

Tuesday, 24 September 2024

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 2 (10.00 am)
 3 **LADY HALLETT:** Mr Scott.
 4 **MR SCOTT:** Good morning, my Lady. Please may we call
 5 Professor Sir Michael McBride who can be sworn.
 6 **PROFESSOR SIR MICHAEL MCBRIDE**
 7 **LADY HALLETT:** Welcome back, Sir Michael.
 8 **A.** My Lady.
 9 **MR SCOTT:** Good morning, Professor McBride.
 10 **A.** Good morning.
 11 **Q.** You have been Northern Ireland's Chief Medical Officer
 12 since September 2006.
 13 **A.** That's correct.
 14 **Q.** And I'm just going to set out a little bit of your
 15 professional background. So from 1994 to 2006 you
 16 worked as an HIV consultant at the Royal Group of
 17 Hospitals Trust in Belfast.
 18 **A.** That's correct.
 19 **Q.** You were appointed medical director of the Royal Group
 20 of Hospitals in August 2002. In September 2006 you were
 21 appointed as Northern Ireland's Chief Medical Officer.
 22 Between March and August 2009 you were appointed acting
 23 permanent secretary of the Department of Health and
 24 chief executive of the Northern Ireland Health and
 25 Social Care at the request of the then minister?

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1 Northern Ireland, is it? It's Health and Social Care?
 2 **A.** That's correct. I mean, the NHS refers predominantly to
 3 England but certainly in Northern Ireland it's referred
 4 to Health and Social Care. It's really an umbrella term
 5 which we use which refers collectively to the rules and
 6 responsibilities of the department, the Health and
 7 Social Care Board, Public Health Agency and the five
 8 trusts.
 9 **Q.** I just wonder if you could keep up your voice a little
 10 bit. I'm having a little bit of difficulty hearing you,
 11 sorry.
 12 It's often said that Northern Ireland's health and
 13 social care system is unique because trusts provide
 14 social services rather than local authorities?
 15 **A.** That's correct. Northern Ireland's had an integrated
 16 health and social care system since 1973.
 17 **Q.** And the Department of Health lies at the top of Health
 18 and Social Care as responsible for healthcare policy;
 19 that's correct?
 20 **A.** Correct. Policy, legislation, setting priorities,
 21 allocating funding to the rest of the system.
 22 **Q.** Then I'm just going to skip over HSCB for a minute.
 23 There are six Northern Ireland health and social
 24 care trusts, five geographical and one ambulance
 25 service, that's correct?

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1 **A.** That's correct.
 2 **Q.** From November 2014 to February 2017, at the request of
 3 the then health minister, you were appointed the
 4 chief executive of Belfast Health and Social Care Trust,
 5 and you served until February 2017, and that was in
 6 parallel to your role as CMO?
 7 **A.** That is also correct, yes.
 8 **Q.** You are a fellow of the Royal College of Physicians in
 9 London and in Ireland, you have been awarded an honorary
 10 professorship and doctorate by Queens University of
 11 Medical Science for Distinction in medicine, and in
 12 March 2022 you were elected to honorary fellowship of
 13 the Faculty of Public Health?
 14 **A.** That's correct.
 15 **Q.** Then you were knighted in 2021 for services to public
 16 health in Northern Ireland?
 17 **A.** Yes.
 18 **Q.** Professor McBride, I just want to provide a brief
 19 overview of the structure of the healthcare systems in
 20 Northern Ireland. I'm very conscious that my Lady has
 21 heard this in both Module 1 and also has
 22 an understanding from Module 2C, so we're not going to
 23 go into this in great detail, but just to help identify
 24 matters.
 25 Starting with the name, it's not called the NHS in

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1 **A.** That's correct.
 2 **Q.** And the trusts are responsible for effectively
 3 implementing department mental policy; is that right?
 4 **A.** They are -- well, effectively delivering services
 5 according to standards which are set by the department.
 6 **Q.** And just to have a flavour of effectively what's on the
 7 ground for patients in Northern Ireland, how many
 8 hospitals are there in Northern Ireland?
 9 **A.** Oh --
 10 **Q.** About 19?
 11 **A.** About that, yes. I mean, obviously it's a changing
 12 landscape because there is ongoing structural reform and
 13 the range of services provided in each of those is
 14 currently being looked and being reviewed.
 15 **Q.** In terms of the regional distribution of hospitals,
 16 clearly there are a couple of hospitals in Belfast but
 17 would you say that they are fairly distributed across
 18 Northern Ireland?
 19 **A.** They are. I mean, the vast majority of the regional
 20 services, so for instance neurosurgery, regional
 21 vascular surgery, the very specialist services, would be
 22 provided within the Belfast Trust, although there are
 23 some elements of those services also provided elsewhere.
 24 So there is a concentration of regional services in
 25 larger geographical conurbations, so in Belfast, Derry,

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1 Londonderry, and also then there are a range of more
2 general hospital services and local hospital services to
3 meet the needs of local populations.

4 **Q.** So if you're living in Northern Ireland, what's the kind
5 of furthest, in terms of driving distance, you'd ever
6 really be from a hospital?

7 **A.** I mean, certainly in some rural parts of the west of the
8 province, probably within 60 to 90 minutes would be
9 about the longest time to have a journey to a specialist
10 centre.

11 **Q.** And as you say, if most of the very specialist services
12 are focused in Belfast, it would take two to three hours
13 at most for anybody in Northern Ireland to get to those
14 centres; is that right?

15 **A.** Probably considerably less than that. I mean, obviously
16 we do have specialist transport services in relation to
17 road transport through the Northern Ireland Ambulance
18 Service, but we also have the Northern Ireland air
19 ambulance, which -- you know, in very, very
20 time-critical incidents, so, for instance, if there's
21 a significant trauma or, indeed, if there's
22 a significant medical or surgical issue which requires
23 rapid transfer, then we would use the Northern Ireland
24 Ambulance Service.

25 We also have, again, very specialist Northern

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1 **A.** That's correct.

2 **Q.** Then you had the Health and Social Care Board, and that
3 was responsible for governance of commissioning?

4 **A.** Yes, the commissioning plan direction was issued by the
5 department. It was then considered by the Health and
6 Social Care Board, with the support of the Public Health
7 Agency. The -- as the joint commissioners of services,
8 a bit like the commissioning model that still exists in
9 England, the board and the PHA then would have engaged
10 directly with the trusts, and each trust would've
11 developed what was called a service and budgetary
12 agreement. So basically the -- here are the priorities
13 that the department has set, this is how we will meet
14 those priorities within the resource that we are
15 allocated. So it was a very -- I suppose a very well
16 defined transactional process.

17 And then the board, Health and Social Care Board,
18 would've performance managed the trust to ensure that
19 the trust delivered on their commitments within the --
20 the agreement.

21 **Q.** Then just to get the flavour of what that would've
22 looked like. As I said, the plan that was in place at
23 January 2020, what would those priorities have looked
24 like, in terms of the headline priorities?

25 **A.** Well, those priorities would've covered a wide range of

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1 Ireland Specialist Transfer and Retrieval service,
2 NISTAR, which is responsible for the rapid transport of
3 patients to specialist centres should they require care
4 there.

5 **Q.** And in terms of the intensive care units in Northern
6 Ireland, about ten of them?

7 **A.** Yes, some are in that region.

8 **Q.** Roughly how many GP surgeries were there in -- or maybe
9 I should say GP practices -- in around March 2020?

10 **A.** At around that time there were somewhere in the region
11 of 320 general practice services. That number has
12 decreased more recently and I think currently there are
13 around 312.

14 **Q.** I said I was skipping over HSCB.

15 So in terms of the relationship you have department
16 at the top, and is the right that the department issues
17 an annual commissioning plan direction?

18 **A.** That was the case prior to the pandemic and prior to
19 the -- the board -- the closure of the Health and Social
20 Care Board and then it being amalgamated into the
21 department, but that was historically the approach that
22 was taken.

23 **Q.** Sorry, I should have clarified. So in let's call it
24 January 2020 that was the position: the department
25 issued a commissioning?

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1 issues. So, for instance, it would've covered issues
2 around waiting times, waiting times for outpatient
3 appointment, waiting times for inpatient treatment,
4 specific targets in around cancer waiting times. So
5 a range of service-specific targets. But it would also
6 have included quality indicators, so it would've
7 contained targets about reductions in
8 healthcare-associated infections, for example. It
9 would've contained targets about reducing the
10 prescribing of -- inappropriate prescribing of
11 antibiotics. So a range of both service metrics but
12 also quality, aim-proven metrics.

13 Now, that's only a small example. These were
14 extremely comprehensive documents with a significant
15 number of targets within them.

16 **Q.** It had been the intention from 2015 that the Health and
17 Social Care Board (HSCB) would be closed, and the
18 intention of that was to enhance the department's
19 strategic leadership and control of the system; is that
20 correct?

21 **A.** Yes, that was the decision made by the then minister
22 back in November 2015.

23 **Q.** Why was that considered necessary, to enhance the
24 department's strategic leadership and control of the
25 system?

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1 **A.** I think the general view was that Northern Ireland
2 perhaps was too small a health economy to have
3 a separation or a very distinct separation between
4 department, the commissioning of services and then the
5 provision of services.

6 And there was a move then to ensure that -- and
7 with -- that journey has continued, that we move to
8 a much more integrated care system which actually puts
9 at the heart of it local communities, puts at the heart
10 of it not just delivering services but improving the
11 health and wellbeing of the population, which was a core
12 priority of the reforms to Health and Social Care that
13 happened in 2009.

14 We do benefit in Northern Ireland from having
15 an integrated health and social care system, as you say,
16 and this was seen as an opportunity to make sure that we
17 derived the full benefits of that integration.

18 And I think it's probably important to make this
19 point because it was a real strength during the
20 pandemic. There is a very -- the interconnectedness of
21 the various elements within Northern Ireland is more
22 straightforward given the fact that, you know, we are
23 a relatively small geographical area, and, you know,
24 that was a significant strength during the response to
25 the pandemic, where we responded effectively as a single

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1 give effect to that because we had no ministers for
2 three years during that period.

3 **Q.** Did it feel like during the pandemic there was too much
4 distance between the department and the trusts?

5 **A.** No. Absolutely not. I mean, as I say, and I tried to
6 articulate this in my statement, there's a very close
7 working relationship between the trusts, the Health and
8 Social Care Board, the PHA, and indeed the department
9 across a whole range of areas.

10 I mean, that was both by necessity and by design.
11 The demands on the entire health and social care system
12 in Northern Ireland were immense during the pandemic.

13 It was only by working collectively and effectively
14 as a single entity that we were able to respond
15 efficiently and effectively to those demands, and
16 I think that interconnectedness, you know, that ability
17 to get people into a room -- well, of course, during the
18 pandemic we couldn't get people into a room, but
19 virtually -- have discussions with people who we all had
20 good working relationships with, served us very, very
21 well and hopefully served the population of
22 Northern Ireland well.

23 **Q.** I just want to move now looking at your roles and
24 responsibilities and then structures during the middle
25 of the pandemic. I'm going to deal with these

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1 entity.

2 But I think the overall impression, to answer your
3 question, was that we had too many layers perhaps and
4 that there was greater efficiency to be gained by
5 collapsing some of those layers.

6 **Q.** Well, that was where the question was going. So HSCB
7 hadn't been closed prior to April 2022?

8 **A.** That's correct.

9 **Q.** So did Northern Ireland miss out in the benefit of
10 having that collapsing of those layers during the course
11 of the pandemic?

12 **A.** I think if -- if indeed the intent achieved the outcome
13 that was the purpose of that -- those changes, I think
14 the answer to that is yes. I think we're still working
15 through that transition period because the Health and
16 Social Care Board then became part of the department in
17 April 2022 and is now the Strategic Planning and
18 Performance Group within the department.

19 We are now advancing the new model for the
20 integrated care system which I alluded to earlier.
21 I think that there was undoubtedly a period, and I've
22 alluded to this in my statement, of uncertainty between
23 that announcement being made in 2015 and then that being
24 realised in 2022.

25 But of course, we didn't have the wherewithal to

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1 relatively briefly.

2 So your role is to provide independent professional
3 advice to the health minister, you're accountable to the
4 health minister, and you are also accountable to the
5 permanent secretary in his role as the department's
6 accounting officer; is that correct?

7 **A.** That's correct, yes.

8 **Q.** You say that your role is to provide independent
9 professional advice. Independent of what?

10 **A.** In -- well, independent of political influence, or other
11 considerations of that nature. You know, if I'm asked
12 for my professional opinion, I base it on evidence. And
13 that evidence could come from research, that evidence
14 could come from expert clinical opinion, which I rely on
15 as well, and on knowing the limitations of my own
16 knowledge, and also relying on expert clinical opinion.

17 So the amalgamation of and triangulation of all of
18 that would inform my professional advice, so I don't
19 take any other considerations on board. My advice is my
20 advice and I provide that independently of any other
21 consideration.

22 **Q.** Because you're in a slightly different position, for
23 example, to Professor Sir Chris Whitty: where OCMO is
24 effectively a different structure, you are very much
25 within the Department of Health?

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1 **A.** Yes, I mean, it's a different role with different
2 responsibilities, and it's a different system.
3 But it is the system that -- as -- as was designed
4 in Northern Ireland, it was the job to which I applied
5 and the job to which I was -- a role that I was
6 appointed to.

7 **Q.** Because as part -- as CMO you are also member of the
8 department's top management group, which is the main
9 vehicle for managing the department on a day-to-day
10 basis?

11 **A.** Yes, correct.

12 **Q.** What was your working relationship like with senior
13 figures at the start of the pandemic? Because, for
14 example, the health minister, Robin Swann, started in
15 his role on 11 January 2020. So how is he was it to
16 build a working relationship with him?

17 **A.** I mean, the successor or otherwise of any Chief Medical
18 Officer is to build effective working relationships with
19 senior colleagues within the department and certainly
20 with ministers, and to ensure that at all times through
21 the advice that we provide, that we provide that advice,
22 as we've discussed, professional advice, in an impartial
23 way to the best of our ability.

24 So the fact that the pandemic hit some three weeks
25 after the Executive had reformed, there were new

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1 nursing in the Belfast Trust at the time, and she was
2 accountable to the director of nursing of the Belfast
3 Trust, so there was no reporting line to me. So, you
4 know, she was not and I would not regard Charlotte as
5 subordinate to me. I mean, she had a range of expertise
6 and competence and experience in areas that I wouldn't
7 have had.

8 **Q.** But when a group of people travel effectively up through
9 the ranks together, that working relationships can form,
10 was there a culture of challenging and testing your
11 views and your advice that you were providing as CMO?

12 **A.** Yes. I mean, I think that the -- I think my approach to
13 these things is that -- is to surround yourself with
14 very able people, many people who are often more able
15 and knowledgeable about a particular subject than you
16 are, and to ensure that they are empowered to challenge
17 and to question, and it's my responsibility to listen,
18 to hear, and to act on that accordingly.

19 And there were many examples where, you know, the
20 Chief Scientific Advisor would've had perhaps -- not
21 a different view but a nuanced view or interpretation of
22 science for instance during the pandemic and I would
23 very much have taken on board, in many instances been
24 guided by, his advice.

25 You know, similarly, with the Chief Nursing Officer,

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1 ministers in post who were really just getting into
2 their -- their brief, did -- you know, like -- well, it
3 did present some challenges. However, I have to say
4 that, as with all previous ministers, I rapidly
5 developed an effective working relationship with the
6 then newly appointed health minister, Minister Swann.

7 **Q.** And in terms of your -- well, not your -- the Chief
8 Scientific Advisor for the Department of Health and also
9 the Chief Nursing Officer at the time, both of them had
10 come from Belfast Trust, in -- before they were
11 appointed CSA and CNO; is that correct?

12 **A.** The Chief Nursing Officer, former Chief Nursing Officer,
13 had also worked in a number of other organisations in
14 Northern Ireland. She'd served in the South Eastern
15 Trust previous to working in the Belfast Trust. I had
16 known her in both of those roles and it's correct, yes,
17 the Chief Scientific Advisor had previously worked as
18 a joint appointment, an academic appointment, between
19 Queens University Belfast and the Belfast Trust.

20 **Q.** But both of them had been subordinates to you within the
21 Belfast Trust; is that correct?

22 **A.** Well, I wouldn't -- I wouldn't describe the -- the
23 then -- sorry, former Chief Nursing Officer, who gave
24 evidence earlier -- or last week, was the deputy --
25 a chief nursing -- a director -- deputy director of

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1 who -- you know, by nature of the demands at that time,
2 there was a division of responsibility, there had to be
3 division of responsibility, because, you know, it was
4 not possible for me to be involved or nor would it be
5 appropriate. So, again, the then Chief Nursing Officer
6 would've led on material issues. I would've provided --

7 **Q.** Sorry --

8 **A.** -- (overspeaking) -- support to her.

9 **Q.** Forgive me, Professor McBride, can I cut through this.
10 We will look at specific examples in due course about
11 the interactions.

12 **A.** Okay.

13 **Q.** But you are satisfied that you were having your views
14 and your advice challenged by those people you were
15 working with? When I say "challenge", I don't
16 necessarily mean in a detrimental way, just it was being
17 tested and it was being -- effectively made sure it was
18 as good and strong as it possibly could be?

19 **A.** Yes. I mean, we were dealing with such uncertainty at
20 that time that we relied on each other to challenge
21 these fine -- at times very finely balanced judgement
22 calls that we were making. So that judgement, that
23 challenge, was absolutely vital and essential.

24 **Q.** Because you mentioned earlier on about the size of
25 Northern Ireland and therefore the size of those who --

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1 the size of teams of those who can be within the health
2 service.

3 So, as CMO, you're head of the Chief Medical
4 Officer's group, and that's comprised of yourself, two
5 deputy CMOs and several medical advisers.

6 How many advisers?

7 **A.** The senior medical advisers, there were four in total,
8 two of them were part-time.

9 **Q.** So it's a team of 7 within your group?

10 **A.** Well --

11 **Q.** So yourself, the two DCMOs and then the medical
12 advisers --

13 **A.** Not 7 who were time equivalent. As I say, there were
14 two full-time DCMOs, myself, and two full-time senior
15 medical officers and two part-time.

16 **Q.** And so just to have a look at some of the aspects that
17 your role covered.

18 So CMOG acts as a sponsor for the Public Health
19 Agency and the Regulation and Quality Improvement
20 Authority. For those people who aren't necessarily
21 familiar with all the bodies, that's broadly equivalent
22 to the CQC?

23 **A.** That's correct, yes.

24 **Q.** And how much time did that take up in your role, as
25 a sponsor of those two bodies?

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1 protection directorate, emergency planning and
2 resilience and response directorate, and the quality and
3 safety and improvement directorate are no longer part of
4 your group?

5 **A.** That's correct.

6 **Q.** That takes me to the question: why have they been
7 removed from within the responsibility of CMOG?

8 **A.** I think this was a decision made by the new permanent
9 secretary, one that I supported in relation to some
10 internal restructuring within the department.

11 I think it was in part an acknowledgment that the
12 responsibilities and the remit that I was carrying were
13 very broad, and the demands of that were very
14 significant.

15 And it was an opportunity to provide some -- it
16 built on the work that I had already done in terms --
17 which you alluded to, in terms of separating out the
18 health protection directorate and the emergency planning
19 and response directorate. So -- I think it also had the
20 advantage of freeing up more of my time professionally
21 to provide advice and support across more areas for the
22 department. Because as well as my policy responsibility
23 at that time, I also had professional responsibility to
24 provide advice and support to other policy areas, such
25 as, for instance, primary care, mental health,

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1 **A.** The -- the sponsorship -- the sponsorship would've
2 largely been managed by policy officials within CMO
3 group, so they would've dealt with the day-to-day
4 issues.

5 I would have attended sponsorship review meetings
6 and accountability review meetings with the permanent
7 secretary. And if there were issues that arose, then
8 those would've been brought to my attention. But
9 I wouldn't have been involved in the day-to-day
10 sponsorship arrangement.

11 **Q.** Okay.

12 So the role also included population health
13 directorate, which at that time included
14 responsibilities for health improvement, health
15 protection and emergency planning.

16 I think as was noted in the Module 1 report,
17 my Lady -- paragraph 2.78 for those who wish to review
18 it -- since that time, the Chief Medical Officer's group
19 has been restructured with the establishment of a health
20 protection directorate and emergency planning resilience
21 and response directorate, following internal review.

22 But I think it's actually right, Professor McBride,
23 that even since then Chief Medical Officer's group has
24 been further restructured, in November 2023.

25 So the population health directorate, health

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1 et cetera, and having the policy responsibilities, the
2 budgetary responsibilities, the HR issues
3 responsibilities, was not seen, and I would agree, as
4 necessarily the most effective use of my time.

5 **LADY HALLETT:** Professor McBride, I'm afraid sometimes your
6 voice goes down, it becomes very soft at the end of the
7 sentence, and you speak quite quickly and both the
8 stenographer and I are struggling a little. So if I can
9 encourage you to speak slowly and to speak up, I'd be
10 really grateful, thank you.

11 **A.** Yes, my Lady.

12 **MR SCOTT:** Just moving now to the HSC structural response to
13 the pandemic.

14 So we heard that tiers of the emergency response
15 within the health system are generally referred to as
16 health gold, health silver, health bronze, and those are
17 the strategic, tactical and operational response.

18 Let's kind of move as past the names and actually
19 look at what they're doing.

20 So effectively it works from the bottom up, doesn't
21 it, that you don't have to have gold, you can have
22 silver without gold and --

23 **A.** That correct, yes.

24 **Q.** So health bronze is effectively the operational -- the
25 trust-level response; is that right?

20

1 A. Yes.

2 Q. And health silver, that's not actually a departmental
3 body, is it?

4 A. No, it isn't.

5 Q. So that's made up of the Public Health Agency, what was
6 HSCB at the time, and then also the Business Services
7 Organisation.

8 So did the department have no role in health silver?

9 A. No, you know, the -- it's not to say that we had no
10 role -- in any emergency situation that you -- principle
11 of subsidiarity applies so that all issues are managed
12 at the lowest possible level and escalated to the next
13 level as required for decision.

14 So the department -- when the full bronze, silver
15 and gold arrangements were activated, as we would do in
16 a significant or catastrophic incident, as --

17 Q. Such as the pandemic?

18 A. -- such as the pandemic -- then the department would
19 activate health gold, the various --

20 Q. I'm going to come on to health gold, it's just at the
21 moment in terms of whether the department had any
22 involvement in health silver or whether the department
23 rested effectively within health gold?

24 A. Within health gold, yes.

25 Q. Why is it the department had no role within health
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1 A. Correct.

2 Q. And that's set out under, as I say, the department's
3 emergency response plan.

4 And effectively your role was to oversee the
5 departmental response?

6 A. It -- well, it --

7 Q. That's -- that's the title at action card 1 of the
8 emergency response plan, it's not my words.

9 A. Yes, it is. I'm happy to elaborate on that but, yes, it
10 is in the action card, yes.

11 Q. And, yes, you have the minister above you who is
12 effectively fundamentally responsible for the health
13 response, is that correct?

14 A. Yes.

15 Q. And your responsibility, you're making informed
16 decisions in relation to how the sector should respond,
17 providing health advice, professional dental and
18 pharmaceutical advice -- presumably that's through your
19 Chief Pharmaceutical Officer and others supporting
20 you -- public health policy and safety and quality
21 policy, including standards, guidelines and professional
22 regulation.

23 That seems a very broad role.

24 A. Mm.

25 Q. Would you be able to describe, in the middle of the
23

1 silver? Is it effectively you would've been duplicating
2 your roles?

3 A. Yes, I mean the role of the department in, you know,
4 a serious or catastrophic emergency is to provide
5 strategic direction and co-ordination. I mean, our
6 role -- and again, I think, Chair -- my Lady, we covered
7 this within the -- with Module 1, is clearly set out
8 within the emergency response plan.

9 Q. Yes.

10 A. And silver is responsible for the co-ordination at
11 a system level across the various provider
12 organisations, and when activated and health gold is
13 activated, it would be providing situation reports to
14 the department and would be escalating issues that
15 required decision because of their significance or
16 policy implications.

17 Q. We'll look at some of those in due course.

18 And just for completeness, so those bodies within
19 health silver decide when health silver should be
20 activated?

21 A. Yes.

22 Q. And that was activated on 22 January 2020.

23 Then in terms of health gold, and you've been
24 describing what health gold does, you, as CMO, are chair
25 of health gold, that's right?
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1 pandemic what was your typical day like? None of us
2 have been CMOs, Professor McBride. It would be helpful
3 to have an understanding of what your day was like.

4 A. There was no typical day during the pandemic, because
5 every day presented very unique challenges. I think
6 that -- you know, I mean, I think I said previously, in
7 my previous witness statements, I think it's now,
8 looking back, very hard to convey both the complexity
9 and the pace of events and the challenging and difficult
10 issues that we were facing. And I think that was
11 compounded by the very significant degree of uncertainty
12 that we faced.

13 So we were relying on what we had already -- for
14 instance, if we look at the virus, what we already knew
15 about coronaviruses, we were relying on first
16 principles, what we knew about -- already about good
17 public health practice, good infection prevention
18 control, and we were actively seeking to generate more
19 knowledge, more information, more evidence. You know,
20 reaching out to other countries who were slightly ahead
21 of us in the pandemic, China, other European countries,
22 Italy, France, to ascertain the impact that the virus
23 was having, how the disease was manifesting, those that
24 were most at risk. Actively at that time, even then,
25 thinking about research for novel treatments, looking at
24

1 previous treatments for other viruses. Again, thinking
2 through vaccines and starting up vaccine research
3 trials.

4 Also, thinking through the -- and planning the
5 measures that we would have to put in place in the
6 population to contain the virus, it was clear very early
7 on this was a highly contagious virus, it was an
8 extremely infectious virus. Our knowledge of how it was
9 spreading, where it was spreading, was significantly
10 constrained, by the -- the level of testing that was
11 available to us at that time --

12 **Q.** Professor McBride, I don't want you to jump too far
13 ahead of me, we'll be going through this in terms of the
14 time, it's just a matter, as I say, to give a flavour of
15 the issues that you were facing.

16 Can I just ask a very simple, hopefully fundamental
17 question: do you think you did your best for the
18 population of Northern Ireland in the response to the
19 pandemic?

20 **A.** I think each and every one of us, you know, from those
21 in the front line to those of us in government to
22 ministers to every minister sitting around the Executive
23 table, at all times tried to do our every best. I don't
24 think that -- that there's no doubt about that.

25 I think that -- and we did that, you know, based on
25

1 available to you at the time?

2 **A.** Well, as always, ultimately, my Lady, it will be for the
3 Inquiry to determine in terms of the answers to that
4 question, as I've -- as I've said in my statement.
5 I think there were some issues because of the pace of
6 events. I think there were certainly some issues in
7 terms of, you know -- and I'm sure we'll probably come
8 on to this later -- in relation to communications, so,
9 for instance, to those shielding in terms of how we
10 conveyed information, how we conveyed information in
11 a balanced way which allowed people to make choices
12 about what was important to them.

13 **Q.** Is that within the shielding context?

14 **A.** Yes.

15 And empowered them and give them self-agency.
16 Because it became very difficult later on, when actually
17 the harms and benefit analysis changed, then to provide
18 assurance to the population of people who had been
19 shielding who were clinically extremely vulnerable.

20 And, looking back, I think some of the initial
21 messaging around that could've been more nuanced.

22 I think certainly that was something which, as I'm
23 sure we'll come on to, I was concerned about and was
24 concerned -- really, from May 2021; I had commissioned
25 some research to seek the views of people who had been

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1 the knowledge and information that we had at that time
2 and we made -- ministers made some very difficult
3 decisions, weighing up some very difficult issues in
4 terms of the health consequences, social consequences,
5 the economic consequences. We, all of us, were very
6 mindful of the impact that it was also having on -- on
7 the health service, on routine services that people
8 would normally expect, the care they would normally
9 expect, and the fact that we were having to ramp up
10 services to deal with the anticipated surge in people
11 requiring respiratory support and intensive care, and
12 that was constraining our ability to deliver care as --
13 as we would do. So we were all very mindful of those
14 challenges.

15 And as I said at the time, you know, there were --
16 there were no easy solutions, there were no simple
17 answers, there were just a series of very difficult
18 challenges, and we made at all times decisions which we
19 believed were in the best interests of the public that
20 we serve.

21 **Q.** So, on the basis that all decisions were in the best
22 interests of the public that you serve, with the benefit
23 of hindsight, do you believe you got all those decisions
24 right or were there any that you wish you had taken
25 a different decision on? Even if that knowledge wasn't

26

1 shielding, in terms of the impact it was having on them.

2 **Q.** We will come back to that.

3 Beyond the shielding points, as I say, are there any
4 lessons that you personally have learned from your
5 experience as the Northern Ireland CMO?

6 **A.** There probably are at several levels. I think if we
7 take it at the personal level and the very human impacts
8 of the pandemic, undoubtedly a piece of work that
9 I commissioned earlier in the pandemic was around the
10 psychological aftermath of the pandemic and -- when
11 I commissioned that work back in March, and
12 a consequence of that --

13 **Q.** So just -- March 2020?

14 **A.** Yes, so very, very early on. And I had envisaged that
15 this was going to have some really profound impacts.
16 I think it's referenced in my -- in my statement.

17 That identified that there would be impacts in those
18 who were bereaved during the pandemic, either as
19 consequence of losing someone to Covid or indeed a death
20 of someone not from Covid because of the changes that we
21 had to put in place around the normal grieving and
22 cultural and ritual traditions around death.

23 So I commenced a programme of work around
24 bereavement support.

25 **Q.** In terms of how the outcome of that review/report

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1 process, doesn't really matter what we call it, how did
 2 that impact upon your decision-making in the pandemic?
 3 Was that something that was always at the forefront of
 4 your mind?
 5 **A.** I think it was something that certainly I -- I --
 6 I think that we must do better in health social care
 7 around bereavement care and bereavement support. It was
 8 something, yes, I was mindful throughout my career. It
 9 was quite clear this was going to be a particular issue.
 10 **Q.** Clear from when?
 11 **A.** Well, from pretty early on I would say, but whenever we
 12 introduced the restrictions in around funerals and
 13 people paying respects.
 14 **Q.** So March?
 15 **A.** Yes.
 16 I then -- you know, I mean, I know you don't want to
 17 go into all the details at this stage, but I established
 18 a bereavement network at that stage. We developed
 19 a range of guidance and supports for people. You know,
 20 for children who were bereaved, individuals who were --
 21 had -- had died in nursing homes, for both their carers
 22 and for staff, and ultimately we -- that resulted in
 23 a report which saw the establishment of the Northern
 24 Ireland Bereavement Network, and we now have as a result
 25 of that a bereavement, Bereaved NI, website, which is
 29

1 fact that there was much more that we need to do, not
 2 just as health service but as professionals and as
 3 a society, about encouraging those conversations and
 4 putting in place the mechanisms to support individuals.
 5 **Q.** Thank you.
 6 I want to move now to one specific area that the
 7 Chair has heard a lot about over the past two weeks.
 8 It's infection prevention and control.
 9 What was your role in terms of the infection
 10 prevention and control measures that should apply in
 11 Northern Ireland during the pandemic?
 12 **A.** I mean, I think I -- I did not have a direct role in the
 13 infection prevention and control measures that were to
 14 apply in Northern Ireland at the time. We had
 15 an infection prevention control cell which was headed up
 16 by the Public Health Agency, who have expertise
 17 infection prevention and control.
 18 There is already a considerable amount of expertise
 19 infection prevention and control within the health
 20 service, so that infection prevention and control cell
 21 led on the advice and guidance around those measures
 22 during the pandemic.
 23 **Q.** Yes, and I think that's set out in your statement, and
 24 I think you also say that:
 25 "There was to my knowledge no IPC guidance developed
 31

1 a source of support available to individuals who have
 2 suffered a bereavement.
 3 Now, I think that was a direct consequence of some
 4 of the experiences in the pandemic and the fact that --
 5 I think that we need to enhance arrangements in that
 6 area.
 7 Another particular area, under that sort of the
 8 people bit of the learning, was the work that we did
 9 around the ethics guidance and support framework for
 10 clinicians --
 11 **Q.** We'll be coming to some of the detail.
 12 **A.** Another element which I think is crucially important in
 13 that same context was work that we started during the
 14 pandemic and a policy document that we published in
 15 October 2022 around advanced care planning. And that
 16 is, you know, a systematic and structured way about
 17 people identifying when they are well, about things that
 18 matter to them, and having structured conversations with
 19 the individuals that matter to them about things that
 20 they wish in terms of their personal wishes, their
 21 financial wishes, medical wishes in terms of treatment
 22 and care at the end of life, et cetera.
 23 And that work is being rolled out at present.
 24 So I do think that the pandemic has shone a light on
 25 that, for me personally a very important light, on the
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1 solely in [Northern Ireland] and the IPC Cell within the
 2 PHA in [Northern Ireland] did not diverge from the UK
 3 wide IPC guidance."
 4 Is that your understanding?
 5 **A.** Well, there was guidance developed but it didn't
 6 differ -- there was guidance provided in Northern
 7 Ireland but it was aligned and fully aligned with the
 8 IPC guidance in the rest of the UK.
 9 **Q.** So even if you had no direct role in the creation of it,
 10 I mean, you must have been aware of the guidance?
 11 **A.** Yes, yes. But as I say, the nature of my other
 12 responsibilities were such, you know, as I say, I wasn't
 13 directly overseeing that guidance or its development.
 14 But we did -- certainly the UK CMOs and our senior
 15 clinicians call, which were happening regularly,
 16 would've got updates of any developments or changes
 17 recommended in the IPC guidance. So it was a high-level
 18 involvement but not in the detail.
 19 **Q.** You say the Senior Clinicians Group and you said met
 20 regularly, roughly how regularly?
 21 **A.** Oh, it met weekly. And, you know, that happened really
 22 through -- throughout the pandemic.
 23 **Q.** And those -- Senior Clinicians Group, did that have any,
 24 as far as you were concerned, any oversight of the IPC
 25 cell?
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- 1 **A.** No, it didn't have oversight. But certainly we would've
2 had updates from the UK -- the HSA representative, who
3 was sitting on -- a member of the Senior Clinicians
4 Group about plans of -- for engagement or, you know,
5 discussions which were to be had at the UK -- four
6 nations UK IPC cell, of which the PHA represented
7 Northern Ireland.
- 8 **Q.** So as far as you were concerned, would you have seen it
9 as your role to scrutinise the guidance that was coming
10 out and apply your own personal knowledge to it?
- 11 **A.** No, I mean, I think the -- I mean, part of my role as
12 Chief Medical Officer is to recognise the limitations of
13 my expertise. I'm not an expert in infection prevention
14 and control and there are others that are expert.
- 15 You know, I think had I -- you know, had I been
16 aware of something within that guidance which I felt was
17 of concern, within the limits of my professional or
18 which -- I would've certainly challenged that, but very
19 much I was reliant on those who were expert in the area.
- 20 **Q.** So in terms of issues such as routes of transmission,
21 where was your advice coming from?
- 22 **A.** My advice would've been coming from colleagues within
23 the UKHSA. And I understand you heard -- you had
24 evidence from UKHSA, the Health Security Agency, last
25 week. So, again, that would be the source of expert

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- 1 an expert in the differentiation between aerosol and
2 droplet.
- 3 What I would say is that I think that it's probably
4 unhelpful to have a dichotomous view between -- to
5 transmission, because obviously, as was indicated, it
6 really depends on -- on the circumstances, very much on
7 the environment and ventilation, how infectious the
8 individual is.
- 9 And obviously our knowledge on the routes of
10 transmission of SARS-Cov-2 changed incrementally
11 throughout the pandemic, so what we understood --
- 12 **Q.** Sorry, just to be clear, this is understanding you
13 gathered from the advice that you were providing, it's
14 not your own understanding that's grown during the
15 course of the pandemic?
- 16 **A.** That's correct, yes. I mean ...
- 17 **Q.** Just in terms of the droplet/aerosol dispute in terms of
18 the route of transmission, were you aware of those two
19 differing views during the course of the pandemic?
- 20 **A.** I would've been aware of those views, I do recall --
21 I don't recall all of the detail but I do recall it
22 being raised at the UK Senior Clinicians. I -- there
23 was -- and I think I've also addressed this in my
24 statement -- there was a group, a subgroup, set up to
25 establish to look at aerosol-generating procedures and

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- 1 advice.
- 2 **Q.** So there was nothing local in Northern Ireland that was
3 providing any separate advice about routes of
4 transmission for example?
- 5 **A.** No, there wasn't. And, you know, as I've made clear in
6 Module 1, you know, in Northern Ireland we do not have,
7 given our scale and size, the, you know, technical
8 ability to replicate that expertise in Northern Ireland,
9 and that's why we benefit so much from the links and --
10 effective established links that we have with the
11 UK Health Security Agency.
- 12 **Q.** So in terms of the droplet or airborne/aerosol routes of
13 transmission, did you have any view of that or were you
14 just accepting the advice that you had been provided?
- 15 **A.** I accepted the advice that I was provided.
- 16 **Q.** And do you have any views on another topic we've heard
17 about, about the different benefits offered by FRSMs
18 compared to FFP3 masks?
- 19 **A.** I mean, it is, clearly, a complex area. I did listen to
20 the evidence from Susan Hopkins last week. She is
21 clearly much more knowledgeable of these matters than
22 I am and I would defer to her interpretation of that.
- 23 We did cover this and address this within the CMO
24 technical report, but, as I say, I'm not an expert
25 infection prevention control, nor would I say that I'm

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- 1 there was a Northern Ireland representative on that
2 group.
- 3 **Q.** Slightly different topic though because I think what was
4 on the list of AGPs is a slightly different issue as
5 opposed to whether AGPs should've existed in the first
6 place.
- 7 **A.** Yes.
- 8 **Q.** Just one point I just want to ask you about, you say:
9 "I did listen to the evidence from Susan Hopkins
10 last week. She is clearly much more knowledgeable of
11 these matters than I am and I would defer to her
12 interpretation of that."
- 13 Why would you defer to her interpretation as opposed
14 to any of the other evidence that we've heard about the
15 aerosol droplets?
- 16 **A.** I haven't -- I haven't listened to any of the other
17 evidence. I haven't had a chance to read the other
18 evidence. I know you have had other evidence from
19 Professor Beggs and others, but that's not something
20 I've had time to consider.
- 21 **Q.** I want to move now then to the capacity of HSC at the
22 start of the pandemic.
- 23 Did the population of Northern Ireland have the
24 healthcare service that they needed at the start of the
25 pandemic?

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- 1 **A.** No.
- 2 **Q.** Why not?
- 3 **A.** The health service in Northern Ireland and -- was
- 4 a health service that was well overdue for structural
- 5 reform. That hadn't happened for a variety of reasons.
- 6 There had been a number of reviews.
- 7 The more recent --
- 8 **Q.** Can I briefly encapsulate two paragraphs from the
- 9 Module 1 report, just to see if you agree with them and
- 10 maybe encapsulate those.
- 11 So, at paragraph 5.83 it's reported that:
- 12 "Professor Sir Michael McBride, Chief Medical
- 13 Officer for Northern Ireland from September 2006, told
- 14 the Inquiry that the health service in 2020 was not even
- 15 as resilient as it had been in 2009."
- 16 That's correct?
- 17 **A.** Yes, I agree with that, yes.
- 18 **Q.** And paragraph 5.84:
- 19 "Issues of funding are political decisions that
- 20 properly fall to elected politicians. However, it
- 21 remains the case that the surge capacity of the four
- 22 nations' public health and healthcare systems to respond
- 23 to a pandemic was constrained by their funding."
- 24 Again, you agree with that?
- 25 **A.** Yes.

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- 1 unacceptable level before the pandemic and have been
- 2 worsening steadily since 2014."
- 3 In March -- sorry:
- 4 "Prior to the pandemic, waiting times for elective
- 5 care were the worst in the UK and among the worst in
- 6 Europe."
- 7 And in terms -- if we can just go down three
- 8 paragraphs:
- 9 "Waiting times are currently so long in Northern
- 10 Ireland that Emergency Departments ... and other urgent
- 11 pathways have increasingly become the default entry
- 12 point for patients requiring treatment, either due to
- 13 patients waiting so long that their condition becomes
- 14 urgent, or because EDs are seen as a faster way of
- 15 accessing diagnosis and treatment. Fixing waiting times
- 16 will therefore also help take some of the pressure away
- 17 from EDs."
- 18 Did that reliance upon emergency departments have
- 19 an impact upon the way that the population or the
- 20 healthcare system responded in the early stages of the
- 21 pandemic?
- 22 **A.** I think it -- it affected our capacity to respond. It
- 23 reflected on our capacity to surge to respond to the
- 24 demands of individuals presenting with Covid that needed
- 25 care. And I think as a consequence of this elective

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- 1 **Q.** As I say, I don't want to go too far behind funding
- 2 issues. But, for example, was HSC actually equipped to
- 3 meet the needs of the Northern Ireland population at the
- 4 start of 2020?
- 5 **A.** No, I don't believe it was, and I think that that's
- 6 demonstrated by the problems that the population was
- 7 experiencing with access to care, and the frustrations
- 8 that those providing that care had been -- experienced
- 9 for many, many years.
- 10 And as I said in my statement, I think that many
- 11 health professionals, those working in the service, the
- 12 leadership in the service were increasingly becoming
- 13 demoralised at the gap between the need and our capacity
- 14 to deliver that.
- 15 **Q.** Can I please show you -- it's INQ000374049.
- 16 This is the Elective Care Framework report
- 17 from June 2021, I presume a document you're very
- 18 familiar with?
- 19 **A.** I am familiar with it, yes.
- 20 **Q.** This is one produced by the department, so these are the
- 21 department's words?
- 22 **A.** That's correct.
- 23 **Q.** Then -- it's that section under "Waiting times
- 24 pre-pandemic". So:
- 25 "Waiting times in Northern Ireland were at an

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- 1 services in Northern Ireland were -- downturned earlier
- 2 and for longer than other jurisdictions, and I think
- 3 that is something which is also covered within that
- 4 report.
- 5 **Q.** Yes, I think that's a line from the report itself.
- 6 But does that also end up in a cultural situation
- 7 where the population are likely, even in the early
- 8 stages of a pandemic, to go to an emergency department
- 9 rather than seeking help initially from any other
- 10 source?
- 11 **A.** Well, potentially, but that's not what happened. And
- 12 I can elaborate on that if you wish.
- 13 **Q.** And if we can just go, please, just in terms of waiting
- 14 times and comparisons across the United Kingdom, if we
- 15 can go to page 27, which is internal page 26 of this
- 16 document.
- 17 Thank you very much.
- 18 I mean, it's that middle paragraph. I think the
- 19 opening line of the paragraph above -- we don't need to
- 20 highlight it -- does say:
- 21 "Direct comparison ... is not readily available
- 22 because in the rest of the UK, waiting time data are no
- 23 longer collected ... as is ... the case in Northern
- 24 Ireland."
- 25 But this is the comparison that's been drawn by the

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1 department.

2 So pre-Covid figures, in England at the end
3 of November 2019, 1,398 people waiting more than
4 52 weeks on the pathway to start treatment whereas in
5 Northern Ireland, population 1.9 million, there were
6 over 100,000 people waiting for more than 52 weeks for
7 the first outpatient appointment.

8 So effectively comparatively about 2,000 times
9 worse? Is that --

10 **A.** Yes, roughly, yes.

11 **Q.** Thank you, that can come down now.

12 Are the reasons why those waiting lists in Northern
13 Ireland were so long compared to the rest of the
14 United Kingdom, are those reasons relevant to HSC's
15 ability to respond to the pandemic, particularly in
16 those early stages?

17 **A.** I think in relation to the negative impact that there
18 was on people waiting for planned care, treatment and
19 care, absolutely yes. In relation to the ability to
20 respond to people requiring acute care for a range of
21 medical and surgical conditions, no. And given that --
22 and if we look at its ability to respond to people
23 needing acute care from Covid, no. But there's
24 absolutely no doubt that there was an extremely negative
25 consequence for people waiting for planned care that was

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1 silver and gold --

2 **Q.** Both of those are structural responses?

3 **A.** Yes.

4 **Q.** In terms of -- and I probably should ask the question
5 more specifically.

6 In terms of the healthcare response, what was
7 available to the healthcare system in Northern Ireland
8 about how it should respond to a pandemic?

9 **A.** Well, the -- within health silver they have a joint
10 response emergency protocol, which has been in place for
11 quite a number of years, which is reviewed annually,
12 which is a tripartite agreement between the Public
13 Health Agency, the Health and Social Care Board and the
14 Business Services Organisation which outlines the role
15 and responsibilities of each organisation, the resources
16 that they will commit, and also how they will work
17 collectively. So they have a -- a well rehearsed plan
18 which they activated, as you've indicated previously, on
19 the -- on 22 January, with the activation of health
20 silver.

21 **Q.** Right. And what would that plan actually help them do?
22 Again, was it a structural issue or would it actually
23 tell them -- give them an understanding, an example,
24 an outline of how they should respond in the event of
25 a pandemic?

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1 delayed during the pandemic, that was delayed further
2 than elsewhere and delayed for longer than elsewhere, as
3 a consequence of the situation that the health service
4 in Northern Ireland was at the start of the pandemic.

5 **Q.** I want to move now and look at initial planning and the
6 response.

7 In your statement you refer to:

8 "... [your] role ... leading and coordinating policy
9 and operational oversight of the public health and
10 health service response to the 2009 H1N1 pandemic ..."

11 So you'd had some experience of how to respond in
12 the initial stages of a pandemic prior to the Covid
13 pandemic arriving.

14 In terms of the planning/plans experience that had
15 been available to you in January 2020, what did you have
16 at your disposal? What tools were there for you to be
17 able to respond?

18 **A.** Well, we -- in terms of tools, we had the --
19 Northern Ireland's crisis management arrangements in
20 terms of -- at the highest level of government for
21 activation of those arrangements. We had within the
22 department the department's emergency response plan,
23 which I alluded to earlier, which basically laid out
24 a very systematic way of responding to situations with
25 a modular approach with the various levels, bronze,

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1 **A.** Well, working -- a practical example on that is what
2 they did was they -- in anticipation of the surge that
3 we were going to see in terms of people presenting with
4 Covid who were acutely unwell, they developed surge
5 plans across a number of specialties, so primary care,
6 secondary care, so that's people requiring hospital
7 care, and across tertiary services, so specialist
8 hospital services, and develop a surge plan for health
9 and social care, that's both care homes, social care,
10 mental health facilities, learning disability
11 facilities, so that came together in a surge plan which
12 was published in March.

13 So those are very practical outworked about how the
14 health service would respond to the pressures of the
15 pandemic.

16 Similarly, there was a plan which was developed in
17 terms of how people would continue to receive emergency
18 care and treatment for individuals presenting with heart
19 attacks, strokes, people who had vascular bleeds or
20 individuals who had cancer. So those two elements of
21 work, both for Covid and critical/urgent non-Covid care,
22 was all being co-ordinated by the Health and Social Care
23 Board, working with the PHA, working with the Health and
24 Social Care trusts and the ambulance service.

25 **Q.** But those had been developed in the early stages, I'm

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1 trying to get at -- let's say 1 January 2020, what
2 outline plans were there? Is it simply there was the
3 2013 influenza pandemic preparedness guide? Was there
4 anything else to suggest: in the event of a pandemic,
5 this is how you should go about surge plans, this is how
6 you should go about visiting guidance; was there
7 anything like that?

8 **A.** In terms of those specific elements, in terms of was
9 there guidance on the development of visiting guidance,
10 no. In terms of surge planning, that had -- work had
11 been initiated at a UK level around US planning, and
12 again I've -- I responded to this and provided evidence
13 in Module 1 on this issue.

14 Surge plans had been submitted to the department,
15 I understand, although they weren't brought to my
16 attention, back in January 2019 for surge planning in
17 relation to an influenza pandemic. Obviously colleagues
18 were of the view that they required additional work.
19 And that work was then subsequently undertaken by the
20 Health and Social Care Board with the PHA.

21 So while there hadn't been signed-off plans, there
22 had been planning in place for surge planning for
23 pandemic flu. I think it's a separate question whether
24 or not the scale of that surge planning for pandemic flu
25 would ultimately have dealt with what we actually saw

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1 capabilities that we can deploy at pace and at scale for
2 a range of scenarios and a range of a potential
3 pathogens, whether those are contact, such as mpox,
4 which we're -- is in the news at the moment, or whether
5 that's transmitted by vector routes, such as Zika virus,
6 or those that are transmitted through respiratory routes
7 such as flu and coronavirus.

8 **Q.** I'm trying to understand from the perspective of the
9 initial stages of the response of the pandemic in 2020
10 whether there were those flexible, adaptable plans on
11 the shelf that can be deployed at pace and at scale,
12 whether those actually existed in Northern Ireland that
13 helped you in the initial stages of the response or
14 whether they weren't there?

15 **A.** I think I've answered that question, my Lady, but maybe
16 I shall -- unless I've misunderstood the question.

17 What -- we did have generic plans. We did have
18 those in place both within the department, within the
19 Health and Social Care Board, PHA and within the trusts,
20 and we adapted and modified those plans to deal with the
21 coronavirus pandemic.

22 **Q.** To what extent in those early stages did you consider
23 that decisions should be made on a regional basis as
24 opposed to within each individual trust? When I say
25 those early stages, I mean late January 2020.

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1 with this pandemic.

2 **Q.** How helpful was that influenza planning guidance? Did
3 it actually provide you with a great deal of assistance
4 in the early stages in the pandemic response?

5 **A.** Crisis response, emergency response, and again I've
6 given evidence to this in Module 1, both in my oral --
7 in the oral hearing and my witness statement, is
8 agnostic in terms of what the particular challenges.

9 So the structures that you alluded to earlier and
10 that we've covered earlier were extremely effective and
11 useful in applying those arrangements, that command and
12 control -- or those command and control arrangements,
13 those reporting arrangements, those intelligence
14 gathering arrangements, were extremely helpful in the
15 early stages of the pandemic, because those are what we
16 had and those are what we relied on, those were what we
17 knew. And we weren't starting from scratch, so we did
18 have plans which we adapted.

19 The truth of the matter is that every emergency is
20 different. Every epidemic is different. Every pandemic
21 is different. And as, my Lady, I gave evidence during
22 Module 1, I don't think that -- that the idea that we
23 somehow or other can have a plan on a shelf for every
24 eventuality for pandemic preparedness is the wrong
25 approach, it's about having flexible, adaptable

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1 **A.** I believe decisions were made on a regional basis. You
2 know, once the silver was established on 22 January,
3 that was -- the role of silver is to ensure regional
4 co-ordination, and that's the role that they fulfilled.

5 **Q.** So would it be wrong to suggest that the department
6 would set policy and then it would be up to the trust to
7 implement that policy and that the department didn't
8 monitor how that policy was being implemented?

9 **A.** That would be wrong, yes.

10 **Q.** Because in terms of -- in terms of understanding the
11 impact of the policy that the department has been set,
12 the department has set, it's right that there needs to
13 be a mechanism for which you couldn't review the
14 feedback and that you can review the impact of those
15 decisions. Is that right?

16 **A.** Yes.

17 **Q.** Do you think in Northern Ireland that there was that
18 sufficient mechanism for the department reviewing that
19 feedback and reviewing the decisions that it had taken
20 and the policy decisions that it had set?

21 **A.** Again, I seek clarity in terms of what policy -- are we
22 talking about in normal course of business or are we
23 talking about policy decisions in relation to the
24 pandemic?

25 **Q.** In relation to the pandemic.

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1 **A.** There were -- I believe there was. I mean, I've already
 2 explained when we established the health gold, which was
 3 established on 27 January, we were getting regular
 4 reports from -- situation reports from health silver
 5 which was advising on escalating issues that needed
 6 a strategic decision, and those issues were then being
 7 brought to health gold at the strategic cell which I was
 8 chairing when not otherwise involved in other
 9 responsibilities, and health gold was setting the
 10 strategic direction, providing leadership to the health
 11 service response, but similarly it was tasked with
 12 providing advice and support to the minister in terms of
 13 other UK considerations and also providing support to
 14 other Northern Ireland government departments.

15 So I am satisfied that those arrangements were
 16 effective and that there was oversight of what was
 17 actually happening on the ground, but that came through
 18 health silver, and obviously it would depend on health
 19 silver bringing the matter to our attention.

20 **Q.** So in general the department was learning from the
 21 impact of the decisions that it had taken?

22 **A.** Yes. I mean, again, I think back to the starting point
 23 of our discussion. Northern Ireland's a very small
 24 healthcare system, we are very connected, and during
 25 that initial response that connectivity was a huge

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1 counterparts, which included the Public Health Agency in
 2 Northern Ireland. That had a number of work streams in
 3 relation to establishing testing capability and capacity
 4 in relation to planning for first cases, how those would
 5 be managed, in terms of communication of those
 6 arrangements out to general practice.

7 And there were, at that stage, plans around how the
 8 transfer pathways for individuals who -- when we
 9 detected our first cases.

10 There was also planning going on across government
 11 work within the department around making Covid
 12 a notifiable disease. We were issuing guidance,
 13 specific travel guidance, about people returning from
 14 certain countries, around self-isolation. We were
 15 establishing a helpline for individuals who were
 16 returning who developed symptoms.

17 **Q.** So all of that was happening on and around 22 January or
 18 was this coming later? Because I want to make sure
 19 we're doing this chronologically, Professor McBride.

20 **A.** Well, I mean, again, I can't now recall the exact
 21 sequence of the timeline and I would need to refer back
 22 to my previous statement in earlier modules.

23 **Q.** Well, can I please show you INQ000130312.

24 We've got a slightly different display system when
 25 it comes to a spreadsheet, but do you recognise this

51

1 strength. So it wasn't just even the formal reporting
 2 arrangements that there were through the emergency
 3 response plan but also we were in regular contact and
 4 informal contact with leaders within the health and
 5 social care system in Northern Ireland.

6 **Q.** I want to look at this chronologically if I can, just to
 7 have an understanding of the decisions that were being
 8 taken and the information that is available to you at
 9 the time.

10 I think this goes back to 22 January 2020, where
 11 health silver was established.

12 On the same day you offered to meet the minister to
 13 discuss the department's preparation, planning and
 14 readiness, and you say in your email to the minister on
 15 that day that extensive planning preparation liaison was
 16 ongoing.

17 What was going on at that time within Northern
 18 Ireland?

19 **A.** I mean, again, I have covered this within my statement
 20 at 2C. At that stage, at that time, there was regular
 21 four UK nations meetings happening, there was almost
 22 daily UK CMO calls, where we were sharing intelligence
 23 and information as it emerged. The Public Health
 24 England, as it was then, later UK Health Security
 25 Agency, was also hosting four nation calls with its

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1 spreadsheet?

2 **A.** I don't think I've seen this spreadsheet before, no.

3 **Q.** If we can go to the "Decisions" tab at the bottom. Does
 4 that look familiar now? I think that was contained in
 5 your evidence proposal, some of these rows.

6 **A.** Yes, I mean, I'm happy to address any questions about it
 7 but I would not normally, you know, have seen the
 8 readouts from the meetings.

9 **Q.** Okay. But you are content that this is likely to be the
 10 strategic cell readouts comprising details of decisions
 11 and actions?

12 **A.** I'm content that that is the case, yes.

13 **Q.** Then if we could please go back to the "Actions" tab.
 14 Thank you.

15 And we can see there that we have 27 January, and
 16 this is action number 2, so this is about a high-level
 17 cross-government escalation plan.

18 So this is the same day that the emergency response
 19 plan was implemented, when the department's emergency
 20 operations centre -- that's part of health gold -- was
 21 stood up; is that right?

22 **A.** Yes.

23 **Q.** And so effectively is this where half of health gold,
 24 the EOC, as I am going to refer it, that's been
 25 activated, the strategic cell, the more decision-making

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1 side of things, that hasn't yet been stood up and that
 2 isn't going to be stood up until 4 March; is that right?
 3 **A.** That's correct, yes.
 4 **Q.** So in these early stages, and again it's not a memory
 5 test, if you're not entirely sure, please do say, what
 6 responses within Northern Ireland about the -- the
 7 healthcare system as opposed to the general health of
 8 the population, how was the healthcare system responding
 9 in these early stages in 2020?
 10 **A.** Well, certainly from the establishment of the EOC, and
 11 certainly we would've been getting daily situation
 12 reports, I would've been in the EOC on a daily basis at
 13 that time, and any matters that were arising that
 14 required to be brought to my attention would've been
 15 brought to my attention.
 16 **Q.** So you were content at that time that the situation
 17 within the healthcare system in Northern Ireland was
 18 effectively under control?
 19 **A.** I would not use at the word "under control". I mean,
 20 I think that we were doing the best that we could in the
 21 circumstances that we found ourselves. I don't think --
 22 and -- "under control", I mean, I think it's a -- it's
 23 not a term that I would -- I would use in the context of
 24 the pandemic and -- and what subsequently unfolded.
 25 We were doing -- we were taking a methodical and
 53

1 a report of a case that occurred in Germany as I recall.
 2 **Q.** What was your understanding about the risk of
 3 asymptomatic transmission at that time?
 4 **A.** Well, our understanding of asymptomatic transmission was
 5 based on what we knew of previous coronaviruses, similar
 6 to SARS-Cov-2, the causative agent of Covid-19.
 7 However, there were obviously clear differences between
 8 SARS-Cov-2 and other viruses that caused SARS, for
 9 instance, or MERS, but obviously, you know, we didn't
 10 have that clarity of information at that time.
 11 So I think we were always alert to the possibility
 12 that there could possibly be a symptomatic infection,
 13 but again that was something that we didn't have
 14 sufficient evidence of at that time. It was something
 15 that was actively considered by SAGE and by NERVTAG, the
 16 New and Emerging Respiratory Virus Technical Advisory
 17 Group.
 18 So it really wasn't until I think the NERVTAG
 19 meeting of 13 May that concerns were flagged about
 20 asymptomatic transmission.
 21 **Q.** But in terms of when you have identified that there is
 22 evidence of an issue such as asymptomatic transmission
 23 arising from SARS-Cov-2 distinct from any of the other
 24 coronaviruses, what was your approach at a time like
 25 that? Did you apply a cautious approach in terms of
 55

1 planned approach to the situation as it evolved.
 2 **Q.** Moving on to 28 January --
 3 **LADY HALLETT:** Do you want to carry on into January,
 4 Mr Scott? It's up to you.
 5 **MR SCOTT:** I've got two very different times in front of me,
 6 sorry, I thought it was 7 minutes past rather than
 7 quarter past. No, I'm entirely content to break there,
 8 my Lady, apologies.
 9 **LADY HALLETT:** We shall return at 11.30.
 10 (11.15 am)
 11 (A short break)
 12 (11.30 am)
 13 **LADY HALLETT:** Mr Scott.
 14 **MR SCOTT:** Thank you, my Lady.
 15 Mr McBride, we were just moving on to asymptomatic
 16 transmission. We're on 28 January 2020 in terms of the
 17 chronological flow.
 18 It's right that the four UK CMOs had a WhatsApp
 19 group in 20 --
 20 **A.** That's correct, yes.
 21 **Q.** And on 28 January you sent a message to the other CMOs
 22 saying that there was evidence consistent with
 23 asymptomatic transmission during the incubation period.
 24 Do you remember that?
 25 **A.** I do remember that, yes. That was in relation to
 54

1 what impact that would have within spread within the
 2 healthcare system?
 3 **A.** Well, I think if you look at the response to the
 4 WhatsApp on that same chain, as I recall, although
 5 I don't recall the exact wording, I think the response
 6 back from colleagues and I think it may have been --
 7 **Q.** Professor Sir Chris Whitty?
 8 **A.** -- from Professor Sir Chris Whitty was the possibility
 9 of --
 10 **Q.** Yes --
 11 **A.** But not evidence of. And I have to say I concurred
 12 with -- I was raising the possibility, as I said
 13 earlier, that we should be alert to this, but quite
 14 correctly Professor Whitty was flagging that we did not
 15 have evidence of this.
 16 I mean, I can continue but --
 17 **Q.** No. So when you have a possibility of something like
 18 asymptomatic transmission happening -- asymptomatic
 19 transmission is going to have a very significant impact
 20 upon the spread of a virus in a place such as Northern
 21 Ireland; is that right?
 22 **A.** Yes. Well, it depends on several factors. Knowing that
 23 asymptomatic transmission occurs is quite separate from
 24 knowing to what extent asymptomatic transmission occurs.
 25 Clearly if there's an extensive asymptomatic
 56

1 transmission then you are correct, that is a very
 2 significant problem for any jurisdiction including
 3 Northern Ireland. But again, even -- and at that stage
 4 we did not know -- when we knew that there was and
 5 I mentioned NERVTAG said yesterday there is evidence of
 6 asymptomatic transmission back, as I recall, in mid-May,
 7 we did not then know the extent of that. It wasn't
 8 until there were established studies both in the health
 9 service, the SIREN study and also in the care home
 10 sector, the Vivaldi Study, that the extent -- and
 11 actually ONS surveys in the Office of National
 12 Statistics in due course where it became clear the
 13 extent of asymptomatic transmission.

14 **Q.** Taking a step back, in terms of your protective
 15 approach, cautious approach, the protective principle,
 16 however you want to frame it, when it came to the early
 17 stages of a pandemic, how did you approach that concept
 18 of a cautious approach to new and developing evidence in
 19 response to the SARS-Cov-2?

20 **A.** Well, I think the general approach that we took both at
 21 a population level, in relation to the decisions by
 22 ministers to initiate the social distancing, the advice
 23 to limit social contacts, the subsequent lockdown --

24 **Q.** Sorry, I should specify in terms of how healthcare
 25 systems should respond.

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1 **Q.** And while we're talking about the CMO WhatsApp group,
 2 what was the level of engagement like between the CMOs
 3 during the course of the pandemic?

4 **A.** In those early days practically daily, often twice
 5 daily. Every day, at weekends we often had early
 6 morning calls, late evening calls. I think one of the
 7 strengths of the response to the pandemic was that very
 8 close engagement that we had. We all came from
 9 different professional backgrounds. We had different
 10 ranges of expertise. We had prior to the pandemic very
 11 effective professional working relationships and that
 12 was a real asset during the pandemic response.

13 **Q.** Was it a free and full exchange of information, thoughts
 14 and ideas between the four of you?

15 **A.** Yes, and I think I've addressed that in my evidence to
 16 2C. There was you know -- as I say, we all came from
 17 different professional backgrounds within medicine.
 18 There was discussion, there was challenge, views were
 19 sought, views were conveyed. You know in the main --
 20 and I'm now struggling to think of any occasions when
 21 there was a significant difference of consensus of
 22 professional view amongst us.

23 **Q.** When there are -- this is a question I've been asked by
 24 one of the CPs to ask -- proposed divergences in
 25 guidance for healthcare systems between the various

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1 **A.** I was going to go on to that, and the measures that we
 2 then put in place in parallel with that. So the social
 3 distancing measures that we put in place in the health
 4 service, one way systems, social distancing, then
 5 waiting areas, moving to remote consultations. All of
 6 those interventions were basically put in place because
 7 obviously there was the possibility of asymptomatic
 8 transmission. So while we didn't have evidence of it,
 9 my point I'm making is that we acted in a precautionary
 10 way because we couldn't be absolutely certain that it
 11 wasn't occurring. But, as I say, if it was we did not
 12 know the extent of it. And equally, we did not know at
 13 that time whether, for instance, if we suppressed all
 14 symptomatic transmission, that asymptomatic transmission
 15 itself would be sufficient to continue to drive the
 16 pandemic so there were lots of unknowns.

17 **Q.** Leaving asymptomatic transmission aside just in terms of
 18 applying you say the precautionary way that you acted
 19 was that the general approach that you would apply; you
 20 would act in a precautionary way when there was
 21 uncertainty in the evidence?

22 **A.** I think that was the general approach that we adopted.
 23 We obviously reviewed on an ongoing basis the measures
 24 that we had in place, the advice that we were providing,
 25 and updating that as new evidence emerged.

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1 devolved administrations for England, were those
 2 discussed in advance of implementation by the CMOs or
 3 not?

4 **A.** I missed the start, but I think it was about divergence
 5 in guidance was it?

6 **Q.** Yes. If the different healthcare systems were going to
 7 do different things did the CMOs talk about it ahead of
 8 time?

9 **A.** Obviously policy decisions are for ministers and we
 10 cannot in advance of ministers' policy decisions
 11 determine what ministers decide. But we would have made
 12 each other aware of advice that has been put to
 13 ministers. So there was a level of awareness, but you
 14 know what we didn't do -- what we couldn't have and
 15 didn't have was advance warning of ministerial decisions
 16 because those were the prerogative ministers.

17 **Q.** One of the other questions I've been asked to ask is are
 18 there any lessons that could be learned in respect of
 19 communication between the four CMOs for any future
 20 pandemic?

21 **A.** It's essential, it's vital. You mentioned earlier about
 22 what was it like, what was your average day like. We
 23 were a huge source of professional support to each
 24 other. The combination brought huge strengths. I hope
 25 that the advice that we provided to respective ministers

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1 and respective jurisdictions benefited from that. And
 2 also, it was a great sense of personal support as well
 3 which was absolutely vital, yes.

4 **Q.** Stepping back into the timeline, so I just want to move
 5 to 4 February 2020, at this point there's zero cases in
 6 Northern Ireland; is that correct?

7 **A.** Yes. The first case was the 27th, yes.

8 **Q.** So at that time, you were seeking to arrange a meeting
 9 with PHE and HSCB about reasonable worst-case scenario
 10 pandemic flu surge planning. So that had been just over
 11 a week since the EOC had been activated. Why is it that
 12 there had been that week gap for you then to start to
 13 consider surge planning?

14 **A.** The work had already commenced. It wasn't that I was
 15 considering surge planning. The work had already
 16 commenced by the Health and Social Care Board and the
 17 PHA. The purpose of my meeting was to seek assurance on
 18 the progress of that work. I subsequently attended
 19 a meeting with colleagues from the Health and Social
 20 Care Board and the PHA on 11 February.

21 **Q.** Yes.

22 **A.** They advised me at that meeting that the work had
 23 already started and it had commenced. There had already
 24 had been communication out to health and social care
 25 trusts, and they were already beginning the surge

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1 instance. There are a set of criteria, six criterion in
 2 total --

3 **Q.** I understand how they operate. It's about how
 4 Northern Ireland deals with those cases.

5 **A.** So in the situations where a case that's classified as
 6 a high consequence infectious disease is there is
 7 an arrangement for transfer for those patients to other
 8 parts of the UK to the beds that exist in the rest of
 9 the United Kingdom.

10 Unfortunately, there are no HCID beds either in the
 11 Republic of Ireland, so that does present some
 12 particular geographical challenges.

13 **Q.** The sea; is that correct?

14 **A.** Sorry?

15 **Q.** The sea, geographical consequences?

16 **A.** Yes. I mean, as an alternative what the PHA was doing
 17 at that stage, as well as working with the Health and
 18 Social Care Board around the transfer arrangements, was
 19 again working with the regional infectious diseases unit
 20 in the Belfast Trust to develop pathways for any
 21 individuals that couldn't be transferred to an HCID unit
 22 in the rest of the UK to be managed within the regional
 23 infectious disease unit within the Belfast Trust.

24 **Q.** I think it's right that actually the first case in
 25 Northern Ireland wasn't able to be transferred to

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1 planning. So it wasn't that my meeting was initiating
 2 that. What I was doing was seeking assurance that
 3 progress was being made on that surge planning.

4 **Q.** We will come on to 17 February where those plans have
 5 been provided to you and your response to those.

6 **A.** Sure.

7 **Q.** But also on 4 February it is referenced about HCIDs,
 8 high consequence infectious diseases. It's right that
 9 there are no HCID beds in Northern Ireland?

10 **A.** That's correct, yes.

11 **Q.** And so what PHA were seeking to do is they were seeking
 12 to determine the number of HCID beds available in the
 13 Republic of Ireland. Is that correct?

14 **A.** Yes.

15 **Q.** In the early stages of a pandemic where a pathogen has
 16 been declared as an HCID, what happens in
 17 Northern Ireland, given that there are no HCIDs?

18 **A.** Well, the arrangements are that there are -- as you
 19 know, there are only a small number of high consequence
 20 infectious disease beds across the UK, I think some
 21 30 in total. They are not designed to deal with large
 22 scale epidemics or pandemics. Obviously with their
 23 numbers they cannot. They are there to deal with the
 24 rare cases of imported disease that we do see in the UK,
 25 such as some of the haemorrhagic fevers, Lassa fever for

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1 England.

2 **A.** That is correct, yes. That case was managed in the
 3 Regional Infectious Disease Centre in the Belfast Trust.

4 **Q.** In the event of the early stages of a future pandemic,
 5 would the same situation arise in Northern Ireland, that
 6 you have an early case and actually the transfer routes
 7 aren't open to transfer somebody to England? Would it
 8 be the infectious diseases ward, I think it's 7A within
 9 the Belfast Trust. Is that what would apply?

10 **A.** It is correct, it is a 7A, and, as I say, as
 11 a fail-safe, if indeed those transfer arrangements were
 12 not possible, then the individual would be managed in
 13 the specialist infectious disease unit in the Belfast
 14 Trust, correct.

15 **LADY HALLETT:** Sorry, I'm not following, 7-day?

16 **MR SCOTT:** 7A, it's just the ward.

17 **LADY HALLETT:** Oh, I see.

18 **A.** -- it's my Lady, it's level 7 in the Belfast City
 19 Hospital. It's a specialist unit within that -- or
 20 specialist beds within the unit.

21 **LADY HALLETT:** Thank you.

22 **MR SCOTT:** Because in terms of, just very briefly on this
 23 point, the transfer, there are existing I think it's
 24 private transfer arrangements, isn't it? Effectively
 25 they're not intended to function very well in the course

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1 of a pandemic and transporting somebody who has what has
2 been classified at that time as a highly contagious
3 infectious disease. Is that correct?

4 **A.** Yes, those responsibilities fall within the remit of the
5 Health and Social Care Board and the relevant policy
6 team within the department. You're correct; there are
7 particular challenges with the transfer of patients,
8 particularly with private providers. During the
9 pandemic some special arrangements were put in place by
10 the Health and Social Care Board and I think those are
11 covered in my statement.

12 **Q.** Yes.

13 I'm going to move on from that topic and come back
14 to the surge plans. I think we were talking about
15 17 April.

16 **A.** That's the February.

17 **Q.** Thank you for correcting me.

18 So, as you say, this is 17 February. This is the
19 tail end of almost two weeks since you'd had the meeting
20 with PHA and HSCB. As I say, surge planning had been
21 going on for longer than that at this stage. And
22 an iteration of that surge plan was provided to you and
23 you say that you consider that initial iteration was not
24 acceptable.

25 If I can, please, have on the screen INQ000421784.

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1 So there needed to be, to my mind, those plans
2 needed to be all interconnected. And also there needed
3 to be a regional plan as to when and how we would
4 activate a Nightingale facility. As I looked at the
5 plans at that time I felt that more work was needed.

6 **Q.** Yes. I think just in terms of the third bullet point,
7 in relation to secondary care:

8 "- each Trust had a [local level plan] ... all ...
9 plans needed to connect at a regional level to ensure
10 regional consistency ... [and] had to connect the total
11 system with health and social care ..."

12 Because I think you were well aware at that point in
13 time in Northern Ireland that you were going to require
14 all trusts to effectively contribute towards the
15 Nightingale because there wasn't capacity just within
16 one trust to cope with it. Is that correct?

17 **A.** Yes, and I think it is back to my earlier point the
18 response to the pandemic required in all --
19 a single-system response, and what I was seeking to do
20 was basically to ensure that there was
21 a Northern Ireland HSC response which ensured that
22 everyone had access to the care that they needed and
23 that there was equitable access to care and that, as
24 best we could, that we provided care for those patients
25 who were acutely unwell with Covid while continuing to

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1 That's page 142, paragraph 223.

2 This is your statement. If we can just go up to --
3 the one above, in relation to critical care:

4 "- the focus of this surge plan was based on
5 a Nightingale ... there were some local inconsistencies
6 in the local escalation stages ..."

7 What do you mean by "there were some
8 inconsistencies"?

9 **A.** Basically back to your earlier questions about the
10 regional approach, when I reviewed the plans as
11 I recall -- and I can't recall the detail given the
12 passage of time -- there was inconsistencies in terms of
13 decision-making about escalation, so how bed capacity
14 would be increased, and that differed across the various
15 plans that I considered.

16 Now, to ensure equitable access, which is crucially
17 important given the anticipated pressures, there needs
18 to be a commonality of approach across how and when
19 those additional beds would be escalated, and
20 particularly also in relation how those beds would be
21 staffed. Because in all likelihood what we were
22 anticipating was there would be significant pressure on
23 healthcare workers, on nursing staff, on
24 physiotherapists, allied health professionals, doctors
25 working in intensive care.

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1 maintain services for those who required emergency or
2 time-critical treatment for other conditions.

3 **Q.** And effectively that could only come through the
4 department that regional level. Is that correct?

5 **A.** Well, no, I mean -- the role of the HSCB, PHA, BSO at
6 silver is to ensure regional co-ordination. The
7 department sets strategic direction. That's what I was
8 doing in terms of setting strategic direction chairing
9 health gold, but it's the role of health silver to
10 ensure that regional co-ordination.

11 What I was pointing out here was that I felt there
12 was further work to be done in ensuring that regional
13 co-ordination.

14 I would add one caveat I might add which is
15 important.

16 **Q.** Okay.

17 **A.** That it was difficult and challenging for the Health and
18 Social Care Board, the PHA and health trusts to plan for
19 the range of eventuality that might occur, because as --
20 at that time our modelling that we had in terms of what
21 those pressures might be was not as advanced as it
22 became then later in the pandemic. So they were dealing
23 with a significant deal of uncertainty and planning in
24 the context of that uncertainty.

25 **Q.** In terms of that modelling, it wasn't Northern Irish

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1 modelling at that point in time; that was modelling
 2 conducted by SAGE?
 3 **A.** That's correct, yes.
 4 **Q.** You talk in there about setting strategic. If you are
 5 talking about surge planning across the entirety of
 6 Northern Ireland, that is a strategic decision; correct?
 7 **A.** It's a tactical strategic decision. You know, I make
 8 that distinction because it is an important distinction.
 9 The principle of subsidiarity within any crisis response
 10 is crucial. If it isn't abided by, what happens is that
 11 if all decisions have to be made from the department, it
 12 paralyses the rest of the system.
 13 So it has to be only those matters which are
 14 important to be elevated through the department for
 15 either a policy decision, a strategic decision, but that
 16 regional layer, the co-ordination of the regional
 17 response, as is outlined in the emergency response plan,
 18 is the responsibility of health silver working with
 19 health bronze, and simply what I was indicating to
 20 health silver, which, you know, is the responsibility of
 21 health gold, was I was testing on behalf of health gold
 22 and the department those plans and basically requesting
 23 further work.
 24 **Q.** So if you had signed off on those plans at that time,
 25 and you thought those plans were significant, what would

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1 **A.** That's correct, yes.
 2 **Q.** But surge planning is essential in terms of a strategic
 3 overview level because you are talking about what
 4 services you were going to effectively not be able to
 5 provide, how you're going to redeploy?
 6 **A.** Yes.
 7 **Q.** That is a very high-level decision. So can you explain
 8 why these discussions were taking place in
 9 late February, but the strategic cell was not yet in
 10 place at that time?
 11 **A.** As I said in answer to an earlier question, there was
 12 a high level of connection between all parts of the
 13 service at this stage. When we stand up health gold,
 14 which we did in early March, that puts in place
 15 an additional set of requirements on health silver and
 16 on health bronze in reporting arrangements.
 17 What I was satisfied was happening at that time,
 18 prior to the activation of health gold, was there was
 19 active surge planning going on within the health and
 20 social care system.
 21 I had sought assurances on that. I had met with the
 22 chief executive of the Health and Social Care Board, the
 23 Public Health Agency and their team on 11 February and
 24 was assured that work was ongoing.
 25 Here we're seeing the outworkings of that and

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1 have happened, would they have been adopted then and
 2 there?
 3 **A.** Well, I've no doubt, as happened anyway, those plans
 4 would have been modified as time went on --
 5 **Q.** But at the time they were presented to you rather than
 6 later.
 7 **A.** When those plans were presented, I think we were
 8 probably -- there was a subsequent workshop which was
 9 held by the Health and Social Care Board on 5 March. So
 10 there was an ongoing process of refinement of those
 11 plans. So what we received at that point in time was
 12 still very much in development.
 13 And that was right because, as our knowledge
 14 developed and as we developed more information from the
 15 modelling about where those pressures would be, the
 16 numbers of people, for instance, who would require
 17 admission, the number who would require oxygen, the
 18 number that would require critical care admission, then
 19 those plans were constantly refined.
 20 So there wasn't a point in time where we said "This
 21 is the plan, we're going to stick to it", these plans
 22 were constantly refined because they needed to be
 23 constantly refined.
 24 **Q.** But this early stage in late February, you hadn't stood
 25 up to the strategic cell. That's correct?

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1 I commissioned further work based on that.
 2 So I think the point I would make is that that
 3 strategic oversight, that policy direction, was being
 4 clearly communicated, was being understood and was being
 5 acted on by colleagues at health silver.
 6 **Q.** So even if the strategic cell wasn't there, it made no
 7 difference?
 8 **A.** Well, the health gold serves an important purpose and
 9 role.
 10 **Q.** I am just focusing on strategic cell because half of
 11 health gold the emergency operating centre had been up
 12 since --
 13 **A.** That's correct.
 14 **Q.** So it's the second part, that strategic decision-making
 15 that I'm trying to focus on.
 16 **A.** Yes. What I'm saying is that even before the activation
 17 of health gold that strategic oversight was being
 18 provided prior to the activation of health gold.
 19 I think we've just given a good example where I was
 20 working with colleagues, policy colleagues, within the
 21 department, within secondary care, health policy group,
 22 again actively considering the surge planning. Yes,
 23 you're correct, we hadn't activated the strategic cell
 24 at that point in time, but that strategic oversight
 25 strategy consideration was already in play at that time.

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- 1 Q. That document can come down now. Thank you.
 2 Just in terms of that thread of activation and the
 3 strategic cell, that happened on 4 March. Did that
 4 happen because that was the day that the first suspected
 5 cases arrived in Northern Ireland?
- 6 A. No, the first confirmed case in Northern Ireland was
 7 27 February.
- 8 Q. So why hadn't the strategic cell been stood up when the
 9 cases had arrived in Northern Ireland?
- 10 A. Well, it was the first case. I mean, I think that the
 11 emergency response plan is designed to be modular. And
 12 as we covered earlier, bronze can be set up without
 13 health silver being set up. So, for instance, if
 14 an incident is at a single trust level, then health
 15 bronze will address that. If an incident is occurring
 16 across several trusts, then health silver is activated.
 17 And the health gold is designed to be modular as
 18 well. So the urgency operations cell, as you mentioned
 19 earlier, was activated on 27 January following the
 20 activation of health silver. So, again, reports that
 21 would have been generated by health silver were already
 22 being received by the department. The department
 23 already had oversight of those.
 24 So it doesn't and didn't require the health gold, in
 25 my judgement, to be activated on 27 January.

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- 1 If we can have up on screen INQ000430391.
 2 Do you recognise this document? It was a dashboard
 3 that was provided by the Department of Health.
- 4 A. Yes, I think this is the Covid-19 dashboard that was
 5 developed, yes.
- 6 Q. Yes. And then you can see the top left corner, PHE.
 7 Had this come from PHE, and then may have been adapted
 8 by Northern Ireland?
- 9 A. Oh, sorry, apologies, yes, this is a PHE document,
 10 sorry.
- 11 Q. But then this is the information from Northern Ireland.
 12 And then if we can just scroll down on column A, it
 13 appears that the types of data that are highlighted in
 14 orange or yellow -- I can't quite tell the difference --
 15 are the ones where information has been kept, but the
 16 ones in white is not recorded on this dashboard. There
 17 are some there -- you can see, for example, staff
 18 absences, staff illness, staff deaths, PPE stock.
 19 Let's leave aside the PPE stock but in terms of
 20 staff absences and staff illness, was that information
 21 being recorded in Northern Ireland?
- 22 A. Sorry, I'm not sure -- what time is this document?
- 23 Q. Well, we can see there this is 1 March. You can see
 24 from column E.
 25 And then if we go up to the top row, please.

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- 1 We did activate it on 4 March, and, in my view, it
 2 is always a judgement call, but in my view that was
 3 a proportionate and appropriate time to activate it.
 4 Once you activate health gold, basically what it means
 5 is that the department effectively stops all other
 6 activity. It reverts into business continuity
 7 arrangements. It generates its own work in terms of the
 8 demands it places on the system.
- 9 The balance has to be between planning and
 10 preparation, and providing health silver and bronze with
 11 the head space and room to get on and do the planning
 12 and preparation as opposed to the department activating
 13 health gold and asking for twice-daily situation reports
 14 in terms of what's going on on the ground.
- 15 So I was satisfied at that stage that there was
 16 significant awareness and intelligence of what was going
 17 on in the system, that we had mechanisms for matters to
 18 be escalated through the EOC and the department. That
 19 those could be brought to my attention or other policy
 20 leads within the department.
- 21 In my judgement, the activation of the strategic
 22 cell was both timely and appropriate when it was
 23 activated in early March.
- 24 Q. Okay. I want to pick up that thread in terms of the
 25 information that was available to you.

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- 1 You can see there that deaths by setting cases,
 2 cases by age group. That's all there from 1 March.
- 3 A. Okay. Well, firstly information on staff absences
 4 doesn't fall within my professional or policy remit.
 5 The responsibility for and the recording of staff
 6 absences is a core responsibility of the employer,
 7 ie the health and social care trusts. But it was not
 8 something certainly, as I say, at that stage that I was
 9 responsible for or that was information that was being
 10 fed to myself.
- 11 Q. In a pandemic where you're talking about surge planning,
 12 how you're going to provide the capacity, particularly
 13 in the situation that Northern Ireland finds itself with
 14 its lack of resilience, using your words, did you not
 15 need to know information such as staff absences, staff
 16 illness, staff deaths?
- 17 A. Well, that information, there was an HR cell within the
 18 strategic cell which we've already established was put
 19 in place in early March. That cell through health
 20 silver from the trusts would've been collating that
 21 information. Again, as I've made clear in my evidence
 22 and witness statement to 2C and in this statement, that
 23 principle of subsidiarity would arise.
 24 So the chairs of the individual policy cells within
 25 the strategic cell were all policy leads within the

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1 department. They would have been dealing with and
2 addressing issues such as concerns around HR, human
3 resource issues, staff absences, occupational health
4 advice, et cetera, so those matters would've been
5 considered within those policy cells and would be
6 brought to my attention as chair of health gold as
7 necessary.

8 But given the division of responsibilities that
9 I had at that time, it would not have been humanly
10 possible for me to be -- or indeed appropriate for me to
11 be across all of the detail of the work that was being
12 undertaken by those 13 policy cells within the strategic
13 cell.

14 **Q.** Trying to cut through this a little bit, staff absences
15 were being recorded.

16 **A.** They were, yes.

17 **Q.** And that information was available to the strategic cell
18 even if it wasn't necessarily on your desk. Put it that
19 way.

20 **A.** Yes.

21 **Q.** So you would've been informed if there had been specific
22 staff absences in any certain area, if it was necessary?

23 **A.** If it was necessary. I mean, it would've been a matter
24 which the HR policy cell would've dealt with.

25 **Q.** Okay.

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1 forwarded the information, but I absolutely do believe
2 that it should've been validated, verified and collated.

3 I mean, there is a statutory requirement on trusts
4 under the RIDDOR regulations, so the risk of diseases --
5 apologies, I've forgotten the exact acronym.

6 **Q.** Don't worry, just use the acronym --

7 **A.** -- to actually report such occurrences. So that
8 isn't -- that is a statutory requirement.

9 **Q.** But isn't it more than that, more fundamental than that?
10 As the Chief Medical Officer, didn't you want to know
11 about the staff within HSC who died as a result of the
12 pandemic?

13 **A.** I mean, of course as Chief Medical Officer I would wish
14 to know, but again, as I said earlier, those
15 responsibilities, those professional policy
16 responsibilities did not fall directly within my remit.

17 There were many, many demands and many
18 responsibilities that I had in the pandemic. I had to
19 rely on others to fulfill their responsibilities during
20 the pandemic. You know, as I said earlier, I could not
21 be everywhere. I could not be across every detail.
22 Indeed that in itself would not have been effective in
23 terms of the wider pandemic response and indeed would've
24 been disempowering to those who were more knowledgeable
25 in the area that I was.

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1 Wouldn't you need to know about every single staff
2 death from the pandemic?

3 **A.** That is a matter that, yes, the minister was very keen
4 that the department was made aware of. He asked me as
5 chair of health gold to write to the trusts in Northern
6 Ireland, which I did, as I recall, in early May, just to
7 make absolutely certain that information was being
8 recorded.

9 And I understand that information was and I can
10 recall that information being reported on a daily basis
11 in relation to staff who had acquired Covid and any
12 deaths from Covid in staff employed by the health
13 service.

14 **Q.** So even if it's not on that dashboard, each staff death
15 was being recorded within the department?

16 **A.** Well, it was being reported to the department.

17 I understand, in communication which has now been
18 relayed to the Inquiry, that that information wasn't
19 necessarily collated. But it was being reported on
20 a daily basis into the department and into the HR policy
21 cell.

22 **Q.** Do you think it should have been collated on reflection?

23 **A.** I absolutely do think it should've been collated. And
24 I understand that the department has advised that it did
25 not validate that information to ensure that all trusts

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1 **Q.** Looking at the data the department was actually keeping
2 during the pandemic, was it keeping information such as
3 the number of hospitals who were closing emergency
4 departments? Because we have a statement from the
5 Department of Health setting out the data that was held,
6 and the response often was "You need to ask the trusts."
7 Was there not that central repository of information
8 within the department to help it understand precisely
9 what was the picture on the ground in Northern Ireland?

10 **A.** Again, there was a Covid-19 surge directorate, which
11 would've been working with health silver in relation to
12 that. I mean, I would've expected that information to
13 certainly be held at health silver, but, as I say,
14 again, I was chairing the strategic cell, but again
15 I had to delegate those responsibilities to the relevant
16 policy leads within health policy group who were leading
17 on secondary care.

18 Such was the nature of the response required that
19 principle of subsidiarity and everyone leading on what
20 they were knowledgeable on was absolutely crucially
21 important. It would just not have been feasible or
22 possible for me to be across that level of detail, but
23 certainly that level of detail would've been held and
24 certainly known by trusts who move informed health
25 silver, and the relevant policy cells within the

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1 department would have been briefed on that. Certainly
2 that briefing would have been brought to the minister's
3 attention if it was necessary.

4 **Q.** Are you satisfied that you, as CMO, as chair of health
5 gold, had the sufficient information and data available
6 to you, that you needed to perform that role?

7 **A.** I think you know looking back I think that -- the
8 availability of data was I think one area of learning
9 for future pandemics. That applies across so many, many
10 areas and the ability to link that data.

11 And there were challenges with data. There were
12 challenges, you know, in -- relating to the development
13 of the dashboard and testing data. There were
14 challenges in relation to monitoring PPE supplies.
15 There were challenges across so, so many areas.

16 I think that was a reflection of the unprecedented
17 circumstances that we found ourselves in and the
18 unprecedented challenges that the pandemic presented.

19 There was much more information that I would've
20 liked to have at my disposal than I did have. However,
21 as chair of health gold, we had to work with what we had
22 and then develop what we needed and we took that
23 approach throughout the pandemic.

24 **Q.** Let's deal with specifics.

25 Was there any information that you needed that you
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1 data because I think that's really important in terms of
2 bringing the public with us given the asks that we were
3 making of them.

4 I think that the information around clusters and
5 outbreaks was certainly a source of frustration to me
6 early in the pandemic and colleagues in the PHA did put
7 in place arrangements to collate that information. We
8 did provide that information on a weekly basis to the
9 executive to inform decisions around NPIs and to inform
10 engagement with local government and the various sectors
11 where we were seeing clusters and outbreaks. So that
12 was one issue.

13 Certainly we encountered challenges early on in the
14 pandemic in relation to the reporting of deaths and
15 explaining the challenge, the difference between how we
16 were recording deaths using the approach about
17 individuals who had tested positive within the last
18 28 days, whether they had died of Covid or not, versus
19 the official statistics from the Northern Ireland
20 Statistical Research Agency.

21 The minister was very keen and we needed to have
22 access to the place of death and that was something
23 which was put in place in due course by NISRA.

24 I think that there were also significant data
25 challenges in relation to the recording of certain
83

1 didn't have access to that to your mind caused
2 a significant detriment to your role?

3 **A.** In terms -- significant detriment --

4 **Q.** I'm trying to take it above the generality about things
5 that you thought were actually important, or key pieces
6 of data that you were missing.

7 **A.** I think there were -- I mean, for instance there was, in
8 the early days, there was difficulty in collating
9 information around clusters of outbreaks for instance
10 and that was a challenge which was addressed.

11 In the early part of the pandemic, prior to the
12 establishment and the work that I commissioned to
13 establish the Covid-19 dashboard, we did not have the
14 ability to present that information in the public domain
15 around the number of people who were testing positive,
16 the number of people who were in hospital, the number of
17 people who were in intensive care.

18 **Q.** When you say "ability to present that information"
19 present to it who? Do you mean for you to understand
20 it?

21 **A.** No, no, no, no in a public-facing way, and I think --

22 **Q.** I'm not so concerned, Professor McBride, about
23 public-facing, I'm interested about the impact upon your
24 role.

25 **A.** Okay. Well, maybe we can come back to the public-facing
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1 characteristics such as ethnicity, such as disability,
2 in relation to the data that was accessible to me.

3 That was problematic and challenging.

4 **Q.** Can I just talk specifically about ethnicity because
5 I think you raise in your statement, if we can have
6 INQ000421784. It's page 247, paragraph 424.

7 As you say:

8 "Ethnic minorities form a much smaller proportion of
9 the population than in many other regions of the UK, and
10 ethnicity is not well coded in NI health care records.

11 As a consequence, analysis regarding ethnic minorities
12 was not available due to the poor coding of ethnicity in
13 health care records and it was not possible to look at
14 trends in those from different ethnic backgrounds nor to
15 analyse [the] impacts ..."

16 Was that not an issue that had been foreseen ahead
17 of the pandemic, that there was poor ethnicity coding in
18 various records?

19 **A.** Well, again it wouldn't have been an area that fell
20 within my professional policy remit, but certainly it
21 was an issue right across the public sector and
22 government that had been recognised in the racial
23 equality report that was published in 2015 by the
24 executive office that ethnic coding across departments
25 and their arm's length bodies of public services was not
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1 uniform and there were gaps and there was a commitment
2 to improve that.

3 Now, within the healthcare systems, one can record
4 ethnicity, but there is not uniform recording of
5 ethnicity and that is something that clearly does need
6 to be improved.

7 **Q.** As part of your response to the pandemic, you will have
8 become aware of the disproportionate impact of Covid-19
9 on black and minority ethnic workers in particular. Is
10 that right?

11 **A.** Yes.

12 **Q.** So I presume you would've wanted to look at the data and
13 to say how is this impact playing out in Northern
14 Ireland. Did you do that?

15 **A.** I couldn't do that because I didn't have the data to do
16 that. As I say, absolutely would've wished to do that,
17 but because of the lack of data that was not possible.

18 **Q.** What was done to improve that situation?

19 **A.** Again, it was not something that fell within my direct
20 remit and responsibility. There has been working that's
21 been taken forward by the department since that in terms
22 of the department is represented by the health and
23 social care system in a cross-departmental working group
24 which is looking at securing more uniformity and better
25 ethnic monitoring in Northern Ireland.

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1 a disproportionate impact?

2 **A.** There was work commissioned by Professor Chris Whitty
3 which -- I think was back in April, around 2020, and
4 there was a report published in 2020, one of our deputy
5 chief medical officers Dr Naresh Chada was a member of
6 that group.

7 We could not -- and in the middle of the pandemic it
8 was just not possible, given the other demands that
9 there were, for us to work to modify the systems to
10 extract that information, given the many other demands
11 that there were. But certainly what we did was we took
12 significant measures to try to address that.

13 I mean, I can give two examples, if that --

14 **LADY HALLETT:** Well, just really what I wanted to ask you
15 was -- so you became aware from a report in April 2020?

16 **A.** Yes.

17 **LADY HALLETT:** We're now September '24, and, as Mr Scott
18 suggested by his tone when he said "still", we still
19 don't have any changes to ensure that you can record
20 ethnicity where there's a disproportionate impact?

21 **A.** Well, my Lady, I can't advise on the work. That's why
22 I'm very hesitant to answer this. I cannot advise of
23 the work that's been taken over by others with policy
24 responsibility for that and I can't answer to the cross
25 departmental working group, which I'm not a member of,

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1 **Q.** Sorry, can I just clarify; they're still looking at it?

2 **A.** That's what I understand. I'm not directly involved in
3 the work and I don't have any responsibility for that,
4 but it is something that needs to be improved and
5 significantly improved.

6 **Q.** Okay. Can I just take you back to an action in that log
7 that came out of.

8 It's INQ000130312. It's in the action sheet and
9 it's reference 817. Apologies, this is going to require
10 scrolling down. It's quite a long way down.

11 Apologies, my Lady; we don't quite have the same
12 technology to manage spreadsheets as we do other
13 documents.

14 Thank you.

15 I will come back to that reference,
16 Professor McBride, I don't want to disrupt the, flow but
17 it's in relation to -- are you aware if there were any
18 discussions about whether recording of ethnicity was
19 a GDPR issue?

20 **A.** Again, that's outwith my professional area and
21 competence. I can't answer that question.

22 **Q.** Okay.

23 **LADY HALLETT:** So when did it become obvious in
24 Northern Ireland that ethnicity might be having -- those
25 from an ethnic minority background might be suffering

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1 in terms of what progress has been made on ethnic
2 minority monitoring. It was a commitment within the
3 2015 -- I think it was published in 2015 Racial Equality
4 Strategy to improve monitoring, but I cannot advise you
5 in terms of what progress has been taken forward.

6 **LADY HALLETT:** 2015?

7 **A.** I think that's the date of the publication.

8 **LADY HALLETT:** I thought at the beginning when Mr Scott was
9 asking you about your role in the Department of Health,
10 you're part of the top management group. I mean, is
11 this not an issue that's come to the attention of those
12 on the top management group?

13 **A.** I've not been involved in any discussions where that's
14 been raised at top management group.

15 **LADY HALLETT:** Who will we need to ask?

16 **A.** I beg your pardon?

17 **LADY HALLETT:** Who would we need to ask?

18 **A.** Who -- I suspect probably the Executive Office in terms
19 of -- who I believe, and I may be incorrect, have
20 responsibility for the racial equality strategy, and
21 perhaps an update in relation to the work of the
22 cross-departmental group, which I understand has
23 representatives from all government departments and
24 other agencies.

25 **LADY HALLETT:** I think we'll be hearing from Mr Swann, won't

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1 we, Mr Scott? Can we make sure that those who are
2 advising him and the department are aware of my concern
3 about this issue?

4 **MR SCOTT:** Yes, my Lady.

5 In terms of the timings, I'm very grateful for the
6 assistance I've received in finding the references that
7 I'm looking for. There is row 918. It's reference 889.
8 It's dated 15 June 2020:

9 "Consideration is required from the SIRO."

10 I presume that's an information officer of some
11 description.

12 "This is a GDPR issue for the recording of ethnicity
13 and nationality of people admitted with Covid -- in
14 order to establish that there was a disproportionate
15 impact on BAME communities and to support the targeting
16 of health protection messages, consideration should be
17 given to recording the ethnicity and nationality of
18 people admitted with Covid."

19 Again, is it the same answer that you don't know
20 what the outworkings were of that suggestion on 15 June?

21 **A.** No, I mean, I do note that it's indicated that it's
22 closed, but I don't know what that indication of being
23 closed means, whether it was actioned and what other
24 ongoing work there is. I mean, I should say that you
25 know we did do significant work in Northern Ireland

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1 point in time.

2 The department has also recently published a data
3 strategy, and with the indication that it will develop
4 a data institute, but those are areas that, again, are
5 outwith my direct responsibilities as Chief Medical
6 Officer.

7 **Q.** Coming back to what is within your remit as Chief
8 Medical Officer, so the first meeting of the strategic
9 cell was on 9 March 2020; is that correct?

10 **A.** That's correct.

11 **Q.** And again, looking at that log, which we don't need to
12 bring back up, topics that were discussed about silver
13 requesting an urgent decision about the early suspension
14 of elective non-urgent procedures to commence on
15 16 March, you're looking for guidance required for
16 immune compromised and that was to be raised at
17 a cross-government call. And silver was asked what
18 guidance on visitors to hospital available in relation
19 to reducing footfalls in hospitals.

20 So you're looking there at effectively shielding,
21 visiting and suspending care.

22 Is that 9 March effectively where we see the
23 strategic cell really start to take grasp of how the
24 healthcare system responded in Northern Ireland?

25 **A.** Well, I think we see a very clearly outlined systematic

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1 looking at inequalities, but that was you know looking
2 at sex deprivation, et cetera. But we could not do any
3 specific work on ethnicity.

4 The -- NISRA, the Northern Ireland Statistical Research
5 Agency, did some work and did publish a report
6 in August 2020 where it used, as I recall, country of
7 origin as a proxy for ethnicity. Now, that's far from
8 satisfactory, and that report was published in
9 August 2020. I think there was very, very limited
10 analysis, as I recall, that could be carried out in that
11 report because of the very small numbers of deaths that
12 had occurred across the various ethnic minority groups.

13 So, again, it was a very unsatisfactory piece of
14 analysis.

15 **Q.** And just one final point in terms of who whose
16 responsibility this is, I think it is your statement
17 that says ethnicity is not well coded in Northern
18 Ireland healthcare records. That's not an Executive
19 decision, is it; that's a Department of Health decision?

20 **A.** That is a Department of Health decision. I mean, there
21 is -- as I mentioned earlier, that the department has
22 progressed work around the roll-out, and I think I've
23 addressed this in my statement, around an electronic
24 patient care record. There is the facility to record
25 ethnicity within that. It is not well recorded at this

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1 approach. I mean, I wouldn't say that we haven't taken
2 grasp prior to that date if that's the inference in the
3 question.

4 **Q.** It was the strategic cell taking grasp rather than
5 anything else?

6 **A.** Yes, I mean, I think that the department was fully aware
7 of the work and planning and preparation that was going
8 on within the wider HS, the wider health and social care
9 system, prior to that date.

10 But yes, in terms of that systematic approach, the
11 establishment of the relevant policy cells, the turning
12 down of all effectively all departmental business,
13 effectively the department going into a business
14 continuity planning arrangements and eventually stopping
15 everything else but Covid, yes, that is the date.

16 **Q.** And I think it's right that there were around 15 cases
17 or so on 9 March?

18 **A.** I cannot recall.

19 **Q.** If you take it from me that's what's contained in that
20 dashboard there were 15 cases on 9 March.

21 So there may not be many cases in Northern Ireland,
22 but presumably you were looking at what was happening in
23 England, what had been happening in Italy what had been
24 happening in the rest of the world and how quickly these
25 issues can spread? Is that fair?

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1 A. Yes.

2 Q. So is it not a little late on 9 March for the strategic
3 cell to be dealing with urgent decisions about
4 suspending elective care, shielding guidance, and
5 visitation?

6 A. I mean, we would not want to suspend elective care
7 prematurely. I mean, the suspension of elective care or
8 reducing elective care has very fundamental and serious
9 consequences for the population in Northern Ireland so
10 we did it when it was necessary and appropriate to do so
11 to ensure that we were able to balance the need for
12 people requiring hospital care with Covid.

13 I mean, as I recall, the first admission to
14 intensive care in Northern Ireland was not until
15 15 March.

16 Q. Mm-hm.

17 A. So it would've been disproportionate and, in my view,
18 inappropriate to downturn elective care prematurely
19 given the very significant consequences it would have
20 for the population in Northern Ireland.

21 Q. Yes, but in terms of completing your plan for preventing
22 elective surgery, should that have been done at an early
23 stage compared to 9 March? Because there's a difference
24 between when your plan is complete to when you then
25 implement that plan.

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1 Q. So did the strategic cell provide any benefit then on
2 9 March?

3 A. I'm not saying that it didn't provide benefit. I'm
4 saying that it was activated at a time when we
5 recognised that there was a need at that stage for more
6 strategic co-ordination at the policy level. Because as
7 policies, the strategic cell fulfilled several
8 functions. Its role is to provide strategic leadership
9 and co-ordination to health silver.

10 It's also to ensure that the support to the health
11 minister. It's also there to provide support to other
12 government departments which it had already been doing
13 in any event in terms of their planning and preparation
14 and briefing. But also to ensure that the minister is
15 supported and providing, feeding into the other, the
16 wider UK response.

17 So there are very many elements to the roles and
18 responsibility of the strategic cell.

19 Q. Okay. And you were talking there about the wider UK
20 response, let's look at one of those. So your statement
21 says that on 15 March Professor Sir Chris Whitty
22 circulated a note on shielding and that note reflected
23 discussions between the four CMOs.

24 What discussions had there been between the four of
25 you about the benefit or whether shielding should be

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1 A. Well, the plan -- I mean, the plan -- the ongoing work
2 on the plan, resulted in the publication of the plan on
3 19 March. And that included a comprehensive plan across
4 21 service areas in terms of surge planning. And it was
5 published, as I say, on that date, and that was the
6 outworkings of the work that had been going on
7 from February. And that plan was subsequently revised
8 and updated.

9 There was also a subsequent document which was
10 published some time later which was the outworkings of
11 intensive engagement and with the health and social care
12 service about protecting critical services during Covid.
13 So throughout all of this time, this was an iterative
14 and ongoing process. And I think it is absolutely wrong
15 to suggest that it was only when the strategic cell was
16 established and the first meeting of 9 March that this
17 all started to happen or started to be co-ordinated.

18 The emergency response and the planning and
19 preparation that was underway continued and it didn't
20 require the strategic cell necessarily to be activated
21 for that to occur and you can see that the engagement
22 and the direct engagement that I was having with
23 colleagues within the Health and Social Care Board and
24 the PHA in early and mid-February I think is evidence of
25 that.

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1 introduced?

2 A. I mean, the details of this I don't now recall given the
3 passage of time, but essentially the context of the
4 broad context of the discussions were that we had a new
5 pathogen which the population had no prior exposure to.
6 There was no pre-existing immunity. There was no
7 treatment available. There were no vaccines available.
8 And the likelihood and timeline for treatments and
9 vaccines being available may well be a year or more. So
10 there was no realistic possibility or probability of
11 effective medical counter measures at that time.

12 And we discussed firstly -- and in that context we
13 discussed the emerging -- and it was only emergent
14 information at that stage -- about those who were most
15 at risk of severe disease.

16 And as I said earlier, we gained much of that
17 information from those countries that were further ahead
18 of us in the pandemic.

19 And the overall policy approach was that in those
20 circumstances new virus, no pre-existing immunity that
21 we needed to protect those who appeared from the
22 emerging evidence were at greatest risk. And that
23 informed the policy on shielding. And that was the sort
24 of the broad context of the -- of the discussions that
25 were held.

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1 Q. And what was your view on the benefits and the risks of
2 implementing shielding?

3 A. I think we were all acutely aware of the significant
4 negative impacts of (unclear). We did say at the time
5 that the policy was announced, and I recall saying this
6 during some of the media briefings at this stage, that
7 this was about protecting the vulnerable from the virus,
8 but it wasn't about removing the vulnerable from
9 society.

10 Because we were very, very acutely aware of the very
11 negative impacts that -- you know, effectively advising
12 people to limit their social contacts, to stay at home,
13 to not to go out into public places for those caring for
14 them or living with them to take such a precautionary
15 approach would have profound social, psychological and
16 mental health consequences. And we were very, very
17 mindful of it.

18 So it was a very, very difficult judgement in terms
19 of trying to strike that right balance. But in the
20 consequences, as I've said, with no immunity and a new
21 virus that was clearly causing very severe disease in
22 some people, it was the only course of action that was
23 available to us at that time.

24 Q. So there were no alternatives?

25 A. Well, I mean, were there any alternatives? I just say
97

1 whether shielding as a concept was working?

2 A. Well, I think I've covered this again in my statement.
3 I mean I think it's very difficult now to assess the
4 effectiveness of shielding, in terms of -- I mean, it
5 depended on individuals following the shielding advice
6 as best they could and recognising this was really,
7 really difficult.

8 It was very difficult for those who were asked to
9 shield and indeed on their family and on their carers.
10 But we didn't do any sort of realtime assessment of its
11 effectiveness, and indeed it would be difficult now to
12 do any retrospective assessment of its effectiveness
13 given the sort of universal application of it at that
14 time.

15 I mean, certainly what I did do, however, was
16 in May, 27 May I did commission the Patient Client
17 Council in Northern Ireland to do research to hear the
18 views of people who had been shielding because --

19 Q. Well, that impacted upon the decision to pause shielding
20 at the end of July. But the decision to impose
21 shielding, you must have gone into it with
22 an understanding of this isn't going to be forever, we
23 need to have a mechanism for when it's going to end.

24 How did you measure the point or how did you
25 anticipate that you would measure the point at which it
99

1 we did several things in parallel.

2 Q. You did -- your final line of your sentence was "It was
3 the only course of actions available to us at the time."

4 A. Well, I do say later on in the statement -- well, in
5 terms of, yes, only available course of action to us at
6 the time in the context of the individuals who were
7 extremely clinically vulnerable. But clearly the best
8 approach to protecting those who were clinically
9 extremely vulnerable is to suppress the transmission of
10 the virus in the community.

11 And we had that sort of two-headed approach. We
12 were at that time also had provided general population
13 advice around social distancing, reducing contacts, that
14 had, you know, prior to the decision on the first
15 lockdown on 23 March. So we were taking efforts using
16 non-pharmaceutical interventions to reduce community
17 transmission, because we knew and always knew that
18 keeping community transmission down was actually the
19 most effective way of protecting the vulnerable.

20 But the difficulty was that the only -- we also knew
21 that the only way out of this pandemic was with medical
22 counter measures, with treatments and vaccines as I've
23 said earlier and that was unfortunately, you know,
24 an indeterminate period in the future.

25 Q. How did you plan to measure -- this is you personally --
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1 should end?

2 A. I mean, the feeling, you know, by its nature was
3 a broad brush approach. It's not -- you know, it wasn't
4 an exact science. We didn't have all the information
5 and data that we needed. We didn't have all the
6 knowledge that we needed and, you know, as the -- as the
7 policy and shielding evolved, there were groups that
8 were added to it later as evidence occurred around their
9 susceptibility of individuals living with
10 Down's syndrome, individuals with stage 5 kidney
11 disease, et cetera --

12 Q. Forgive me, Professor McBride, it's not quite answering
13 the question about at the time that shielding was
14 introduced about as opposed to when aspects are added on
15 later.

16 A. Well, the answer to the question is that whenever levels
17 of community transmission were at a level where we felt
18 that the advice on shielding could reasonably be relaxed
19 and/or until such times as we saw significant changes in
20 population behaviour, to protect those who were most
21 vulnerable.

22 And I think as we all knew and can look back now and
23 experience, the population at large was extremely
24 altruistic in terms of the steps that it took to protect
25 the vulnerable in society. You know, it's hard -- it's
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1 hard to imagine, you know, coming here this morning on
2 the tube, that not so very long ago we were all wearing
3 face coverings, we were all social distancing, we were
4 all in one way systems in shops.

5 So children suffered hugely because of the impact on
6 their education. So there were steps that we as
7 a society took to protect others that were vulnerable
8 and that made a safer environment for those who were
9 shielding.

10 I mean, in Northern Ireland, for instance, and in
11 February '21, as we were relaxing further the shielding
12 advice, we introduced a distance aware scheme, similar
13 to a scheme in Wales, because we'd heard from people who
14 were shielding that they were -- had previously been
15 shielding, that they were concerned that the rest of the
16 population had relaxed too much, that they weren't
17 respecting social distancing and some -- or, indeed,
18 wearing of face coverings and some of the things that
19 kept them safe.

20 **Q.** Forgive me, Professor McBride, if I can just bring you
21 back to the decision to impose shielding. You said
22 earlier on when I was asking you about lessons learnt,
23 communications, "in terms of how we conveyed information
24 in a balanced way which allowed people to make choices
25 about what was important to them", you also talked about

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1 being provided. You know, what was the scientific basis
2 for this. So there were some very clear and strong
3 messages.

4 I think back to your question in terms of what I'd
5 do differently, I think that given the profound
6 consequences that shielding had, I think the primary
7 approach to a future pandemic should be about
8 suppressing the transmission of the virus and only
9 keeping shielding in reserve if indeed it's necessary,
10 and if it's necessary then for as shortish time as is
11 possible.

12 The other really important thing for me in shielding
13 was it understandably was very, very difficult to take
14 a more nuanced approach to shielding advice when
15 circumstances changed. So whenever we had interrupted
16 the link between transmission and severe disease through
17 drug treatments and vaccines, and what we had and what
18 we needed to do in the future is to ensure that we give
19 people a greater sense of agency for making decisions,
20 making decisions about the risks and those trade-offs in
21 terms of risk and benefit and give people whoever have
22 to shield again a greater sense of control. Because
23 I think the approach that was taken -- in good faith
24 initially -- did not fully think through the loss of
25 agency and loss of control that people would experience,

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1 an initial messaging.

2 What did you learn or what have you learnt from the
3 way that the initial messaging around shielding was
4 carried out and what would be improved?

5 **A.** I think that while we endeavoured to ensure that we
6 communicated the advice clearly as honestly as we could
7 based on the information that we had, and tried to keep
8 that updated in a variety of ways, I think the net
9 result of the advice on shielding again, as I said in my
10 statement, was that we engendered a significant degree
11 of fear in those who were shielding, fear and anxiety.

12 That was clearly one of the significant findings
13 within the work that I'd commissioned with the
14 Patient Client Council to undertake. People felt
15 significant fear and anxiety, not to the extent that
16 they required psychological support or -- at least that
17 was the survey information in Northern Ireland.

18 **Q.** How would you prevent that happening again?

19 **A.** I think that -- I think -- I think there's also a couple
20 of other important points from that survey which if
21 I could maybe expand upon.

22 I think the population also communicated in that
23 survey that at times they felt ignored. And they asked
24 for clearer guidance on a more regular basis and
25 actually a clear rationale for why the guidance was

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1 and the real fear then that people had about re-entering
2 society, starting to engage again in the activities of
3 daily life and --

4 **Q.** And accessing healthcare?

5 **A.** And accessing healthcare.

6 I mean, we did a particular survey in
7 Northern Ireland which indicated that -- well, we know
8 generally people accessing GP surgeries, people
9 accessing -- presenting to emergency departments reduced
10 significantly. We did a lot of work communicating to
11 the public that the health service was open for those
12 who needed urgent treatment and care, but certainly the
13 information and analysis directorate within the
14 department did some work which identified, I think I can
15 provide it to the Inquiry if it's helpful, I think it
16 was up to about a third of people if they were offered
17 an appointment to see their GP or attend hospital would
18 be reluctant to do so.

19 So absolutely that was a challenge. We did put in
20 place mechanisms where there was remote consultation, GP
21 remote consultations, consultant consultations, but
22 I think that undoubtedly it had a consequence, and we
23 have evidence of that, of people who were shielding not
24 accessing the care that they needed at times.

25 **Q.** In terms of Northern Ireland and actually disseminating

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1 all of the letters, the Department of Health statement
2 says it took a number of weeks for all of the shielding
3 letters to be issued.

4 Does that not cause a problem for people who believe
5 that they may need to shield but who haven't yet
6 received a letter? Is there anything that can be done
7 to make sure if a decision is taken in future to impose
8 shielding that actually the message gets out much
9 quicker to those who --

10 **A.** Well, again -- yes, I think it's a very important point.
11 Again, I wasn't responsible for the technical aspects of
12 the operation and the implementation of the issue of
13 letters. Those in the policy cell in the department
14 worked with the trusts and with the Health and Social
15 Care Board to ensure the letters went out from GPs and
16 trusts to those who needed to shield.

17 In answering your question, I think the other
18 important point is we did communicate to those that
19 thought they were shielding that if they didn't receive
20 a letter to contact their GP or contact their hospital
21 consultant if they thought they should be on at the
22 shielding list and hadn't received a letter, so we did
23 have that as a fail-safe.

24 **Q.** How easy was that for people to do to actually get
25 access to the GP or access to their consultant?

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1 and telephone systems.

2 The shift to telemedicine for GPs, and the use of
3 the telephone systems, effectively was the GPs telephone
4 infrastructure in Northern Ireland able to cope with
5 that shift or effectively was the system overwhelmed?

6 **A.** I mean, again, I'm going to -- I'm afraid I still living
7 in the analogue area and IT is not my, you know, area of
8 competence, so others would be better placed to answer
9 that.

10 What I would say was that during the pandemic we did
11 have to put in place significant investment into
12 technology in general practice. I think -- I mean those
13 were issues that had been identified by GP leaders in
14 Northern Ireland and had been for some time.

15 **Q.** When you say "some time", roughly how long?

16 **A.** Oh --

17 **Q.** Years?

18 **A.** Certainly we had conducted a -- the department had
19 established -- and I was not directly involved in this
20 work -- had established a working group in 2016 which
21 had produced a report which had three -- indicated three
22 main objectives in terms of general practice in Northern
23 Ireland. One, to strengthen the general practice
24 workforce. Two, to improve clinical pathways and
25 integrated care. And I think the third one was about

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1 **A.** Well, look, I can't answer that question but we did put
2 significant additional investment into telephony
3 services in general practice really from early on in the
4 pandemic because again much of general practice switched
5 to remote consultation so there was significant
6 investments in technology in general practice in
7 particular.

8 But to answer your specific question, I mean,
9 I understand that the difficulty in relation to -- the
10 bulk of the letters issued I understand have been
11 advised on 27 March. There were some letters that took
12 longer. The reason being the GPs were advised to
13 prioritise those that they felt were most at risk and
14 actually had to search their own databases.

15 **Q.** There wasn't a centralised database?

16 **A.** There wasn't centralised database.

17 But then, you know, every pandemic would be
18 different. The underlying conditions that make people
19 extremely clinically vulnerable will differ depending on
20 the pandemic so there wasn't a centralised database.

21 But I understand, although not directly involved,
22 the department did provide search engines to be used in
23 GP systems to identify individuals.

24 **Q.** Just conscious of the time, my Lady, one further
25 question in relation to IT particularly in IT systems

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1 driving innovation and issues such as telephony.
2 Remote reporting was identified as one of those areas.

3 Now, askmyGP had been launched in and around 2019,
4 which is a mechanism whereby, you know, GPs can have
5 consultations with patients. There was a very low
6 uptake of it initially in general practice because, as
7 doctors we like to see people face-to-face. So
8 I think --

9 **Q.** Professor McBride, if I can just bring you back to the
10 question.

11 Were GPs able to cope with the shift to telemedicine
12 at the early stage of the pandemic or was the system not
13 able to cope?

14 **A.** I can't answer that question. It wasn't an area within
15 my remit.

16 **MR SCOTT:** Thank you, my Lady.

17 **LADY HALLETT:** Just before we break, Professor, can you
18 help; you've mentioned introducing guidance on social
19 distancing, reducing contacts, one-way system remote
20 consultations. When was this guidance published?

21 **A.** Erm --

22 **LADY HALLETT:** You said it was before the first lockdown.
23 Are we talking about March?

24 **A.** We are. In terms of within health and social care, yes.
25 The workshop that I referred to on 5 March which was to

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1 further develop the surge planning that had been under
2 way throughout February, as I understand it, considered
3 all of those aspects, about one-way systems, separate
4 waiting areas, remote access, consultations, and there
5 was ongoing work on those areas from that very early
6 date.

7 So by, probably the middle of March and certainly
8 prior to the first -- well, sorry, not prior to, but in
9 advance of there being a significant number of cases
10 detected in Northern Ireland, there was separate
11 facilities for people attending with Covid symptoms.

12 So, for instance, they were advised not to attend
13 but to phone first, phone their GP. We'd established
14 Covid-19 primary care centres where individuals were
15 assessed by GPs, were tested and referred on into
16 secondary care if necessary.

17 So all of that planning and preparation and putting
18 those arrangements in place occurred in the time frames
19 from early March up to about mid-March.

20 **LADY HALLETT:** I'm not so much interested in the planning,
21 I've heard a lot about planning over the last few
22 months, what I'm interested in is when were the members
23 of the public in Northern Ireland told "Keep your
24 distance, reduce your contacts". Not planning.

25 **A.** Well, that -- oh, sorry; I thought we were talking about
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1 Thank you.

2 Then that is your email in response, because that
3 email had been passed on to you from the minister's
4 private office?

5 **A.** That's correct, yes -- (overspeaking) --

6 **Q.** Talking --

7 **A.** -- my response, yeah.

8 **Q.** Talking about:

9 "The nature and volume of correspondence from health
10 professionals nurse, doctors and others is entirely
11 inappropriate even allowing for the current significant
12 understandable anxiety."

13 You're talking about:

14 "... no circumstances ... [escalating] such
15 matters ..."

16 That's what codes of practice are for.

17 It doesn't -- well, if we can just go up, just --
18 we'll continue with the thread.

19 You had the response from the Chief Nursing Officer,
20 who agrees it's "not the right approach", but she is
21 reflecting the fact that there are significant concerns.
22 And at the bottom paragraph:

23 "There is a deep lack of clarity and understanding
24 regarding appropriate use of PPE and in particular FFP3.

25 A professional letter on its own won't do it for me. We
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1 the health service as opposed to public. That would
2 have been at the same time as that message was
3 communicated to the rest of the UK. From memory I think
4 that was around 16 March.

5 **LADY HALLETT:** It was shortly before the first --

6 **A.** Yes, yes.

7 **LADY HALLETT:** Thank you very much. 1.50.

8 (12.50 pm)

(The short adjournment)

10 (1.50 pm)

11 **LADY HALLETT:** Mr Scott.

12 **MR SCOTT:** My Lady.

13 Professor McBride, before the break we were talking
14 about communications. I'd like to carry on with
15 that thread.

16 If we can have on the screen INQ000445772.

17 And if we could please start at page -- ideally
18 page 3, I will just summarise that.

19 So there's an email that had been received by the
20 health minister on 17 March, I think from a nurse,
21 commenting on concerns about downgrading of PPE. Do you
22 remember --

23 **A.** I do, yes. Thank you.

24 **Q.** And if we can please go to page 3.

25 That email was then -- if we can scroll up, please.
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1 need to reissue simple and clear advice and
2 information."

3 Then your response is:

4 "The guidance is clear, whether clearly communicated
5 understood and applied as separate considerations."

6 Do you think that there was sufficient communication
7 to healthcare workers in Northern Ireland about what the
8 standards were of PPE that they should be wearing in
9 order to assuage concerns that they had?

10 **A.** I mean, clearly at that time, given the volume and
11 nature of the concerns that were raised, there was much
12 more that needed to be done to provide clarity on the
13 guidance and the rationale for the guidance and actually
14 to address what were genuine concerns and anxiety.

15 I mean, there was a real sense of fear, which was
16 entirely understandable. These were individuals who
17 were putting themselves in harm's way in the treatment
18 and care of others.

19 **Q.** Did those communications come, given that they'd been
20 raised with you?

21 **A.** Well, they had. I mean, the first communication on
22 infection prevention and control, whilst I wasn't
23 directly involved, had issued on the -- in --
24 10 January, when it was online with an agreed approach
25 across the UK. It had issued from the Public Health
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1 Agency in Northern Ireland in -- in conjunction with
2 other organisations, Public Health England, et cetera,
3 at that time.

4 The difficulty --

5 **Q.** This is -- this is 18 March. This is after the
6 downgrade from HCID --

7 **A.** No, no -- and what I was going on to say was that from
8 that date there was a subsequent revisions and updates
9 to the guidance.

10 Now, I think what this is specifically concerning is
11 the decision in and around mid-March to change the PPE
12 guidance on the basis that Covid was no longer
13 considered an HCID. So clearly in that transition from
14 the advice around PPE that was being provided -- on
15 infection prevention and control that was being provided
16 prior to that decision, there was clearly not a clear
17 understanding of the rationale for why that decision had
18 been made.

19 To my mind, what I was flagging here was -- and
20 we've covered this in the CMO technical report -- there
21 were significant issues around the clarity of the
22 communication, the ownership for the responsibility to
23 ensure that was communicated by employers to their staff
24 in a consistent -- consistent way.

25 **Q.** And did that clarity come in Northern Ireland?

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1 look at the evidence. But it was a continual challenge,
2 understandably, to provide the latest evidence-based
3 guidance and to ensure that that was understood by all
4 concerned.

5 I think, you know, there were reasonable questions.
6 I think we need to anticipate that in future pandemics.
7 But there was considerable effort made to ensure that
8 there was an understanding.

9 We did, subsequent to this, publish on the 28th --
10 I think it was around the end of March, the further
11 letter from myself and the Chief Nursing Officer which
12 advised on the guidance published to link to the
13 evidence base, so that individuals could look at that
14 evidence base, and it also contained leaflets and a link
15 to a video about PPE.

16 So I think we took concerted action but that did not
17 prevent concerns being made after this date, and those
18 continued throughout the pandemic, about the
19 appropriateness of the IPC guidance and about the
20 appropriateness of PPE guidance.

21 **Q.** I want to move on to the 20 March direction to the RQIA.
22 I am not asking from -- this from a care perspective.

23 The direction was given effectively for the RQIA to
24 cease inspections of hospitals. Is that correct?

25 **A.** To pause the inspection of hospitals, yes.

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1 **A.** I believe that clarity did come. There were a number of
2 actions that were taken on foot of this, the -- for
3 instance, the Chief Nursing Officer developed a range of
4 guidance videos around appropriate PPE. Now, again,
5 it's beyond her remit as Chief Nursing Officer but she
6 worked very closely with the director of nursing within
7 the PHA. The IPC cell was subsequently established,
8 with its first meeting on -- on 20 March --

9 **Q.** I appreciate that all that, Professor McBride, it's
10 simply a matter -- I asked did the clarity come, you say
11 you believe clarity did come. Were you receiving
12 concerns subsequently in 2020 from healthcare workers
13 that the level of PPE that they were being advised to
14 wear was not sufficient?

15 **A.** I think that -- I gave you specific examples of action
16 that was taken on foot of this -- I mean --

17 **Q.** Well, first, could you please answer the question about
18 whether you received those concerns rather than the
19 action that you took?

20 **A.** Well, concerns continued to be flagged throughout the
21 pandemic, not just in 2020 but certainly each time that
22 there were new variants which emerged.

23 Again, the evidence around transmissibility and
24 infectiousness was reviewed by UKHSA, was reviewed by
25 IPC cell. There were specific subgroups established to

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1 **Q.** Yes.

2 Did you consider whether it may have been a better
3 alternative for the RQIA to have had the ability to
4 inspect hospitals in -- as they ended up doing later on
5 in that year -- they were reviewing IPC measures and how
6 those issues were being applied, things that were
7 directly relevant to healthcare workers during the
8 middle of the pandemic?

9 **A.** There was a need -- in terms of did I consider it, yes,
10 that was part of the consideration, but there was
11 absolutely a need to ensure that we reduced, in as far
12 as possible, all unnecessary footfall into healthcare
13 facilities so that we could protect individuals in those
14 facilities and staff and those facilities --

15 **Q.** Can I just ask, in terms of unnecessary then, how many
16 people would come in from the RQIA if they were to
17 conduct an assessment of the IPC --

18 **A.** Oh, if you're talking about -- if you're talking about
19 a trust, it would be a team of individuals would come in
20 from -- from RQIA. Again, I would just point out, and
21 again, that separate to the arrangements in England,
22 RQIA does not have a regular programme of planned
23 inspections in hospitals in Northern Ireland, they are
24 not registered with RQIA in the same way that CQC is.
25 So the inspections that RQIA undertake tend to be

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1 thematic inspections, which we request, as of -- you
2 alluded to the hospital inspection by IPC in September,
3 which I commissioned from RQIA.

4 **Q.** And that produced some useful recommendations --

5 **A.** It did.

6 **Q.** -- and points of learning. So, on reflection, do you
7 think that maybe there would've been a benefit for the
8 RQIA conducting IPC reviews in hospitals at an earlier
9 stage in the pandemic, particularly when trusts are
10 starting in the early stage of their response?

11 **A.** I don't. I think that there is significant IPC
12 expertise already within the health service in Northern
13 Ireland, as I've mentioned earlier. There are IP --
14 infection prevention and control teams with -- on each
15 trust in Northern Ireland. Each trust can draw on the
16 support of the Public Health Agency, which again has
17 expertise in infection prevention control, if they have
18 any concerns or, for instance, if they have an outbreak.

19 So at that stage I did not believe, and again
20 I still do not believe at that stage, that there
21 would've been added benefit from a regulatory approach
22 with RQIA inspection.

23 **LADY HALLETT:** Professor McBride, can I also ask what
24 happens from the hospital's point of view if you send in
25 an inspection team. Presumably they don't just wander

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1 **MR SCOTT:** Yes, thank you. I don't need to take you to
2 Ms Donaghy's statement now.

3 Can I please deal with prioritisation then.

4 If we can, please, have on screen INQ000474259, and
5 it's page 217. It's paragraph 503.

6 This is the spotlight statement from the Belfast
7 Trust.

8 And then, as you can see there, it's:

9 "... the UK Government avoided providing guidance on
10 some difficult discussions in respect of issues such as
11 reverse triage ... This should not have defaulted to HSC
12 Trusts and front line clinical teams to make these
13 decisions ..."

14 Just with that in mind from the Belfast Trust,
15 Belfast Trust were the ones responsible for the
16 Nightingale hospital, that's correct?

17 **A.** That's correct, yeah.

18 **Q.** So in terms of any high levels of surge numbers, they
19 were the ones who were going to have to deal with the
20 most number of ICU patients, critical care patients?

21 **A.** Correct. With the support of the other trusts, yes.

22 **Q.** Yes, in terms of staffing and --

23 **A.** Yes.

24 **Q.** Can I please go to INQ000377146.

25 So this is an email on 25 March 2020 and it's from,

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1 around the hospital on their own, members of staff have
2 to respond to their questions and show them around. So,
3 I mean, how many members of staff are you taking away
4 from their other duties to respond to an inspectorate?

5 **A.** Again, I would be speculating, Chair -- my Lady, but
6 a significant number of staff, because what RQIA do in
7 their inspections -- I mean, RQIA are also different in
8 that they are professional inspectors, they're all
9 registered nurses, allied health professionals or social
10 workers, so they inspect clinical and non-clinical
11 areas, they meet with staff, they meet with visitors,
12 and they do go where they choose to go, because that's
13 the purpose of unannounced inspections.

14 So it would've been -- it certainly -- and again,
15 Ian Trenholm -- and I note in his evidence to the
16 Inquiry makes that point that it would -- to continue
17 inspections would've added further pressures to an
18 already pressurised service, with staff being pulled in
19 multiple directions.

20 So in my view, and I think Briege Donaghy, who is
21 the now chair of RQIA, said in her own statement, and
22 I would agree and concur, that the pause in hospital
23 inspections had -- likely to have minimal impact in
24 relation to the work that RQIA carries out in the
25 statutory sector.

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1 I believe, a senior figure within the Belfast Trust who
2 is talking about boundaries about service expectations
3 for critical care.

4 And it's talking there about starting from
5 a position where nursing workforce is not at capacity.

6 We've seen a lot of evidence about surge planning in
7 your statement.

8 I'd just like to go down, please, to the bottom of
9 this email. Thank you.

10 And it's number 17:

11 "Triage for admission to intensive care will be
12 inevitable.

13 "18. Triage for suitability to continue ICU support
14 will be inevitable."

15 So there seems to be a relationship between an email
16 they sent on 25 March 2020 and their statement
17 suggesting that it was beneficial to get guidance.

18 Do you think that there was sufficient guidance
19 provided to healthcare workers in Northern Ireland about
20 the possibility -- sorry, to be used in the event
21 that -- issues such as triage for admission to intensive
22 care or suitability to continue support, do you think
23 there was sufficient guidance provided to them?

24 **A.** I do and I'm happy to elaborate on that if you wish.

25 **Q.** Please do, and please would you indicate when it was

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1 provided and why it was provided in sufficient detail,
2 given that the trust still believe there wasn't
3 sufficient guidance.

4 **A.** Well, this was -- this was in early on in advance of the
5 work that we undertook. I mean, the first point I would
6 make is that decisions around the appropriateness of
7 clinical care can only be made by clinical teams, and
8 can only ever be made in the -- an estimate of the
9 capacity to benefit of an individual from a particular
10 intervention or a treatment, irrespective of what the
11 intervention or treatment is.

12 You know there can be no blanket policies, you know
13 there can be no approach which is based on assessment of
14 frailty or age, it has to be based on two simple
15 questions: from any intervention can an individual -- is
16 there a greater likelihood than not that an individual
17 would benefit? And then the second question is, if the
18 answer is yes, they're likely to be benefit -- benefit,
19 is that what this individual would wish? The simple
20 issue of consent.

21 There is no doubt that at this time there was
22 significant anxiety within all professions, nursing,
23 medical and others, and indeed within the wider
24 leadership within the health and social care system,
25 including myself, that the demand for access to

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1 professional guidance by the General Medical Council in
2 terms of good decision-making at the end-of-life
3 treatment and care and the recommendations by the
4 Resuscitation Council and GMC guidance on consent, and
5 that all health professionals continue to be guided by
6 the legal frameworks which they can -- which they would
7 comply, outlined the Northern Ireland Act, Human Rights
8 Act, Disquality (*sic*) Discrimination Act.

9 And we put in place, as I recall, two workshops to
10 work with clinicians who had genuine concerns --

11 **Q.** Excuse me for cutting across you, Professor McBride,
12 I think you have set out in your statement a large
13 amount of what was done. The question I'm asking you
14 is, you had a senior clinician from the Belfast Trust
15 who is saying in effect, in their statement, that they
16 didn't receive sufficient guidance. Do you respect that
17 opinion, that he's saying, "No, we didn't get the
18 guidance that we needed", even if you feel the guidance
19 was there?

20 **A.** I mean, the senior colleague you referred to, I --
21 I respect his -- his opinion. I disagree with his
22 assessment of the guidance and support was -- provided.
23 I believe that the guidance was provided. And we did --
24 not only did we provide the written guidance but we
25 established workshops to ensure that guidance was

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1 specialist service including intensive care would
2 outstrip our ability to meet that demand.

3 In terms of Chris Hagan's statement, who is a valued
4 colleague, who I respect, I do not think and I do not
5 agree, but I do agree with the expert report by
6 Summers(?) et al, that there can never be a circumstance
7 where we have triage by resource, in other words,
8 whereby the ability of someone's -- a decision under
9 someone's -- whether they can access treatment is
10 dependent on our ability to provide that.

11 So what I did, recognising those concerns, was
12 I established a Covid-19 clinical ethics forum. The
13 first meeting of that was on 15 April. In June we
14 developed a clinical guidance which issued to the
15 service. We extensively worked with the critical care
16 network, and again this email is from the then chair of
17 the Critical Care Network, the Palliative Care Network
18 the Frailty Network, with hospital chaplains, faith
19 leaders. We consulted with the equality commissioner,
20 the commissioner of human rights in Northern Ireland, we
21 engaged, we consulted and we presented that ethical
22 advice and guidance framework.

23 And if I could just finish on this and then -- and
24 what that made explicitly clear was that, throughout the
25 pandemic, decisions of this nature needed to be based on

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1 understood --

2 **Q.** Okay.

3 **A.** -- and was applied.

4 **Q.** Because in terms of when you're talking about -- that
5 document can come down now, thank you.

6 When you've been redeploying staff, redeploying
7 predominantly theatre staff, recovery staff -- is that
8 right? When you were redeploying what is inevitably
9 inexperienced staff into intensive care, don't you need
10 to make sure that there's very strong and very clear
11 prioritisation guidance so that those people -- even the
12 senior figures may have that experience but you do have
13 a number of people working in ICU who don't have that
14 level of experience and do you need to help them and
15 reflect that level of inexperience with guidance?

16 **A.** Staff who were redeployed, nursing staff, for instance,
17 into critical care, with airway skills, were always
18 working under supervision of a critical care nurse.
19 That's the reassurance that I was provided all times.

20 In terms of -- you're correct in the underlying
21 point in your question, which is critical care staff,
22 experienced clinicians, make such decisions in
23 conjunction with individual patients and relatives on
24 an ongoing basis. The role of a -- the role of a doctor
25 as a professional is to balance risk and to hold risk

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1 and to all times -- at all times act in what is the best
2 interests of the patient.
3 I am satisfied that we provide sufficient guidance.
4 I'm not aware -- I mean, there was professional guidance
5 provided by other expert bodies which we've referenced
6 in the ethical guidance and framework, but I am
7 satisfied that we provided sufficient clarification on
8 the extant position.

9 Not only did we do that but we pointed to, in that
10 guidance, the reassurance that had been offered by the
11 General Medical Council and the BMA in their statements,
12 which is referenced in the document, that, you know,
13 decisions made by doctors in -- in -- in the
14 circumstances where the best interests of the patient
15 are concerned, that they need have no concern when
16 they're --

17 **Q.** Can I --

18 **A.** And I think the other thing I would add is --

19 **Q.** Just can I just -- (overspeaking) --

20 **A.** No, I think it's really -- I do want to finish this
21 point because it is a really important point.

22 Not only that, but we established in every trust in
23 Northern Ireland clinical ethics committees.

24 **LADY HALLETT:** Yes.

25 **A.** And they had the support of -- of the regional clinical
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1 and then part 2 was about some worked examples,
2 including decisions around cancer treatment,
3 including -- DNACPR is only but one example, and also
4 then pointing to the support that was available to
5 health professionals.

6 **Q.** Can I move now to DNACPRs.

7 Were you aware of concerns expressed during the
8 pandemic of the inappropriate use of DNACPRs in Northern
9 Ireland?

10 **A.** There was -- there was correspondence received by the
11 minister, raised by elected representatives in Northern
12 Ireland. There were concerns reported in the media.
13 I was not aware of substantive issues in that regard but
14 there were certainly concerns that had been addressed to
15 the -- the minister and the minister responded to those
16 concerns, firstly confirming there was no blanket policy
17 in Northern Ireland, that the same approach in terms of
18 adherence to good -- the guidance and good medical
19 practice and GMC, Resuscitation Council guidance
20 applied, that people would receive the care that was
21 appropriate.

22 So every effort was taken to provide assurances.
23 I'm not certain that necessarily those assurances
24 necessarily provided answers to all of the questions
25 that were being raised but we did our very best to

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1 ethics committee which we supported. We made clear in
2 the guidance that we provided if doctors faced or other
3 health professionals faced ethical dilemmas, then advice
4 and support was available to them within their
5 individual trusts. So I do think we addressed the
6 concern. But, sorry, I --

7 **MR SCOTT:** No, I was cutting across you --

8 **A.** -- talked over you, sorry.

9 **Q.** I just wanted to clarify in my own head whether at this
10 point we were talking about prioritisation guidance or
11 guidance in relation to DNACPRs, for example. I wasn't
12 quite sure what you were talking about there, because
13 DNACPRs --

14 **A.** I think DNA -- we're talking about the totality of care.
15 It doesn't matter whether we're talking -- I mean,
16 again, the guidance that we issued talked about cancer
17 care, it talked about the treatment and the balance of
18 decisions and -- that doctors and others need to weigh
19 up in terms of treating people with Covid versus the
20 delays in treatment to people with other conditions such
21 as cancer. So it talked about decisions to admit to
22 hospital.

23 So it -- you know, the guidance was divided into two
24 halves: the ethical principles underpinning -- part 1 --
25 and the legal obligations of all health professionals;
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1 provide assurance to the public in Northern Ireland.

2 **Q.** Two specific points I'd just like to deal with.

3 If we can go to INQ000421784, page 713.

4 It's paragraph 275 of your statement, where you're
5 talking about:

6 "The Department had considered reissuing a DNACPR
7 form for use during the pandemic to support clinical
8 decision making but on the advice of the regional
9 Clinical Ethics Forum it was identified that there was
10 a need for further work ..."

11 The Department of Health's second statement says
12 that the department didn't seek the advice from the
13 clinical ethics forum, and actually the chair of the
14 forum became aware that the department was considering
15 reissuing the form through the clinicians, who were
16 concerned about the timing of any reissue.

17 Firstly, is that sequence right, that it was going
18 to be -- the form was going to be reissued and it was
19 only because the chair of the forum became aware that it
20 was going to be issued rather than it had actually been
21 provided to the ethics forum for their views?

22 **A.** With the passage -- I can't absolutely be specific in
23 relation to that. I do know that -- what I can be
24 specific about is that the -- the chair of the ethics
25 committee approached myself and advised that this had

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1 been raised by a member of the committee, who basically
2 felt it was premature to issue a form of such
3 an issue -- this was about -- you know, if I could just
4 explain the context.

5 This was not about a new policy in relation to
6 DNACPR but to ensure, as happens in England
7 I understand, that a decision made in relation to DNACPR
8 that was made in an acute setting could then be applied,
9 if appropriate, in a community setting.

10 The concerns that were raised to me by the chair
11 reflecting the discussion at the ethics committee was
12 that it would be inappropriate to do so without raising
13 awareness amongst the public about the absolute nature
14 of DNACPR, the risk of those being misinterpreted and
15 the need for there to be significant education and
16 training within the profession -- further education
17 training within the profession. And the advice was that
18 that should be taken forward as -- in a holistic way, as
19 is, indeed, recommended by the UK Resuscitation Council
20 as part of advanced care planning, which I alluded to
21 earlier.

22 **Q.** Can I just -- in terms of that care and hospital
23 setting, can I just take you back to one of the actions
24 again from the decision log.

25 It's INQ000130312. It's at 618.

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1 particular setting, an acute setting when someone is
2 acutely unwell, basically saying that somehow or other
3 that will apply when someone has potentially recovered
4 from their illness and is well, and is in a community
5 setting. I do not think that that blanket approach is
6 appropriate.

7 I do think it needs to be reassessed and revisited
8 with the individual, with their family and carers, with
9 their permission, at each stage in that person's
10 journey --

11 **Q.** Do you know --

12 **LADY HALLETT:** If you transfer -- forgive me interrupting.

13 If you transfer them, you're undermining the
14 principle that it's a clinical decision?

15 **A.** Exactly.

16 **LADY HALLETT:** Because the hospital doctor, for example, if
17 it's come from the GP, is not making a clinical
18 decision, he's accepting somebody else's clinical
19 decision?

20 **A.** My Lady, I absolutely agree. And also people's
21 circumstances change. You know, people get better, and
22 their assessment of quality of life and what's important
23 to them changes. And I -- you know, so I -- I have
24 reservations about that sort of -- a form which was
25 applied without appropriate public awareness and without

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1 I'll read it out just in terms of the interests of
2 speed, because I know it takes time to come on the
3 screen:

4 "At present the DNAR does not transfer between acute
5 and community settings. When the patient is discharged
6 from hospital the GP has to review and should sign
7 a DNAR. When a patient is admitted to hospital then it
8 is reviewed and a DNAR put in place by the hospital
9 doctor. There is a new form which is transferable but
10 this has never been verified by Department of Health and
11 is therefore not available to practitioners -- can we
12 have clarity on this please?"

13 So is this suggesting that on 2 April that there was
14 a form that was looking to be issued that was talking
15 about transferring DNARs from a hospital setting or
16 a community setting and vice versa?

17 **A.** I mean, this was work that was taken forward by health
18 silver. It wasn't work that I initiated. When it was
19 brought to my attention I took on board the advice of
20 the chair of the ethics committee and the ethics
21 committee and that form did not issue it.

22 From a professional -- professional perspective, my
23 position on this is clear. I do not necessarily believe
24 without the appropriate training and safeguards that
25 it's appropriate to have a decision that is made in one

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1 necessarily enhanced training and understanding within
2 the profession. And what we did in Northern Ireland,
3 which I -- work which I initiated, was -- as I mentioned
4 earlier, was initiated work to develop advanced care
5 planning. And we published that policy for now and for
6 the future in October 2022, and it's basically how
7 people can sit down with people that are important to
8 them and discuss what matters to them, personally,
9 financially, legally, but also in terms of what they
10 wish in terms of future treatment. And we have -- are
11 rolling out a programme of training for health
12 professionals.

13 Those unfortunately, and one of the tragic
14 experiences of this pandemic was -- and there were lots
15 of extenuating circumstances, those conversations did
16 not happen to the extent that they should have,
17 although, as I say, there were circumstances whereby the
18 conversation is more difficult because of social
19 distancing and PPE. But what the guidance made very,
20 very clear was that, you know, no blanket approaches,
21 every case to be weighed up individually in terms of
22 what's in the best interest of the individual, and
23 underlined -- and it was underlined in the document --
24 about the extra effort that needed to be made to have
25 those conversations with patients, with relatives and

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1 how critically important they were, because otherwise
 2 decisions are misunderstood.

3 **LADY HALLETT:** Are you accepting from that answer that the
 4 guidance wasn't always followed to the extent that it
 5 should've been? In other words, hard-pressed medical
 6 staff may have been saying that the notice was
 7 appropriate when they hadn't had the full consultation
 8 with the family, with the patient?

9 **A.** I -- I personally don't know of circumstances where
 10 that's the case. My concern is that there were
 11 circumstances where that may have been the case. And my
 12 concern furthermore is you now have bereaved families
 13 who have a level of distrust in terms of decisions were
 14 made, why those decisions were made, by whom those
 15 decisions were made, and that -- that is deeply
 16 concerning.

17 And I think that's why wider societal approach to
 18 advanced care planning, of which the medical element is
 19 a very significant aspect, is really, really important.

20 **LADY HALLETT:** Ever since I've been appointed chair of this
 21 Inquiry, Professor, I've had complaints from bereaved
 22 family members that notices were issued when the patient
 23 wasn't able to give their consent, when there had been
 24 no consultation with the family, and also -- and I don't
 25 know if this is a concern that has come to you -- that

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1 At the -- we talked about data earlier on.
 2 At the early stages of the pandemic, was there
 3 tracking brought in in Northern Ireland for any
 4 long-term impacts of Covid as it became post-Covid
 5 syndrome or Long Covid?

6 **A.** No.

7 **Q.** Do you think there should've been?

8 **A.** Well, firstly, I mean we weren't -- at that time we
 9 weren't aware of the extent or severity of Long Covid.
 10 That only became clear really in the -- in the summer of
 11 2020. And the first sort of real published study that
 12 I recall being aware of was a study from Switzerland in
 13 or around July the following year which pointed to the
 14 range of symptoms and the number of people that were
 15 affected.

16 However, I mean, I think as I said in my statement,
 17 we do know that many viral illnesses are associated with
 18 post-viral syndromes. However, I think the -- the
 19 severity and the sort of life-altering impacts of
 20 Long Covid were not anticipated and that knowledge only
 21 became available to us as we progressed through the
 22 pandemic.

23 There absolutely were not adequate services in terms
 24 of a -- a specialist service provided. There were
 25 services provided across trusts in Northern Ireland,

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1 do not resuscitate notices, I'll call them shorthand,
 2 were treated as do not treat notices.

3 **A.** And again, last point first. The guidance that we
 4 issued was very, very clear, and repeated it in several
 5 pages, that DNACPR was only relating to cardiopulmonary
 6 resuscitation, it did not apply to other treatment
 7 modalities. It is very specific to that.

8 And again, that is only a decision, again, made
 9 ideally in consultation with the individual patient,
 10 their family, and again it's in best interests --
 11 I mean, it would be unethical to instigate treatment,
 12 any treatment, whether it's CPR or anything else, which
 13 is likely to be futile, that has no prospect of recovery
 14 for a patient, and actually what it's doing is
 15 prolonging death. That would be unethical from
 16 a professional perspective. But that doesn't obviate
 17 the need to have those conversations.

18 But I absolutely accept if you're in intensive care,
 19 you're in full PPE, you're wearing the FFP3, et cetera,
 20 the pressures that were on staff, it is possible,
 21 although I don't know of cases where those conversations
 22 may not have had to the full extent that they should
 23 have.

24 **MR SCOTT:** If I may move on to a different topic, my Lady.
 25 I'd like to cover Long Covid.

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1 some of them very, very excellent, but not co-ordinated
 2 services.

3 **Q.** I just want to go back to having a tracking effectively.
 4 You said many viruses have post-viral consequences and
 5 that you weren't aware of what became Long Covid until
 6 effectively the middle of the year.

7 Isn't that the point of monitoring long-term impacts
 8 on a virus such as Covid, that you are able to identify
 9 at an earlier stage these issues within
 10 Northern Ireland?

11 **A.** Well, I mean, I think -- it wasn't just within
 12 Northern Ireland. I mean, I think before you can track
 13 something you have to be able to define it, you have to
 14 be able to diagnose it, you need to be able to exclude
 15 other conditions, you need to know how to investigate
 16 it, and none of those conditions applied early on.

17 So it is -- I mean, I agree with you, it would be
 18 optimal to say: here is the constellation of symptoms
 19 that are associated with post-Covid syndrome or
 20 Long Covid, these are the systems they affect in terms
 21 of cardiovascular, neurological, et cetera, but at that
 22 early stage we did not have that knowledge or
 23 information to -- even for us to pose the question to
 24 those that will be collecting such data as to what they
 25 would be looking for.

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1 So in all honesty I don't know how we would've
2 undertaken that at that point in time, and particularly
3 as we were dealing with so many the issues in responding
4 to the pandemic.

5 **Q.** So, looking ahead, if there was another pandemic, have
6 you had any thoughts about how you may track any
7 post-viral consequences or would the same position
8 apply?

9 **A.** At this present moment in time the same position would
10 apply, certainly from a Northern Ireland context.

11 I do think that we need to turn our minds to when
12 new diseases emerge. You know, we can't just be relying
13 on the observations of the astute clinician and
14 individuals presenting, we need to have a more proactive
15 means of identifying the sequelae of new infections than
16 we currently have.

17 And as you -- as you identify, a -- we shouldn't
18 necessarily -- although there will always be a period
19 where we'll be relying on research data to form the
20 basis of how extensive that is, but I agree with the
21 premise of your question which is that we should seek to
22 develop mechanisms so that we can detect the sequelae
23 earlier.

24 **Q.** I believe you said that there weren't adequate responses
25 to deal with the response to Long Covid. In your

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1 to be launched? I mean, that's a year and four months?

2 **A.** I think the -- well, as I say, it wasn't in the absence
3 of other services, those other services were in place,
4 the self-support services were in place in terms of
5 structured self-management support of people living with
6 Long Covid. There were specific services in individual
7 trusts. So those services continued but certainly the
8 recommendation in the report and what was an aspiration
9 of mine, and the minister agreed, was that we needed to
10 have a specialist service for people with Long Covid.

11 The minister agreed to that I believe in -- some
12 initial work was done, a scoping paper was provided to
13 the department -- and I think the detail of this is
14 outlined in the minister's statement -- in February and
15 the minister commissioned the service I think in -- in
16 the June of 2021 and there was ongoing engagement over
17 that period.

18 But as I say, colleagues in the Health and Social
19 Care Board I know were actively developing the service,
20 but again they'll be better placed to answer the time
21 that elapsed. But it was complex, it wasn't -- it
22 wasn't straightforward to ensure we got the right
23 services in place with the appropriate funding.

24 **Q.** Is it a reflection of the difficulty in Northern Ireland
25 of establishing a new service in 2021, that sometimes

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1 opinion, when did Northern Ireland start to have
2 adequate services to deal with it?

3 **A.** Well, I was asked by the minister to commission work
4 in July 2020, which produced a report which identified
5 that whilst there were some excellent services in
6 Northern Ireland for people with Long Covid that they
7 were not necessarily well connected. There was no, as
8 we later developed, a single-stop shop approach. So you
9 had psychological support, physical support, breathing
10 clinical support, social support, but it was not
11 an integrated service model.

12 So one of the recommendations from that report was
13 an integrated service model would be developed and the
14 Health and Social Care Board was then tasked in due
15 course with commissioning that service, working with
16 trusts in Northern Ireland, and taking on board NICE
17 guidance at the time in relation to the most appropriate
18 treatment for people living with Long Covid.

19 The service was subsequently established but that
20 bespoke service was established in November 2021. But
21 as I say, the other services that were extant were in
22 place until these -- I suppose the specialist service
23 commenced at that time.

24 **Q.** Do you know why it took from July 2020, when that work
25 was commissioned, until 1 November 2021 for the service

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1 these things take a long time because you haven't got
2 the capacity to rearrange them?

3 **A.** Erm -- I'm -- well, I mean, I think the -- the minister
4 was very clear in his expectation so there was a degree
5 of urgency with this.

6 **Q.** Was it ever formalised in a framework document or
7 anything like that? Because I understand the
8 minister -- there are amendments to framework documents
9 which then prioritise different services in different
10 ways?

11 **A.** There are -- I mean, in -- there -- I've no doubt there
12 would've been -- health policy group colleagues within
13 the department would've issued a -- a letter on behalf
14 of the minister commissioning the service. There was
15 funding identified of some 1.9 million for the service.
16 I mean, I wasn't directly involved in -- in those
17 aspects of the planning, given the other
18 responsibilities I had. As I say, I had carried out the
19 initial work that the minister had asked of me and
20 pointed to the service model that needed to be developed
21 and subsequently was commissioned and delivered.

22 **Q.** Moving to shielding, and this is in the latter part
23 of 2020.

24 Northern Ireland paused shielding at the end
25 of July 2020?

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1 A. 31 July 2020, yes.
 2 Q. And was that following the UK advice that had been --
 3 come in the middle of June, that this was to
 4 be -- (overspeaking) --
 5 A. No, no, I think --
 6 Q. What was the reason for it then?
 7 A. The -- well, you know, by 27 July and certainly
 8 throughout July we were having a handful of cases a day
 9 in terms of confirmed Covid cases. By that date,
 10 thankfully, we had had no deaths from Covid from -- for
 11 some 14 days. There was very low levels of community
 12 transmission.

13 There -- also I had at that stage received the
 14 readout from, and then we subsequently published, the
 15 Patient and Client Council report about the negative
 16 commence of shielding, psychological, social, on
 17 individuals that had been affected. That information,
 18 along with the low level of community transmission, was
 19 fed into a submission to the minister on the -- as
 20 I recall, 16 June, and included my advice that pausing
 21 should be shielded (*sic*) for adults and children in
 22 Northern Ireland from 31 July.

23 We did have conversations at the UK CMO meeting.
 24 That submission, as I recall, also reflected that
 25 England were planning to do the same. I don't recall

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1 decision. There was a statement from myself on the
 2 department's website on the date of 31 July. But we
 3 ensured and were anxious to ensure that all of the
 4 mental health support, online support, GP support,
 5 consultant access support was still available --
 6 available to people who had previously been shielding.
 7 Q. Two very closely related questions. Firstly is, do you
 8 think that there was sufficient support provided after
 9 the decision had been taken to pause shielding for those
 10 who had been shielding? And secondly, do you think that
 11 those who had been shielding felt that there was
 12 sufficient support provided for them in Northern Ireland
 13 after the decision had been taken?

14 A. I know that some didn't and I've alluded to that in my
 15 statement. I think in part that was due to the
 16 psychological and social impacts of shielding that had
 17 had on individuals and people remained very fearful.

18 Could we have more comprehensively addressed that?
 19 Could we have given people greater agency and sense of
 20 control? Could we have provided more information and
 21 assurance? Possibly.

22 It proved very hard to allow people the ability to
 23 make nuanced decisions about levels of risk that were
 24 posed to themselves, which was -- after the shielding
 25 was paused we tried to do. We tried to provide

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1 what the other jurisdictions did at that stage.

2 Q. And I also think it's right to say that that was
 3 a decision that was actually taken by the Northern
 4 Ireland Executive, to agree to the pausing the
 5 shielding. I think that was on 18 June, around then,
 6 and then the decision came in on 31 July; does that
 7 sound right to you?

8 A. That's absolutely correct.

9 I mean, I think in that -- that paper did go to the
 10 Executive, because this -- this was a big decision
 11 because, you know, we'd effectively -- the consequences
 12 of our advice had been to effectively remove people who
 13 were clinically extremely vulnerable from society for
 14 12 weeks, with all the consequences, and the Executive
 15 wished to be assured that we had an appropriate
 16 mechanism in place. So in that submission we had --
 17 would need to be in place for some time, so that's if,
 18 you know, people were feeling isolated or lonely or
 19 needed assistance with shopping or ...

20 Because we realised it would be difficult for people
 21 to be -- to reintroduce themselves into society.
 22 I mean, we were still urging caution to people who were
 23 shielding at that stage. I issued a statement --
 24 a letter, a further letter to those who were shielding
 25 at the -- on 22 June explaining the rationale for the

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1 information that would empower individuals to make their
 2 own decisions about what was -- mattered in levels of
 3 risk.

4 We did provide lots of support, as I've alluded to.

5 I think we could always have provided more. I'm not
 6 certain now what more that would've looked like but
 7 I know from many, many people they felt that there was
 8 a lack of support, there was a lack of advice, that it
 9 could've been better.

10 And for those that felt that then I'm sorry we
 11 couldn't have done more, and perhaps, you know, one of
 12 the -- one of the findings from -- the Inquiry will look
 13 at in the future: is there learning in terms of how we
 14 communicate that it doesn't engender fear, disempower,
 15 still gives people a sense of agency in terms of
 16 assessing risk and making decisions?

17 Q. Is that -- do you think that's a recurring theme
 18 throughout the response to the pandemic, whether it be
 19 in shielding or PPE or other settings, where maybe more
 20 could be done to communicate the reasons. I think
 21 Professor Gould was talking about winning the hearts and
 22 minds of those -- do you think that that's something
 23 that could've been done better?

24 A. I think, yes, had we -- I think had we had more time
 25 and things not moving at such a pace we probably

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1 would've done things differently.

2 You know, if you even think of the decisions that
3 were made around social distancing, the first lockdown,
4 those decisions were broad brush and made at pace. And
5 if you reflect back, and I think we can all remember
6 back the language that was used at that time caused huge
7 anxiety and concern. And we were all sitting watching
8 what was evolving around the world.

9 So I think that is a -- a very valid point that the
10 communication of messaging -- you know, how we
11 communicate to older people about -- and we saw the --
12 the impact it had on older people particularly who were
13 shielding and not seeing family and friends. And they
14 may have made different decisions if they had been
15 empowered to make decisions about things that really
16 matter and are important.

17 So -- and I think that equally applies in healthcare
18 settings with healthcare workers, that it is about
19 empowering people with the information and understanding
20 and winning hearts and minds. And it was quite clear
21 from the email you alluded to earlier, on 18 March, that
22 we hadn't won hearts and minds and we hadn't secured the
23 trust and hadn't explained often enough or well enough
24 why there was the change in the PPE requirement.

25 So I -- I absolutely accept that that is a general
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1 an area that -- you know, we can't wait to the next
2 pandemic to start to think about, you know, visiting in
3 those settings, you know, people at end of life or
4 visiting care homes, you know, I think another area
5 where we acted in what we thought were the best
6 interests and the best information that we had --

7 **Q.** Can I slightly head you away from focusing on care
8 homes. If we can just on visiting within healthcare
9 settings. It may be the answer is the same, in which
10 case fine, but if we can --

11 **A.** Well, I think the answer is the same because many people
12 within care homes are actually approaching the end of
13 life, and it is important that we recognise that the
14 sense of isolation and loneliness has detrimental
15 impacts on them from a physical health point of view as
16 well, as well as the impact on family. So I'm not
17 certain we always got the balance right around
18 end-of-life decisions around visiting. I mean, these
19 are --

20 **Q.** Can I just interrupt you there, what would you do
21 differently?

22 **A.** I think that -- I think we need to perhaps take a more
23 nuanced approach and greater flexibility around
24 particular circumstances, give greater agency to
25 professionals working in those environments. I think

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1 learning point, yes.

2 **Q.** Again, similar topic in terms of visiting guidance. You
3 weren't directly involved I think is your wording --

4 **A.** No.

5 **Q.** -- in creating the visiting guidance.

6 I presume that you were aware of what the visiting
7 guidance was and what the restrictions were?

8 **A.** Yes.

9 **Q.** So if you thought that the balance has been drawn in the
10 wrong place, you could and would have said so?

11 **A.** Yes.

12 **Q.** Again on that communication point -- well, let me ask
13 a slightly earlier question. Do you think that the
14 balance was drawn correctly in terms of end-of-life
15 care?

16 **A.** I know that the former Chief Nursing Officer, and
17 colleague, answered this question. I don't think we got
18 the balance right in all instances. But it -- these --
19 these decisions and judgements were finely balanced
20 about, you know, protecting the individuals who were
21 coming in to visit, bringing those individuals into, you
22 know, busy ICU staff and PPE -- ICU environments that
23 had been escalated with additional beds. They weren't
24 straightforward.

25 But I -- I think that -- in the future I think it is
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1 blanket approaches more generally are not helpful.

2 I mean, at peak times during the pandemic, when
3 transmission was very, very high, there were significant
4 risks to -- to individuals particularly going into those
5 environments.

6 I think we possibly could've taken a more nuanced
7 approach and I think we should bear that in mind that
8 not being able to visit someone -- you know, you don't
9 get that time back again. And I'm not certain that --
10 you know, while we're very mindful of that, we -- we
11 should've tried to accommodate that more. You know,
12 there will be many people here today, others
13 represented, you know, who at times will be living with
14 the sense of guilt and the consequences of not being
15 present.

16 **Q.** If I can then move on to another topic, in terms of
17 planning and effectively re-planning for -- I think it
18 was called the third surge, and that was the one
19 in January and February of 2021. I think the second
20 surge was slightly later in 2020; is that right?

21 **A.** Sorry, yes, the -- well, you see, the second surge was
22 actually two surges, it was wild-type and then we had
23 Alpha.

24 **Q.** Let's forget the terminology, it doesn't matter.

25 In early 2021 it was anticipated that the critical
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1 care numbers were going to be the highest that they had
2 been --

3 **A.** Yes.

4 **Q.** And it's right that in early '21 that the minister
5 approved a new regional approach to ensure that any
6 available theatre capacity was allocated for patients
7 most in need of surgery. What was the benefit of
8 bringing in that regional approach of all theatre
9 capacity?

10 **A.** I think that I suppose the decision had been made
11 somewhat prior to that, and I think the key decision was
12 made in June of 2020, when there was the -- we moved
13 away from the emergency response approach to the
14 pandemic into, as we've described previously, business
15 continuity approach. So there was the formation of the
16 Rebuild Management Board.

17 We changed the framework document, which is the
18 document which looks at the relationship between the
19 various parts of the system, and we had a much more
20 centralised approach to rebuilding and restarting health
21 and social care services. So that was chaired by the
22 perm sec of the department but it had the
23 chief executives from all of the trusts so it was very
24 much a Northern Ireland collective approach to try to
25 get services back on track.

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1 the Executive on non-pharmaceutical intervention and --
2 interventions, the restrictions. I was advising in
3 relation to the roll-out of the Covid vaccine, new
4 therapeutics. I was overseeing the work by the PHA in
5 relation to contact tracing. I had established
6 a directorate on travel.

7 So my focus at that stage was, rightfully in my
8 view, focused on the wider public health response. The
9 perm sec was, correctly, leading on that aspect of the
10 rebuilding of health and social care services and the
11 plan, the critical care plan that you've alluded to.
12 Sorry, I misunderstood.

13 **Q.** No, no, I asked a poor question if you misunderstood it.

14 So that was in the summer of 2020 then when there
15 was that change to --

16 **A.** There was, yes.

17 **Q.** Effectively you moved on to the broader societal NPIs,
18 issues -- when I say move on, you were no longer the
19 chair of the gold command?

20 **A.** That's correct, yes.

21 **Q.** In terms of then any decisions about testing, and
22 testing of healthcare workers and the approach to the
23 testing of healthcare workers in late 2020/early 2021,
24 did you have any involvement in that?

25 **A.** I -- I -- early in the pandemic I had established

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1 That resulted then in a number of actions that were
2 agreed in that Rebuild Management Board. There was work
3 undertaken in May, as I recall, 2020 which informed that
4 rebuild management framework. And then the strategy
5 that you referred to in June '21 was basically how we
6 recover, restore and redesign elective services.

7 And again, that was under the aegis of the Rebuild
8 Management Board. But as I say, every trust, the Health
9 and Social Care Board and the PHA were involved in the
10 development of that plan.

11 **Q.** Yes, but that's a slightly different plan. That's the
12 elective plan. Isn't this the critical care plan --

13 **A.** Oh, sorry.

14 **Q.** -- in January 2021 about allocating capacity across the
15 entirety of Northern Ireland?

16 **A.** Yes, I mean, I wasn't directly involved in the
17 development of that plan because, as I say, all of that
18 work was then taken forward by the integrated Covid gold
19 command which had been set up in the October of 2020.

20 **Q.** But as CMO you must have been aware of the
21 fact -- (overspeaking) --

22 **A.** Oh, yes, I absolutely was aware of it. But at that
23 stage -- I mean, just to point out, that we were opening
24 up society. My key role at that stage had moved on to
25 the public health response. I was advising on the --

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1 an Expert Advisory Group on Testing, which was led by
2 the -- at associate director level within the Public
3 Health Agency, and that basically had expertise from
4 within Northern Ireland, within the laboratory services,
5 from within microbiology, virology, and that group
6 provided expert advice to the department, to myself,
7 through my team, and then to minister about approaches
8 to testing in Northern Ireland.

9 **Q.** Because you set out in your statement that on 14 January
10 you issued a letter to all trusts setting out
11 arrangements for the use of a new rapid test for
12 Covid-19 in all emergency departments that delivered
13 results within 12 minutes, and that:

14 "... helped support the management of significant
15 demands on our EDs and on the HSC system as a whole."

16 Was that a letter that was in your name but you
17 hadn't been directly involved in the process leading up
18 to that and it had come from the testing group?

19 **A.** I can't recall the specific letter. I suspect it
20 probably did issue in my name. But I can't -- I can't
21 absolutely now recall. But certainly the advice from
22 the Expert Advisory Group on Testing would've been
23 received by the department. I would've considered that
24 and made a recommendation to the minister. So I was
25 involved in the decision and I can't now recall but

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1 I suspect I recommended the roll-out of that to
 2 ED departments in Northern Ireland.
 3 **Q.** But were you involved in any way in the pilot of
 4 asymptomatic testing using lateral flow devices that
 5 commenced in January 2021?
 6 **A.** Well, yes, in that I was getting regular updates from
 7 the Expert Advisory Group on Testing, yes. And they
 8 were also linking through with colleagues in the other
 9 jurisdictions.
 10 There were a number of new testing techniques that
 11 became available towards the latter part, and again
 12 forgive me if I get the timelines wrong here, probably
 13 in the latter part of 2020, in Northern Ireland we had
 14 been piloting from October testing of staff using one of
 15 those new testing technologies, LAMP -- or loop --
 16 isothermal amplification. It's basically a very rapid
 17 test on saliva to give a positive or negative result.
 18 So we had started to roll that out in two trusts, the
 19 Belfast Trust and the Western Trust in Northern Ireland.
 20 And in parallel there had been work undertaken by --
 21 UK Health Security Agency and University of Oxford
 22 validating lateral flow devices, as you've alluded to,
 23 and considering their utility as an additional measure
 24 to ensure effective control of infection within
 25 healthcare settings. And that, as you say, was piloted
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1 **A.** Yes, that's the Expert Advisory Group on Testing.
 2 **Q.** Yes. So a pilot of LFDs had commenced on
 3 22 January 2021. A recommendation was made by the
 4 testing group on 12 March to stop the pilot and
 5 implement a full roll-out of the testing programme.
 6 Then:
 7 "On 4 June 2021 I wrote to ... Trust Chief [Execs]
 8 to request that ... Trusts develop robust preparations
 9 and plans for a significant expansion ..."
 10 Why did it take almost three months from the
 11 recommendation to implement the full roll-out to then
 12 you talking to trust chief executives about developing
 13 preparations and plans for that roll out?
 14 **A.** I mean, again, I would need to look back through the
 15 detail of this but the -- the roll-out of the testing of
 16 healthcare workers was under the aegis of a subgroup
 17 within the Public Health Agency, so I was not within the
 18 department directly leading on that roll-out.
 19 **Q.** Would you agree that that took a bit too long in terms
 20 of the --
 21 **A.** Again, I would separate out the work that the PHA was
 22 doing in terms of rolling out testing versus me writing
 23 the letter seeking assurances that there's robust plans
 24 and it's actually happening.
 25 I think what this was based on, I attended a meeting
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1 in Northern Ireland, the Southern Trust, in January.
 2 **Q.** Yes, that's the last point I wanted to come to.
 3 So England had been conducting those tests in --
 4 from around 9 November 2020. Does that accord -- or
 5 you're not entirely sure?
 6 **A.** I think they started piloting it in a number of trusts.
 7 And similarly, an approach had been taken I think around
 8 that same time towards -- in December in Scotland and
 9 Wales. I know that the Expert Advisory Group on Testing
 10 had considered how best to expand testing of healthcare
 11 workers, looking at the benefits of continuing the
 12 expansion of the -- the LAMP test that I referred to
 13 earlier versus the benefits of using LFDs.
 14 So, I mean, it was -- I mean, there was an ongoing
 15 exercise of assessing which tests were most effective,
 16 the frequency that testing should be applied. And as
 17 you say, that then began -- the roll-out in Northern
 18 Ireland began in January.
 19 **Q.** Well, if we can, please, go to INQ000421784, and it's
 20 page 237, it's paragraph 408.2.
 21 Again, this is your statement, Professor McBride.
 22 It's the first half there, thank you.
 23 So:
 24 "Under the overnight at the ... EAG-T ..."
 25 That's the testing group --
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1 of the -- the subgroup basically to check in on
 2 progress, and I was probably -- I -- as I seem to
 3 recall, I was simply indicating that, in my view, we
 4 needed to do more testing, including, as I recall at
 5 that stage, the -- as I say, I recall at that stage the
 6 testing of non-frontline healthcare workers. So at that
 7 stage, well, we were testing frontline healthcare
 8 workers but I actually felt it was important,
 9 recognising the roles and interactions there are between
 10 clinical assistants, ward assistants, porters,
 11 et cetera, et cetera, I felt it was really, really
 12 important that that also extended to non -- people who
 13 were fulfilling roles other than doctors, nurses and
 14 allied health professionals.
 15 **Q.** Erm --
 16 **A.** So, I -- as I say, this wasn't me saying "Oh, now do
 17 this", this was already being done and I was basically
 18 saying let's get on and make sure that this is expanded
 19 further to include non-frontline -- although I like that
 20 word, "non-frontline" -- healthcare workers.
 21 **Q.** Do you think that in Northern Ireland there was
 22 sufficient protection for healthcare workers in terms of
 23 the support that they were being offered when they were
 24 working during the pandemic?
 25 **A.** I'm not certain that there was sufficient support
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1 available to healthcare workers working anywhere during
2 the pandemic. And I only wish that we -- we could've
3 done more.

4 I have been looking back on it. You know, these
5 were my friends and my colleagues. You know, my
6 daughter was working in intensive care during the
7 pandemic. You know, I think what -- whether you were
8 working in intensive care or working in a ward or
9 working in a care home, these were harrowing experiences
10 that people were experiencing. You know, I mean, we
11 were asking nursing staff to facilitate individuals
12 saying goodbye to family using iPads. They had been
13 present in the most intimate of conversations. So
14 I think that had a very significant impact.

15 I alluded to earlier what I commissioned in March
16 was a paper on the psychological impact and aftermath of
17 the pandemic. We put in place a number of things after
18 that, including enhanced support for healthcare workers.
19 We established a health and wellbeing framework which
20 was published on 16 April. We start -- established
21 psychological support helplines for individuals, safe
22 spaces with some organisation within critical care
23 organisation where -- services where people could seek
24 support.

25 We put in place arrangements within care homes for
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1 social care within the health service performed
2 admirably, did their level best, and did what they
3 thought was right at that time.

4 I think the one message I would ask the Inquiry to
5 consider is to consider some of the innovation that we
6 introduced in Northern Ireland, whether that was digital
7 innovation, introduction of technology, new data
8 systems, innovative models in terms of providing care
9 differently, remote consultations, how GPs work
10 differently, how hospital services were provided
11 differently, what we did around bereavement support,
12 what we did around anticipatory care.

13 But I think we just need to free up the health
14 service in Northern Ireland, give it the adequate
15 service that it needs to actually provide an adequate
16 level of care that the population deserve. Because
17 I think we've certainly demonstrated in the pandemic
18 that we -- that if you empower the frontline and those
19 working in it, they know the change that needs to be
20 made, and I think we have an opportunity to make those
21 changes. The challenges that lie ahead, ironically, for
22 the health service in Northern Ireland, but again across
23 the rest of the UK, will require the courage and
24 determination that saw the foundation of the health
25 service, and I think what we saw during the pandemic is

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1 staff which had information about how -- staff
2 wellbeing, you know, simple things like tea and coffee.

3 I mean, there was always more we could've done.
4 And, you know, I know, speaking to colleagues, you know
5 the pandemic had a heavy, heavy toll on those working in
6 very difficult circumstances.

7 And I have no doubt that there's -- what was -- much
8 more that we could've done. We did provide number of
9 online resources, mental health support, apps which
10 offered access to and signposted to mental health
11 services, but, you know, I don't think you can --
12 I mean, I don't think you can ever necessarily
13 comprehend the impact that had or adequately address
14 those impacts. And yes, I wish we -- I wish we could've
15 done more.

16 **Q.** Finally, Professor McBride, are there any
17 recommendations for how the healthcare system in
18 Northern Ireland would respond, are there any
19 recommendations you would invite the chair to consider?

20 **A.** I mean, I think -- and I've said this in the closing
21 comments in my statement -- that, you know, obviously
22 when all's said and done this inquiry will judge the
23 response by the health service in Northern Ireland in
24 line with this module. I think that, you know, as
25 I said, that individuals at all levels within health and

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1 that that courage and determination is there and we just
2 need to liberate it.

3 **Q.** If I can just press you just one stage further,
4 Professor McBride, those seem to be recommendations
5 based on things that have gone well. Is there any
6 recommendations arising other of things that didn't go
7 well, in Northern Ireland?

8 **A.** I think I mentioned earlier some of the challenges
9 around communication, whether that was communication
10 with healthcare workers or whether that was
11 communication with the public. I think that we had put
12 in tremendous efforts to, you know, deal with some of
13 the -- the myths and -- that were being generated at
14 that time.

15 And this was the first pandemic that we faced in
16 a -- in an era of social media and 24-hour news, and
17 I think there's some aspects of the communication that
18 we could've done better, at a variety of levels.

19 I think there are definitely issues around data,
20 access to data -- we touched on this earlier -- coding
21 of data, in terms of driving improvements in the health
22 service and assessing the quality of care that people
23 are receiving. But also that data that informs the
24 impact of the inequalities in society, and we touched on
25 earlier in terms of ethnic minorities or people living

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1 with disabilities. So I think we have work to do.

2 We have started on a journey, as I indicated, with
3 the Department of Health's data strategy, established
4 a data institute, but we need resources to ensure that
5 we can realise the benefits of that.

6 So that analytical capacity, the ability to link
7 data sources across government is -- is a key
8 consideration, I think, for the Inquiry to -- to
9 consider as well.

10 **MR SCOTT:** My Lady, those are the questions.

11 **LADY HALLETT:** Can I just ask a couple of other questions in
12 relation to testing, Professor McBride.

13 **Questions from THE CHAIR**

14 **LADY HALLETT:** The reason Mr Scott hasn't gone into in any
15 greater detail is, as you know, we have a separate
16 module on test and trace, but can I just ask this for
17 the benefit of those who are watching.

18 In responding to a pandemic it's well known that one
19 of the things you had to do is test, test, test and
20 trace to try to contain it. Yes?

21 **A.** Absolutely.

22 **LADY HALLETT:** Yes. I've also heard that at the start of
23 the pandemic around the UK -- this isn't just Northern
24 Ireland -- we didn't have the capacity to scale up test
25 and trace for a pandemic.

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1 individuals with suspected Covid from people that don't
2 have Covid so that we can maintain elective services and
3 we don't have individuals who should've been having
4 treatment having that treatment delayed.

5 I think there are a range -- and we didn't have the
6 tests early on to be able to differentiate that. And as
7 you alluded to, Mr Scott, earlier, in January I was
8 writing out to trusts -- or someone on my behalf was
9 writing to trusts about how to improve flows in ED
10 departments and actually make sure that we didn't have
11 people with Covid mixing with people who didn't.

12 **LADY HALLETT:** You couldn't know if you didn't have a test?

13 **A.** And you can't know if you don't have a test.

14 **LADY HALLETT:** Who was responsible in Northern Ireland for
15 taking steps to scale up the testing capacity?

16 **A.** Ultimately --

17 **LADY HALLETT:** Summarise.

18 **A.** Ultimately that would be the department. And the
19 department would task the Health and Social Care Board
20 to work with -- which is now within the department -- to
21 work with the pathology network. Again, which I've
22 covered in my statement.

23 **LADY HALLETT:** And when were the first steps taken, can you
24 remember?

25 **A.** In response to Mr Scott's statement earlier, that was

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1 **A.** Yes, I mean, I restricted my comments on learning to the
2 scope of this module, but as I've said earlier in my
3 response to M1 and M2C, one of the biggest impediments
4 in the early stages of the pandemic, and it forced some
5 very difficult policy decisions, was how to use testing
6 and how to scale it up.

7 You know -- and, my Lady, you'd asked me previously
8 in the M2C about the number of tests we had in Northern
9 Ireland, which -- you know, at the end of March, for
10 instance, which was somewhere in the region of 800
11 or 900. We were -- we did start testing in Northern
12 Ireland on 10 February in one of 12 or 13 centres across
13 the UK, but then we had 40 tests a day. So we did not
14 have -- I mean, that capacity to scale up testing was
15 a major impediment.

16 Similarly, and again I've said this in my M2C
17 statement, the ability to scale up contact -- contact
18 tracing was a significant impediment. And I think that
19 has to be an important learning point in responding to
20 a future pandemic.

21 Now, the test will be different and the approach
22 will be different, but that flexible scalable capability
23 across diagnostics in terms of how we, for instance,
24 maintain health services, how we separate out, as
25 Chris Hagan said in his statement, more effectively

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1 very early February. There was a four-nation group
2 which was established -- I think those calls were
3 occurring, you know, from early -- I think maybe
4 late January but certainly, I can recall, from
5 early February those discussions about scaling up the
6 laboratory capacity were ongoing. And we started
7 testing in Northern Ireland in the Regional Virus
8 Laboratory on 10 February.

9 **LADY HALLETT:** Not just talking about scaling up, do you
10 know when the first steps in Northern Ireland were taken
11 to scale up testing?

12 **A.** I -- well, there are two aspects to that, and I know
13 we'll cover this in a later module, but we took steps at
14 that time in February and March to scale up what we call
15 pillar 1 testing. So that was the laboratories within
16 Northern Ireland. And I established the scientific
17 consortium which had all of the universities in Northern
18 Ireland working with the private sector in Northern
19 Ireland --

20 **LADY HALLETT:** So it's February/March?

21 **A.** February/March --

22 **LADY HALLETT:** First steps February --

23 **A.** Yeah, and then obviously we signed up and signed into,
24 I think in early March, the pillar 2 national testing
25 programme, and the minister agreed to that, and then we

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1 saw that programme rapidly increase.

2 **LADY HALLETT:** Thank you. I just thought it was only fair,
3 when we're looking at decisions that had been taken,
4 that we put it in the context of the fact that there
5 wasn't the scale-up capacity for testing.

6 **A.** No.

7 **LADY HALLETT:** Very well, we'll break now. I'm sorry, one
8 more session to go, Professor McBride. I shall return
9 at 3.20 for the final session. You will be finished
10 this evening, I promise.

11 **(3.05 pm)**

12 **(A short break)**

13 **(3.20 pm)**

14 **LADY HALLETT:** We now come to the core participant
15 questions, Professor McBride. They all have limited
16 time so I know they will all be very grateful if you
17 could focus on the question. If we need more
18 information, we can ask for it.

19 Mr Wilcock.

20 **Questions by MR WILCOCK KC**

21 **MR WILCOCK:** Professor, I've been given -- I represent
22 Northern Ireland Covid Bereaved Families for Justice, as
23 I think you probably already know, and I've been given
24 permission to ask you some questions on two topics,
25 nosocomial infection and DNACPR, following on from the
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1 that a number of deficiencies in the existing estate at
2 those locations, including the physical condition,
3 functionable suitability, including lack of isolation
4 rooms, compliance with standards, including poor
5 ventilation, or lack of single rooms with en suite
6 facilities, and a lack of effective space utilisation,
7 including poor spacing between beds and multi-bed bays,
8 all contributed to the likelihood of transmission of
9 infection in wards?

10 **A.** I think there's absolutely no doubt that the fabric of
11 hospitals, particularly old hospitals which have limited
12 bed space, have limited isolation rooms and poor
13 ventilation, all contribute to increased risk in those
14 settings.

15 **Q.** That was a feature throughout Northern Irish hospitals,
16 wasn't it?

17 **A.** It was a feature throughout a number of hospitals. We
18 do have other new-builds, hospitals in Northern Ireland,
19 obviously it was less challenging in those environments.

20 This is a highly infectious virus, and despite all
21 the infection prevention control arrangements that were
22 in place, sadly people did acquire Covid in hospital,
23 and sadly quite a number of people died as a consequence
24 of that.

25 **Q.** What is your view of the proposition that one important
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1 answers you gave this afternoon.

2 Dealing with the first topic first, nosocomial
3 infection. As you know, Professor, one of the most
4 publicised outbreaks of Covid in a hospital setting in
5 Northern Ireland during the pandemic was in the
6 Craigavon and Daisy Hill hospitals in the autumn of 2020
7 in which 15 of 32 patients with Covid-19 were reported
8 to have died, and 12 of whose premature death appeared
9 to have been directly attributed to by Covid.

10 A serious adverse incident review was carried out by
11 the relevant trust, the Southern Trust. And it
12 estimated that 10 to 20 per cent of patients admitted to
13 hospital in the first wave for non-Covid 9 conditions
14 acquired Covid-19 during their hospital stay, and up to
15 one in six SARS Covid infections among hospitalised
16 patients with Covid in England during the first six
17 months of the pandemic could be attributed to nosocomial
18 infection.

19 Do you accept that there was therefore a significant
20 risk, sadly, to the health and life of those attending
21 hospital for non-Covid reasons during the pandemic due
22 to the risk of nosocomial infection?

23 **A.** Absolutely, yes.

24 **Q.** Do you agree with the conclusions of the report -- that
25 I just quoted -- into the outbreak at Craigavon Hospital
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1 lesson from the pandemic and the scale of nosocomial
2 infection that then occurred is that where a treatment
3 could be safely delivered in the community rather than
4 hospital then that should've been the first response?

5 **A.** I think certainly that is correct. And if we look at
6 those very vulnerable individuals, and a number of those
7 were receiving treatment in a haematology unit and were
8 immunosuppressed, I know that the cancer network did
9 look to facilitate treatment, home treatment,
10 alternative treatment, that would've kept people out of
11 hospital. However, there are certain conditions which
12 themselves were life-limiting had they not -- those
13 individuals not received very effective treatments such
14 as bone marrow transplant, et cetera. And unfortunately
15 and sadly many of those individuals then, as
16 a consequence, were much more vulnerable to Covid.

17 **Q.** We understand your answer.

18 Next question. The report also found that, and
19 I quote: instances of inconsistent and inadequate
20 communication with patients, families and healthcare
21 workers during the events they were looking into. In
22 many cases there were no records of communication of
23 Covid test results to the patients of their families.
24 Similarly, both patients and their families were
25 provided with very little specific information regarding
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1 the outbreaks being investigated, which, the report
2 found, may have led to confusion regarding isolation
3 requirements and visiting restrictions.

4 Are you aware that that complaint was all too common
5 during the pandemic throughout Northern Ireland and not
6 just at the Craigavon and Daisy Hill hospitals?

7 **A.** As I alluded to earlier, I think that communication was
8 a challenge. I did read the detail of that report,
9 although I was not directly involved in the generation
10 of that report in preparation for the Inquiry today.

11 I think there were significant challenges across all
12 of those areas which apply to a greater or lesser extent
13 in hospitals in Northern Ireland.

14 **Q.** In your statement you state that the Department of
15 Health welcomed the publication of the final report,
16 which we both know contained recommendations for
17 strengthening IPC measures in the hospitals as well as
18 the systems for overseeing and ensuring best practice
19 across the health and social care in Northern Ireland.

20 Have all of the recommendations in the report now
21 been implemented?

22 **A.** Again, the majority of those recommendations were for
23 the Southern Trust, I'm not in a position to advise in
24 terms of those outstanding recommendations. I think
25 that the -- the primary, one of the primary concerns in

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1 **Q.** DNACPR.

2 You told Mr Scott this afternoon about the various
3 guidances you issued in relation to ethical principles
4 and legal obligations of all health professionals when
5 taking -- when treating people with Covid during the
6 pandemic.

7 Now, many of the members of the group I represent
8 have made it clear that in their collective or
9 individual experiences their relatives were, and
10 I quote, "given up on and are simply abandoned to their
11 fate".

12 We have heard, and I know you have read, an expert
13 report from Professor Summers and Dr Srirangalingam that
14 whatever guidance was given on DNACPR, I quote,
15 "variations in decision-making and conscious or
16 subconscious application of clinical thresholds are
17 likely to have occurred through the sheer complexity of
18 circumstances inherent in the pandemic".

19 In that context, what steps were taken -- and you
20 can take it we know about the guidance you've issued --

21 **A.** Okay.

22 **Q.** -- but what steps were taken to prevent such disparities
23 over and above the guidance?

24 **A.** As I mentioned earlier, in terms of the detailed
25 engagement that went on in terms of developing the

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1 relation to the report was the fabric of old buildings,
2 poor ventilation, and that will require a major
3 investment in estate and major rebuild of some hospital
4 facilities in Northern Ireland and right across the
5 United Kingdom. So unfortunately I cannot provide you
6 detail in terms of progress on those recommendations,
7 but what I have been advised is that in advance of the
8 publication of the report the department had been
9 advised that all of the recommendations were being
10 progressed, or had been progressed, and the learning was
11 being implemented even before the report was published
12 in 2023.

13 **Q.** I make no criticism, but it took about three years for
14 the report to be published, didn't it?

15 **A.** Yes, I mean I think in context it's not normal for SAI
16 reports, serious adverse incident reports, to be
17 published, but given the particular impact of this
18 outbreak and understandable concern that was generated,
19 the minister at the time gave an undertaking that it
20 would be put into the public domain and the report
21 subsequently was.

22 **Q.** Mr McBride, it was my fault, I tempted you into an area
23 that we didn't need to go into. But it's entirely my
24 fault. Can I move on to my second topic.

25 **A.** Okay, sorry.

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1 guidance, there was also, as I recall, two workshops
2 with clinicians in Northern Ireland explaining the
3 guidance, working through the guidance from a practical
4 perspective. So it wasn't just we issued a document, we
5 actually, as a system, put in place arrangements to try
6 and ensure what was in the document was understood and
7 was applied.

8 But I did read the expert report, and I do concur
9 with it, and I -- and that's why I think the -- my
10 answer earlier about the importance of advance care
11 planning is crucially important. And again that was
12 something that was highlighted in the CQC, Care Quality
13 Commission Report, looking at this very issue around
14 DNACPR, which was published, I think, in 2021. And
15 again it made the point about the importance of advanced
16 care planning, improved public awareness and improved
17 training within the health professionals.

18 **Q.** Well, many people may think that the answer you've just
19 given about the training on the guidance is really part
20 of issuing the guidance. Let me ask the question in
21 a different way.

22 What, if any, investigations were undertaken to
23 establish whether or not there was a disparity in the
24 implementation of the guidance?

25 **A.** There were no investigations undertaken. No -- I mean,

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1 I -- no such concerns or specific circumstances were
 2 brought to my attention for me to investigate or for
 3 others to investigate. But I -- I have to say I did
 4 watch all of the impact videos from those bereaved in
 5 Northern Ireland, and the very specific concerns that
 6 were made clear around DNACPR were not lost on me.
 7 And I think we have much further work that we need
 8 to do, and hopefully we will do, with the implementation
 9 of advanced care planning, and particularly the element
 10 of it which is the ReSPECT programme, which is
 11 recommendations for emergency care and Treatment, which
 12 is crucially important that we know the wishes of
 13 individuals and families towards the end of life.
 14 **Q.** Just to make sure I understood your answer correctly,
 15 are you saying that you were aware of the general
 16 controversy over the issue but you took no steps to find
 17 out if there were individual examples of it?
 18 **A.** I -- basically any circumstance of that nature would've
 19 been matters for the individual trusts to consider, if
 20 families had raised concerns about their particular
 21 loved one and the circumstances -- circumstances around
 22 communication or decision-making. Those would not be
 23 matters, as Chief Medical Officer, which I would have
 24 direct responsibility for or would have been in
 25 a position to act on. Those would've been matters

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1 was going -- but the only other thing I would point out
 2 is that there were very significant pressures in the
 3 system at that time. And as my Lady asked earlier,
 4 those pressures may have resulted in communication not
 5 being as it should've been.
 6 And as a consequence significant mistrust and
 7 distrust and hurt and sense of guilt and -- has
 8 developed as a consequence, and we need to -- to address
 9 that and redress that.
 10 **MR WILCOCK:** Thank you very much.
 11 **A.** Thank you.
 12 **LADY HALLETT:** Thank you very much, Mr Wilcock.
 13 Mr Thomas. I'm very sorry, did I steal one your
 14 questions or part of one of your questions? If I did,
 15 apologies.
 16 **Questions by PROFESSOR THOMAS KC**
 17 **PROFESSOR THOMAS:** My Lady --
 18 **LADY HALLETT:** Don't worry, Mr Thomas is used to people
 19 having the back chair. I'm afraid those who choose to
 20 sit over there will put their ...
 21 **PROFESSOR THOMAS:** Good afternoon Professor McBride.
 22 I represent FEMHO, that's the Federation of Ethnic
 23 Minority Healthcare Organisations.
 24 FEMHO has noted the significant and disproportionate
 25 impact of the pandemic on black, Asian and minority

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1 which, when family made concerns, should have been or --
 2 and could have been considered by the particular trust
 3 concerned.
 4 **Q.** Well, in England the Care Quality Commission produced
 5 reports in November 20 and March 21 on this issue.
 6 Do you accept that particularly given the levels of
 7 distrust that you've told us such disparities can
 8 engender among people in the community, that in Northern
 9 Ireland specific investigation into this issue might
 10 have been helpful?
 11 **A.** Again, I'm not sure I know an answer to that. I do
 12 believe --
 13 **Q.** You can either say yes or no.
 14 **A.** I'm uncertain. I think that what I would say is that
 15 individuals, families, have a right to expect, that
 16 there's explanations provided to them as to why
 17 decisions were made, the circumstances in which those
 18 decisions are made. And that's made very clear in the
 19 guidance document that you referred -- we discussed
 20 earlier. And that extra effort should be taken in the
 21 pandemic to ensure that those considerations happened.
 22 And if that didn't occur, then I think those
 23 individual families have a right to an explanation as to
 24 why it didn't happen. And I would encourage them to
 25 engage, if they haven't already, with the service as it

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1 ethnic healthcare workers.
 2 I want to touch very quickly upon the question that
 3 my Lady stole from me earlier today.
 4 You mentioned that you became aware of the
 5 disproportionate infection and death rates among black,
 6 Asian and minority ethnic healthcare workers
 7 in April 2020. I heard that correctly, didn't I?
 8 **A.** Yes, I think, as I recall, information in relation to
 9 that and concerns in that respect were discussed at the
 10 UK senior clinicians and also at the UK CMO meeting,
 11 yes.
 12 **Q.** So here is an ever so slightly modified question.
 13 As a senior figure, once you became aware of the
 14 serious disparities, what role did you play in ensuring
 15 that effective steps were taken to protect black, Asian
 16 and minority ethnic healthcare workers?
 17 **A.** Well, I think -- I mean, that report was published, that
 18 information was available in Northern Ireland and
 19 disseminated in Northern Ireland. It was for employers
 20 then to carry out risk assessments in relation to
 21 individuals in terms of the risk and whether or not they
 22 should be perhaps removed from frontline roles. So, for
 23 instance, we just touched on the ethical advice and
 24 guidance framework that was published in June. That
 25 specifically in that document referred to black and

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1 ethnic minority groups who may need to be provided with
2 alternative roles and responsibilities during the
3 pandemic because of the increased risk.

4 So it was something we were alert to, it was
5 something that employers, the trusts providing health
6 services were aware of, and they have a duty of care to
7 ensure that they safeguard the staff within their
8 employment.

9 **Q.** That I understand.

10 But I suppose what I'm asking you is what systems
11 were in place to ensure that this information was acted
12 upon?

13 **A.** I mean, I was -- as I say, there was a specific HR
14 policy cell within health code, I was not directly
15 responsible for that. And I don't wish to appear to be
16 ducking the question and saying -- and being unhelpful
17 to the Inquiry. But the range of issues that I was
18 dealing with and the complexity of the issues was such
19 that, you know, I had to delegate and rely on other
20 colleagues who had to legal responsibilities for this
21 area, and indeed working with the colleagues in the
22 Health and Social Care Board and PHA to working with
23 trusts to ensure appropriate action was taken.

24 Because ultimately the responsibility for acting on
25 such information rests with the employer.

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1 impacts and going forward in a future pandemic?

2 **A.** Well, I mean obviously every pandemic will be different.

3 The issue around increased vulnerability in black
4 and ethnic minority groups is complex because there are
5 a range of factors that contribute to that. In some
6 instances it's due to a greater incidence of underlying
7 health conditions, sometimes it's actually related to
8 some environmental factors as well.

9 I think that there needs to be greater cognisance in
10 the future in terms of the particular risks that
11 individual healthcare workers might experience.

12 And I think the principle, the ethical principle of
13 reciprocity is really important in this respect, so that
14 if you have a healthcare worker who is putting
15 themselves in harm's way and is at greater risk, that
16 that greater risk should inform decisions about how they
17 work, where they work, and that should be a priority and
18 the employer has responsibility --

19 **Q.** Sorry, I'm not following. Forgive me, I'm not quite
20 following.

21 Are you saying that the responsibility falls on the
22 healthcare worker?

23 **A.** No, absolutely -- but what I was saying that was the
24 employer.

25 **Q.** Okay.

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1 So, to answer your question, I was not receiving or
2 did not receive assurances that appropriate action was
3 being taken, but certainly employers would understand
4 that there's an expectation that they fulfil their duty
5 of care to their employees.

6 **Q.** Well, perhaps you can help me with this.

7 Are you able to assist us with any policies or
8 actions implemented to address the disparities
9 identified to minimise what was preventable harm?

10 **A.** At the level at which I was working as Chief Medical
11 Officer I cannot provide you with the direct operational
12 evidence of that, or the practical outworkings of that,
13 that is not something which, as Chief Medical Officer,
14 I would have detailed knowledge of. That is something
15 which others would be able to assist the Inquiry with
16 who were employers at that time with the responsibility
17 for the employee. But again that is not something which
18 I had oversight or responsibility for.

19 **Q.** All right.

20 Let me move on. I have two more questions and then
21 I have finished.

22 Perhaps you can help us with this.

23 What do you think could and should have been done to
24 reduce the inequalities for ethnic minority healthcare
25 workers to ensure that they didn't suffer such disparate

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1 **A.** The principle of reciprocity means is a responsibility
2 on the employer to ensure that healthcare workers who
3 had increased risk, irrespective of what that increased
4 risk is, on the basis of that increased risk, that
5 measures are taken to protect them. And that may
6 include a number of things. It may include, for
7 instance, removing them from higher risk environments
8 where they may be exposed to the virus, or it may be
9 preferentially offering them vaccination, for instance,
10 to ensure that they are better protected in any future
11 pandemic.

12 **Q.** Understood.

13 **A.** I think, you know, there are clearly issues within
14 Northern Ireland which we touched on earlier in relation
15 to ethnic monitoring in terms of which needs to be --

16 **Q.** Okay, let me come on to my very final -- my very
17 final -- my final question.

18 Given your role, would you agree that you have some
19 responsibility to ensure that recommendations are
20 followed through? If not, who should be held
21 accountable for ensuring that lessons are learned?

22 **A.** In general terms or in the specific issue?

23 **Q.** Well, if -- help us with both.

24 **A.** Okay. In -- in general terms I think it was
25 a collective responsibility, I think I have personal --

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1 professional and personal responsibilities to ensure
2 that learning arising from this Inquiry and all its
3 modules is implemented. And I think also responsibility
4 to supporting and informing others who have primary
5 responsibility for those issues in terms of providing
6 advice as to how they might prioritise actions to
7 address those issues.

8 So I think it's twofold. I think it's ensuring that
9 recommendations are implemented, and ensuring that those
10 are prioritised, and reminding others of their
11 responsibility to implement those recommendations.

12 **PROFESSOR THOMAS:** My Lady, thank you.

13 **LADY HALLETT:** Thank you very much, Mr Thomas, very
14 grateful.

15 Ms Sivakumaran. You are right over there. Far
16 right at the back.

17 **Questions by MS SIVAKUMARAN**

18 **MS SIVAKUMARAN:** I appear on behalf of the Long Covid
19 Groups, and I will be asking questions about provision
20 of care for children and young people with Long Covid.

21 Now, I appear at -- my -- I realise it might feel
22 a little bit strange because I'm asking questions from
23 behind, but when you are answering them please do direct
24 your answers towards the Chair.

25 **A.** Okay.

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1 with Long Covid would be referred in to existing
2 paediatric services, which is the situation at present
3 within Northern Ireland.

4 **Q.** Okay.

5 And so taken from that, and being referred in to
6 existing paediatric services, they're not referred in to
7 any dedicated Long Covid services?

8 **A.** But been referred in to paediatric services, the
9 paediatricians would then determine the most appropriate
10 approach to deal with the various sequelae that children
11 with Long Covid would be experiencing. So they would
12 have access to the full range of paediatric services and
13 other specialists that were within paediatric units in
14 Northern Ireland.

15 **Q.** And the Inquiry's heard evidence from Long Covid
16 experts, Professor Brightling and Dr Evans, and they've
17 said at paragraph 84 of their report to this Inquiry in
18 Module 3 that regions with fewer patients of Long Covid
19 and lower rates of Covid-19 -- this is in relation to
20 children, and young people -- are likely to have
21 inexperienced healthcare professionals. And that
22 supports a need for a virtual multidisciplinary team
23 which delivers -- which could deliver post-Covid
24 children and young people hubs. Deliver services
25 through these hubs.

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1 **Q.** Now, you've explained already that the first Long Covid
2 clinics were established in November 2021.

3 Children can't be referred in to those clinics, can
4 they?

5 **A.** Well, as I say, there were clinics in place prior to
6 2021, as I explained earlier. But the first
7 commissioned service for people suffering -- adults with
8 Long Covid was in November 2021. In Northern Ireland we
9 have sought to fully implement the relevant NICE
10 guideline ng188, and in terms of the advice to the
11 Health and Social Care Board who commissioned the
12 service, that was to provide a service for an adult
13 patient and I can expand on that if you wish.

14 **Q.** Well, just focusing on children and young people for
15 now. I don't think you've actually quite answered
16 that --

17 **A.** Okay.

18 **Q.** -- children can't be referred in to those clinics.

19 **A.** Well, the -- the NICE guidance, the relevant NICE
20 guidance that I reference, said that there was a lack of
21 evidence in relation to the most effective approaches in
22 terms of treatment for children.

23 In Northern Ireland that NICE guidance was discussed
24 with the paediatricians in Northern Ireland, and there
25 was an agreement that individual children -- children

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1 Now, you've explained how it's going through general
2 services, but would you agree that a virtual
3 multidisciplinary team, delivering -- which delivers
4 through a Long Covid children and young persons' hub,
5 could provide a specialised, age appropriate support for
6 children with Long Covid?

7 **A.** Yes, I did read that report, I think that's a very good
8 suggestion. I think a similar approach has been taken,
9 for instance in primary care, by the Royal College of
10 General Practice, whereby general practitioners with
11 a particular interest in Long Covid have formed
12 a virtual network to provide, you know, mutual support
13 and to provide regular updates.

14 I think there is much merit in that model, yes.

15 **Q.** And would you recommend that such services are provided
16 for children and young people in Northern Ireland?

17 **A.** I mean I -- obviously that's ultimately a matter for the
18 Inquiry to determine the merits of that. I think
19 personally there is much merit in it. It will be
20 ultimately a decision for a minister. I certainly would
21 wish to engage with local paediatricians in Northern
22 Ireland who obviously are more expert in this area than
23 I, and those with a particular interest in this area, as
24 to the relative merits of that.

25 **MS SIVAKUMARAN:** Thank you.

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1 My Lady, Mr Scott has covered the second set of
 2 questions we have permission for, and we no longer seek
 3 to pursue that line of question with this witness.
 4 **LADY HALLETT:** Thank you very much for your help.
 5 **Questions by MR JACOBS**
 6 **LADY HALLETT:** Mr Jacobs. I'm afraid Mr Jacobs is also over
 7 there. I think they are testing you, Professor.
 8 **A.** Yes, I find it very difficult not to look at people when
 9 I'm speaking to them.
 10 **LADY HALLETT:** I know. Well, look at them while they ask a
 11 question and then turn round when you answer it, if that
 12 makes you feel better.
 13 **A.** Okay. What was that, sorry?
 14 **LADY HALLETT:** Look at Mr Jacobs while he's asking the
 15 question and turn round to me --
 16 **A.** Okay.
 17 **MR JACOBS:** I don't think that's a command, I don't think
 18 you have to, but if it makes you feel more comfortable.
 19 Professor, a small number of questions on behalf of
 20 the Trade Union Congress.
 21 The first topic is the discussion earlier in your
 22 evidence that regulatory inspections were right to be
 23 reduced on the basis in part that it would add pressure.
 24 You refer to continued inspections adding further
 25 pressures to already pressured services, with staff

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1 hospital -- essentially cease the hospitals' inspections
 2 in Northern Ireland -- you're losing that external
 3 scrutiny. But again that was a decision that we made
 4 balancing up the adverse consequence in terms of
 5 pressure on staff, potentially introducing infection,
 6 and these were finely balanced decisions.
 7 But, you know, I accept the point you're making.
 8 **Q.** Professor, if we put that finely balanced decision to
 9 one side and focus on the future, on the next pandemic,
 10 if we are going to express dismay in this room as
 11 a society at the loss of life of healthcare staff,
 12 including the disproportionate loss of life of black and
 13 ethnic minority health workers, if we're going to
 14 endeavour to keep them safe, in the next pandemic do you
 15 think actually that finely balanced decision should be
 16 made differently, and it should be recognised that
 17 actually, in the early moments of crisis when safety is
 18 most precarious, when vulnerable groups are most at
 19 risk, actually that's when regulatory input needs to
 20 maintain if not increase?
 21 **A.** I -- I do think that in planning and preparing for the
 22 next pandemic we need to consider iterative ways in
 23 terms of how we might maintain a proportionate
 24 inspection approach using, perhaps as we did -- as we
 25 did in Northern Ireland, or certainly within the care

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1 being pulling multiple directions.
 2 Clearly, Professor, hospitals in month one of the
 3 pandemic or in its early stages are going to be under
 4 all sorts of pressures, reorganising staff, reorganising
 5 equipment, and so on.
 6 Might it not actually be important in that context
 7 to have that regulatory pressure on health and safety,
 8 difficult though it may be, so it doesn't get lost
 9 amongst those competing priorities?
 10 **A.** I think you make a valid point, and it is an important
 11 consideration, as I alluded to in my response to
 12 Mr Scott earlier, that these were finely balanced
 13 judgement calls.
 14 I think that it's important to point out that the
 15 primary responsibility for the quality and safety of
 16 care resides with the provider of that care in Northern
 17 Ireland as across the rest of the UK. And then the
 18 second order of responsibility with the Commissioner, in
 19 this case the Health and Social Care Board working
 20 jointly with the PHA.
 21 Regulation is an inspection is, you know, a belt and
 22 braces that, you know, is the external eyes and ears, to
 23 provide assurances that all is well or to point to
 24 things that are not well. And there is no doubt that in
 25 taking the decision to pause the inspections of the

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1 homes sector, remote inspections or a hybrid approach to
 2 inspections, using technology, and in such a way that it
 3 remains intelligent-led, evidence-based and
 4 proportionate to the other pressures.
 5 I know that in Northern Ireland the RQIA are
 6 currently looking at such innovative approaches to how
 7 inspections might be adapted to ensure that a degree of
 8 oversight could be maintained if similar circumstances
 9 arise again.
 10 **Q.** And clearly the objective is something that is
 11 meaningful rather than a burden on services, but it
 12 sounds perhaps as if we're pushing at an open door, at
 13 least in the general principle of meaningful, regulatory
 14 input, including in the early stages?
 15 **A.** Yes, I mean I think -- I mean, we did utilise the skills
 16 in -- of RQIA in the -- in the pandemic responses, to
 17 say they are all qualified health professionals, they
 18 established a service support team, I know for later
 19 modules, which was essential in providing support
 20 into -- into care homes. But I do agree that from my
 21 perspective, and certainly from a Northern Ireland
 22 perspective, I do think that we need to again re-examine
 23 the relative merits of that enhanced scrutiny in terms
 24 of eyes and ears from outside, that fresh look as to how
 25 that might be maintained to some extent in a meaningful

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1 and proportionate way such as you've suggested.
 2 **Q.** Professor, I'm going to try and deal briefly with
 3 a slightly different perhaps related point.

4 Paragraph 68 of your statement -- I don't think you
 5 need to turn to it -- you describe analysis to the
 6 effect that occupations with higher risk, including --
 7 included those with high levels of close contact,
 8 including health and social care. And it also included
 9 those with low pay.

10 Would it be correct to say that those in frontline
 11 healthcare roles, on low pay, porters, cleaners, and so
 12 on, are at the intersection of two risk factors: lower
 13 pay with higher associated comorbidities, but also
 14 a setting and type of work that carries risk?

15 **A.** I would absolutely agree with that, yes.

16 **Q.** And how does pandemic response in the next pandemic
 17 account for that, account for those low workers in
 18 healthcare set -- sorry, low paid workers in healthcare
 19 settings being at that particular risk?

20 **A.** Well -- and you would expect me to say this as Chief
 21 Medical Officer -- the primary objective must be to
 22 improve the health and wellbeing of the entire
 23 population, and -- and reduce and address the huge
 24 inequalities that we see in health. The fact that
 25 people live longer because of their environmental and

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1 quality patient care.

2 **MR JACOBS:** And I think I probably have gone over time for
 3 which I apologise. Thank you, Professor.

4 **LADY HALLETT:** Thank you very much, Mr Jacobs.

5 Yes, Samantha Jones. I'm not going to make the same
 6 mistake this time.

7 Questions by MS JONES

8 **MS JONES:** Thank you, my Lady, I'm very grateful.

9 Professor McBride, I ask questions on behalf of the
 10 Disability Charities Consortium. I have permission to
 11 ask you questions on three topics. So turning firstly
 12 to the topic of capturing inequalities.

13 You say in your statement -- and we don't need to
 14 turn it up -- at paragraph 424, that: in terms of data
 15 and analysis with respect to inequalities in Northern
 16 Ireland, we were able to review the impact of the
 17 pandemic in relation to age, gender and social
 18 deprivation.

19 And I know you were asked some questions about that
 20 earlier.

21 Can I take it from that that you were not able to
 22 review the impact of the pandemic on disabled people?

23 **A.** That's correct. And I think -- and again I have read
 24 the witness statements from some of those that you
 25 represent -- and I would agree that the recording of

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1 social circumstances, socioeconomic circumstances, is
 2 invidious. And I know it's not a matter that this
 3 inquiry can address, but certainly from -- by policy
 4 responsibilities, working with other government
 5 departments, our primary objective under making life
 6 better, which is the depart -- the executive's policy
 7 about improving health and wellbeing and addressing
 8 health and equalities, we must invest more in addressing
 9 the underlying factors that contribute to that, the
 10 societal factors, the employment factors, that actually
 11 put those individuals at risk.

12 I think specifically, though, looking at a very
 13 practical basis in terms of what to do within employers
 14 -- when I was chief executive for a short time within
 15 the Belfast Trust I established a programme of staff
 16 wellbeing programmes, health and fitness programmes.
 17 I think as -- in health we need to be an employer of
 18 choice, we need to demonstrate that when you work for
 19 the health service, apart from those that we provide
 20 care to, working for the health service that we will
 21 invest in you, in your health and wellbeing, and keeping
 22 you fit and well.

23 As employers I think we -- as employers we have
 24 a duty of care to invest in the wellbeing of our staff
 25 because that, we know, translates into better and higher

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1 data on those who are disabled is very poor within
 2 health and social care systems. We don't have, at this
 3 moment, a standard definition of what we mean. We have
 4 a definition -- a legal definition of what it means in
 5 terms of, you know, physical, mental and during. We
 6 would need to do a specific piece of work looking at --
 7 I don't want to use technical terms -- but ICD term
 8 codes. So we needed to identify the conditions that
 9 individual with -- would result in people being
 10 disabled, and then we would need to maintain a way of
 11 capturing that information, recording that information.
 12 That does not exist at present, and I don't think that
 13 quality information exists anywhere in the UK at the
 14 moment and that needs to be addressed.

15 **Q.** And is that work being done currently by the department
 16 in Northern Ireland?

17 **A.** No, no, it is not being done currently by the
 18 department. Again, it would require a
 19 cross-departmental approach, it would require input in a
 20 Northern Ireland context, certainly from health, but
 21 also from the department for communities and others. It
 22 would require a cross-government approach.

23 Because obviously different parts of government hold
 24 information, and they hold -- all hold it in different
 25 ways, and that -- there isn't necessarily a consistent

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1 sharing of that information. And we would need -- so,
2 for instance, we could use those individuals who are on
3 disability living allowance as a mechanism to ensure
4 that we extract that information from health records.

5 **Q.** One follow-up question to that.

6 We've heard from earlier witnesses about the Office
7 of National Statistics was able to collect data on the
8 impact of the pandemic on disabled people, amongst other
9 protected characteristics groups.

10 Is that data something that the department could use
11 to look at the disparities and the impact on disabled
12 people? And, if not, why not?

13 **A.** It certainly -- I mean, again I think the data, even in
14 the UK -- sorry, in England -- is not robust and not
15 well recorded.

16 I am not in a position, because again it's not my
17 direct responsibility to answer whether or not it's
18 worse -- more poorly recorded in Northern Ireland than
19 elsewhere.

20 In ONS, it would be Northern Ireland, the Northern
21 Ireland Statistical Research Agency, which is an arm's
22 length body of Department of Finance, carries --
23 conducts statistical analysis to inform policy. And
24 that could be an area working with other departments
25 that that information could be developed in a similar

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1 **A.** I don't now recall.

2 **Q.** If I say this, we've seen in other documents -- and
3 I can take you to some if we need to -- that
4 a collective decision was made on 30 September 2020, and
5 that was based on the interim QCovid findings. Is that
6 something that you would agree with?

7 **A.** In terms of the time frame, I accept, you know, your
8 premise or your point that it was 30 September. It was
9 certainly based on QCovid analysis, and -- and, with the
10 passage of time, I don't recall -- sorry, I'm
11 anticipating your next question, sorry.

12 **Q.** Thank you.

13 So my next question is -- without needing to take
14 you to those documents -- is that we heard the decision
15 was made collectively by you and your CMO colleagues on
16 30 September 2020. But we know from your statement and
17 other documents that it was only on 26 November that the
18 department announced that adults with Down's Syndrome
19 would be added to the list.

20 Can you account for why there was that delay in that
21 announcement from the decision?

22 **A.** I don't now recall. I mean, I -- my recollection -- and
23 obviously it's not accurate -- was that when the advice
24 was provided the decision was made to add it to --
25 sorry, a decision was made to add it to the list and it

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1 way as you describe with ONS.

2 **Q.** Thank you.

3 Moving on to the second topic then of shielding and
4 those in the clinically and extremely vulnerable
5 category, which I'll just refer to as the CEV for
6 shorthand. Again, we don't need to turn to it, but at
7 paragraph 129 of your statement you say that:

8 "As indicated above [in other paragraphs of your
9 statement] the CEV list was kept under continuous review
10 and on 26 November 2020, the Department announced that
11 adults with Down's Syndrome had been added to the
12 Clinically Extremely Vulnerable list as recent evidence
13 indicated that adults with Down's syndrome were in the
14 high-risk category for severe disease."

15 Now, first question, is that the -- a decision that
16 you made with your fellow CEV -- sorry, fellow CMOs to
17 add adults with Down's Syndrome to the CEV list?

18 **A.** Yes, representatives -- we worked very closely across
19 the UK, we had a UK expert panel which members of the
20 department were involved in those discussions. And the
21 recommendations from the expert panel came to full UK
22 CMOs for consideration, and we did approve it at that
23 time.

24 **Q.** Do you recall that the decision, the date of the
25 decision, when you made that, with the other CMOs?

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1 was added. I -- I can't explain what the rationale was
2 or what the factors were that contribute to the delay
3 and actually adding it officially to the list.

4 **Q.** You say at paragraph 129 of your statement that once
5 that announcement had been made you wrote to adults with
6 Down's Syndrome to advise them that they had been
7 included on the list, and you advised what this meant
8 for them. And in your statement you've exhibited
9 a template letter detailing that advice.

10 Now, just in terms of when that letter was sent,
11 it's dated in the -- on the template,
12 just November 2020, but we don't have a specific day on
13 when it was sent.

14 Can you recall when it was sent in November, and
15 would it been after the announcement was made by the
16 department?

17 **A.** I think -- my recollection is that we were all would've
18 made the announcement at the same time, and we all
19 issued the correspondence at the same time, given the
20 close cooperation that was going across the UK. I don't
21 recall the -- the exact date. I do recall that we also
22 issued an easy read version --

23 **Q.** Yes.

24 **A.** -- with the letter, so that again it would be understood
25 with -- by people with -- living with Down's Syndrome.

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1 But I don't recall the dates or timing.

2 **Q.** Yes. But, to be clear, it's likely that you would've
3 sent that letter after the announcement was made by the
4 department, you wouldn't have sent it earlier than
5 26 November?

6 **A.** I think that that would -- I think that's a reasonable
7 conclusion, yes.

8 **Q.** And I appreciate your earlier answers on this so you
9 might be able to help me, but are you aware of any
10 negative impact that was or could've been caused to
11 adults with Down's Syndrome by only informing them that
12 they were added to the CEV list on 26 November, or
13 thereafter, when the decision had actually been made at
14 the end of September?

15 **A.** I'm not -- certainly, you know, there was a reasonable
16 expectation, and I don't know the circumstances, and
17 I now can't recall that -- when, as UK CMOs, we made
18 that decision that that advice would've been acted upon.
19 I don't know why the apparent delay or what the
20 rationale for that was. Sorry.

21 **Q.** Okay, thank you.

22 My third and final topic then is on DNACPRs.
23 And at paragraph 275 of your statement -- and again
24 I don't believe we need to go to it unless you'd like me
25 to take you there -- is that you say prior

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1 guidance at the time?

2 **A.** Again, this is a 63-page document, and I think if you go
3 to page 5 and page 14 of the document, it is explicit in
4 stating that there needs to be discussion with the
5 patient and also with family. I think page -- I think
6 it's page 14 talks about a clear explanation, and that
7 that clear explanation is of critical importance. And
8 I think the term is to "avoid future misunderstanding".
9 So in the executive summary it makes it very clear,
10 so that's on page 5, and then that same point is
11 reiterated at page 14, and then there's a section, which
12 again isn't here and isn't displayed, around
13 decision-making during the pandemic and when there are
14 resourcing pressures. And again it's made explicit
15 there. So I just urge caution in terms of taking that
16 in the wider context of the -- of the guidance itself.

17 **LADY HALLETT:** But it would be better, if the guidance is
18 saying "include members of the family and the patient
19 where possible" if, when you have a list of objectives,
20 or -- or criteria to be deployed, then it says there
21 "family", even if it says it elsewhere in the document,
22 wouldn't it?

23 **A.** Well, it says it on the first page of the document. If
24 you go to -- you know, if you go to page 5, it is
25 explicit, and it is explicit throughout the document,

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1 to October 2022 you had interim guidance in place, and
2 that was in the form of the Covid-19 Guidance Ethical
3 Advice and Support Framework which supported DNACPR
4 decision-making for clinical teams.

5 Now, could we just go to that guidance, if that's
6 possible? It's INQ000381325.

7 So that there. I appreciate there was an earlier
8 version published in June 2020, and this is the version
9 that was updated on 21 September 2020.

10 And if we could just go to page 29, please.

11 You see at the bottom of that page, that's the
12 section that is numbered 7.5, and it's the section on
13 DNACPRs. Thank you.

14 And then if we can go over to page 30, and it's the
15 fourth paragraph down which I'd like to ask you about.
16 So there, as you can see, it says -- and I am sure you
17 are familiar with this anyway --

18 **A.** Yes.

19 **Q.** -- "DNACPR decisions should be made in conjunction with
20 other members of the multi-disciplinary team, including
21 the GP."

22 Now, my question is the guidance doesn't say
23 expressly that the decision should be made with the
24 individual or their family. Is that something that you
25 would agree was not expressly stated in the interim

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1 my Lady. But I mean I do -- I do accept that when --
2 that referencing earlier pages would've been helpful.
3 But --

4 **LADY HALLETT:** But people goes to chunks of it, don't they?
5 We all know documents are sent through from some body
6 above and we'll go to the page we find most useful. If
7 some clinicians took that page, they're not going to see
8 the reference --

9 **A.** The only other point I would make, my Lady, is that GMC
10 guidance on this is absolutely clear. I mean, that was
11 published in -- the GMC guidance published in 2010. So
12 this isn't the only document. And the legislation
13 rights-based approach and all the relevant legislation
14 was referenced in this document, and specific emphasis
15 in both the Resuscitation Council UK Guidance of 2016,
16 GMC guidance is about discussions and issues of consent
17 with individuals and their families.

18 So I think in con -- you know, taking this page in
19 context, I think I would just caveat it with wider
20 guidance and earlier parts of the document.

21 **LADY HALLETT:** Ms Jones.

22 **MS JONES:** Thank you, my Lady, that was going to be my final
23 question, so thank you very much.

24 **LADY HALLETT:** Thank you.

Questions by MS POLASCHACK

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1 **LADY HALLETT:** Ms Polascheck, where are you? Oh, that way.

2 Right. Can you see --

3 **MS POLASCHECK:** I think hopefully I'm in the right position
4 for you to look at me. And if I'm lucky I think --
5 well, if you're lucky I think I'm the last questioner,
6 so double bonus for you today.

7 I ask questions on behalf of clinically vulnerable
8 families who are a group who advocate and provide
9 support for the clinically vulnerable, the clinically
10 extremely vulnerable, and of course their families.

11 And I just have one topic of -- of questions today
12 about the design of the shielding programme. And in
13 particular the way the protection of shielding was
14 directed towards individuals, not their families or the
15 wider household.

16 So first, did you or your office give any advice
17 when developing the shielding programme about how many
18 clinically and vulnerable, clinically extremely
19 vulnerable people, lived with others, and particularly
20 with other people who weren't shielding?

21 **A.** We didn't have those numbers, and -- but what we did do,
22 and I think it is in the letter which issued on the --
23 around 27 March, we did provide guidance into people who
24 were shielding about the -- what others living with them
25 and carers' steps that they should be taking to protect

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1 next question, which was whether you gave any advice on
2 the feasibility and the real world challenges for those
3 people who were trying to follow that advice?

4 **A.** We sought to do so. Whether we effectively and
5 comprehensively did so is another question, and, you
6 know, obviously those who were shielding did communicate
7 directly with me at the time. And I think it was
8 undoubtedly more difficult for some who were shielding
9 than for others. We were also, when we issued that
10 guidance, we were very keen to emphasise the important
11 other things that people should do in terms of their
12 physical health, their mental health, and sources of
13 support that were available to them. But I -- I --
14 I accept that was -- that the advice for many would've
15 been difficult to implement.

16 **Q.** Thank you, Professor.

17 You've said that there wasn't that data available to
18 you about numbers of those shielding who were living
19 with others at the outset. We know that in England, at
20 least, ONS started by July 2020, indicated that
21 74 per cent of CEV people lived with others, and
22 15 per cent lived with children under 16.

23 So once shielding was implemented, did equivalent
24 data -- was equivalent data available in Northern
25 Ireland? And, if so, were those numbers ever used to

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1 them. So the letter wasn't just directed to those
2 shielding, but also contained advice -- to the best of
3 my recollection contained specific advice to individuals
4 living with individuals who were shielding or providing
5 care to individuals who were shielding. And we
6 reinforced that on -- on multiple occasion during media
7 briefings and further statements from the department.

8 **Q.** So that's right, Professor, but it's also correct that
9 in that same letter we know that shielding individuals
10 were told to socially distance from those that they
11 lived with so to maintain a 2-metre distance from them
12 and to eat separately from them as well. For example,
13 in conjunction with those -- their loved ones taking
14 those steps?

15 **A.** Yes, obviously the practical implications of that, if
16 you are living in a small home, you know, with other
17 individuals living with you, you know, the advice did
18 say about, you know, if you can use separate bathrooms,
19 et cetera, et cetera, et cetera. Going into the kitchen
20 when others aren't there. Ventilation.

21 The practical outworkings of that, I think for
22 individuals who were shielding, and indeed for those who
23 lived with them, was extremely challenging, and I accept
24 that.

25 **Q.** Thank you, Professor. Because you've anticipated my
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1 revise or advise on that individual focus of the
2 shielding programme?

3 **A.** My role -- and it was as indicated in my statement --
4 was to provide the professional technical advice in
5 relation to shielding and who was clinically extremely
6 vulnerable. The operational aspects of the
7 implementation were with policy colleagues within the
8 department, including the issuing of letters, et cetera.

9 There was some analysis conducted. I don't have the
10 figures with me in terms of the number of people who
11 were shielding in Northern Ireland, I think we probably
12 had more people shielding in Northern Ireland per head
13 of the population than elsewhere. But I don't have the
14 breakdown that you've just described in terms of those
15 living with family, other family members or those living
16 with children.

17 **MS POLASCHECK:** Thank you, Professor.

18 My Lady, those are all my questions.

19 **LADY HALLETT:** Thank you very much indeed. I think that
20 completes the questions now.

21 Another very long day for you -- oh, Mr Wilcock.

22 **Further questions by MR WILCOCK KC**

23 **MR WILCOCK:** Just a request for an additional Rule 10, it
24 may not have reached you yet. It will take about
25 a minute to answer and a minute to ask.

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1 **LADY HALLETT:** As it's you, Mr Wilcock!

2 **MR WILCOCK:** That's very kind, thank you very much.

3 Professor, I asked you questions about whether the

4 recommendations of the Craigavon serious adverse

5 incident review had been implemented, and you responded

6 by correctly observing that the majority of those were

7 directed towards the Southern Trust.

8 It's right, however, isn't it, that one of the

9 recommendations was directed both to the Trust and the

10 Department of Health, PHA, and the Health and Social

11 Care Board, and stated that Northern Ireland should

12 implement a Northern Ireland infection prevention and

13 control framework to provide consistency between trusts,

14 and that the absence of such a framework had resulted in

15 a variation of investment in the regional IPC workforce,

16 workforce resources, policy and management between

17 trusts in Northern Ireland.

18 The question I have been asked to ask is: has that

19 been complied with?

20 **A.** If I understand the question, or part of the question

21 correctly, it's about IPC framework. In Northern

22 Ireland we do have an IPC --

23 **Q.** Was one introduced following the --

24 **A.** No, we've have always had a regional Northern Ireland

25 IPC framework.

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1 considerable time and effort, appropriately so, in

2 scaling up those individuals. So it is additional

3 investment, additional training, and ensuring more

4 consistency of approach.

5 **Q.** So you're going to get me into trouble.

6 Can I -- does it comes to this: there was

7 a framework, whatever the framework was, it hasn't been

8 altered, enhanced or amended as a result of

9 the Inquiry's report, but you accept that more

10 investment in this area is needed in Northern Ireland.

11 Is that a summary of your answer?

12 **A.** I -- I don't genuinely know whether the framework has

13 been updated since the pandemic. That's not within my

14 direct area of responsibility. I do absolutely accept

15 there is more investment required in this area of work.

16 **MR WILCOCK:** Thank you very much indeed. Thank you,

17 my Lady.

18 **LADY HALLETT:** Thank you, Mr Wilcock.

19 That now completes the questions for you, Professor

20 McBride. It's been another long day for you, and I know

21 the demands that the Inquiry has been making on you.

22 I wish I could say it's the last time we're going to

23 call on you. I honestly don't know.

24 **A.** I was hoping you would say -- you're fed up seeing me.

25 **LADY HALLETT:** For the likes of you, who keep coming to help

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1 **Q.** Right.

2 **A.** I'm not directly responsible for -- that work was taken

3 forward by the Public Health Agency. That is in

4 existence. I noticed one of the expert reports

5 indicated that it wasn't aware whether there was or

6 whether there wasn't. There was and has been for

7 a considerable number of years a regional IPC report.

8 As to the consistent application of that, again I'm

9 not in a position to advise. I think it's back to the

10 other expert witness report which talked about hearts

11 and minds, people need -- healthcare workers need to be

12 empowered to implement the control and would need to

13 understand the benefits of that. There needs to be

14 significant investment, Chair, I would suggest in terms

15 of infection prevention control teams and infection

16 prevention and control training.

17 Traditionally it's the preserve and expertise of

18 infection control nurses, but it's everyone's

19 responsibility. And I think that one other learning

20 from the pandemic is that we need to do much, much more

21 in this space, including ensuring that we have an

22 awareness of and training around infection prevention

23 control in those healthcare workers working in care

24 home -- in care homes, in pharmacy, et cetera. Because

25 the learning from the pandemic was we needed to invest

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1 me, you know, I meant to check at lunchtime but the

2 trouble is I have so many modules.

3 **A.** I do appreciate that.

4 **LADY HALLETT:** Anyway, we're really grateful to you for the

5 help that you've given, and I'm sorry it's been such

6 a long and I hope not too gruelling day but I suspect it

7 has been quite gruelling. But anyway, thank you.

8 **A.** Well, I stand ready to assist the Inquiry in any way

9 I can, my Lady.

10 **LADY HALLETT:** Thank you very much indeed.

11 **(The witness withdrew)**

12 **LADY HALLETT:** 10.00 tomorrow, please.

13 **(4.15 pm)**

14 **(The hearing adjourned until**

15 **Wednesday 25 September 2024 at 10.00 am)**

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