Tuesday, 24 September 2024

(10.00 am)

LADY HALLETT: Mr Scott.

MR SCOTT: Good morning, my Lady. Please may we call Professor Sir Michael McBride who can be sworn.

PROFESSOR SIR MICHAEL MCBRIDE

LADY HALLETT: Welcome back, Sir Michael.

A. My Lady.

MR SCOTT: Good morning, Professor McBride.

A. Good morning.

Q. You have been Northern Ireland's Chief Medical Officer since September 2006.

A. That's correct.

Q. And I'm just going to set out a little bit of your professional background. So from 1994 to 2006 you worked as an HIV consultant at the Royal Group of Hospitals Trust in Belfast.

A. That's correct.

Q. You were appointed medical director of the Royal Group of Hospitals in August 2002. In September 2006 you were appointed as Northern Ireland's Chief Medical Officer. Between March and August 2009 you were appointed acting permanent secretary of the Department of Health and chief executive of the Northern Ireland Health and Social Care at the request of the then minister?

A. That's correct.

Q. From November 2014 to February 2017, at the request of the then health minister, you were appointed the chief executive of Belfast Health and Social Care Trust, and you served until February 2017, and that was in parallel to your role as CMO?

A. That is also correct, yes.

Q. You are a fellow of the Royal College of Physicians in London and in Ireland, you have been awarded an honorary professorship and doctorate by Queens University of Medical Science for Distinction in medicine, and in March 2022 you were elected to honorary fellowship of the Faculty of Public Health?

A. That's correct.

Q. Then you were knighted in 2021 for services to public health in Northern Ireland?

A. Yes.

Q. Professor McBride, I just want to provide a brief overview of the structure of the healthcare systems in Northern Ireland. I'm very conscious that my Lady has heard this in both Module 1 and also has an understanding from Module 2C, so we're not going to go into this in great detail, but just to help identify matters.

Starting with the name, it's not called the NHS in

Northern Ireland, is it? It's Health and Social Care?

A. That's correct. I mean, the NHS refers predominantly to England but certainly in Northern Ireland it's referred to Health and Social Care. It's really an umbrella term which we use which refers collectively to the rules and responsibilities of the department, the Health and Social Care Board, Public Health Agency and the five trusts.

Q. I just wonder if you could keep up your voice a little bit. I'm having a little bit of difficulty hearing you, sorry.

It's often said that Northern Ireland's health and social care system is unique because trusts provide social services rather than local authorities?

A. That's correct. Northern Ireland's had an integrated health and social care system since 1973.

Q. And the Department of Health lies at the top of Health and Social Care as responsible for healthcare policy; that's correct?

A. Correct. Policy, legislation, setting priorities, allocating funding to the rest of the system.

Q. Then I'm just going to skip over HSCB for a minute.

There are six Northern Ireland health and social care trusts, five geographical and one ambulance service, that's correct?

A. That's correct.

Q. And the trusts are responsible for effectively implementing department mental policy; is that right?

A. They are -- well, effectively delivering services according to standards which are set by the department.

Q. And just to have a flavour of effectively what's on the ground for patients in Northern Ireland, how many hospitals are there in Northern Ireland?

A. Oh --

Q. About 19?

A. About that, yes. I mean, obviously it's a changing landscape because there is ongoing structural reform and the range of services provided in each of those is currently being looked and being reviewed.

Q. In terms of the regional distribution of hospitals, clearly there are a couple of hospitals in Belfast but would you say that they are fairly distributed across Northern Ireland?

A. They are. I mean, the vast majority of the regional services, so for instance neurosurgery, regional vascular surgery, the very specialist services, would be provided within the Belfast Trust, although there are some elements of those services also provided elsewhere. So there is a concentration of regional services in larger geographical conurbations, so in Belfast, Derry,

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

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

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

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

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

We also have, again, very specialist Northern

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

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

A. Yes, some are in that region.

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

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

Q. I said I was skipping over HSCB.

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

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

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

A. That's correct.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

entity.

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

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

A. That's correct.

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

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

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

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

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

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

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

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

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

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

relatively briefly.

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

A. That's correct, yes.

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

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

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

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

A. Yes, I mean, it's a different role with different responsibilities, and it's a different system.

But it is the system that -- as -- as was designed in Northern Ireland, it was the job to which I applied and the job to which I was -- a role that I was appointed to.

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

A. Yes, correct.

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

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

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

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

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

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

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

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

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

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

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

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

You know, similarly, with the Chief Nursing Officer,

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

Q. Sorry --

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

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

A. Okay.

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

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

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

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

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

How many advisers?

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

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

A. Well --

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

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

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

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

A. That's correct, yes.

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

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

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

Q. Okay.

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

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

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

So the population health directorate, health

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

A. That's correct.

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

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

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

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

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

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

A. Yes, my Lady.

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

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

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

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

A. That correct, yes.

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

A. Yes.
Q. And health silver, that's not actually a departmental body, is it?
A. No, it isn't.
Q. So that's made up of the Public Health Agency, what was HSCB at the time, and then also the Business Services Organisation.
So did the department have no role in health silver?
A. No, you know, the -- it's not to say that we had no role -- in any emergency situation that you -- principle of subsidiarity applies so that all issues are managed at the lowest possible level and escalated to the next level as required for decision.
So the department -- when the full bronze, silver and gold arrangements were activated, as we would do in a significant or catastrophic incident, as --
Q. Such as the pandemic?
A. -- such as the pandemic -- then the department would activate health gold, the various --
Q. I'm going to come on to health gold, it's just at the moment in terms of whether the department had any involvement in health silver or whether the department rested effectively within health gold?
A. Within health gold, yes.
Q. Why is it the department had no role within health

silver? Is it effectively you would've been duplicating your roles?
A. Yes, I mean the role of the department in, you know, a serious or catastrophic emergency is to provide strategic direction and co-ordination. I mean, our role -- and again, I think, Chair -- my Lady, we covered this within the -- with Module 1, is clearly set out within the emergency response plan.
Q. Yes.
A. And silver is responsible for the co-ordination at a system level across the various provider organisations, and when activated and health gold is activated, it would be providing situation reports to the department and would be escalating issues that required decision because of their significance or policy implications.
Q. We'll look at some of those in due course.
And just for completeness, so those bodies within health silver decide when health silver should be activated?
A. Yes.
Q. And that was activated on 22 January 2020.
Then in terms of health gold, and you've been describing what health gold does, you, as CMO, are chair of health gold, that's right?

A. Correct.
Q. And that's set out under, as I say, the department's emergency response plan.
And effectively your role was to oversee the departmental response?
A. It -- well, it --
Q. That's -- that's the title at action card 1 of the emergency response plan, it's not my words.
A. Yes, it is. I'm happy to elaborate on that but, yes, it is in the action card, yes.
Q. And, yes, you have the minister above you who is effectively fundamentally responsible for the health response, is that correct?
A. Yes.
Q. And your responsibility, you're making informed decisions in relation to how the sector should respond, providing health advice, professional dental and pharmaceutical advice -- presumably that's through your Chief Pharmaceutical Officer and others supporting you -- public health policy and safety and quality policy, including standards, guidelines and professional regulation.
That seems a very broad role.
A. Mm.
Q. Would you be able to describe, in the middle of the

pandemic what was your typical day like? None of us have been CMOs, Professor McBride. It would be helpful to have an understanding of what your day was like.
A. There was no typical day during the pandemic, because every day presented very unique challenges. I think that -- you know, I mean, I think I said previously, in my previous witness statements, I think it's now, looking back, very hard to convey both the complexity and the pace of events and the challenging and difficult issues that we were facing. And I think that was compounded by the very significant degree of uncertainty that we faced.
So we were relying on what we had already -- for instance, if we look at the virus, what we already knew about coronaviruses, we were relying on first principles, what we knew about -- already about good public health practice, good infection prevention control, and we were actively seeking to generate more knowledge, more information, more evidence. You know, reaching out to other countries who were slightly ahead of us in the pandemic, China, other European countries, Italy, France, to ascertain the impact that the virus was having, how the disease was manifesting, those that were most at risk. Actively at that time, even then, thinking about research for novel treatments, looking at

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

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

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

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

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

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

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

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

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

available to you at the time?

A. Well, as always, ultimately, my Lady, it will be for the Inquiry to determine in terms of the answers to that question, as I've -- as I've said in my statement.

I think there were some issues because of the pace of events. I think there were certainly some issues in terms of, you know -- and I'm sure we'll probably come on to this later -- in relation to communications, so, for instance, to those shielding in terms of how we conveyed information, how we conveyed information in a balanced way which allowed people to make choices about what was important to them.

Q. Is that within the shielding context?

A. Yes.

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

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

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

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

Q. We will come back to that.

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

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

Q. So just -- March 2020?

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

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

So I commenced a programme of work around bereavement support.

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

process, doesn't really matter what we call it, how did that impact upon your decision-making in the pandemic? Was that something that was always at the forefront of your mind?

A. I think it was something that certainly I -- I -- I think that we must do better in health social care around bereavement care and bereavement support. It was something, yes, I was mindful throughout my career. It was quite clear this was going to be a particular issue.

Q. Clear from when?

A. Well, from pretty early on I would say, but whenever we introduced the restrictions in around funerals and people paying respects.

Q. So March?

A. Yes.

I then -- you know, I mean, I know you don't want to go into all the details at this stage, but I established a bereavement network at that stage. We developed a range of guidance and supports for people. You know, for children who were bereaved, individuals who were -- had -- had died in nursing homes, for both their carers and for staff, and ultimately we -- that resulted in a report which saw the establishment of the Northern Ireland Bereavement Network, and we now have as a result of that a bereavement, Bereaved NI, website, which is

a source of support available to individuals who have suffered a bereavement.

Now, I think that was a direct consequence of some of the experiences in the pandemic and the fact that -- I think that we need to enhance arrangements in that area.

Another particular area, under that sort of the people bit of the learning, was the work that we did around the ethics guidance and support framework for clinicians --

Q. We'll be coming to some of the detail.

A. Another element which I think is crucially important in that same context was work that we started during the pandemic and a policy document that we published in October 2022 around advanced care planning. And that is, you know, a systematic and structured way about people identifying when they are well, about things that matter to them, and having structured conversations with the individuals that matter to them about things that they wish in terms of their personal wishes, their financial wishes, medical wishes in terms of treatment and care at the end of life, et cetera.

And that work is being rolled out at present.

So I do think that the pandemic has shone a light on that, for me personally a very important light, on the

fact that there was much more that we need to do, not just as health service but as professionals and as a society, about encouraging those conversations and putting in place the mechanisms to support individuals.

Q. Thank you.

I want to move now to one specific area that the Chair has heard a lot about over the past two weeks. It's infection prevention and control.

What was your role in terms of the infection prevention and control measures that should apply in Northern Ireland during the pandemic?

A. I mean, I think I -- I did not have a direct role in the infection prevention and control measures that were to apply in Northern Ireland at the time. We had an infection prevention control cell which was headed up by the Public Health Agency, who have expertise infection prevention and control.

There is already a considerable amount of expertise infection prevention and control within the health service, so that infection prevention and control cell led on the advice and guidance around those measures during the pandemic.

Q. Yes, and I think that's set out in your statement, and I think you also say that:

"There was to my knowledge no IPC guidance developed

solely in [Northern Ireland] and the IPC Cell within the PHA in [Northern Ireland] did not diverge from the UK wide IPC guidance."

Is that your understanding?

A. Well, there was guidance developed but it didn't differ -- there was guidance provided in Northern Ireland but it was aligned and fully aligned with the IPC guidance in the rest of the UK.

Q. So even if you had no direct role in the creation of it, I mean, you must have been aware of the guidance?

A. Yes, yes. But as I say, the nature of my other responsibilities were such, you know, as I say, I wasn't directly overseeing that guidance or its development. But we did -- certainly the UK CMOs and our senior clinicians call, which were happening regularly, would've got updates of any developments or changes recommended in the IPC guidance. So it was a high-level involvement but not in the detail.

Q. You say the Senior Clinicians Group and you said met regularly, roughly how regularly?

A. Oh, it met weekly. And, you know, that happened really through -- throughout the pandemic.

Q. And those -- Senior Clinicians Group, did that have any, as far as you were concerned, any oversight of the IPC cell?

A. No, it didn't have oversight. But certainly we would've had updates from the UK -- the HSA representative, who was sitting on -- a member of the Senior Clinicians Group about plans of -- for engagement or, you know, discussions which were to be had at the UK -- four nations UK IPC cell, of which the PHA represented Northern Ireland.

Q. So as far as you were concerned, would you have seen it as your role to scrutinise the guidance that was coming out and apply your own personal knowledge to it?

A. No, I mean, I think the -- I mean, part of my role as Chief Medical Officer is to recognise the limitations of my expertise. I'm not an expert in infection prevention and control and there are others that are expert.

You know, I think had I -- you know, had I been aware of something within that guidance which I felt was of concern, within the limits of my professional or which -- I would've certainly challenged that, but very much I was reliant on those who were expert in the area.

Q. So in terms of issues such as routes of transmission, where was your advice coming from?

A. My advice would've been coming from colleagues within the UKHSA. And I understand you heard -- you had evidence from UKHSA, the Health Security Agency, last week. So, again, that would be the source of expert

advice.

Q. So there was nothing local in Northern Ireland that was providing any separate advice about routes of transmission for example?

A. No, there wasn't. And, you know, as I've made clear in Module 1, you know, in Northern Ireland we do not have, given our scale and size, the, you know, technical ability to replicate that expertise in Northern Ireland, and that's why we benefit so much from the links and -- effective established links that we have with the UK Health Security Agency.

Q. So in terms of the droplet or airborne/aerosol routes of transmission, did you have any view of that or were you just accepting the advice that you had been provided?

A. I accepted the advice that I was provided.

Q. And do you have any views on another topic we've heard about, about the different benefits offered by FRSMs compared to FFP3 masks?

A. I mean, it is, clearly, a complex area. I did listen to the evidence from Susan Hopkins last week. She is clearly much more knowledgeable of these matters than I am and I would defer to her interpretation of that.

We did cover this and address this within the CMO technical report, but, as I say, I'm not an expert infection prevention control, nor would I say that I'm

an expert in the differentiation between aerosol and droplet.

What I would say is that I think that it's probably unhelpful to have a dichotomous view between -- to transmission, because obviously, as was indicated, it really depends on -- on the circumstances, very much on the environment and ventilation, how infectious the individual is.

And obviously our knowledge on the routes of transmission of SARS-Cov-2 changed incrementally throughout the pandemic, so what we understood --

Q. Sorry, just to be clear, this is understanding you gathered from the advice that you were providing, it's not your own understanding that's grown during the course of the pandemic?

A. That's correct, yes. I mean ...

Q. Just in terms of the droplet/aerosol dispute in terms of the route of transmission, were you aware of those two differing views during the course of the pandemic?

A. I would've been aware of those views, I do recall -- I don't recall all of the detail but I do recall it being raised at the UK Senior Clinicians. I -- there was -- and I think I've also addressed this in my statement -- there was a group, a subgroup, set up to establish to look at aerosol-generating procedures and

there was a Northern Ireland representative on that group.

Q. Slightly different topic though because I think what was on the list of AGPs is a slightly different issue as opposed to whether AGPs should've existed in the first place.

A. Yes.

Q. Just one point I just want to ask you about, you say:

"I did listen to the evidence from Susan Hopkins last week. She is clearly much more knowledgeable of these matters than I am and I would defer to her interpretation of that."

Why would you defer to her interpretation as opposed to any of the other evidence that we've heard about the aerosol droplets?

A. I haven't -- I haven't listened to any of the other evidence. I haven't had a chance to read the other evidence. I know you have had other evidence from Professor Beggs and others, but that's not something I've had time to consider.

Q. I want to move now then to the capacity of HSC at the start of the pandemic.

Did the population of Northern Ireland have the healthcare service that they needed at the start of the pandemic?

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

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

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

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

department.
So pre-Covid figures, in England at the end of November 2019, 1,398 people waiting more than 52 weeks on the pathway to start treatment whereas in Northern Ireland, population 1.9 million, there were over 100,000 people waiting for more than 52 weeks for the first outpatient appointment.
So effectively comparatively about 2,000 times worse? Is that --
A. Yes, roughly, yes.
Q. Thank you, that can come down now.
Are the reasons why those waiting lists in Northern Ireland were so long compared to the rest of the United Kingdom, are those reasons relevant to HSC's ability to respond to the pandemic, particularly in those early stages?
A. I think in relation to the negative impact that there was on people waiting for planned care, treatment and care, absolutely yes. In relation to the ability to respond to people requiring acute care for a range of medical and surgical conditions, no. And given that -- and if we look at its ability to respond to people needing acute care from Covid, no. But there's absolutely no doubt that there was an extremely negative consequence for people waiting for planned care that was

delayed during the pandemic, that was delayed further than elsewhere and delayed for longer than elsewhere, as a consequence of the situation that the health service in Northern Ireland was at the start of the pandemic.
Q. I want to move now and look at initial planning and the response.
In your statement you refer to:
"... [your] role ... leading and coordinating policy and operational oversight of the public health and health service response to the 2009 H1N1 pandemic ..."
So you'd had some experience of how to respond in the initial stages of a pandemic prior to the Covid pandemic arriving.
In terms of the planning/plans experience that had been available to you in January 2020, what did you have at your disposal? What tools were there for you to be able to respond?
A. Well, we -- in terms of tools, we had the -- Northern Ireland's crisis management arrangements in terms of -- at the highest level of government for activation of those arrangements. We had within the department the department's emergency response plan, which I alluded to earlier, which basically laid out a very systematic way of responding to situations with a modular approach with the various levels, bronze,

silver and gold --
Q. Both of those are structural responses?
A. Yes.
Q. In terms of -- and I probably should ask the question more specifically.
In terms of the healthcare response, what was available to the healthcare system in Northern Ireland about how it should respond to a pandemic?
A. Well, the -- within health silver they have a joint response emergency protocol, which has been in place for quite a number of years, which is reviewed annually, which is a tripartite agreement between the Public Health Agency, the Health and Social Care Board and the Business Services Organisation which outlines the role and responsibilities of each organisation, the resources that they will commit, and also how they will work collectively. So they have a -- a well rehearsed plan which they activated, as you've indicated previously, on the -- on 22 January, with the activation of health silver.
Q. Right. And what would that plan actually help them do? Again, was it a structural issue or would it actually tell them -- give them an understanding, an example, an outline of how they should respond in the event of a pandemic?

A. Well, working -- a practical example on that is what they did was they -- in anticipation of the surge that we were going to see in terms of people presenting with Covid who were acutely unwell, they developed surge plans across a number of specialties, so primary care, secondary care, so that's people requiring hospital care, and across tertiary services, so specialist hospital services, and develop a surge plan for health and social care, that's both care homes, social care, mental health facilities, learning disability facilities, so that came together in a surge plan which was published in March.
So those are very practical outworked about how the health service would respond to the pressures of the pandemic.
Similarly, there was a plan which was developed in terms of how people would continue to receive emergency care and treatment for individuals presenting with heart attacks, strokes, people who had vascular bleeds or individuals who had cancer. So those two elements of work, both for Covid and critical/urgent non-Covid care, was all being co-ordinated by the Health and Social Care Board, working with the PHA, working with the Health and Social Care trusts and the ambulance service.
Q. But those had been developed in the early stages, I'm

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

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

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

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

with this pandemic.

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

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

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

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

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

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

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

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

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

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

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

A. That would be wrong, yes.

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

A. Yes.

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

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

Q. In relation to the pandemic.

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

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

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

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

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

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

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

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

What was going on at that time within Northern Ireland?

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

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

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

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

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

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

Q. Well, can I please show you INQ000130312.

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

spreadsheet?

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

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

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

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

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

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

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

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

A. Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. Yes.

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

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

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

A. Sure.

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

A. That's correct, yes.

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

A. Yes.

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

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

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

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

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

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

Q. The sea; is that correct?

A. Sorry?

Q. The sea, geographical consequences?

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

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

England.

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

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

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

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

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

LADY HALLETT: Oh, I see.

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

LADY HALLETT: Thank you.

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

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

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

Q. Yes.

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

A. That's the February.

Q. Thank you for correcting me.

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

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

That's page 142, paragraph 223.

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

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

What do you mean by "there were some inconsistences"?

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

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

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

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

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

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

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

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

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

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

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

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

Q. Okay.

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

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

modelling at that point in time; that was modelling conducted by SAGE?
A. That's correct, yes.
Q. You talk in there about setting strategic. If you are talking about surge planning across the entirety of Northern Ireland, that is a strategic decision; correct?
A. It's a tactical strategic decision. You know, I make that distinction because it is an important distinction. The principle of subsidiarity within any crisis response is crucial. If it isn't abided by, what happens is that if all decisions have to be made from the department, it paralyses the rest of the system.

So it has to be only those matters which are important to be elevated through the department for either a policy decision, a strategic decision, but that regional layer, the co-ordination of the regional response, as is outlined in the emergency response plan, is the responsibility of health silver working with health bronze, and simply what I was indicating to health silver, which, you know, is the responsibility of health gold, was I was testing on behalf of health gold and the department those plans and basically requesting further work.
Q. So if you had signed off on those plans at that time, and you thought those plans were significant, what would

have happened, would they have been adopted then and there?
A. Well, I've no doubt, as happened anyway, those plans would have been modified as time went on --
Q. But at the time they were presented to you rather than later.
A. When those plans were presented, I think we were probably -- there was a subsequent workshop which was held by the Health and Social Care Board on 5 March. So there was an ongoing process of refinement of those plans. So what we received at that point in time was still very much in development.

And that was right because, as our knowledge developed and as we developed more information from the modelling about where those pressures would be, the numbers of people, for instance, who would require admission, the number who would require oxygen, the number that would require critical care admission, then those plans were constantly refined.

So there wasn't a point in time where we said "This is the plan, we're going to stick to it", these plans were constantly refined because they needed to be constantly refined.
Q. But this early stage in late February, you hadn't stood up to the strategic cell. That's correct?

A. That's correct, yes.
Q. But surge planning is essential in terms of a strategic overview level because you are talking about what services you were going to effectively not be able to provide, how you're going to redeploy?
A. Yes.
Q. That is a very high-level decision. So can you explain why these discussions were taking place in late February, but the strategic cell was not yet in place at that time?
A. As I said in answer to an earlier question, there was a high level of connection between all parts of the service at this stage. When we stand up health gold, which we did in early March, that puts in place an additional set of requirements on health silver and on health bronze in reporting arrangements.

What I was satisfied was happening at that time, prior to the activation of health gold, was there was active surge planning going on within the health and social care system.

I had sought assurances on that. I had met with the chief executive of the Health and Social Care Board, the Public Health Agency and their team on 11 February and was assured that work was ongoing.

Here we're seeing the outworkings of that and

I commissioned further work based on that.

So I think the point I would make is that that strategic oversight, that policy direction, was being clearly communicated, was being understood and was being acted on by colleagues at health silver.
Q. So even if the strategic cell wasn't there, it made no difference?
A. Well, the health gold serves an important purpose and role.
Q. I am just focusing on strategic cell because half of health gold the emergency operating centre had been up since --
A. That's correct.
Q. So it's the second part, that strategic decision-making that I'm trying to focus on.
A. Yes. What I'm saying is that even before the activation of health gold that strategic oversight was being provided prior to the activation of health gold.
I think we've just given a good example where I was working with colleagues, policy colleagues, within the department, within secondary care, health policy group, again actively considering the surge planning. Yes, you're correct, we hadn't activated the strategic cell at that point in time, but that strategic oversight strategy consideration was already in play at that time.

Q. That document can come down now. Thank you.

Just in terms of that thread of activation and the strategic cell, that happened on 4 March. Did that happen because that was the day that the first suspected cases arrived in Northern Ireland?

A. No, the first confirmed case in Northern Ireland was 27 February.

Q. So why hadn't the strategic cell been stood up when the cases had arrived in Northern Ireland?

A. Well, it was the first case. I mean, I think that the emergency response plan is designed to be modular. And as we covered earlier, bronze can be set up without health silver being set up. So, for instance, if an incident is at a single trust level, then health bronze will address that. If an incident is occurring across several trusts, then health silver is activated.

And the health gold is designed to be modular as well. So the urgency operations cell, as you mentioned earlier, was activated on 27 January following the activation of health silver. So, again, reports that would have been generated by health silver were already being received by the department. The department already had oversight of those.

So it doesn't and didn't require the health gold, in my judgement, to be activated on 27 January.

We did activate it on 4 March, and, in my view, it is always a judgement call, but in my view that was a proportionate and appropriate time to activate it. Once you activate health gold, basically what it means is that the department effectively stops all other activity. It reverts into business continuity arrangements. It generates its own work in terms of the demands it places on the system.

The balance has to be between planning and preparation, and providing health silver and bronze with the head space and room to get on and do the planning and preparation as opposed to the department activating health gold and asking for twice-daily situation reports in terms of what's going on on the ground.

So I was satisfied at that stage that there was significant awareness and intelligence of what was going on in the system, that we had mechanisms for matters to be escalated through the EOC and the department. That those could be brought to my attention or other policy leads within the department.

In my judgement, the activation of the strategic cell was both timely and appropriate when it was activated in early March.

Q. Okay. I want to pick up that thread in terms of the information that was available to you.

If we can have up on screen INQ000430391.

Do you recognise this document? It was a dashboard that was provided by the Department of Health.

A. Yes, I think this is the Covid-19 dashboard that was developed, yes.

Q. Yes. And then you can see the top left corner, PHE. Had this come from PHE, and then may have been adapted by Northern Ireland?

A. Oh, sorry, apologies, yes, this is a PHE document, sorry.

Q. But then this is the information from Northern Ireland.

And then if we can just scroll down on column A, it appears that the types of data that are highlighted in orange or yellow -- I can't quite tell the difference -- are the ones where information has been kept, but the ones in white is not recorded on this dashboard. There are some there -- you can see, for example, staff absences, staff illness, staff deaths, PPE stock.

Let's leave aside the PPE stock but in terms of staff absences and staff illness, was that information being recorded in Northern Ireland?

A. Sorry, I'm not sure -- what time is this document?

Q. Well, we can see there this is 1 March. You can see from column E.

And then if we go up to the top row, please.

You can see there that deaths by setting cases, cases by age group. That's all there from 1 March.

A. Okay. Well, firstly information on staff absences doesn't fall within my professional or policy remit. The responsibility for and the recording of staff absences is a core responsibility of the employer, ie the health and social care trusts. But it was not something certainly, as I say, at that stage that I was responsible for or that was information that was being fed to myself.

Q. In a pandemic where you're talking about surge planning, how you're going to provide the capacity, particularly in the situation that Northern Ireland finds itself with its lack of resilience, using your words, did you not need to know information such as staff absences, staff illness, staff deaths?

A. Well, that information, there was an HR cell within the strategic cell which we've already established was put in place in early March. That cell through health silver from the trusts would've been collating that information. Again, as I've made clear in my evidence and witness statement to 2C and in this statement, that principle of subsidiarity would arise.

So the chairs of the individual policy cells within the strategic cell were all policy leads within the

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

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

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

A. They were, yes.

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

A. Yes.

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

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

Q. Okay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. Let's deal with specifics.

Was there any information that you needed that you

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

A. In terms -- significant detriment --

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

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

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

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

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

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

A. Okay. Well, maybe we can come back to the public-facing

data because I think that's really important in terms of bringing the public with us given the asks that we were making of them.

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

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

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

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

characteristics such as ethnicity, such as disability, in relation to the data that was accessible to me.

That was problematic and challenging.

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

As you say:

"Ethnic minorities form a much smaller proportion of the population than in many other regions of the UK, and ethnicity is not well coded in NI health care records. As a consequence, analysis regarding ethnic minorities was not available due to the poor coding of ethnicity in health care records and it was not possible to look at trends in those from different ethnic backgrounds nor to analyse [the] impacts ..."

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

A. Well, again it wouldn't have been an area that fell within my professional policy remit, but certainly it was an issue right across the public sector and government that had been recognised in the racial equality report that was published in 2015 by the executive office that ethnic coding across departments and their arm's length bodies of public services was not

uniform and there were gaps and there was a commitment to improve that.

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

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

A. Yes.

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

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

Q. What was done to improve that situation?

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

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

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

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

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

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

Thank you.

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

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

Q. Okay.

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

a disproportionate impact?

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

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

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

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

A. Yes.

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

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

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

LADY HALLETT: 2015?

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

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

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

LADY HALLETT: Who will we need to ask?

A. I beg your pardon?

LADY HALLETT: Who would we need to ask?

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

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

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

MR SCOTT: Yes, my Lady.

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

"Consideration is required from the SIRO."

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

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

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

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

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

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

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

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

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

point in time.

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

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

A. That's correct.

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

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

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

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

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

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

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

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

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

A. I cannot recall.

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

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

A. Yes.
Q. So is it not a little late on 9 March for the strategic cell to be dealing with urgent decisions about suspending elective care, shielding guidance, and visitation?
A. I mean, we would not want to suspend elective care prematurely. I mean, the suspension of elective care or reducing elective care has very fundamental and serious consequences for the population in Northern Ireland so we did it when it was necessary and appropriate to do so to ensure that we were able to balance the need for people requiring hospital care with Covid.

I mean, as I recall, the first admission to intensive care in Northern Ireland was not until 15 March.
Q. Mm-hm.
A. So it would've been disproportionate and, in my view, inappropriate to downturn elective care prematurely given the very significant consequences it would have for the population in Northern Ireland.
Q. Yes, but in terms of completing your plan for preventing elective surgery, should that have been done at an early stage compared to 9 March? Because there's a difference between when your plan is complete to when you then implement that plan.

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

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

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

Q. So did the strategic cell provide any benefit then on 9 March?
A. I'm not saying that it didn't provide benefit. I'm saying that it was activated at a time when we recognised that there was a need at that stage for more strategic co-ordination at the policy level. Because as policies, the strategic cell fulfilled several functions. Its role is to provide strategic leadership and co-ordination to health silver.

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

So there are very many elements to the roles and responsibility of the strategic cell.
Q. Okay. And you were talking there about the wider UK response, let's look at one of those. So your statement says that on 15 March Professor Sir Chris Whitty circulated a note on shielding and that note reflected discussions between the four CMOs.

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

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

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

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

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

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

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

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

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

Q. So there were no alternatives?

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

we did several things in parallel.

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

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

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

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

Q. How did you plan to measure -- this is you personally --

whether shielding as a concept was working?

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

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

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

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

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

should end?

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

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

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

And I think as we all knew and can look back now and experience, the population at large was extremely altruistic in terms of the steps that it took to protect the vulnerable in society. You know, it's hard -- it's

hard to imagine, you know, coming here this morning on the tube, that not so very long ago we were all wearing face coverings, we were all social distancing, we were all in one way systems in shops.

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

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

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

an initial messaging.

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

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

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

Q. How would you prevent that happening again?

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

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

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

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

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

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

Q. And accessing healthcare?

A. And accessing healthcare.

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

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

Q. In terms of Northern Ireland and actually disseminating

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

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

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

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

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

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

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

Q. There wasn't a centralised database?

A. There wasn't centralised database.

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

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

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

and telephone systems.

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

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

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

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

A. Oh --

Q. Years?

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

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

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

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

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

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

MR SCOTT: Thank you, my Lady.

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

A. Erm --

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

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

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

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

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

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

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

A. Well, that -- oh, sorry; I thought we were talking about

the health service as opposed to public. That would have been at the same time as that message was communicated to the rest of the UK. From memory I think that was around 16 March.

LADY HALLETT: It was shortly before the first --

A. Yes, yes.

LADY HALLETT: Thank you very much. 1.50.

(12.50 pm)

(The short adjournment)

(1.50 pm)

LADY HALLETT: Mr Scott.

MR SCOTT: My Lady.

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

If we can have on the screen INQ000445772.

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

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

A. I do, yes. Thank you.

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

That email was then -- if we can scroll up, please.

Thank you.

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

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

Q. Talking --

A. -- my response, yeah.

Q. Talking about:

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

You're talking about:

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

That's what codes of practice are for.

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

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

"There is a deep lack of clarity and understanding regarding appropriate use of PPE and in particular FFP3. A professional letter on its own won't do it for me. We

need to reissue simple and clear advice and information."

Then your response is:

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

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

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

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

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

A. Well, they had. I mean, the first communication on infection prevention and control, whilst I wasn't directly involved, had issued on the -- in -- 10 January, when it was online with an agreed approach across the UK. It had issued from the Public Health

Agency in Northern Ireland in -- in conjunction with other organisations, Public Health England, et cetera, at that time.

The difficulty --

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

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

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

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

Q. And did that clarity come in Northern Ireland?

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

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

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

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

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

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

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

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

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

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

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

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

A. To pause the inspection of hospitals, yes.

Q. Yes.

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

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

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

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

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

Q. And that produced some useful recommendations --

A. It did.

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

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

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

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

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

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

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

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

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

Can I please deal with prioritisation then.

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

This is the spotlight statement from the Belfast Trust.

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

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

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

A. That's correct, yeah.

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

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

Q. Yes, in terms of staffing and --

A. Yes.

Q. Can I please go to INQ000377146.

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

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

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

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

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

And it's number 17:

"Triage for admission to intensive care will be inevitable.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

understood --

Q. Okay.

A. -- and was applied.

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

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

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

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

and to all times -- at all times act in what is the best interests of the patient.

I am satisfied that we provide sufficient guidance. I'm not aware -- I mean, there was professional guidance provided by other expert bodies which we've referenced in the ethical guidance and framework, but I am satisfied that we provided sufficient clarification on the extant position.

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

Q. Can I --

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

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

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

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

LADY HALLETT: Yes.

A. And they had the support of -- of the regional clinical

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

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

A. -- talked over you, sorry.

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

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

So it -- you know, the guidance was divided into two halves: the ethical principles underpinning -- part 1 -- and the legal obligations of all health professionals;

and then part 2 was about some worked examples, including decisions around cancer treatment, including -- DNACPR is only but one example, and also then pointing to the support that was available to health professionals.

Q. Can I move now to DNACPRs.

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

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

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

provide assurance to the public in Northern Ireland.

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

If we can go to INQ000421784, page 713.

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

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

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

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

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

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

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

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

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

It's INQ000130312. It's at 618.

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

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

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

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

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

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

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

Q. Do you know --

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

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

A. Exactly.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

At the -- we talked about data earlier on.

At the early stages of the pandemic, was there tracking brought in in Northern Ireland for any long-term impacts of Covid as it became post-Covid syndrome or Long Covid?

A. No.

Q. Do you think there should've been?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Northern Ireland paused shielding at the end of July 2020?

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

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

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

what the other jurisdictions did at that stage.
Q. And I also think it's right to say that that was a decision that was actually taken by the Northern Ireland Executive, to agree to the pausing the shielding. I think that was on 18 June, around then, and then the decision came in on 31 July; does that sound right to you?
A. That's absolutely correct.

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

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

decision. There was a statement from myself on the department's website on the date of 31 July. But we ensured and were anxious to ensure that all of the mental health support, online support, GP support, consultant access support was still available -- available to people who had previously been shielding.
Q. Two very closely related questions. Firstly is, do you think that there was sufficient support provided after the decision had been taken to pause shielding for those who had been shielding? And secondly, do you think that those who had been shielding felt that there was sufficient support provided for them in Northern Ireland after the decision had been taken?
A. I know that some didn't and I've alluded to that in my statement. I think in part that was due to the psychological and social impacts of shielding that had had on individuals and people remained very fearful.

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

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

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

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

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

And for those that felt that then I'm sorry we couldn't have done more, and perhaps, you know, one of the -- one of the findings from -- the Inquiry will look at in the future: is there learning in terms of how we communicate that it doesn't engender fear, disempower, still gives people a sense of agency in terms of assessing risk and making decisions?
Q. Is that -- do you think that's a recurring theme throughout the response to the pandemic, whether it be in shielding or PPE or other settings, where maybe more could be done to communicate the reasons. I think Professor Gould was talking about winning the hearts and minds of those -- do you think that that's something that could've been done better?
A. I think, yes, had we -- I think had we had had more time and things not moving at such a pace we probably

would've done things differently.

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

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

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

So I -- I absolutely accept that that is a general

learning point, yes.

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

A. No.

Q. -- in creating the visiting guidance.

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

A. Yes.

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

A. Yes.

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

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

But I -- I think that -- in the future I think it is

an area that -- you know, we can't wait to the next pandemic to start to think about, you know, visiting in those settings, you know, people at end of life or visiting care homes, you know, I think another area where we acted in what we thought were the best interests and the best information that we had --

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

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

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

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

blanket approaches more generally are not helpful.

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

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

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

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

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

In early 2021 it was anticipated that the critical

care numbers were going to be the highest that they had been --

A. Yes.

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

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

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

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

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

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

A. Oh, sorry.

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

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

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

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

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

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

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

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

A. There was, yes.

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

A. That's correct, yes.

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

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

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

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

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

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

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

I suspect I recommended the roll-out of that to ED departments in Northern Ireland.

Q. But were you involved in any way in the pilot of asymptomatic testing using lateral flow devices that commenced in January 2021?

A. Well, yes, in that I was getting regular updates from the Expert Advisory Group on Testing, yes. And they were also linking through with colleagues in the other jurisdictions.

There were a number of new testing techniques that became available towards the latter part, and again forgive me if I get the timelines wrong here, probably in the latter part of 2020, in Northern Ireland we had been piloting from October testing of staff using one of those new testing technologies, LAMP -- or loop -- isothermal amplification. It's basically a very rapid test on saliva to give a positive or negative result. So we had started to roll that out in two trusts, the Belfast Trust and the Western Trust in Northern Ireland.

And in parallel there had been work undertaken by -- UK Health Security Agency and University of Oxford validating lateral flow devices, as you've alluded to, and considering their utility as an additional measure to ensure effective control of infection within healthcare settings. And that, as you say, was piloted

in Northern Ireland, the Southern Trust, in January.

Q. Yes, that's the last point I wanted to come to.

So England had been conducting those tests in -- from around 9 November 2020. Does that accord -- or you're not entirely sure?

A. I think they started piloting it in a number of trusts. And similarly, an approach had been taken I think around that same time towards -- in December in Scotland and Wales. I know that the Expert Advisory Group on Testing had considered how best to expand testing of healthcare workers, looking at the benefits of continuing the expansion of the -- the LAMP test that I referred to earlier versus the benefits of using LFDs.

So, I mean, it was -- I mean, there was an ongoing exercise of assessing which tests were most effective, the frequency that testing should be applied. And as you say, that then began -- the roll-out in Northern Ireland began in January.

Q. Well, if we can, please, go to INQ000421784, and it's page 237, it's paragraph 408.2.

Again, this is your statement, Professor McBride. It's the first half there, thank you.

So:

"Under the overnight at the ... EAG-T ..."

That's the testing group --

A. Yes, that's the Expert Advisory Group on Testing.

Q. Yes. So a pilot of LFDs had commenced on 22 January 2021. A recommendation was made by the testing group on 12 March to stop the pilot and implement a full roll-out of the testing programme.

Then:

"On 4 June 2021 I wrote to ... Trust Chief [Execs] to request that ... Trusts develop robust preparations and plans for a significant expansion ..."

Why did it take almost three months from the recommendation to implement the full roll-out to then you talking to trust chief executives about developing preparations and plans for that roll out?

A. I mean, again, I would need to look back through the detail of this but the -- the roll-out of the testing of healthcare workers was under the aegis of a subgroup within the Public Health Agency, so I was not within the department directly leading on that roll-out.

Q. Would you agree that that took a bit too long in terms of the --

A. Again, I would separate out the work that the PHA was doing in terms of rolling out testing versus me writing the letter seeking assurances that there's robust plans and it's actually happening.

I think what this was based on, I attended a meeting

of the -- the subgroup basically to check in on progress, and I was probably -- I -- as I seem to recall, I was simply indicating that, in my view, we needed to do more testing, including, as I recall at that stage, the -- as I say, I recall at that stage the testing of non-frontline healthcare workers. So at that stage, well, we were testing frontline healthcare workers but I actually felt it was important, recognising the roles and interactions there are between clinical assistants, ward assistants, porters, et cetera, et cetera, I felt it was really, really important that that also extended to non -- people who were fulfilling roles other than doctors, nurses and allied health professionals.

Q. Erm --

A. So, I -- as I say, this wasn't me saying "Oh, now do this", this was already being done and I was basically saying let's get on and make sure that this is expanded further to include non-frontline -- although I like that word, "non-frontline" -- healthcare workers.

Q. Do you think that in Northern Ireland there was sufficient protection for healthcare workers in terms of the support that they were being offered when they were working during the pandemic?

A. I'm not certain that there was sufficient support

available to healthcare workers working anywhere during the pandemic. And I only wish that we -- we could've done more.

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

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

We put in place arrangements within care homes for

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

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

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

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

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

social care within the health service performed admirably, did their level best, and did what they thought was right at that time.

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

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

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

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

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

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

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

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

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

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

MR SCOTT: My Lady, those are the questions.

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

Questions from THE CHAIR

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

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

A. Absolutely.

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

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

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

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

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

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

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

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

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

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

A. Ultimately --

LADY HALLETT: Summarise.

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

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

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

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

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

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

LADY HALLETT: So it's February/March?

A. February/March --

LADY HALLETT: First steps February --

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

saw that programme rapidly increase.
LADY HALLETT: Thank you. I just thought it was only fair, when we're looking at decisions that had been taken, that we put it in the context of the fact that there wasn't the scale-up capacity for testing.
A. No.
LADY HALLETT: Very well, we'll break now. I'm sorry, one more session to go, Professor McBride. I shall return at 3.20 for the final session. You will be finished this evening, I promise.
(3.05 pm)
(A short break)
(3.20 pm)
LADY HALLETT: We now come to the core participant questions, Professor McBride. They all have limited time so I know they will all be very grateful if you could focus on the question. If we need more information, we can ask for it.
Mr Wilcock.
Questions by MR WILCOCK KC
MR WILCOCK: Professor, I've been given -- I represent Northern Ireland Covid Bereaved Families for Justice, as I think you probably already know, and I've been given permission to ask you some questions on two topics, nosocomial infection and DNACPR, following on from the

answers you gave this afternoon.
Dealing with the first topic first, nosocomial infection. As you know, Professor, one of the most publicised outbreaks of Covid in a hospital setting in Northern Ireland during the pandemic was in the Craigavon and Daisy Hill hospitals in the autumn of 2020 in which 15 of 32 patients with Covid-19 were reported to have died, and 12 of whose premature death appeared to have been directly attributed to by Covid.
A serious adverse incident review was carried out by the relevant trust, the Southern Trust. And it estimated that 10 to 20 per cent of patients admitted to hospital in the first wave for non-Covid 9 conditions acquired Covid-19 during their hospital stay, and up to one in six SARS Covid infections among hospitalised patients with Covid in England during the first six months of the pandemic could be attributed to nosocomial infection.
Do you accept that there was therefore a significant risk, sadly, to the health and life of those attending hospital for non-Covid reasons during the pandemic due to the risk of nosocomial infection?
A. Absolutely, yes.
Q. Do you agree with the conclusions of the report -- that I just quoted -- into the outbreak at Craigavon Hospital

that a number of deficiencies in the existing estate at those locations, including the physical condition, functionable suitability, including lack of isolation rooms, compliance with standards, including poor ventilation, or lack of single rooms with en suite facilities, and a lack of effective space utilisation, including poor spacing between beds and multi-bed bays, all contributed to the likelihood of transmission of infection in wards?
A. I think there's absolutely no doubt that the fabric of hospitals, particularly old hospitals which have limited bed space, have limited isolation rooms and poor ventilation, all contribute to increased risk in those settings.
Q. That was a feature throughout Northern Irish hospitals, wasn't it?
A. It was a feature throughout a number of hospitals. We do have other new-builds, hospitals in Northern Ireland, obviously it was less challenging in those environments.
This is a highly infectious virus, and despite all the infection prevention control arrangements that were in place, sadly people did acquire Covid in hospital, and sadly quite a number of people died as a consequence of that.
Q. What is your view of the proposition that one important

lesson from the pandemic and the scale of nosocomial infection that then occurred is that where a treatment could be safely delivered in the community rather than hospital then that should've been the first response?
A. I think certainly that is correct. And if we look at those very vulnerable individuals, and a number of those were receiving treatment in a haematology unit and were immunosuppressed, I know that the cancer network did look to facilitate treatment, home treatment, alternative treatment, that would've kept people out of hospital. However, there are certain conditions which themselves were life-limiting had they not -- those individuals not received very effective treatments such as bone marrow transplant, et cetera. And unfortunately and sadly many of those individuals then, as a consequence, were much more vulnerable to Covid.
Q. We understand your answer.
Next question. The report also found that, and I quote: instances of inconsistent and inadequate communication with patients, families and healthcare workers during the events they were looking into. In many cases there were no records of communication of Covid test results to the patients of their families. Similarly, both patients and their families were provided with very little specific information regarding

the outbreaks being investigated, which, the report found, may have led to confusion regarding isolation requirements and visiting restrictions.

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

A. As I alluded to earlier, I think that communication was a challenge. I did read the detail of that report, although I was not directly involved in the generation of that report in preparation for the Inquiry today.

I think there were significant challenges across all of those areas which apply to a greater or lesser extent in hospitals in Northern Ireland.

Q. In your statement you state that the Department of Health welcomed the publication of the final report, which we both know contained recommendations for strengthening IPC measures in the hospitals as well as the systems for overseeing and ensuring best practice across the health and social care in Northern Ireland.

Have all of the recommendations in the report now been implemented?

A. Again, the majority of those recommendations were for the Southern Trust, I'm not in a position to advise in terms of those outstanding recommendations. I think that the -- the primary, one of the primary concerns in

relation to the report was the fabric of old buildings, poor ventilation, and that will require a major investment in estate and major rebuild of some hospital facilities in Northern Ireland and right across the United Kingdom. So unfortunately I cannot provide you detail in terms of progress on those recommendations, but what I have been advised is that in advance of the publication of the report the department had been advised that all of the recommendations were being progressed, or had been progressed, and the learning was being implemented even before the report was published in 2023.

Q. I make no criticism, but it took about three years for the report to be published, didn't it?

A. Yes, I mean I think in context it's not normal for SAI reports, serious adverse incident reports, to be published, but given the particular impact of this outbreak and understandable concern that was generated, the minister at the time gave an undertaking that it would be put into the public domain and the report subsequently was.

Q. Mr McBride, it was my fault, I tempted you into an area that we didn't need to go into. But it's entirely my fault. Can I move on to my second topic.

A. Okay, sorry.

Q. DNACPR.

You told Mr Scott this afternoon about the various guidances you issued in relation to ethical principles and legal obligations of all health professionals when taking -- when treating people with Covid during the pandemic.

Now, many of the members of the group I represent have made it clear that in their collective or individual experiences their relatives were, and I quote, "given up on and are simply abandoned to their fate".

We have heard, and I know you have read, an expert report from Professor Summers and Dr Srirangalingam that whatever guidance was given on DNACPR, I quote, "variations in decision-making and conscious or subconscious application of clinical thresholds are likely to have occurred through the sheer complexity of circumstances inherent in the pandemic".

In that context, what steps were taken -- and you can take it we know about the guidance you've issued --

A. Okay.

Q. -- but what steps were taken to prevent such disparities over and above the guidance?

A. As I mentioned earlier, in terms of the detailed engagement that went on in terms of developing the

guidance, there was also, as I recall, two workshops with clinicians in Northern Ireland explaining the guidance, working through the guidance from a practical perspective. So it wasn't just we issued a document, we actually, as a system, put in place arrangements to try and ensure what was in the document was understood and was applied.

But I did read the expert report, and I do concur with it, and I -- and that's why I think the -- my answer earlier about the importance of advance care planning is crucially important. And again that was something that was highlighted in the CQC, Care Quality Commission Report, looking at this very issue around DNACPR, which was published, I think, in 2021. And again it made the point about the importance of advanced care planning, improved public awareness and improved training within the health professionals.

Q. Well, many people may think that the answer you've just given about the training on the guidance is really part of issuing the guidance. Let me ask the question in a different way.

What, if any, investigations were undertaken to establish whether or not there was a disparity in the implementation of the guidance?

A. There were no investigations undertaken. No -- I mean,

I -- no such concerns or specific circumstances were brought to my attention for me to investigate or for others to investigate. But I -- I have to say I did watch all of the impact videos from those bereaved in Northern Ireland, and the very specific concerns that were made clear around DNACPR were not lost on me.

And I think we have much further work that we need to do, and hopefully we will do, with the implementation of advanced care planning, and particularly the element of it which is the ReSPECT programme, which is recommendations for emergency care and Treatment, which is crucially important that we know the wishes of individuals and families towards the end of life.

Q. Just to make sure I understood your answer correctly, are you saying that you were aware of the general controversy over the issue but you took no steps to find out if there were individual examples of it?

A. I -- basically any circumstance of that nature would've been matters for the individual trusts to consider, if families had raised concerns about their particular loved one and the circumstances -- circumstances around communication or decision-making. Those would not be matters, as Chief Medical Officer, which I would have direct responsibility for or would have been in a position to act on. Those would've been matters

which, when family made concerns, should have been or -- and could have been considered by the particular trust concerned.

Q. Well, in England the Care Quality Commission produced reports in November 20 and March 21 on this issue.

Do you accept that particularly given the levels of distrust that you've told us such disparities can engender among people in the community, that in Northern Ireland specific investigation into this issue might have been helpful?

A. Again, I'm not sure I know an answer to that. I do believe --

Q. You can either say yes or no.

A. I'm uncertain. I think that what I would say is that individuals, families, have a right to expect, that there's explanations provided to them as to why decisions were made, the circumstances in which those decisions are made. And that's made very clear in the guidance document that you referred -- we discussed earlier. And that extra effort should be taken in the pandemic to ensure that those considerations happened.

And if that didn't occur, then I think those individual families have a right to an explanation as to why it didn't happen. And I would encourage them to engage, if they haven't already, with the service as it

was going -- but the only other thing I would point out is that there were very significant pressures in the system at that time. And as my Lady asked earlier, those pressures may have resulted in communication not being as it should've been.

And as a consequence significant mistrust and distrust and hurt and sense of guilt and -- has developed as a consequence, and we need to -- to address that and redress that.

MR WILCOCK: Thank you very much.

A. Thank you.

LADY HALLETT: Thank you very much, Mr Wilcock.

Mr Thomas. I'm very sorry, did I steal one your questions or part of one of your questions? If I did, apologies.

Questions by PROFESSOR THOMAS KC

PROFESSOR THOMAS: My Lady --

LADY HALLETT: Don't worry, Mr Thomas is used to people having the back chair. I'm afraid those who choose to sit over there will put their ...

PROFESSOR THOMAS: Good afternoon Professor McBride. I represent FEMHO, that's the Federation of Ethnic Minority Healthcare Organisations.

FEMHO has noted the significant and disproportionate impact of the pandemic on black, Asian and minority

ethnic healthcare workers.

I want to touch very quickly upon the question that my Lady stole from me earlier today.

You mentioned that you became aware of the disproportionate infection and death rates among black, Asian and minority ethnic healthcare workers in April 2020. I heard that correctly, didn't I?

A. Yes, I think, as I recall, information in relation to that and concerns in that respect were discussed at the UK senior clinicians and also at the UK CMO meeting, yes.

Q. So here is an ever so slightly modified question.

As a senior figure, once you became aware of the serious disparities, what role did you play in ensuring that effective steps were taken to protect black, Asian and minority ethnic healthcare workers?

A. Well, I think -- I mean, that report was published, that information was available in Northern Ireland and disseminated in Northern Ireland. It was for employers then to carry out risk assessments in relation to individuals in terms of the risk and whether or not they should be perhaps removed from frontline roles. So, for instance, we just touched on the ethical advice and guidance framework that was published in June. That specifically in that document referred to black and

ethnic minority groups who may need to be provided with alternative roles and responsibilities during the pandemic because of the increased risk.

So it was something we were alert to, it was something that employers, the trusts providing health services were aware of, and they have a duty of care to ensure that they safeguard the staff within their employment.

Q. That I understand.

But I suppose what I'm asking you is what systems were in place to ensure that this information was acted upon?

A. I mean, I was -- as I say, there was a specific HR policy cell within health code, I was not directly responsible for that. And I don't wish to appear to be ducking the question and saying -- and being unhelpful to the Inquiry. But the range of issues that I was dealing with and the complexity of the issues was such that, you know, I had to delegate and rely on other colleagues who had to legal responsibilities for this area, and indeed working with the colleagues in the Health and Social Care Board and PHA to working with trusts to ensure appropriate action was taken.

Because ultimately the responsibility for acting on such information rests with the employer.

So, to answer your question, I was not receiving or did not receive assurances that appropriate action was being taken, but certainly employers would understand that there's an expectation that they fulfil their duty of care to their employees.

Q. Well, perhaps you can help me with this.

Are you able to assist us with any policies or actions implemented to address the disparities identified to minimise what was preventable harm?

A. At the level at which I was working as Chief Medical Officer I cannot provide you with the direct operational evidence of that, or the practical outworkings of that, that is not something which, as Chief Medical Officer, I would have detailed knowledge of. That is something which others would be able to assist the Inquiry with who were employers at that time with the responsibility for the employee. But again that is not something which I had oversight or responsibility for.

Q. All right.

Let me move on. I have two more questions and then I have finished.

Perhaps you can help us with this.

What do you think could and should have been done to reduce the inequalities for ethnic minority healthcare workers to ensure that they didn't suffer such disparate

impacts and going forward in a future pandemic?

A. Well, I mean obviously every pandemic will be different.

The issue around increased vulnerability in black and ethnic minority groups is complex because there are a range of factors that contribute to that. In some instances it's due to a greater incidence of underlying health conditions, sometimes it's actually related to some environmental factors as well.

I think that there needs to be greater cognisance in the future in terms of the particular risks that individual healthcare workers might experience.

And I think the principle, the ethical principle of reciprocity is really important in this respect, so that if you have a healthcare worker who is putting themselves in harm's way and is at greater risk, that that greater risk should inform decisions about how they work, where they work, and that should be a priority and the employer has responsibility --

Q. Sorry, I'm not following. Forgive me, I'm not quite following.

Are you saying that the responsibility falls on the healthcare worker?

A. No, absolutely -- but what I was saying that was the employer.

Q. Okay.

A. The principle of reciprocity means is a responsibility on the employer to ensure that healthcare workers who had increased risk, irrespective of what that increased risk is, on the basis of that increased risk, that measures are taken to protect them. And that may include a number of things. It may include, for instance, removing them from higher risk environments where they may be exposed to the virus, or it may be preferentially offering them vaccination, for instance, to ensure that they are better protected in any future pandemic.

Q. Understood.

A. I think, you know, there are clearly issues within Northern Ireland which we touched on earlier in relation to ethnic monitoring in terms of which needs to be --

Q. Okay, let me come on to my very final -- my very final -- my final question.

Given your role, would you agree that you have some responsibility to ensure that recommendations are followed through? If not, who should be held accountable for ensuring that lessons are learned?

A. In general terms or in the specific issue?

Q. Well, if -- help us with both.

A. Okay. In -- in general terms I think it was a collective responsibility, I think I have personal --

professional and personal responsibilities to ensure that learning arising from this Inquiry and all its modules is implemented. And I think also responsibility to supporting and informing others who have primary responsibility for those issues in terms of providing advice as to how they might prioritise actions to address those issues.

So I think it's twofold. I think it's ensuring that recommendations are implemented, and ensuring that those are prioritised, and reminding others of their responsibility to implement those recommendations.

PROFESSOR THOMAS: My Lady, thank you.

LADY HALLETT: Thank you very much, Mr Thomas, very grateful.

Ms Sivakumaran. You are right over there. Far right at the back.

Questions by MS SIVAKUMARAN

MS SIVAKUMARAN: I appear on behalf of the Long Covid Groups, and I will be asking questions about provision of care for children and young people with Long Covid.

Now, I appear at -- my -- I realise it might feel a little bit strange because I'm asking questions from behind, but when you are answering them please do direct your answers towards the Chair.

A. Okay.

Q. Now, you've explained already that the first Long Covid clinics were established in November 2021.

Children can't be referred in to those clinics, can they?

A. Well, as I say, there were clinics in place prior to 2021, as I explained earlier. But the first commissioned service for people suffering -- adults with Long Covid was in November 2021. In Northern Ireland we have sought to fully implement the relevant NICE guideline ng188, and in terms of the advice to the Health and Social Care Board who commissioned the service, that was to provide a service for an adult patient and I can expand on that if you wish.

Q. Well, just focusing on children and young people for now. I don't think you've actually quite answered that --

A. Okay.

Q. -- children can't be referred in to those clinics.

A. Well, the -- the NICE guidance, the relevant NICE guidance that I reference, said that there was a lack of evidence in relation to the most effective approaches in terms of treatment for children.

In Northern Ireland that NICE guidance was discussed with the paediatricians in Northern Ireland, and there was an agreement that individual children -- children

with Long Covid would be referred in to existing paediatric services, which is the situation at present within Northern Ireland.

Q. Okay.

And so taken from that, and being referred in to existing paediatric services, they're not referred in to any dedicated Long Covid services?

A. But been referred in to paediatric services, the paediatricians would then determine the most appropriate approach to deal with the various sequelae that children with Long Covid would be experiencing. So they would have access to the full range of paediatric services and other specialists that were within paediatric units in Northern Ireland.

Q. And the Inquiry's heard evidence from Long Covid experts, Professor Brightling and Dr Evans, and they've said at paragraph 84 of their report to this Inquiry in Module 3 that regions with fewer patients of Long Covid and lower rates of Covid-19 -- this is in relation to children, and young people -- are likely to have inexperienced healthcare professionals. And that supports a need for a virtual multidiscipliniary team which delivers -- which could deliver post-Covid children and young people hubs. Deliver services through these hubs.

Now, you've explained how it's going through general services, but would you agree that a virtual multidiscipliniary team, delivering -- which delivers through a Long Covid children and young persons' hub, could provide a specialised, age appropriate support for children with Long Covid?

A. Yes, I did read that report, I think that's a very good suggestion. I think a similar approach has been taken, for instance in primary care, by the Royal College of General Practice, whereby general practitioners with a particular interest in Long Covid have formed a virtual network to provide, you know, mutual support and to provide regular updates.

I think there is much merit in that model, yes.

Q. And would you recommend that such services are provided for children and young people in Northern Ireland?

A. I mean I -- obviously that's ultimately a matter for the Inquiry to determine the merits of that. I think personally there is much merit in it. It will be ultimately a decision for a minister. I certainly would wish to engage with local paediatricians in Northern Ireland who obviously are more expert in this area than I, and those with a particular interest in this area, as to the relative merits of that.

MS SIVAKUMARAN: Thank you.

My Lady, Mr Scott has covered the second set of questions we have permission for, and we no longer seek to pursue that line of question with this witness.

LADY HALLETT: Thank you very much for your help.

Questions by MR JACOBS

LADY HALLETT: Mr Jacobs. I'm afraid Mr Jacobs is also over there. I think they are testing you, Professor.

A. Yes, I find it very difficult not to look at people when I'm speaking to them.

LADY HALLETT: I know. Well, look at them while they ask a question and then turn round when you answer it, if that makes you feel better.

A. Okay. What was that, sorry?

LADY HALLETT: Look at Mr Jacobs while he's asking the question and turn round to me --

A. Okay.

MR JACOBS: I don't think that's a command, I don't think you have to, but if it makes you feel more comfortable.

Professor, a small number of questions on behalf of the Trade Union Congress.

The first topic is the discussion earlier in your evidence that regulatory inspections were right to be reduced on the basis in part that it would add pressure. You refer to continued inspections adding further pressures to already pressured services, with staff

being pulling multiple directions.

Clearly, Professor, hospitals in month one of the pandemic or in its early stages are going to be under all sorts of pressures, reorganising staff, reorganising equipment, and so on.

Might it not actually be important in that context to have that regulatory pressure on health and safety, difficult though it may be, so it doesn't get lost amongst those competing priorities?

A. I think you make a valid point, and it is an important consideration, as I alluded to in my response to Mr Scott earlier, that these were finely balanced judgement calls.

I think that it's important to point out that the primary responsibility for the quality and safety of care resides with the provider of that care in Northern Ireland as across the rest of the UK. And then the second order of responsibility with the Commissioner, in this case the Health and Social Care Board working jointly with the PHA.

Regulation is an inspection is, you know, a belt and braces that, you know, is the external eyes and ears, to provide assurances that all is well or to point to things that are not well. And there is no doubt that in taking the decision to pause the inspections of the

hospital -- essentially cease the hospitals' inspections in Northern Ireland -- you're losing that external scrutiny. But again that was a decision that we made balancing up the adverse consequence in terms of pressure on staff, potentially introducing infection, and these were finely balanced decisions.

But, you know, I accept the point you're making.

Q. Professor, if we put that finely balanced decision to one side and focus on the future, on the next pandemic, if we are going to express dismay in this room as a society at the loss of life of healthcare staff, including the disproportionate loss of life of black and ethnic minority health workers, if we're going to endeavour to keep them safe, in the next pandemic do you think actually that finely balanced decision should be made differently, and it should be recognised that actually, in the early moments of crisis when safety is most precarious, when vulnerable groups are most at risk, actually that's when regulatory input needs to maintain if not increase?

A. I -- I do think that in planning and preparing for the next pandemic we need to consider iterative ways in terms of how we might maintain a proportionate inspection approach using, perhaps as we did -- as we did in Northern Ireland, or certainly within the care

homes sector, remote inspections or a hybrid approach to inspections, using technology, and in such a way that it remains intelligent-led, evidence-based and proportionate to the other pressures.

I know that in Northern Ireland the RQIA are currently looking at such innovative approaches to how inspections might be adapted to ensure that a degree of oversight could be maintained if similar circumstances arise again.

Q. And clearly the objective is something that is meaningful rather than a burden on services, but it sounds perhaps as if we're pushing at an open door, at least in the general principle of meaningful, regulatory input, including in the early stages?

A. Yes, I mean I think -- I mean, we did utilise the skills in -- of RQIA in the -- in the pandemic responses, to say they are all qualified health professionals, they established a service support team, I know for later modules, which was essential in providing support into -- into care homes. But I do agree that from my perspective, and certainly from a Northern Ireland perspective, I do think that we need to again re-examine the relative merits of that enhanced scrutiny in terms of eyes and ears from outside, that fresh look as to how that might be maintained to some extent in a meaningful

and proportionate way such as you've suggested.
Q. Professor, I'm going to try and deal briefly with a slightly different perhaps related point.
Paragraph 68 of your statement -- I don't think you need to turn to it -- you describe analysis to the effect that occupations with higher risk, including -- included those with high levels of close contact, including health and social care. And it also included those with low pay.
Would it be correct to say that those in frontline healthcare roles, on low pay, porters, cleaners, and so on, are at the intersection of two risk factors: lower pay with higher associated comorbidities, but also a setting and type of work that carries risk?
A. I would absolutely agree with that, yes.
Q. And how does pandemic response in the next pandemic account for that, account for those low workers in healthcare set -- sorry, low paid workers in healthcare settings being at that particular risk?
A. Well -- and you would expect me to say this as Chief Medical Officer -- the primary objective must be to improve the health and wellbeing of the entire population, and -- and reduce and address the huge inequalities that we see in health. The fact that people live longer because of their environmental and

social circumstances, socioeconomic circumstances, is invidious. And I know it's not a matter that this inquiry can address, but certainly from -- by policy responsibilities, working with other government departments, our primary objective under making life better, which is the depart -- the executive's policy about improving health and wellbeing and addressing health and equalities, we must invest more in addressing the underlying factors that contribute to that, the societal factors, the employment factors, that actually put those individuals at risk.
I think specifically, though, looking at a very practical basis in terms of what to do within employers -- when I was chief executive for a short time within the Belfast Trust I established a programme of staff wellbeing programmes, health and fitness programmes. I think as -- in health we need to be an employer of choice, we need to demonstrate that when you work for the health service, apart from those that we provide care to, working for the health service that we will invest in you, in your health and wellbeing, and keeping you fit and well.
As employers I think we -- as employers we have a duty of care to invest in the wellbeing of our staff because that, we know, translates into better and higher

quality patient care.
MR JACOBS: And I think I probably have gone over time for which I apologise. Thank you, Professor.
LADY HALLETT: Thank you very much, Mr Jacobs.
Yes, Samantha Jones. I'm not going to make the same mistake this time.

Questions by MS JONES

MS JONES: Thank you, my Lady, I'm very grateful.
Professor McBride, I ask questions on behalf of the Disability Charities Consortium. I have permission to ask you questions on three topics. So turning firstly to the topic of capturing inequalities.
You say in your statement -- and we don't need to turn it up -- at paragraph 424, that: in terms of data and analysis with respect to inequalities in Northern Ireland, we were able to review the impact of the pandemic in relation to age, gender and social deprivation.
And I know you were asked some questions about that earlier.
Can I take it from that that you were not able to review the impact of the pandemic on disabled people?
A. That's correct. And I think -- and again I have read the witness statements from some of those that you represent -- and I would agree that the recording of

data on those who are disabled is very poor within health and social care systems. We don't have, at this moment, a standard definition of what we mean. We have a definition -- a legal definition of what it means in terms of, you know, physical, mental and during. We would need to do a specific piece of work looking at -- I don't want to use technical terms -- but ICD term codes. So we needed to identify the conditions that individual with -- would result in people being disabled, and then we would need to maintain a way of capturing that information, recording that information. That does not exist at present, and I don't think that quality information exists anywhere in the UK at the moment and that needs to be addressed.
Q. And is that work being done currently by the department in Northern Ireland?
A. No, no, it is not being done currently by the department. Again, it would require a cross-departmental approach, it would require input in a Northern Ireland context, certainly from health, but also from the department for communities and others. It would require a cross-government approach.
Because obviously different parts of government hold information, and they hold -- all hold it in different ways, and that -- there isn't necessarily a consistent

sharing of that information. And we would need -- so, for instance, we could use those individuals who are on disability living allowance as a mechanism to ensure that we extract that information from health records.

Q. One follow-up question to that.

We've heard from earlier witnesses about the Office of National Statistics was able to collect data on the impact of the pandemic on disabled people, amongst other protected characteristics groups.

Is that data something that the department could use to look at the disparities and the impact on disabled people? And, if not, why not?

A. It certainly -- I mean, again I think the data, even in the UK -- sorry, in England -- is not robust and not well recorded.

I am not in a position, because again it's not my direct responsibility to answer whether or not it's worse -- more poorly recorded in Northern Ireland than elsewhere.

In ONS, it would be Northern Ireland, the Northern Ireland Statistical Research Agency, which is an arm's length body of Department of Finance, carries -- conducts statistical analysis to inform policy. And that could be an area working with other departments that that information could be developed in a similar

way as you describe with ONS.

Q. Thank you.

Moving on to the second topic then of shielding and those in the clinically and extremely vulnerable category, which I'll just refer to as the CEV for shorthand. Again, we don't need to turn to it, but at paragraph 129 of your statement you say that:

"As indicated above [in other paragraphs of your statement] the CEV list was kept under continuous review and on 26 November 2020, the Department announced that adults with Down's Syndrome had been added to the Clinically Extremely Vulnerable list as recent evidence indicated that adults with Down's syndrome were in the high-risk category for severe disease."

Now, first question, is that the -- a decision that you made with your fellow CEV -- sorry, fellow CMOs to add adults with Down's Syndrome to the CEV list?

A. Yes, representatives -- we worked very closely across the UK, we had a UK expert panel which members of the department were involved in those discussions. And the recommendations from the expert panel came to full UK CMOs for consideration, and we did approve it at that time.

Q. Do you recall that the decision, the date of the decision, when you made that, with the other CMOs?

A. I don't now recall.

Q. If I say this, we've seen in other documents -- and I can take you to some if we need to -- that a collective decision was made on 30 September 2020, and that was based on the interim QCovid findings. Is that something that you would agree with?

A. In terms of the time frame, I accept, you know, your premise or your point that it was 30 September. It was certainly based on QCovid analysis, and -- and, with the passage of time, I don't recall -- sorry, I'm anticipating your next question, sorry.

Q. Thank you.

So my next question is -- without needing to take you to those documents -- is that we heard the decision was made collectively by you and your CMO colleagues on 30 September 2020. But we know from your statement and other documents that it was only on 26 November that the department announced that adults with Down's Syndrome would be added to the list.

Can you account for why there was that delay in that announcement from the decision?

A. I don't now recall. I mean, I -- my recollection -- and obviously it's not accurate -- was that when the advice was provided the decision was made to add it to -- sorry, a decision was made to add it to the list and it

was added. I -- I can't explain what the rationale was or what the factors were that contribute to the delay and actually adding it officially to the list.

Q. You say at paragraph 129 of your statement that once that announcement had been made you wrote to adults with Down's Syndrome to advise them that they had been included on the list, and you advised what this meant for them. And in your statement you've exhibited a template letter detailing that advice.

Now, just in terms of when that letter was sent, it's dated in the -- on the template, just November 2020, but we don't have a specific day on when it was sent.

Can you recall when it was sent in November, and would it been after the announcement was made by the department?

A. I think -- my recollection is that we were all would've made the announcement at the same time, and we all issued the correspondence at the same time, given the close cooperation that was going across the UK. I don't recall the -- the exact date. I do recall that we also issued an easy read version --

Q. Yes.

A. -- with the letter, so that again it would be understood with -- by people with -- living with Down's Syndrome.

But I don't recall the dates or timing.
Q. Yes. But, to be clear, it's likely that you would've sent that letter after the announcement was made by the department, you wouldn't have sent it earlier than 26 November?
A. I think that that would -- I think that's a reasonable conclusion, yes.
Q. And I appreciate your earlier answers on this so you might be able to help me, but are you aware of any negative impact that was or could've been caused to adults with Down's Syndrome by only informing them that they were added to the CEV list on 26 November, or thereafter, when the decision had actually been made at the end of September?
A. I'm not -- certainly, you know, there was a reasonable expectation, and I don't know the circumstances, and I now can't recall that -- when, as UK CMOs, we made that decision that that advice would've been acted upon. I don't know why the apparent delay or what the rationale for that was. Sorry.
Q. Okay, thank you.
My third and final topic then is on DNACPRs.
And at paragraph 275 of your statement -- and again I don't believe we need to go to it unless you'd like me to take you there -- is that you say prior

to October 2022 you had interim guidance in place, and that was in the form of the Covid-19 Guidance Ethical Advice and Support Framework which supported DNACPR decision-making for clinical teams.
Now, could we just go to that guidance, if that's possible? It's INQ000381325.
So that there. I appreciate there was an earlier version published in June 2020, and this is the version that was updated on 21 September 2020.
And if we could just go to page 29, please.
You see at the bottom of that page, that's the section that is numbered 7.5, and it's the section on DNACPRs. Thank you.
And then if we can go over to page 30, and it's the fourth paragraph down which I'd like to ask you about. So there, as you can see, it says -- and I am sure you are familiar with this anyway --
A. Yes.
Q. -- "DNACPR decisions should be made in conjunction with other members of the multi-disciplinary team, including the GP."
Now, my question is the guidance doesn't say expressly that the decision should be made with the individual or their family. Is that something that you would agree was not expressly stated in the interim

guidance at the time?
A. Again, this is a 63-page document, and I think if you go to page 5 and page 14 of the document, it is explicit in stating that there needs to be discussion with the patient and also with family. I think page -- I think it's page 14 talks about a clear explanation, and that that clear explanation is of critical importance. And I think the term is to "avoid future misunderstanding".
So in the executive summary it makes it very clear, so that's on page 5, and then that same point is reiterated at page 14, and then there's a section, which again isn't here and isn't displayed, around decision-making during the pandemic and when there are resourcing pressures. And again it's made explicit there. So I just urge caution in terms of taking that in the wider context of the -- of the guidance itself.
LADY HALLETT: But it would be better, if the guidance is saying "include members of the family and the patient where possible" if, when you have a list of objectives, or -- or criteria to be deployed, then it says there "family", even if it says it elsewhere in the document, wouldn't it?
A. Well, it says it on the first page of the document. If you go to -- you know, if you go to page 5, it is explicit, and it is explicit throughout the document,

my Lady. But I mean I do -- I do accept that when -- that referencing earlier pages would've been helpful. But --
LADY HALLETT: But people goes to chunks of it, don't they? We all know documents are sent through from some body above and we'll go to the page we find most useful. If some clinicians took that page, they're not going to see the reference --
A. The only other point I would make, my Lady, is that GMC guidance on this is absolutely clear. I mean, that was published in -- the GMC guidance published in 2010. So this isn't the only document. And the legislation rights-based approach and all the relevant legislation was referenced in this document, and specific emphasis in both the Resuscitation Council UK Guidance of 2016, GMC guidance is about discussions and issues of consent with individuals and their families.
So I think in con -- you know, taking this page in context, I think I would just caveat it with wider guidance and earlier parts of the document.
LADY HALLETT: Ms Jones.
MS JONES: Thank you, my Lady, that was going to be my final question, so thank you very much.
LADY HALLETT: Thank you.
Questions by MS POLASCHACK

LADY HALLETT: Ms Polascheck, where are you? Oh, that way. Right. Can you see --

MS POLASCHECK: I think hopefully I'm in the right position for you to look at me. And if I'm lucky I think -- well, if you're lucky I think I'm the last questioner, so double bonus for you today.

I ask questions on behalf of clinically vulnerable families who are a group who advocate and provide support for the clinically vulnerable, the clinically extremely vulnerable, and of course their families.

And I just have one topic of -- of questions today about the design of the shielding programme. And in particular the way the protection of shielding was directed towards individuals, not their families or the wider household.

So first, did you or your office give any advice when developing the shielding programme about how many clinically and vulnerable, clinically extremely vulnerable people, lived with others, and particularly with other people who weren't shielding?

A. We didn't have those numbers, and -- but what we did do, and I think it is in the letter which issued on the -- around 27 March, we did provide guidance into people who were shielding about the -- what others living with them and carers' steps that they should be taking to protect

them. So the letter wasn't just directed to those shielding, but also contained advice -- to the best of my recollection contained specific advice to individuals living with individuals who were shielding or providing care to individuals who were shielding. And we reinforced that on -- on multiple occasion during media briefings and further statements from the department.

Q. So that's right, Professor, but it's also correct that in that same letter we know that shielding individuals were told to socially distance from those that they lived with so to maintain a 2-metre distance from them and to eat separately from them as well. For example, in conjunction with those -- their loved ones taking those steps?

A. Yes, obviously the practical implications of that, if you are living in a small home, you know, with other individuals living with you, you know, the advice did say about, you know, if you can use separate bathrooms, et cetera, et cetera, et cetera. Going into the kitchen when others aren't there. Ventilation.

The practical outworkings of that, I think for individuals who were shielding, and indeed for those who lived with them, was extremely challenging, and I accept that.

Q. Thank you, Professor. Because you've anticipated my

next question, which was whether you gave any advice on the feasibility and the real world challenges for those people who were trying to follow that advice?

A. We sought to do so. Whether we effectively and comprehensively did so is another question, and, you know, obviously those who were shielding did communicate directly with me at the time. And I think it was undoubtedly more difficult for some who were shielding than for others. We were also, when we issued that guidance, we were very keen to emphasise the important other things that people should do in terms of their physical health, their mental health, and sources of support that were available to them. But I -- I -- I accept that was -- that the advice for many would've been difficult to implement.

Q. Thank you, Professor.

You've said that there wasn't that data available to you about numbers of those shielding who were living with others at the outset. We know that in England, at least, ONS started by July 2020, indicated that 74 per cent of CEV people lived with others, and 15 per cent lived with children under 16.

So once shielding was implemented, did equivalent data -- was equivalent data available in Northern Ireland? And, if so, were those numbers ever used to

revise or advise on that individual focus of the shielding programme?

A. My role -- and it was as indicated in my statement -- was to provide the professional technical advice in relation to shielding and who was clinically extremely vulnerable. The operational aspects of the implementation were with policy colleagues within the department, including the issuing of letters, et cetera.

There was some analysis conducted. I don't have the figures with me in terms of the number of people who were shielding in Northern Ireland, I think we probably had more people shielding in Northern Ireland per head of the population than elsewhere. But I don't have the breakdown that you've just described in terms of those living with family, other family members or those living with children.

MS POLASCHECK: Thank you, Professor.

My Lady, those are all my questions.

LADY HALLETT: Thank you very much indeed. I think that completes the questions now.

Another very long day for you -- oh, Mr Wilcock.

Further questions by MR WILCOCK KC

MR WILCOCK: Just a request for an additional Rule 10, it may not have reached you yet. It will take about a minute to answer and a minute to ask.

LADY HALLETT: As it's you, Mr Wilcock!
MR WILCOCK: That's very kind, thank you very much.
Professor, I asked you questions about whether the recommendations of the Craigavon serious adverse incident review had been implemented, and you responded by correctly observing that the majority of those were directed towards the Southern Trust.
It's right, however, isn't it, that one of the recommendations was directed both to the Trust and the Department of Health, PHA, and the Health and Social Care Board, and stated that Northern Ireland should implement a Northern Ireland infection prevention and control framework to provide consistency between trusts, and that the absence of such a framework had resulted in a variation of investment in the regional IPC workforce, workforce resources, policy and management between trusts in Northern Ireland.
The question I have been asked to ask is: has that been complied with?
A. If I understand the question, or part of the question correctly, it's about IPC framework. In Northern Ireland we do have an IPC --
Q. Was one introduced following the --
A. No, we've have always had a regional Northern Ireland IPC framework.

Q. Right.
A. I'm not directly responsible for -- that work was taken forward by the Public Health Agency. That is in existence. I noticed one of the expert reports indicated that it wasn't aware whether there was or whether there wasn't. There was and has been for a considerable number of years a regional IPC report.
As to the consistent application of that, again I'm not in a position to advise. I think it's back to the other expert witness report which talked about hearts and minds, people need -- healthcare workers need to be empowered to implement the control and would need to understand the benefits of that. There needs to be significant investment, Chair, I would suggest in terms of infection prevention control teams and infection prevention and control training.
Traditionally it's the preserve and expertise of infection control nurses, but it's everyone's responsibility. And I think that one other learning from the pandemic is that we need to do much, much more in this space, including ensuring that we have an awareness of and training around infection prevention control in those healthcare workers working in care home -- in care homes, in pharmacy, et cetera. Because the learning from the pandemic was we needed to invest

considerable time and effort, appropriately so, in scaling up those individuals. So it is additional investment, additional training, and ensuring more consistency of approach.
Q. So you're going to get me into trouble.
Can I -- does it comes to this: there was a framework, whatever the framework was, it hasn't been altered, enhanced or amended as a result of the Inquiry's report, but you accept that more investment in this area is needed in Northern Ireland. Is that a summary of your answer?
A. I -- I don't genuinely know whether the framework has been updated since the pandemic. That's not within my direct area of responsibility. I do absolutely accept there is more investment required in this area of work.
MR WILCOCK: Thank you very much indeed. Thank you, my Lady.
LADY HALLETT: Thank you, Mr Wilcock.
That now completes the questions for you, Professor McBride. It's been another long day for you, and I know the demands that the Inquiry has been making on you. I wish I could say it's the last time we're going to call on you. I honestly don't know.
A. I was hoping you would say -- you're fed up seeing me.
LADY HALLETT: For the likes of you, who keep coming to help

me, you know, I meant to check at lunchtime but the trouble is I have so many modules.
A. I do appreciate that.
LADY HALLETT: Anyway, we're really grateful to you for the help that you've given, and I'm sorry it's been such a long and I hope not too gruelling day but I suspect it has been quite gruelling. But anyway, thank you.
A. Well, I stand ready to assist the Inquiry in any way I can, my Lady.
LADY HALLETT: Thank you very much indeed.
(The witness withdrew)
LADY HALLETT: 10.00 tomorrow, please.
(4.15 pm)
(The hearing adjourned until Wednesday 25 September 2024 at 10.00 am)

I N D E X