Witness Name: Elizabeth Mitchell
Statement No.: WITN7542001
Exhibits: Nil
Dated: 21 December 2022

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF DR ELIZABETH MITCHELL

I provide this statement in response to a request under Rule 9(1) and (2) of the Inquiry Rules 2006 dated 2 November 2022.

I, Elizabeth Mitchell, will say as follows: -

Section 1: Introduction

1.Please set out your name, address, date of birth and professional qualifications.

1. Dr Elizabeth Mitchell, GRO-C Belfast, GRO-C DOB GRO- 56

2. I qualified in medicine in 1980, MB BCh BAO (Second Class Honours), at the Queen's University of Belfast. I was successful in the membership examination for the Royal College of Physicians UK in 1983 and became a Fellow of the Royal College of Physicians Edinburgh in 1997. I achieved Membership of the Faculty of Public Health Medicine (UK) in 1989 and Fellowship of the Faculty in 2000. I was also awarded Membership of the Faculty of Public Health Medicine in Ireland in 2000 and Fellowship of the Royal College of Physicians of Ireland in 2006.

3. I have surrendered my licence to practise but remain on the General Medical Register.

2. Please provide an outline of your employment history, identifying the roles and responsibilities that you have held throughout your career (with relevant dates), with particular reference to those related to matters relevant to the Inquiry's Terms of Reference.

4. My first post after qualification was as Junior House Officer in the Belfast City Hospital in 1980-81. I then worked in hospital medicine as a Senior House Officer in the Royal Victoria Hospital in Belfast for two years, followed by one year as medical registrar in the Belfast City Hospital. In 1984 I entered specialty training in public health medicine (or community medicine as it was then known) in the West Midlands Health Authority Region, England. I subsequently worked at national UK level at the Communicable Disease Surveillance Centre in Colindale, London.

5. I returned to Northern Ireland in 1990 and worked in general public health medicine at the Western Health and Social Services Board for about 1 year, initially as a Senior Registrar in Public Health and then as a Locum Consultant in Communicable Disease Control. In 1991 I was appointed as Consultant in Communicable Disease Control (2 days/week) at the Eastern Health and Social Services Board (this continued until 1995) and was seconded to the post of Senior Medical Officer (3 days/week) at the Department of Health and Social Services (DHSS) with responsibility for communicable disease control and food safety issues. From 1995 I was seconded full time to DHSS as Senior Medical Officer.

6. From April 2000 to June 2007 I was in the post of Principal Medical Officer in the Department (renamed as the Department of Health, Social Services and Public Safety (DHSSPS)). The major objective of the post was to promote and improve the health of the public in Northern Ireland. I had responsibility for the provision of medical advice on all public health issues including health promotion. The responsibilities of my previous DHSSPS posts included the implementation of national immunisation policy within Northern Ireland.

7. I was in the post of Deputy Chief Medical Officer, DHSSPS, from July 2007 until January 2014. From May 2011 I was also the Director of Population Health. In this dual role, I provided direct public health input to the work of the DHSSPS on development of public health policy, strategy and legislation. This included the three domains of public health (health improvement, health protection and health service quality). I was responsible for the Directorate budgets. I managed 40 administrative staff and a public health specialist team. I frequently deputised for the Chief Medical Officer and on two occasions was temporarily promoted to the post of Chief Medical Officer - from May 2006 to September 2006 and from 1 April 2009 to 16 August 2009. From 2008, I was the policy lead in the DHSSPS for Research and Development related to health and social care and worked closely with the Health and Social Care Director of Research and Development.

8. I worked directly with the Ministers advising and supporting them on all aspects of public health. I regularly gave oral and written evidence to the Health Committee of the NI Assembly. I often acted as media spokesperson for the DHSSPS on public health.

9. My last position was on secondment from my substantive post as Deputy Chief Medical Officer, DHSSPS, to the Institute of Public Health in Ireland (IPH). From January 2014 to February 2016 I was a full-time Consultant in Public Health Medicine, supporting IPH in its drive to tackle health inequalities and improve population health across the island. I was a member of the Management Team of the IPH and reported to the Chief Executive of the IPH. From March 2016 until November 2016, when I retired from the Northern Ireland Civil Service and all paid employment, I was interim Chief Executive of the IPH.

10. During the COVID-19 Pandemic, I returned to work as the Director of Contact Tracing for Northern Ireland as a Consultant in Public Health Medicine at the Public Health Agency from December 2020 to June 2022.

3. Please set out your membership, past or present, of any committees, associations, parties, societies or groups relevant to the Inquiry's Terms of Reference, including the dates of your membership and the nature of your involvement.

11. As a Senior Medical Officer I represented DHSS as an observer on the Ad Hoc working party established by Dr JS Metters, Deputy Chief Medical Officer of England in 1995.

12. I represented DHSS as an observer on the Advisory Committee on Microbiological Safety of Blood and Tissues for Transplantation (MSBTT). I do not recall the date when I joined the committee but I think it was probably from its establishment in 1993, nor do I remember how long I represented Northern Ireland on it.

13. I represented DHSS as an observer on the Advisory Group on Hepatitis (AGH). I do not recall the date when I joined the group nor how long I represented NI on it.

14. I represented DHSS as an observer on the Expert Advisory Group on AIDS (EAGA). I do not recall the date when I joined the group nor how long I represented NI on it.

15. I represented DHSS as an observer or assessor on the Spongiform Encephalopathy Advisory Committee. I do not recall the date when I joined the group nor how long I represented NI on it.

16. I do not recall any other committees, associations, parties, societies or groups relevant to the Inquiry's Terms of Reference of which I was a member.

4. Please confirm whether you have provided evidence or have been involved in any other inquiries, investigations, criminal or civil litigation in relation to the human immunodeficiency virus ("HIV") and/or hepatitis B virus ("HBV") and/or hepatitis C virus ("HCV") infections and/or variant Creutzfeldt-Jakob

disease ("vCJD") in blood and/or blood products. Please provide details of your involvement if so.

17. I have not provided evidence or been involved in any other inquiries, investigations, criminal or civil litigation in relation to the issues specified above.

Section 2: The Department of Health and Social Services

5. Please describe your role, functions and responsibilities as Senior Medical Officer (SMO) at the DHSS.

18. In the post of SMO in DHSS I had responsibility for provision of medical advice on matters to do with communicable disease control, food safety and environmental health. The responsibilities of the post included planning and coordinating the implementation of national immunisation policy.

6. Please describe the extent to which you had responsibility for (a) health matters generally and (b) policy in relation to blood and blood products.

19. As SMO I was not responsible for health matters other than those specified in my answer to Question 5. I was not responsible for policy in relation to blood and blood products but provided medical advice to inform policy. This was primarily based on my role as observer on the committees and advisory groups identified in my answer to Question 3 as I have no specialist knowledge or experience in haematology.

7. Please identify a) any ministers who had responsibility for health and/or for blood and blood products during your time as Senior Medical Officer and b) any other civil servants (medical or administrative) who had responsibility for health and/or for blood and blood products during your time as Senior Medical Officer.

20. I had no direct dealings with Ministers under Direct Rule and do not remember the names of ministers during that period.

21. During my time as SMO there were separate administrative and professional advisory hierarchies. The former reported to the Permanent Secretary, Alan Elliott at that time, and the latter to the various chief professional officers, in my case I reported to the Chief Medical Officer, Dr James McKenna, through the Deputy Chief Medical Officer, Dr Clifford Hall. I believe the Assistant Secretary with responsibility for policy in the relevant areas was Mr Jack Scott and, after his retirement, Mr Derek Baker.

9. Please describe in broad terms a) the organisational structure of the DHSS, insofar as relevant to the Inquiry's Terms of Reference; and b) the roles and functions of the DHSS during your time as Senior Medical Officer.

22. During my time as SMO there were separate administrative and professional advisory hierarchies. The former reported to the Permanent Secretary and the latter to the various chief professional officers. The administrative departments were divided into a policy directorate and a directorate known as the Management Executive.

9. Please set out your understanding as to how, in general, decisions about matters relating to health were taken within the DHSS.

23. The Minister was ultimately responsible for decisions in all areas of the Department's work. The policy directorate would brief the minister usually by way of a written submission from the relevant Assistant Secretary and / or the responsible Under Secretary. Where issues spanned the interests of the policy side and the Management Executive, the Permanent Secretary would be involved and, for medical or public health issues, the Chief Medical Officer would provide advice.

24. The Management Executive was responsible for managing implementation of policy and overseeing the four Health and Social Services Boards which were then responsible for running the health services in their respective areas.

10. Please explain which criteria determined whether a matter was of sufficient importance to be brought to the attention of ministers and who would make those decisions.

25. Based on my role and responsibilities as SMO and my recollection and the passage of time, I am not able to answer this question.

11. Please describe in broad terms the extent to which you had interactions directly with ministers and/or with the Chief Medical Officer on matters relating to health generally and to blood and blood products in particular.

26. As SMO I had no direct dealings with Ministers on matters relating to health generally or to blood and blood products. The CMO held weekly medical staff meetings at which current issues would be discussed. I do not recall any specific meetings or discussions but, in general, would have briefed the meeting on current issues including matters relating to blood and blood products. For example, I would have highlighted meetings which I had attended as an observer and any implications for Northern Ireland. The CMO had an open-door policy so I had ready access to him for advice as I would have had with Dr Clifford Hall, DCMO, my line manager. The CMO also held an annual strategic planning meeting with medical staff at which there would be a brief review of the previous year's main issues and a look forward to the coming year and the priority areas for each member of staff. I do not remember any specific details relating to blood or blood products.

12. Please describe, in broad terms, the relationship between DHSS and the Department of Health (Westminster) in respect of health policy in Northern Ireland during your time in office, with particular reference to policy related to blood, blood products, haemophilia and other bleeding disorders, HIV/AIDS and hepatitis.

27. As SMO, other than my involvement as observer on MSBTT, AGH and EAGA and dealings with the secretariat for those committees at that time I cannot comment on the wider relationship between DHSS and the Department of Health (Westminster).

13. Did you have regular interactions with civil servants (medical or administrative) within the Department of Health (Westminster) on issues relevant to the Inquiry's Terms of Reference, and if so with whom?

28. I recall interactions with Dr Jeremy Metters, DCMO, Dr Ailsa Wight, SMO, Dr A Rejman and Dr H Nicholas.

14. How much oversight, if any, did the Department of Health (Westminster) retain over health policy decisions made in respect of Northern Ireland? Please provide any relevant examples.

29. I believe the responsibilities for health policy were completely devolved to Northern Ireland. In my time, there was a general aim to maintain parity for policies like immunisation or other communicable disease issues such as vCJD. I understand this was not always the case, for example, in the 1980s a different approach to public education was taken with AIDS/HIV as there was little evidence of a local issue with injecting drug use at that time. The main difference in approach was that the Northern Ireland campaign placed less emphasis on injecting drug use as a route of transmission of the virus.

30. It was the role of DHSS to formulate, manage, fund and implement health policy in Northern Ireland subject to the allocation of funds from the Department of Finance.

15. To what extent did the DHSS interact with and seek to influence the Department of Health on matters relating to blood and blood products?

31. I am not aware of any interactions or attempts to influence the Department of Health (Westminster) on matters relating to blood and blood products.

16. To what extent did the DHSS attempt to align its policies and activities with those of the Department of Health on such matters and on health policy more generally?

32. In my time, there was a general aim to maintain parity for policies like immunisation or other communicable disease matters including with respect to hepatitis C and blood and blood products. I understand however that this was not always the case, for example, in the 1980s a different approach was taken with AIDS/HIV in Northern Ireland based on the epidemiological picture as there was little evidence of a local issue with injecting drug use. I cannot answer with respect to health policy more generally.

17. When and how would the DHSS be represented on UK wide committees and decision-making bodies regarding blood and blood products, hepatitis or HIV/AIDS?

33. I can only answer this for my own areas of responsibility of infectious diseases. My predecessor, Dr Nick Donaldson, was an observer on certain advisory committees and groups, for example EAGA, and I took over these roles on my appointment as SMO. Subsequently, when new groups were established, DHSS would have been consulted on whether it wished to be represented on the committee and on who should be nominated. This would usually have been through the CMO's office or DCMO. See for example [DHSC0003555_150].

18. What was your understanding, in broad terms, of the role of the Chief Medical Officer ("CMO") for Northern Ireland during your time as Senior Medical Officer? Please comment, in particular, on the following areas:

a. The extent to which the CMO was responsible for informing ministers about risks to public health

34. It is my understanding that the CMO was responsible for informing DHSS ministers about risks to public health and that Dr McKenna would have had access to brief the ministers.

b. The extent to which the CMO was responsible for shaping policy and informing ministers of policy options.

35. I believe the CMO, based on his knowledge and experience, briefing from the DHSS medical team, and his regular contact with senior clinicians, would have given resolved medical and public health advice to administrative colleagues and therefore would have had significant influence on relevant policy development.

c. The extent to which the CMO was responsible for issuing guidance, advice or instruction to clinicians and health bodies as to the risks of infection from blood or blood products.

36. The mechanism for issuing guidance, advice or instruction to clinicians and health bodies on medical and public health matters was to issue a CMO letter. In general, my experience was that if a CMO letter was issued in the other home countries a Northern Ireland CMO letter would also be issued. My recollection is that there would have been a CMO letter issued in Northern Ireland on the Hepatitis C and Blood Transfusion Look Back soon after the one issued in London (3 April 1995). I would have drafted the first version of the Northern Ireland letter which would have been edited by my line manager Dr Clifford Hall, DCMO, before sending to the CMO's office for clearance and signature. I do not recall, given the intervening years, if any other CMO letters were issued on the risks of infection from blood or blood products during my time as SMO. There was also the CMO's annual report which would highlight public health risks and was distributed to senior clinicians and health bodies. I also recall CMO Updates which were a mechanism for alerting doctors to public health matters. The Northern Ireland versions used the English CMO updates as templates and edited the content to suit the local context.

d. The extent to which the CMO was responsible for issuing guidance or advice for patients and for the public.

37. The CMO's Annual Report was a public document. I know that, when Dr Henrietta Campbell was CMO, it was distributed to libraries and schools, but I am uncertain if this was the practice in Dr McKenna's time. The Health Promotion Agency took the lead in issuing advice to the public on public health matters.

19. What contact, if any, would DHSS officials have with the CMOs for England, Wales and Scotland? If there was any contact, please explain how, when and why it would be arranged.

38. Other than the CMO for Northern Ireland, who I understand had regular meetings with his counterparts in the home countries, I am not aware of such contact with one exception. Dr Ken Calman organised a meeting for the four CMOs' teams to meet for a short conference to exchange information and share learning. I attended one of these.

20. To the best of your knowledge and recollection, how significant a role did the CMO for Northern Ireland play in forming policies on blood, blood products and any other matters relevant to the Inquiry's Terms of Reference during your time as Senior Medical Officer?

39. Based on my recollection, because of the passage of time, I am not able to answer this question.

21. Please describe the working relationship between the DHSS and the Belfast Regional Transfusion Centre. In particular please describe the following:

a. **the lines of communication between the DHSSNI and the Belfast RTC;**
b. **the frequency and regularity of interactions between DHSS and Belfast RTC;**
c. **any areas of overlapping responsibility and how these were navigated.**

40. Other than my own occasional contact by phone or in writing with the medical director, Dr Morris McClelland, or his deputy Dr Chitra Bharucha of the Northern Ireland Blood Transfusion Service, I am not able to answer these questions which were outside my area of responsibility.

22. Please describe the working relationship between the DHSS and the Belfast Haemophilia Centre. In particular please describe the following:

a. **the lines of communication between the DHSS and the Belfast Haemophilia Centre;**
b. **the frequency and regularity of interactions between the DHSSNI and the Belfast Haemophilia Centre;**
c. **any areas of overlapping responsibility and how these were navigated.**

41. Other than my own occasional contact by phone, in writing, or meeting in her office with the Director of the NI Haemophilia Reference Centre, Dr Elizabeth Mayne, I am not able to answer these questions which were outside my area of responsibility. My own interaction with Dr Mayne was primarily in the context of the UK HIV and AIDS Surveillance Scheme. Dr Mayne was responsible for reporting cases of HIV/AIDS in patients with haemophilia.

23. To what extent, as far as you can recall, did any of the following matters come to your attention during your time in post:

a. **The risks of serious viruses being transmitted by blood and blood products.**
b. **The introduction of screening of blood donations for HCV.**
c. **The circumstances in which people receiving NHS treatment in Northern Ireland were infected with HIV/HCV/HBV.**
d. **Whether or not compensation or some form of financial support should be provided to those infected with HIV/HCV/HBV from blood or blood products.**

e. **Whether there should be an inquiry into the circumstances in which people receiving NHS treatment in Northern Ireland were infected with HIV/HCV/HBV.**

42. I would have been aware of the risks of serious viruses including what was previously known as non A non B hepatitis being transmitted by blood and blood products through my medical education and knowledge. I was aware of the exclusion categories for blood donors which were aimed at reducing the risk of HIV transmission prior to the introduction of HIV screening tests.

43. The introduction of screening for blood donations for HCV was introduced in September 1991. I joined DHSS in January 1991 and would have been aware of these developments through my attendance at advisory committees and groups in London and having sight of relevant submissions from the Department of Health (Westminster). I do not recall having any direct role in its introduction in Northern Ireland.

44. As mentioned in my answer to Question 22, I was aware that a number of patients with haemophilia in Northern Ireland had acquired HIV infection most likely through infected blood products prior to 1985. As an observer on the Ad Hoc Working Party on the Hepatitis C Look Back I was aware that a small number of blood transfusion recipients had tested positive for HCV in Northern Ireland [WITN4486087]. By 2010, 40 people with haemophilia had been identified who were infected by HCV from NHS treatment [DHNI0001321_001].

45. I was aware of the MacFarlane Trust and Eileen Trust which provided payments to people with haemophilia and others who contracted HIV from infected blood and blood products. I was not directly involved in the administration of these or arrangements in Northern Ireland for making such payments. I would have been aware of the calls for compensation for patients with haemophilia who may have been infected by HCV through sight of submissions from Westminster such as [WITN3430140] and [WITN4486087]. I am not aware of any specific calls in Northern Ireland at that time in addition to the national pressure. Later in my role as Director of Population Health in 2010 I became aware of a letter from Gerry Adams MP to Minister McGimpsey in relation to the Archer Report [DHNI0001321_001]. Similar letters were received from other MLAs and two Assembly Questions were asked. [DHNI0000485 para 17].

24. Please describe the role played by the DHSS in forming, directing and managing health policy for Northern Ireland, with particular reference to matters relating to blood and blood products, and the risk of infection from blood and blood products.

46. I have nothing to add to my answer to Question 9.

Section 3: Calls for Compensation

25. What initiatives were taken by the DHSS to identify individuals who were eligible for Skipton Fund payments? You may find [DHNI0000926] of assistance. In what ways, if any, did these initiatives differ from the Department of Health (Westminster)'s approach?

47. In 2011 when I was DCMO and Director of Population Health, I arranged a meeting with Dr Gary Benson, the Director of the NI Haemophilia Centre at the Belfast City Hospital. I was accompanied by a member of my team who looked after the day to day work on the Skipton Fund. I do not recall the date of this meeting, but it would have been before 1 March 2011 as I mention this meeting in my letter to Dr Neil McDougall [WITN3430146]. The purpose of the meeting was to advise him of the arrangements for making payments from the Skipton Fund to the haemophilia patients under his care. I do not recall the specific circumstances of the mother who had her claim re-examined after initially being turned down. My team member would have cleared any communication with the Skipton Fund about this with me, but I do not now recall if I had to personally intervene. Based on the Barnett share, the money we had earmarked for counselling was extremely small (I believe around £2,500). I am not sure how this money was used. I do not remember if we were able to secure any additional funding for the social worker or data manager highlighted by Dr Benson in his email [DHNI0000926]. Given the small scale of Northern Ireland, we were able to make this personal contact with Dr Benson. I have no knowledge of how the matter was approached in England.

26. What involvement did you have in any consultation between Anne Milton and the Minister of Health in Northern Ireland, Michael McGimpsey, to implement recommendations touching on matters related to Northern Ireland? Please refer to [DHNI0000482].

48. As the Director of Population Health, I cleared the submission prepared by Seamus Camplisson, Principal Officer [DHNI0000482]; other than this I do not recall being involved in the consultation.

27. What involvement did you/the DHSSNI have in the Skipton Fund Review established by Anne Milton on 13 October 2010 and announced by Andrew Lansley on 10 January 2011? You may find [DHNI0000482] and [DHNI0000485] of assistance.

49. My team and I were unaware of the findings of the review and the Westminster Government's response until the day of the Secretary of State's announcement on 10 January 2011 as we were not adequately informed of the findings nor given sight of the report in advance. Officials were informed of the main findings in a teleconference with DH Westminster on 22 December 2010 following which officials were able to outline the main proposals to our Minister and provide estimated costs for NI. I was not directly involved in any teleconferences on these matters.

28. What discussions did you have with the Devolved Administrations of Scotland and Wales concerning the Department of Health (Westminster)'s recommendations following the Skipton Review? How did these discussions influence the DHSSNI's response to the Review? Please consider [DHSC5683895] and [DHSC5683949].

50. I do not recall any personal discussions with Scotland or Wales about DH (Westminster)'s recommendations. My Mother died on 27 September 2011 and I was therefore out of the office for a number of days following her death. It may be that other members of the team held these discussions in my absence.

29. In a letter from yourself to Neil McDougall [DHNI0000462], you note that 'In principle Northern Ireland would seek to maintain parity with England'. How was this decision reached and were other Administrations involved in this decision?

51. As stated in my answer to Question 16, it was a general principle that DHSS would seek to maintain parity but this would be subject to the available funding in the context of other financial pressures. With regard to this specific decision, I was not personally involved in any discussions with the other Devolved Administrations but this may have been agreed at Ministerial teleconferences.

30. The Press Release dated 24 March 2011 [DHNI0000431] notes that two aspects of the review were to be handled differently in Northern Ireland:

a. **The changes to prescription 'season tickets' would not apply in Northern Ireland as prescription charges have been abolished; and**
b. **The proposals for additional access to counselling services would be considered within the current service provision for those with haemophilia in Northern Ireland.**

Why was it decided that the position regarding counselling services would be handled differently in Northern Ireland? You may also wish to refer to [DHNI0000926].

52. As explained in [DHNI0000926], based on the Barnett share, the money we had earmarked for counselling was extremely small (circa £2,500). It would not have been sufficient to cover any bespoke arrangements for counselling and I am not sure how this money was used.

31. What was the position of the DHSS concerning increasing payments in line with the Irish system, as part of the Skipton Fund Review?

53. It is my recollection that consistency of payments across the UK was thought to be the more important consideration – see [DHNI0000482].

32. In a letter to you, dated 7 September 2011 [DHSC5681478], Ailsa Wight stated that, 'DH remains firmly of the view that it is the responsibility of the Devolved Administrations to fund the new hepatitis C payments. Without your formal agreement to fund, we are not able to make progress with the service level agreement between ourselves and with the Agency Agreement between DH and the Skipton Fund itself'. How much influence did DHSS have over funding options for the new Hepatitis C payments?

54. Based on my recollection and the passage of time, I am not able to answer this question.

33. Were you made aware of any issues implementing the new payments from the Skipton Fund review in NI? What impact, if any, did these difficulties have on payments in NI? You may wish to refer to [DHNI0000446], [DHNI0000406] and [DHNI0000926].

55. I was made aware of issues implementing the new payments at the time. I cannot add any additional information to that provided in [DHNI0000446], [DHNI0000406] and [DHNI0000926] because of the passage of time.

Section 4: Public Inquiry

34. To the best of your recollection, what were the recommended lines to take regarding calls for a Government backed Public Inquiry, as noted in [DHSC5482139]? What was your response, and the response of the DHSS, to these recommended lines?

56. I have no recollection of the recommended lines to take or the response of DHSS.

35. Please outline your knowledge, understanding and involvement in the DHSS decision-making process on the issue of holding a public inquiry into contaminated blood and blood products.

57. I was not involved in the DHSS decision-making process on the issue of holding a public inquiry and I have no recollection of this process.

36. To what extent, if at all, was the DHSS's decision not to establish a public inquiry because of a need, whether actual or perceived, to align with the position in Westminster?

58. See my answer to Question 35.

37. What implications did the call for a public inquiry in Scotland and the completion of the independent Archer Inquiry, have in Northern Ireland? You may want to refer to [DHNI0001321_001], [DHSC6365492] and [DHNI0000292].

59. Although I was a copy recipient of [DHNI0000292] and [DHSC6365492] (in my experience it was often the practice for DH(Westminster) officials to copy submissions to the medical observers on advisory committees because they were unsure who the relevant policy officials in NI were), I would have copied or forwarded such documents to the relevant policy official to take any necessary action.

60. I was not the Director of Population Health in 2008 or 2009 and was not directly involved in considering the implications of the call for a public inquiry in Scotland and the completion of the independent Archer Inquiry in Northern Ireland until 2010 - see [DHNI0000482]. This submission notes that £3 million had already been paid to 120 individuals in Northern Ireland by the Skipton fund.

38. In an email dated 13 February 2008 [DHSC6365492], William Connon states that 'it would be very helpful to try and establish a UK wide position' concerning a Public Inquiry. What was the position of the DHSS?

61. I was not the Director of Population Health in 2008 or 2009 and was not directly involved in considering the implications of the call for a public inquiry in Scotland and therefore I am not able to comment on the DHSS position.

Section 5: Hepatitis C Lookback

39. The Inquiry understands that you were a member of the Ad Hoc Working Party on Hepatitis C Look Back. Please explain your role and functions on the Working Party, including how you/the DHSSNI approached the task of locating people who had been infected with HCV via infected blood. You may wish to refer to [DHSC0003555_150, NIBS0001141 and WITN3430146].

62. I represented DHSS on the Ad Hoc Working Party as an observer and attended meetings of the group. I believe I would have been in contact with Dr Rehman and Dr Nicholas between the formal meetings by telephone and fax. In my role as Northern Ireland representative, I liaised with the medical director, Dr Morris McClelland and his deputy Dr Chitra Bharucha of the NIBTS about the look back

procedural guidance which, as the equivalent of a Regional Transfusion Centre, they were expected to implement (see the relevant sections of the guidance set out in Annex A of [WITN4486087]). As explained in my answer to Question 18c, I drafted the equivalent CMO letter for Northern Ireland using the English CMO letter as template. I believe it is likely that Dr McClelland and Dr Bharucha would have conferred with their equivalents in the other countries about the practical implementation of the guidance. I assisted by answering queries as in [NIBS0001141]. It is likely that I would have conferred with Dr Rehman when answering such queries to confirm my understanding of the issue.

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed GRO-C

Dated: 21 December 2022