the face of the documents we've seen -- and I'm thinking there's an email about this on 18 April

that is then reflected in policy advice on 19 April?

A. That's correct, yes.

Q. I think that -- and, again, this was following what was happening in England, and it was only then that it was said that all discharges to care homes -- I will put this properly -- that all individuals who were discharged from care homes should be tested for Covid-19.

As the Inquiry understands the position, it's really around 19 April that that becomes the policy guidance that that testing should take place.

A. I mean, I think that -- I mean, if we look back on this, an important learning point in all of this is the severe limitations that we had and testing capacity. There were many things that we would have wanted to do, in terms of testing, that we just didn't have the tests to do. We did prioritise tests for those in care homes and adult social care and also for vaccines later on. We just didn't have the testing capacity.

I think that there is a wider -- and this is a really important contextual piece, which is: the best way to protect the vulnerable and protect those in care homes is to drive down community transmission. All of the evidence and all the peer-reviewed evidence suggest that the correlation is between community transmission

and outbreaks in care homes.

And, you know, we can bring up the INQ if it would be helpful, but the evidence would suggest that the most significant indicator of care home outbreaks is the size of the care home, which is a proxy measure for footfall.

So the most important thing you can do in a pandemic, such as Covid, is to reduce, tragically and sadly with all the consequences -- reduce the footfall into care homes, and that's, you know, other professionals coming in to make assessments. It's also, sadly and tragically, the consequences of the restrictions that were placed on visiting. It's also in terms of ensuring that you don't have inspectors moving from home to home. And that, actually, if you correct the care home size that the contribution of discharge from hospitals, the evidence would show, made a very small contribution.

The reason I only make that point is not to defend testing or not testing, but I think that, in terms of learning for the future, we really do need to understand what the drivers of infection were in care homes.

The most important thing to protect vulnerable individuals in care homes is the effectiveness of infection prevention and control, which is difficult in a care home because you've got staff who are providing

close personal care with the activities, supporting the activities of daily life. So the infection prevention and control arrangements are crucially important. And, yes, testing of both staff and patients, whether they come in from the community or from hospitals, are also an important part of that.

But had we done nothing else and tested people coming into care homes, sadly and tragically, that would not have prevented the huge consequences that we saw in terms of deaths in care homes.

And I think I make that point only to say that there is important learning in the experience in care homes, and it would be evidentially ... in the evidence, there's no basis for saying that it was solely due to people being discharged from hospitals. Undoubtedly, that did make a contribution, but it wasn't the major factor.

Q. I think another factor must have been, though, the lack of test -- the lack of routine testing in care homes for a very considerable period of time.

A. Well, I think that the testing -- you mean healthcare -- social care staff working in care homes were prioritised for testing from the very first -- sorry, I beg your pardon -- the second version of the interim testing protocol from 28 March. And, you know, I think we all

would have wished to have increased testing in care homes, both in terms of people, you know, where a care home is their home, and in staff working in care homes, and people coming in from care homes and coming out of hospital.

We didn't have the testing capacity, and it was only -- also, the other point was that our knowledge and awareness of the risks, particularly of asymptomatic infection, which we discussed earlier, became clearer.

So we went to extensive efforts -- I'll not rehearse this, and it's covered in my statement. The minister was very clear of the priority he afforded to the testing in care homes and very clear on his direction to us to roll that out as quickly as we could, and we did. Do I wish we could have rolled it out quicker? Of course I do.

Q. I think it's right, and forgive me if I have the chronology wrong, that I think it was the -- by 12 April, there was testing of all symptomatic residents where a care home reported two or more symptoms.

A. Sorry, do you want to run the date past me again, sorry?

Q. 12 April.

A. I think it was before that. Actually, I think from 24 March, we were testing up to five individuals, and then we would say, you know, this is an outbreak.

What we did in the early days was we used the approach that we would use for seasonal flu. So if we had an outbreak in a care home, you would -- and people were symptomatic, we would test up to five individuals, and then we would isolate those individuals, and that was the public health approach and evidence base at that time.

From 12 April, from memory, we then began testing all symptomatic patients in care homes, and then from 24 April, we started testing all symptomatic people living in a care home and staff, and then we started the roll-out of the testing programme in care homes that didn't have outbreaks, from memory, on 11 May, and the minister announced it on 18 May. And then we had the rolling programme of regular testing which began on 3 August.

So we ramped it up as quickly as we could, but, I mean, I think, maybe just to illustrate the point, on 19 March, we had a testing capacity in Northern Ireland of 200 tests. That was all that was available to us. At the end of April, we had a testing capacity of, as I recall, 1,600 tests through a lot of hard work and scale-up. But the Pillar 2, which was the national testing programme, we had something like 300 available to us.

Q. Yes.

A. So, you know, I think if there's anything that needs to come out of the Inquiry, it's the importance of actually having diagnostic capacity and the ability to ramp that up very quickly once you've identified what the next novel virus is and how we're going to test for that.

Q. Because I think it's right that it wasn't until 3 August that there was regular testing of people that lived in care homes every 14 days.

A. No, we didn't -- well, the answer -- well, two parts to that. We did start the rolling programme of testing from 11 May, as I've said, and -- sorry, maybe I have misunderstood. What was the date again?

Q. Regular testing, so periodic testing of people that lived in care homes every 14 days was 3 August.

A. Prior to that, as I said, in May, we started testing and a rolling programme, and the minister announced that on the 18th. And we said that we would complete the testing on all care homes that had previously had outbreaks. We completed that programme, as I recall, on 28 June. And then we announced -- you know, we continued to test.

But you're correct that the rolling programme commenced on 3 August, and we were only able to do that then because we could use the national testing capacity.

And we didn't test every two weeks residents because we did, at the time -- you mentioned earlier about the level of transmission. We altered that, depending on the levels of transmission.

So initially, as I recall, we were testing staff every two weeks and residents every month, because, you know, if you're an 80 year old or an 85 year old in a care home, and you remember those swabs in the early days were very unpleasant. They had -- you know, you had the swab in the back of your throat. You had a swab up both nostrils. And there were many people living in care homes who were confused or who had dementia, and we were genuinely concerned about some of the implications of that.

So we did increase the testing of both, as I recall, staff and residents depending on the level of community transmission which was driving the infections in care homes.

MS DOBBIN: My Lady, I'm conscious that other -- that core participants --

LADY HALLETT: I'm afraid you probably now have run out, Ms Dobbin, sorry.

Ms Campbell.

Questions from MS CAMPBELL KC

MS CAMPBELL: Thank you, my Lady, and thank you,

Sir Michael.

Sir Michael, you know I ask questions on behalf of the Covid Bereaved Families for Justice in Northern Ireland.

I have three topics in ten minutes, so forgive me if we take them at something of a canter. But I want to return, please, to the end of January 2020, and perhaps we can put back on screen the Professor Woolhouse exchange which is at INQ000047559. Thank you. And the second page, please. I want to look at this from a slightly different perspective, Sir Michael.

Firstly, you're very familiar with the content of Professor Woolhouse's email.

A. Yes.

Q. And we know that in the body of his email, he refers to the WHO numbers in terms of the reproductive rate and the case fatality rate. He refers to having -- if one was to put those numbers into an epidemiological model for Scotland, they would have grim predictions, and then he reinforces that, in fact, that's not a worst-case scenario, but just building on essentially the WHO's central estimates and currently available evidence presents a reasonably grim picture. And you know that, and I see that you're nodding.

Firstly about this, and it's a very brief point,

I hope. There wasn't anyone at this stage putting such numbers into an epidemiological model for Northern Ireland, was there?

A. Not at that stage, in that we didn't -- sorry, the answer to your question is no, we weren't doing it at that stage.

We were using -- in early February, we were using the estimates from reasonable worst-case scenario for pandemic flu, and indeed as we alluded to earlier, we did provide that estimate. I think it was early February we did that; I think about 5 or 6 February. So we were doing the same sorts of estimates, but that was based on the reasonable worst case flu scenario which we had agreed as UK CMOs was a reasonable point to start planning from until we got hard data about Covid.

Q. We know that at this stage that Professor Young was still in post, and we know from your earlier evidence that you didn't approach him in terms of any assistance that he could offer within that timeframe and indeed before he left for his period of leave in mid-February.

A. Yeah.

Q. But if we can please scroll up to the first page of this email exchange, because in a response essentially to the same email chain, we can see at the top that Chris, and we understand that to be Professor Sir Chris Whitty, was

asked against a tight timeline for his view in terms of evacuation of UK citizens from Wuhan. And his advice is underneath where the name has been redacted, and he says:

"I think there are two reasons we should be considering evacuating people who are older or have pre-existing health conditions from Wuhan and the surrounding area if they request it ..."

He goes on setting out four essentially reasons for that, but at point (a):

"This seems to be the group most affected by the novel coronavirus, and it is very difficult to determine level of risk as inevitably the data coming out is going to be behind the reality."

So these joint emails, if we put them together and combine them, firstly present a very clear statistical warning in terms of epidemiological statistics that Professor Woolhouse had identified. And, secondly, in terms of Professor Sir Chris Whitty's response, it identified that there was -- there were particular categories of people that needed, even at that early stage, to be prioritised, and those were older people and those with pre-existing health conditions; isn't that right?

A. I mean, I have a view of joining those two together

because I don't think that's -- I mean, we're conflating two separate issues, but I'm happy to answer the question if there's a question there.

Q. Certainly, the statistics that Professor Woolhouse had indicated were worrying. Whether or not they were entirely reliable; certainly they were alarming. And, secondly, and whether it's connected or not, certainly in this email, categories of people who were particularly vulnerable had been identified as priority by Professor Sir Chris Whitty.

A. On the -- Professor Woolhouse's email, that was not informed by any hard data that we had about how Covid would behave --

Q. Yes --

A. -- and I think that's an important point.

Q. Well, it is one that I think you made, in fact, in evidence earlier today.

A. Yeah. So, you know, it was not based -- because, unfortunately, we did not have hard data that would inform the various calculations that you would need to make in terms of what the impact would be. So you were largely -- modelling at that time, such as it was, was based on very, very wide confidence intervals --

Q. Sir Michael, I don't want to stop you, but in fact her Ladyship has heard the evidence --

A. Oh, sorry. Okay.
Q. -- in Module 1 and Module 2 in relation to that as well.
A. Apologies --
Q. I think the point that I do want to focus on is that statistics being reliable or not, or certainly subject to interpretation --
A. Sure.
Q. -- there were categories of people who one needed to be particularly concerned of from the outset.
A. I mean, I think -- I mean, I think this is a really, really important point because what we were -- we, again, on terms of clinical vulnerability -- and I cover this extensively in my statements. It was very difficult to ascertain and compare one healthcare system and the impact that this novel virus was having in a healthcare system compared to a UK healthcare system, and there are two really important factors there because the demographics of the population are different, and the other factor is the health service provision is different. So a novel virus like this could have a very different impact in China, given population density, given the health service as it was, as compared to the demographics of a UK population, depending on its age, characteristics, social deprivation, et cetera, and the health service.

What this was relating to was an observation that, insofar as we could see, that it was older people in China and those with long-term conditions, pre-existing health conditions, that were suffering severe disease. That didn't necessarily translate. And, you know, again, I have covered this in my statement. We were not yet certain or sure at all whether that would translate into a UK scenario.
Q. When did it become obvious to you, Sir Michael, that older people and those with pre-existing health conditions be prioritised --
A. Well, we really had -- we had emerging data globally, but the first hard data that we had, in terms of how this would behave in the UK, was when we had UK cases. And, again, as I've covered in my statement, we had an approach where we examined in detail the first few hundred cases which was to identify those individuals who were hospitalised with severe disease, those that ended up -- so it was really -- you know, to answer your question, it was not until we had experience of the disease in the UK that we were able to say definitively these are the individuals at risk --
Q. So, if I understand you correctly, you were not able to say definitively until presumably some point in mid-March, is that right --

A. That's correct.
Q. -- that older people were particularly vulnerable?
A. We could see what was happening in other countries --
Q. Yes.
A. -- and so, you know, there was an awareness of a level of risk, yes.
Q. Well, given the awareness of the risk, level of risk, and the Chair has heard evidence both in this module and in other modules that there was an awareness that a problem would come when the virus hit hospitals and care homes. At what point did you, in your role as CMO within the Department of Health, direct that there should be particular consideration given to priority groups in preparation for the oncoming pandemic, and those priority groups being older people and those who are vulnerable?
A. Well, I mean, certainly, I worked with the professional colleagues and policy teams leading in this area, so the -- and my team worked very closely with them. So we had the director of Older People's Services and the Chief Social Worker who was leading on this work with support from one of my DCMOs. And we took a number of steps in terms of -- we've already alluded to the guidance that was issued. I mean, the first guidance that went out to care home sector and then --

Q. Okay. I'm going to stop you there because that is the --
A. -- February --
Q. Yes --
A. Sorry.
Q. We know that there was guidance that went out, and in fact --
A. Okay.
Q. -- guidance that we have looked at, or at least been referred to in the course of this module, in relation to care homes was developed in and around 16 March and distributed on 17 March. And we've heard evidence from Mr Lynch, the Commissioner for Older People, about his involvement in that.
Would it be right to say that it really was not until that period of mid-March when there was active consideration given to what was going to happen when this virus hit care homes?
A. No. I mean, again, as I was trying to point out there, the first guidance that went out to care homes was from the chief professional officers in the department and the Chief Social Worker and his director was on 27 February, so it was at the end of February, as opposed to the middle of March. And there was updated guidance then in and around 12 or 13 March.

I think the first -- I mean, that was largely -- early documents were based on Public Health England's assessment of risk around prevention, what to do if someone develops symptoms, around isolation. The first very detailed guidance, as you correctly point out, went out on 17 March, and then there were further iterations of that.

Q. Can I ask you: did you contribute to that guidance?

A. I didn't personally contribute to that, but my Deputy Chief Medical Officer, who I mentioned earlier, has -- a public health consultant -- extensive background in public health did actively contribute to it.

Q. Did you contribute to the Department of Health strategy in relation to -- and I know you said it wasn't a policy as such, but in terms of discharging patients from hospital in order to free up spaces. Is that something that you --

A. No, I didn't. I didn't contribute to that. I didn't provide professional advice into that, and it wasn't because that wasn't a very important area. There were policy colleagues working on that. They were also accessing the best available advice from Public Health England who have experts in this area which we couldn't replicate. They were also working very closely with the Public Health Agency and, as I say, on all aspects of

this. But I personally, due to other commitments, wasn't contributing, no.

Q. I want to ask you about a letter that you wrote on 20 March, and it's INQ000103688. I anticipate it's one that you will be familiar with. It's a letter that you wrote to RQIA instructing it to cease all non-statutory inspections of care homes.

Just to put this into context, we know that at around this time care home guidance had gone out on 17 March. Many care homes, if not all, had in fact stopped visiting in order to protect their residents. We know that there was going to be, if it hadn't started already, a significant discharge of people from hospitals into care homes in order to clear space in hospitals, and we know that many of the people whom I'm representing from then or thereabouts onwards were denied access to their loved ones, and the eyes and ears on the ground were withdrawn.

Did you consider, when you instructed RQIA to cease all non-statutory inspections of care homes, that that would essentially withdraw eyes and ears from what was happening in care homes in that particularly vulnerable time?

A. Just to provide clarity, the letter addresses two things. Firstly, it basically says to RQIA, you know,

"Do not continue with your non-statutory inspections."

Q. Yes.

A. Inspections in care homes are statutory inspections. So, essentially, what we were giving RQIA here was regulatory flexibility. The inspectorial function within RQIA during the 13 weeks when they were given that flexibility did not cease, did not stop. Basically what we were asking them to do and directing them to do was to use an evidence-based, risk-based approach in terms of their inspection. So they did, and over that period, from my memory, conduct 61 inspections. 51 of them were face-to-face and involving(?) visits to care homes. Some of them were remote; others were hybrid.

In terms of the eyes and ears, at that time, RQIA was -- redirected its resources to develop a home support team which was in daily contact with care homes. They developed an app and subsequently a web portal where they were assessing --

Q. I --

A. No, I think it's a really important --

Q. I -- it is important --

A. No, it is important, because --

Q. -- but there is in fact going to be another module on this in --

A. No, but I think this is an important point, if you

wouldn't mind, and I'll finish it very briefly.

There were more eyes and ears in care homes in terms of RQIA -- there were -- the home support team had 3,500 calls. They were professionals providing advice to care homes during the first wave. And the weekend of Easter, there were 400 direct calls into care homes to check in, and those assessments that the department was receiving through professional colleagues within the chief social services officer looked at occupancy, outbreaks, whether they had sufficient PPE, and any testing --

Q. Yes --

A. -- so I think the point about not having eyes and ears, combined with the fact that in the first wave there were, you know, 23,000 hours of nursing time from trusts supporting care homes, I think it's just important that we have a rounded picture. Whether that was enough I think's another matter.

Q. Well, it's a matter for another module, in fact.

A. Yes.

Q. I'm going to move on and deal with, very briefly, co-ordination with the Republic of Ireland. And I want to talk about in particular the memorandum of understanding, and we can put it up, if we may. It's INQ000130355.

The memorandum of understanding, as we understand

it, was developed after a meeting that had happened on 14 March with senior ministers from Northern Ireland, with counterparts including Leo Varadkar and Simon Coveney from the South, and yourself and Dr Holohan --

A. That's correct.

Q. -- were both present at the time. Okay.

There was, in that meeting on 14 March, a desire expressed for joint messaging, a desire expressed for working together, and as a result of that, the memorandum of understanding -- and we can see, in fact, at paragraph 1.2 and 1.3 is in part the outcome.

Now, if we go down -- and, again, just very quickly through it, paragraph 4.2, 4.3, we will see some of the issues that were the subject of it. So public health and non-pharmaceutical measures is one heading, and I'm only going to look at headings. 4.3, common public messages. 4.4, behavioural change. And over the page, please, to paragraph 6 -- well, paragraph 5, we can see is regular engagement, but paragraph 6 in particular, thank you, is that:

"Given that the response to Covid-19 requires a whole-government approach, participants will provide an agreed regular update to our respective administrations."

Then if we can go to the last page, please, we can see the box for signatories, and it is signed or was to be signed by yourself and the Chief Medical Officer for the Republic.

Did you in fact sign it off, as a final --

A. My recollection, it was signed off as a final document, yes.

Q. Given the topics within it, I mean, things like non-pharmaceutical interventions, communications, behavioural change, are not exclusively the remit, if you like, of the Chief Medical Officer but do stray into policy and in fact do stray into politics when it comes to communications. Was consideration given to having this signed off at a higher level?

A. I think that the outworkings of this, Tony Holohan -- or Dr Holohan and myself were supported by respective policy teams. So, following the signing of this, I think our first regular meeting, formal meeting, was on 14 May, so we would have had the respective policy teams from the Republic of Ireland and --

Q. Well, by higher level, in fact I'm thinking of the First Minister, the deputy First Minister, the Taoiseach --

A. Sure.

Q. -- perhaps even the Secretary of State, in order to

generate that two-island, five-nation interest.

A. I was going to come on to that, because I thought the first part of your question was about was it appropriate in terms of the policy issues that were within that.

So I think in terms of the policy issues, I think that format was entirely appropriate, because we had the support of policy colleagues.

You're absolutely right, this is not a substitute for political engagement discourse, and the work that we were doing under the aegises of the MoU did certainly inform our respective updates to minutes or meetings of the North South Ministerial Council. I did support the minister, deputy First Minister and First Minister at quad meetings, which involved the Taoiseach, the Tánaiste and -- at times, and also the Secretary of State.

So those regular political engagements and discussions were ongoing, and certainly when we had the North South ministerial meetings, the Chief Medical Officer in the Republic of Ireland, my counterpart, and I would have provided updates in relation to work that we were separately doing, or of -- also areas of collaboration.

Q. Sir Michael, final topic -- and I know I'm pushing it, my Lady -- you were asked earlier in your evidence about

an email exchange between you and Bernie Rooney in relation to a submission that she had provided to the Executive Office on the -- to the First Minister and deputy First Minister on 30 January.

Bernie Rooney is, we know, a senior civil servant, who at the time was a deputy director of the Executive Office who reported to Chris Stewart, who in turn reported directly to --

A. Yes, yes.

Q. -- the head of the Civil Service. Were you aware of that --

A. Yes, I was.

Q. -- at the time? Okay.

Ms Rooney has provided a statement to the Inquiry, and I wonder if we can have a look at it.

INQ000468508, and it's page 11.

And at this part of her statement she addresses this exchange with you, and it's that that I would like your assistance on.

A. Okay, just to clarify, this isn't in my evidence proposals and I haven't -- I don't think I've read this statement, but I'm happy to try to answer questions as best I can.

Q. I don't want to be unfair to you in any way and if we need to do it in a different way, no doubt we can.

Can we zoom in, please, at paragraph 46, to -- there we go.

This is just to indicate that she had sent the submission which had been requested and approved by her manager to the First Minister and deputy First Minister on that date.

And can we go to the next paragraph, please.

That evening she received a telephone call from the Chief Medical Officer expressing his dissatisfaction that she had prepared and submitted the submission. She apologised and explained that it had been -- she had been asked to prepare it and submit it by Chris Stewart, and that Dr Naresh Chada, the Deputy Chief Medical Officer, had provided input and seen the submission prior to it being forwarded to the First Minister and deputy First Minister.

And the next paragraph, please. In fact the next two paragraphs:

"Dr Michael McBride asked for some amendments to be made and asked me ... [Document read] ... should be cleared by him personally and that this should not happen again."

She amended the submission and ensured that the updated version, including your comments, were presented to the First Minister and deputy First Minister. And it

was after that we see at paragraph 49 that Dr Michael McBride emailed asking her to confirm that the submission had been amended, and that is the email that we had just looked at.

A. Yeah.

Q. Sir Michael, on 30 January you phoned a senior civil servant in the Executive Office in relation to work that she had undertaken briefing the ministers from the Executive Office about a very important issue of pandemic preparedness. That's what --

A. That is correct, yes.

Q. -- the statement indicates. And do you accept that that happened?

A. No, I agree that that happened, and I think I addressed that in my answer earlier, that my rationale for that was to ensure that the First Minister and deputy First Minister were receiving information, in a submission that was a professional and technical nature, that was absolutely correct. I mean, that is a professional responsibility of mine.

I think at that time, as I've said earlier, and as I recall, Bernie -- sorry, Ms Rooney explained to me, I hadn't been aware that the advice and input had been provided by the Deputy Chief Medical Officer. So it was a misunderstanding on my part.

Q. But in fact Ms Rooney indicates that your advice to her was that all submissions to the First Minister and deputy First Minister and the Executive should be cleared by you personally and that it should not happen again that anything should go --

A. I mean, I think that that -- look, I've indicated earlier that I accept the wording in an email. I think that -- and the email is there. What I was referring to was my professional, technical advice.

I mean, this was a rapidly developing situation. It was crucially important, in my view, that the advice to the First Minister and deputy First Minister accurately and fully reflected the picture. And I've already alluded to the email of 29 January, when the references to comments that Professor Sir Chris Whitty made had been misinterpreted and reflected in an email of 29 January. So I had a professional responsibility to ensure that professional -- and then, in the absence of the Chief Scientific Adviser -- professional medical and scientific advice was absolutely robust and accurate.

I absolutely agree that how that's written is, can be interpreted differently. Not -- I mean, it is understood, as I said earlier, I do not clear papers to ministers in other departments, I do not clear papers to the First Minister and deputy First Minister, but what

I would expect to do is clear professional, technical advice to inform those papers, and that happened throughout the pandemic.

MS CAMPBELL: Thank you.

LADY HALLETT: Thank you, Ms Campbell.

Ms Murnaghan, did you have something that you wanted to raise, was there a document?

Questions from MS MURNAGHAN KC

MS MURNAGHAN: There is a document, my Lady.

It's INQ000474210.

My Lady, it's quite convenient.

It leads on, Sir Michael, from the question you have just been posed, this question which was raised before lunch today by Senior Counsel to the Inquiry about the email from yourself to Ms Rooney about clearing documents.

Now, in your response you explained that, and you've explained again, you're referring to clearing in a professional and technical advice and you stated it was crucial, you were confident in respect of the nature of that technical and professional advice.

So if we could look actually at that INQ000474210 document, and in particular at paragraph 2 of that document, we should see the track -- are you able to see, Sir Michael, the track changes on the document?

A. Are those my track changes, or ...?
Q. Yes, it actually doesn't come up on this copy, but we have another copy in which the track changes -- and we can see that they're attributed to your personal email account.

I was wondering if you could look at the track changes, and whether you could consider whether the advice before the addition of your track changes had accurately reflected what had been said at the COBR meeting?
A. I do not believe that before the track changes it fully or comprehensively reflected the discussion at COBR, and I would want to emphasise that is absolutely not a reflection on either Ms Rooney or, indeed, my Deputy Chief Medical Officer. I was at the meeting and I felt it was absolutely essential that the First Minister and deputy First Minister had first-hand read-out of, as CMO, my understanding of what had been said at the meeting and the significance of that.

You know, I felt it was also important to emphasise, and again this point has perhaps been missed as well, that when the WHO declares a pandemic, it doesn't mean that we're going to see the consequences and scale of something that unfolded tragically over the last number of years and we're still -- many are still living with

the consequences.

What it means is that there is a new virus in circulation and it's spreading globally, but it is neutral in terms of what the potential impact is. Because again, at that time, when something's declared a pandemic, you don't wait -- you don't wait to see what the impact is. So for instance, with H1N1, we declared a pandemic. We anticipated a very significant impact and consequence, and that didn't ultimately transpire, it was -- by comparison to this pandemic.

So I think that the additions of those comments, while they may seem to be small, I think are significant contextually.
Q. Yes. And can you relate them, therefore, then, to the context of the email which you sent covering, given that the -- the significance, as you have outlined, to the changes?
A. Yeah, I mean, I think the final sentence is particularly important, where I indicate the need for governments to increase the level of planning and preparedness. And I think this was the point that I was very keen to signal, and I know we've discussed this earlier in my evidence, and that --
LADY HALLETT: I think we're going to have to leave it there.

THE WITNESS: But we needed --
LADY HALLETT: Otherwise, I'm afraid -- I'm so sorry, Sir Michael -- I'm going to have a stenographer downing tools. I'm the one that will pay the penalty, not you.

Is that sufficient? I've got the point.
MS MURNAGHAN: Yes. Very much --
LADY HALLETT: I appreciate the point you wanted to make was that there were amendments that Sir Michael thought he had to make --
MS MURNAGHAN: Yes.
LADY HALLETT: -- given his professional capacity.
MS MURNAGHAN: Yes. Very much obliged.
LADY HALLETT: And that's really the point that Ms Murnaghan was trying to explore.
THE WITNESS: I'm glad you understood it because --
LADY HALLETT: Don't worry, I have been alerted to it.
THE WITNESS: Okay.
LADY HALLETT: I had forewarning, so I knew.
THE WITNESS: All right.
LADY HALLETT: So thank you very much for your help, Sir Michael. I appreciate you helped me in Module 1. It was Module 1, wasn't it, I think?
THE WITNESS: It was Module 1, yes.
LADY HALLETT: And I may well have to call on you again, I'm not sure yet, but --

THE WITNESS: Sure.
LADY HALLETT: And I do understand the demands it makes upon not only you personally but obviously people with whom you work, so I'm very grateful for your help.
THE WITNESS: Happy to be of assistance.
LADY HALLETT: Thank you.

(The witness withdrew)
LADY HALLETT: 10 o'clock on Monday morning. I hope people have as good a weekend as they can.
(4.35 pm)

(The hearing adjourned until 10 am on Monday, 13 May 2024)

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