Friday, 22 July 2022

(10.00 am)

(Proceedings delayed)

(10.03 am)

SIR BRIAN LANGSTAFF: Good morning, Professor McQuiston. Can you hear me?

THE WITNESS: Good morning, Sir Brian. I can hear you fine.

SIR BRIAN LANGSTAFF: Good. And you can see me?

THE WITNESS: I can.

SIR BRIAN LANGSTAFF: That's a good start. In a moment or two I'm going to ask Mary to invite you to affirm. Let me first, though, explain who you're talking to.

There's a small audience here in Aldwych, in Aldwych House in London, but I imagine the bulk of your audience today are going to be online, watching either on YouTube or on live stream.

I can't tell you precisely how many there will be but it may well be approaching three figures.

THE WITNESS: Okay.

SIR BRIAN LANGSTAFF: In a moment or two Ms Scott is going to ask you the questions but first, Mary, please.

I should ask you, you're in the offices of your lawyer, are you?

THE WITNESS: Yes, I am indeed.

SIR BRIAN LANGSTAFF: Very well.

DR ROBERT WHITFORD MCQUISTON (affirmed)

Questioned by MS SCOTT

SIR BRIAN LANGSTAFF: Ms Scott.

MS SCOTT: Can you see and hear me?

A. I can, Ms Scott, yes.

Q. Can I first of all start by asking you this: you have given your name in your witness statement as Dr Robert McQuiston but I see also that you have a professorship, but you call yourself Dr McQuiston, do you?

A. That was a time-limited professorship, so that expired in 2011 *(inaudible)* a doctor.

Q. And your title, Dr, is not because you're a clinical doctor but because you've got a PhD?

A. That's correct.

Q. I'm just now going to go through your -- and go over your career, and give an overview of your career, starting in 1970, where you had a number of roles, principal officer, then deputy principal, then assistant principal, in a range of divisions of the Department of Agriculture for Northern Ireland; is that right?

A. That's correct.

Q. So that was between 1970 and 1984?

A. Yes.

Q. Then in 1984, you took up a role as the assistant

secretary to the Health Service Division of the Department of Health and Social Services in Northern Ireland?

A. Yes, that's right.

Q. And you held that post until 1988?

A. Yes.

Q. And I'm going to come back and ask you some questions about your time in the Health Service Division.

A. Yes.

Q. You then moved from there to become the assistant secretary of the Management and Personnel Division of the DHSS Northern Ireland, between 1988 and 1990.

A. That's right.

Q. You then went on secondment to become the Director of the Northern Ireland Centre for Healthcare Cooperation and Development in 1990.

A. That's correct, yes.

Q. And that was a post you held until 1999.

A. Yes.

Q. And you say that's called Nicare? How do we pronounce that?

A. Nicare, yes.

Q. Nicare. And what did Nicare do?

A. Basically helping other health services around the world to improve their services, perform their services,

mainly in Russia and Central and Eastern Europe, and in the Far East. So they were countries where perhaps there wasn't a satisfactory primary care service, maybe no such thing as general practitioners, very centralised services. So we were helping them to modernise and reform their services.

Q. So you didn't have any role in decision making in Northern Ireland over that period?

A. Not at all during that period, no.

Q. Were you keeping up with what was going on in Northern Ireland during that period?

A. From a general interest point of view, yes, I was.

Q. Then in 1999, again still on secondment from the Department of Health and Social Security, you took up a role as the International Programme Director of Nicare, a role you held until 2004.

A. Yeah. The reason for that was that I was spending more and more time overseas and it was becoming difficult to direct the organisation in Belfast and be overseas at the same time, so we appointed a new director and I became the International Project Director.

Q. Then you became a health and social services adviser to Nicare between 2004 and 2006.

A. Yes, that was after my retirement from the Department in 2004.

Q. And in that role, what were you doing?
A. Actually, the same work, but just with a different heading.
Q. So again, looking at the international picture rather than the domestic picture?
A. Yes, yes.
Q. Then between 2006 and 2011, you were a visiting professor and health policy and management specialist at the Healthcare Research and Development Group at the University of Ulster; is that right?
A. That's right, yes.
Q. Were you teaching? Were you lecturing? What were you doing in that role?
A. What happened was that Nicare ceased to exist in 2006, and a number of us wanted to continue the work we were doing, so we managed to organise this unit at the University, and essentially -- there was no teaching involved, it was purely research, and the same kind of overseas work I had been doing before.
Q. So before getting on to your role between 1984 and 1988 in the Health Services Division, I'm just going to ask you some questions to get an idea about the structure of the Department at the time that you were there in the 1980s.

So is it right to understand from your statement

that the Department was divided into a policy directorate and a management directorate which was known -- and you referred to in your statement -- as the Management Executive.
A. That's correct.
Q. Broadly speaking, what was the difference between the two, those two -- that -- those two parts of the Department?
A. Well, basically the policy side, as the name suggests, was responsible for policy and legislation.

Once policies were decided, and it was a case of implementing policies, that was down to the executive. They were sort of management -- they managed the four health boards and they looked after the personnel issues in the health boards and so forth. So they were more of the hands-on operational side of the Department, whereas the policy side was doing the thinking about how to do things.
Q. We've heard from witnesses from the Department of Health in London that the Department of Health had what they call a sponsorship role for agencies like the Blood Services and so on. Would that role have sat with the management executive?
A. Yes, it would.
Q. How well, in your experience, did dividing the

Department up in that way work?
A. Well, it already had been divided by the time I arrived so I didn't have the previous arrangement to compare it with, but it seemed to work well and it seemed to make sense, and actually I would have found it quite difficult to imagine it working as a single corporate unit, because I think it was the way to do it.
Q. To what extent were you able to or did you have any role in ensuring that the policies that you'd formulated were being implemented in the way that you had foreseen they would be or should be?
A. Well, I can't think of anything specific but there was quite a lot of interchange between the two sides, you know, and I can imagine if something was happening in a way that hadn't been envisaged, there would be exchanges back and forwards, and there probably would be adjustments made accordingly. At the end of the day, the Permanent Secretary was responsible for both sides of the Department, and if there was an issue like that that couldn't be resolved, he would have been called upon.
Q. So in terms of the management of the Department, then the Permanent Secretary sat at the top, over both sides of the Department?
A. That's right.

Q. Then below the Permanent Secretary was who?
A. There were Under-Secretaries and, as far as I recall, there was one Under-Secretary for each side. George Buchanan was the Under-Secretary on the policy side, and I think it was -- Ronnie Sterling was the Under-Secretary on the other side.
Q. And then below the Under-Secretary sat the Assistant Secretaries of the divisions?
A. Yes. And on the policy side there were four divisions. My own, which looked after community health services family practitioner services, personal social services and general hospital services. Then there was another division headed by Jack Scott, looking after acute hospital services, and then, bearing in mind that Health and Social Services are integrated in Northern Ireland, we also had two divisions dealing with Social Services. One, health -- social care for the elderly, and the other social care for children.
Q. In terms of meetings with the Under-Secretaries and the Permanent Secretaries, was there a regular programme of meetings or did you meet with them as and when you needed to?
A. As and when required. On the management side there were more sort of regular structured meetings but on the policy side it was more ad hoc.

Q. Does the same go for meetings with the heads -- with the other Assistant Secretaries sitting in the other divisions?
A. Yes, indeed. I mean, there could be cross-cutting issues that would require, obviously, discussion and interchange, and there may have been issues that involved more than one division, or perhaps the Under-Secretary would be involved along with the relevant Assistant Secretaries.
Q. You've set out in your statement a little bit more detail about the areas of responsibility that your division had, and I'm not going to go to those now, but you tell us you also had a role in relation to health promotion and disease prevention measures, including public education about the risks associated with infectious diseases such as AIDS; is that right?
A. That's correct.
Q. In that role, you attended and sat on and chaired, in fact, some committees and working groups?
A. That's right.
Q. I'll come back to ask you some questions about that a little bit later on this morning.
A. Okay.
Q. Do you know, or can you recall now, whether the management of long-term conditions like bleeding

disorders came under the Acute Division headed by Jack Scott or under the Health Service Division?
A. Issues relating to blood and blood products would have been on Jack Scott's side. He would have been responsible for accident and emergency, surgery, orthopaedics, things like that.
The branch that I had, on general hospital services, would have been concerned more with general medicine, oncology, those kind of issues, cardiology and so forth. So really issues relating to bleeding disorders and bleeding diseases would have fallen on the other side.
Q. How big was the staff team in your division?
A. I had four principal officers, and I suppose that in each of those branches there might have been an average of about ten staff, something like that.
Q. Was that a similar size to Jack Scott's division, can you recall?
A. I would have thought probably in broadly similar -- he may not have had as many branches. I'm not sure.
Q. What was the workload like?
A. Err ... it was fairly substantial, because it's covering, you know, almost all of the Health Service, when you think about it. So yes, I mean, there were a lot of issues most of the time and a fair degree of

pressure, yes.
Q. I'm going to ask you some questions now about how the Chief Medical Officer and his team fitted into the structure. So we've heard evidence that in England there were, at points anyway, dual structures in the Civil Service, so there was an administrative and a medical side. Was that similar in Northern Ireland? Was the Chief Medical Officer the head of his own team, sat outside what you've described to us as the policy division and the management division?
A. I would say sat alongside rather than outside, yeah.
Q. What kind of contact did you have or could you have with either the Chief Medical Officer or any of his clinicians?
A. Well, quite regular contact. Most of the time it would be with his staff but, from time to time, it would be the Chief Medical Officer himself, and he was always quite accessible. There wasn't an issue there at all.
Q. Did you have a particular member of his staff allocated to your division or a particular point of contact or could you just really ask advice from anyone that you wanted to?
A. It depended on the issue. They had things divided between them as to who was responsible for what. I seem to recall that, in my case, most of the contact was with

Dr Nick Donaldson but we would have had contact with some of the other medical staff as well.
Q. Was there a programme or a schedule of regular meetings between you and relevant staff from the CMO team or was it, again, an as and when, ad hoc arrangement?
A. Ad hoc, as and when, yeah.
Q. Now, I'm going to ask you some questions about contact with ministers. It's right to understand, is it, that during your time in the Health Services Division it was a period of Direct Rule in Northern Ireland by the Government in Westminster?
A. It was.
Q. So that means, is this right, that the UK Government had taken over direct responsibility for Government decisions in Northern Ireland --
A. **(The witness nodded)**
Q. -- with ministers in the Northern Ireland Office directing the Northern Ireland Civil Service?
A. That's right.
Q. During your time in the Health Service, Douglas Hurd was the Secretary of State followed by Tom King in September 1985; is that right?
A. I think that's right yeah.
Q. Then Richard Needham was the Parliamentary Under-Secretary of State for Northern Ireland from 1985

to 1992.
A. He was.
Q. And --
A. Prior to that [audio distortion], I think it was.
Q. Sorry, I missed what you just said.
A. Prior to that it was Chris Patten.
Q. Did you have a particular point of contact in the Northern Ireland Office?
A. Not at all, no. I didn't.
Q. Did you have much contact with the Northern Ireland Office?
A. Not really with officials, no. Perhaps on occasions, if you were over in London maybe a minister was answering something in the House, he might have had contact with some of the officials at that time, but normal day-to-day running of the thing, no, not at all. The Minister really was the only contact with the NIO.
Q. Sorry, I missed that. What it was the only contact with the NIO?
A. The Minister, really -- the minister was the only contact.
Q. When you say "the minister", do you mean Richard Needham?
A. I do, yeah, yeah.
Q. In your witness statement you say that Westminster had

an overall coordinating role on issues impacting on the whole of the UK and that, in reality, the main policy initiatives would come from the Department of Health in London out to Northern Ireland; is that the right way to understand it?
A. That's right, although there would be obviously issues from time to time that were specifically local but, as an overarching statement that would be correct, yeah.
Q. The way that those policies came out of the Department of Health would be directly, would it, to you in the Department in Northern Ireland, rather than via the Northern Ireland Office?
A. Yes, directly. Not via the Northern Ireland Office.
Q. Then you also tell us that, once you'd received policy initiatives from London, you would then consider whether to adopt, reject or tailor that policy for Northern Ireland?
A. That's correct, although there would be occasions where there would be no choice in the matter, like, for example, the one I mentioned of the Limited List, drugs that could be prescribed. We wouldn't have had any right to persist/assist? ^wd for that one, we had to do it.
Q. Then you tell us that, once a policy was developed in Northern Ireland, the role that the Minister had would

be to sign off on the policy developed by the Department in Northern Ireland?
A. That's correct, although he would have a role, obviously, in developing the policy as well. At various stages of the process, he would normally be involved.
Q. So is this right: that the Minister was involved in development of policy in health in Northern Ireland over the period that you were there?
A. He was.
Q. But you tell us in your statement that you don't recall the Northern Ireland Office having any role in health policy development. Do you mean by that officials in the Northern Ireland Office?
A. Yes.
Q. You also tell us that you were able to discuss issues of policy directly with the Minister, with Richard Needham. Can you tell us a little bit about how you would go about that, whether or not the decision to approach him was the decision that you would make yourself, and how easily accessible he was to you?
A. He was fairly accessible. What would happen normally would be the issue would be developed, possibly in discussion with the Under-Secretary and/or the Permanent Secretary. A point would come when the Minister needed to be involved. It would be a case of then writing

a note to him through the Private Office, setting out the issue and asking for his approval or for a meeting, perhaps.
He would respond accordingly either in writing, saying, "That's fine, go ahead" or "We need to discuss this, we need to have a meeting". And it depended on the issue, you know, what sort of mix of written and verbal input there was.
Q. In what circumstances would you escalate a matter to the Minister?
A. If it was a new policy, if it was something that perhaps was likely to maybe lead to adverse reactions from sections of the public, or indeed the reverse, if it was likely to be a good news story, the Minister might want to be associated with that. If it was a routine matter, not a new area of policy and one which was unlikely to create any controversy, it wouldn't be referred to.
Q. Would it be right to understand from that that many of the decisions relating to HIV and Aids would have been escalated to the Minister on the basis that they were or could be controversial?
A. Yes. I think that's fair comment.
Q. How about policies with a budgetary implication? Would they be escalated to the Minister?
A. Not necessarily. I think it would depend, if there was

perhaps an issue of prioritising expenditure in one area as opposed to another, he may have been consulted about that kind of issue.

Q. Now you've told us that your Department -- your division, rather, in the Department, had no role in blood and blood products. So is it right to understand that you had no particular relationship with the Northern Ireland Blood Transfusion Service?

A. That is correct.

Q. And equally, you had no particular relationship with any Haemophilia Centres?

A. Correct.

Q. So is it right to understand from that that you can't give the Inquiry any evidence about issues such as decisions made about self-sufficiency of blood products -- of blood and blood products in Northern Ireland?

A. I'm afraid I can't.

Q. Nor whether there were any Governmental policies concerned with prescribing practices for those with bleeding disorders?

A. No.

Q. Equally, is this right: did your division have any role -- is it right to understand your division did not have a role in the payment schemes for those infected

and affected in Northern Ireland?

A. No role there, no.

Q. And your department had no role in licensing and regulation of pharmaceutical companies?

A. No. We had a role, as I recall, in establishing pharmacies, and there was a policy that pharmacies -- new pharmacies couldn't be set up close to existing ones. There had to be a sort of reasonable network. We had a role in that and -- just to ensure that pharmacy services were available as widely as possible and not concentrated in one location.

Q. You've told us a little bit about the Limited List in your witness statement. Can you recall whether blood products were on the Limited List?

A. I'm pretty sure they weren't.

Q. Are you able to help us with how budgets for those treatments were set up or dealt with by the Department?

A. Budgets for blood products?

Q. Yes.

A. No, I'm afraid I couldn't.

Q. Can I then just take you to SCGV0000105_021.

So this is a letter addressed to you dated 4 October 1988. We don't need to turn through, but it's from Dr Macniven from the Scottish Home and Health Department, and it starts by saying:

"I am writing (I hope to the right person!) about the future arrangements for the processing in Scotland of Northern Ireland plasma."

Then it goes on to explain that that Scotland has lost its self-sufficiency and asks questions of you, as a representative of Northern Ireland Department, as to whether or not you would -- we can see at paragraph 4(a) -- withdraw your agreement to fractionate plasma. And then, if we go over the page, (b), invest in the PFC.

So we can see, at paragraph 5, two questions:

"Do you still want your plasma processed by the SNBTS?"

And (b):

"Would you be prepared to contribute to the capital cost of the upgrading at the Protein Fractionation Centre?"

Now is it right to understand that while this correspondence was addressed to you, in fact he hadn't got the right person and that this was passed on to Jack Scott?

A. That is correct. Yeah.

Q. And so --

A. And --

Q. Sorry.

A. At that stage I'd also moved on to the other side of the Department, I think in April of that year, so that's on two accounts he got the wrong person.

Q. Yes, you weren't even in post in the Department by October 1988.

A. That's correct.

Q. And it wouldn't, in any event, have been your successor?

A. It wouldn't have been, no, that's right.

Q. I'm going to turn now to ask you some questions about AIDS and your role in AIDS and HIV.

Now, you have told us that you had a role in health promotion and disease prevention generally for Northern Ireland, in relation to infectious diseases including AIDS.

A. **(The witness nodded)**

Q. I'll come on to ask you some questions in a moment about the role you had in the public education campaigns on AIDS, but just to try to understand whether anything else fell into your remit. Would testing for HIV have fallen into your remit?

A. No. I don't recall any involvement in testing.

Q. So that would have been dealt with by Jack Scott's division?

A. Either Jack Scott's division or the management side of the Department.

Q. How about treatment of those with HIV? So for hospital services for those with HIV?
A. Well, again, I think that would be on Jack's side.
Q. If there were community services for those, for HIV, would that have fallen within your remit?
A. It would.
Q. Do you recall any such services or any decisions having to be made about that?
A. I do. I recall, in the context of the Northern Ireland Committee on AIDS, various initiatives being discussed and agreed, including information packs and videos for GPs, so that, you know, they were -- to help them with dealing with the issue at their level.
Q. So a training and information dissemination role?
A. That's correct.
Q. Were you involved in any of the decisions taken by the Blood Services about the selection of those donors considered to be at risk of HIV?
A. No.
Q. Turning, then, to your role in the various -- well, first of all, the Ministerial Steering Group on AIDS, or sometimes referred to as the Interdepartmental Committee on AIDS.

If we can just do this by reference to a document, CABO0000221, and can we go to page 2, please.

So we can see that this is headed "Ministerial Steering Group on AIDS: 1st Meeting on 2 December 1985". And we can see a number of attendees: for the DHSS we've got Barney Hayhoe MP; the CMO, Dr Acheson; attendees from the Foreign and Commonwealth Office; we've got Lord Glenarthur and others from the Home Office; lord Trefgarne from the Defence; Treasury attendees; Cabinet office; DES, which I understand is the Department of Education and Science; Employment; Welsh Office, an MP there; and there you are representing the Northern Ireland Office; and then Environment; Scottish Office; and DTI.

A. Yes.
Q. So is it right to understand that you were attending this meeting in the place of Richard Needham?
A. That's correct, yeah.
Q. Then if we go over to the third page, please, we can see from the first paragraph:

"Mr Hayhoe welcomed representatives from other Government Departments. He explained that the AIDS infection represented a serious public health problem which had wide implications for many Departments. A paper outlining some of these implications had already been circulated. Much had been done by the DHSS to try to limit the spread of the infection. He hoped that an

Inter-Department Group would be set up following the Chief Medical Officer's presentation on the disease. The aim of the Inter-Departmental Group would be to develop a co-ordinated strategy towards the wider issues connected with the disease."

Then we can see that there is a presentation by the Chief Medical Officer, and that is summarised, and we can see just look at the headings there: "Definition", "Spread", "Epidemiology", and so on.

A. Then if we turn over the page, we can see, after the conclusion of the presentation, that there is a "Discussion", and we see, that first paragraph there:

"Mr Hayhoe said that an announcement would be made that day about the allocation of a further £6.3 million devoted to AIDS measures including a major public health campaign."

Then there is a discussion about the form of that campaign.

Then if we go over the page, we can see at the end, "Conclusion":

"The terms of reference of the official group were agreed. Mr Hayhoe said that he hoped that this Group would meet early in the New Year and prepare a paper for the next meeting of the Ministerial Group."

Is it right to understand that Mr Hayhoe's hope

was realised, that, following the presentation from the Chief Medical Officer, a group was -- an interdepartmental group was set up and there were subsequent meetings?
A. Yes, that's correct.
Q. Then we can see here as well, at the end there, there seems to be another group being set up to advise the ministerial group.
A. Er ...
Q. So we see that Mr Hayhoe said that he hoped this group -- the terms of reference for the official group -- that this group would meet and prepare a paper for the next meeting of the ministerial group.
A. Yes, yes. I'd sort of overlooked the fact that there were two separate groups, I must say, but I would have been attending both, the interdepartmental group and the ministerial group, on most occasions. Richard Needham seemed to, you know, never be available on the occasions of those meetings.
Q. So we can see that that first meeting is 2 December 1985. The second meeting is in April 1986 and we can see that at SHTM0001036.

Again, this is now chaired by Barney Hayhoe. And we can again see you attending -- towards the bottom of the page -- for Northern Ireland. Then I understand

that John MacKay is the Parliamentary Under-Secretary for Scotland, and Mark Robinson Parliamentary Under-Secretary for Wales; is that your understanding as well?

A. Yes. Yes.

Q. If we can just turn over the page, we can see the discussion seems to be focusing on the information campaign. So 1.2.1:

"Mr Hayhoe said that the campaign had been launched in mid March, with two rounds of advertising in the national papers. The advertising was backed up by the College of Health recorded telephone information service and a Health Education Council leaflet."

Then if we go down to 1.2.2, there's more discussion about newspaper advertising, and then:

"Mr Hayhoe said that so far there had been no advertising in local papers and he agreed that this should be considered."

Then there is discussion about the language of the advert and so on.

And if we go over to page 3, we see your contribution at 1.2.4. Mr Robinson makes a comment about the pitch of the advert and reactions from his perspective, and then you say that:

"... many in Northern Ireland had not seen the

advertising ..."

And you suggested that a half page advert was more likely to be read.

So before I ask you questions in relation to that, it's probably helpful just to look at the advert that is being discussed there.

So it's NHBT0007971.

So this is a covering letter -- just to date the attachment, it's dated 13 March 1986 -- and it's said that:

"Tom Murray already sent you ..."

This is to Dr Gunson, so I'm not suggesting you would have seen this letter, but:

"... sent you a copy of the HEC leaflet and details of the advertising campaign that is due to start on Sunday. I now attach a copy of the proof of the advertisement which will be shown to the press this afternoon."

So that's from Dr Acheson.

Then if we go over the page we can see the advert, the national advert, "Are you at risk from AIDS?"

Is this the advertisement you were talking about, do you think, during that meeting?

A. I honestly don't know. I presume it is. And what it was about this advert that wasn't eye catching I'm not

sure. It looks to me as if it would be virtually a full-page advert --

Q. Yes, I think what you're suggesting is that it would be better to have a half a page advert.

A. Yeah, but that wouldn't make a lot of sense if this is the advert we're talking about. Why would I want to reduce it from a page to half a page? It may well be that there was some other advertising that preceded this, I'm not sure.

Q. Can you recall what the factual basis of your contribution to that meeting was? How you had come to understand that not many in Northern Ireland had seen the national advertising campaign?

A. There must have been some discussion about it back in the Department before I went to the meeting, and there must have been, you know, some reaction generally in Northern Ireland, that maybe people hadn't seen it, or it wasn't eye catching enough, or -- I don't know. I presume this appeared on all the national papers which would be circulating in Northern Ireland, and so I'm really at a loss as to what was behind that comment. It's 35 years ago and I can't recall what specifically it was that led to it.

Q. Now is it right to understand that issues about regional or local campaigns wouldn't have been dealt with within

the ministerial group, that was concerned with national matters, but it would have been picked up in the Northern Ireland Committee on AIDS?

A. Yes.

Q. So if we can turn, then, to your work on that committee, and if we can do so by looking first at RHSC0000041_108.

We can see this is a letter from you to Dr McKenna at the Eastern Health and Social Services Board, of 10 November 1985, and it's headed "Ad Hoc Group on AIDS", and you say:

"In recognition of the many and rapidly emerging initiatives" --

SIR BRIAN LANGSTAFF: It's 1986, I think.

MS SCOTT: I'm sorry?

SIR BRIAN LANGSTAFF: It says '86.

MS SCOTT: What did I say?

SIR BRIAN LANGSTAFF: '85.

MS SCOTT: I beg your pardon, it does say 1986.

SIR BRIAN LANGSTAFF: So this is 1986.

MS SCOTT: Thank you.

"In recognition of the many and rapidly emerging initiatives which are taking place in other parts of the United Kingdom in relation to AIDS, it has been decided that a small informal ad hoc group should be established in Northern Ireland. The Department would see the Group

primarily as providing a focal point for ensuring that a coordinated approach to this disease is adopted across all 4 Board Areas. The Group could also serve as a source of advice on specific aspects of AIDS where necessary."

Then it sets out the membership of the group, which of course includes yourself, representatives from the four health boards and Dr Mayne, we can see there, as well.

A. Yes.

Q. First of all, was this your idea, your initiative?

A. I can imagine that the issue was discussed in London, the idea of, you know, the need for this kind of coordinating activity in other parts of the country as well. So I dare say I probably would have initiated the thinking on it, yes.

Q. Does it follow from what you've just said that you think the prompt for it would have been what was being said in London?

A. Well, I think that there could have been -- obviously the issue would be under consideration anyway, but setting up formal groupings to look after these functions may well have come from the discussions in London.

Q. Now, it could be said that setting up group of this kind

in November 1986 was quite late in the piece, given that HIV and -- not HIV -- HTLV-III and AIDS had been around and a matter of concern for some time by then. What would you say to that?

A. Well, I think, first of all, there would have been coordinating activity happening anyway on a more ad hoc basis prior to that. And I think it's -- I'm right in saying it was in '86 that the ministerial group was established, isn't that right, and the interdepartmental group? So activity was going on anyway but formalising the groups seemed to take place both in London and in Northern Ireland around that time.

Q. Yes, so the ministerial group was December 1985, that first meeting was December 1985.

A. The interdepartmental group then followed shortly after that, I think.

Q. In terms of the -- so in terms of the purpose of that group as you've said, it's to coordinate information exchange between the four health boards; that was its primary remit, was it?

A. That's correct. That's correct.

Q. That included potential risk from contaminated blood products?

A. Yes.

Q. Can we turn now then to RHSC0000041_107. This is

a question about the membership of the group. So we've got here a letter, again from you to the general manager, Mr J Lamb, of Southern Health and Social Services Board of 29 December 1986, and you are responding to a letter from him, in which he appears to have suggested that the membership of the Committee formerly known as the "Ad Hoc Group on AIDS" -- now it seems to be called the Northern Ireland Committee on AIDS -- might be extended to include representatives from the dental, nursing and social work professions.

You turned down that request; why was that?

A. Well, I think the feeling was that having the chief administrative medical officer from each board on the Committee provided a conduit for these other professions to make their input. Also, if there were specific issues, say dealing with pharmacy or dealing with nursing, the relevant officers *(inaudible)* to attend those particular meetings.

To increase the membership of the main committee to include all those professions would have resulted in a very cumbersome committee which would have been quite difficult to manage and difficult to reach decisions. So that was the real main reason for not going down that road.

Q. Now, the Inquiry has heard evidence that some dentists

and healthcare professionals in the 1980s were refusing to treat people with AIDS. Were those allegations the sorts of allegations you were aware of at the time?

A. I honestly don't recall that at all. If that happened it must have been a very small number of cases, I don't recall it at all.

Q. We'll look at one meeting minute from the Northern Ireland Committee on AIDS, formerly the Ad Hoc Group on AIDS, DHNI0100055.

So we can see here that this is the minutes of the seventh meeting of the Committee and we can see that you are chairing it, with the other attendees there. If we could go over the page, please, I just want to pick up on two points, paragraph 4.6, "AIDS and Blood Transfusion":

"Dr McQuiston reported that the feeling at national level was that any advertising on this subject was best left to the National Blood Transfusion Service. Members accepted this view. It was noted that blood supplies in Northern Ireland were at a reasonable level but recent surveys amongst students had shown that a significant proportion still thought that HIV virus was transmissible by donating blood."

So is it right to understand from this that the question of what donors should be told about whether or

not they were at high risk and should be excluding themselves from -- deferring themselves from giving blood was a matter not being dealt with by your committee but being dealt with by the Blood Transfusion Service?

A. That is correct. I think the feeling was that what we were trying to do in the Committee was to develop material for the general public which would inform them about how they could adjust their own behaviour to protect themselves and to avoid risk. I think that the risk from -- potential risk from blood transfusions of a different order was not something really that individuals can protect themselves against. They need to be advised, obviously, about the position, which we felt was more appropriate for the Blood Transfusion Service, not to sort of conflate the two issues.

Q. Then if we could turn to the next page, and pick up another point., which is -- if we could go down to paragraph 6, "Publication Education Strategy in Northern Ireland", and you were reporting on a smaller group meeting which had met following -- had met on 9 February, and, following this, a press conference to mark the launch of the new HEA advertising campaign that had been held in Northern Ireland. So that's the context. Then it says this:

"He [I think that must mean you] indicated that in order to map out and develop a regional advertising strategy for Northern Ireland it would be helpful if Boards could submit details of any initiatives they were planning over the next year which could attract regional publicity and thereby help to maintain a continual awareness in the Province."

So is it right to understand from this that the more local regional advertising was being overseen by this committee, with the boards, the health boards, feeding into that strategy?

A. That is correct, yes.

Q. Can you tell us a little bit about what that advertising campaign, that public information campaign, consisted of?

A. Well, it would have been a -- covering many of the areas covered in the national campaign as well, but we had been tailoring messages to suit the Northern Ireland situation, which did vary a few small degrees. One fairly big aspect of difference was in relation to drug misuse, which was at a very, very low level in Northern Ireland at the time, due largely to the security situation, and we felt that in the local strategy we shouldn't be giving emphasis to that because it wasn't a problem. On the contrary, there was

probably a bigger problem for us with people travelling away on business, and so we would have focused in on that to a larger extent, advising people on their behaviour when they were out of the country on business, to avoid the behaviour that could result in infection.

Q. Were there sensitivities in Northern Ireland about messaging regarding the risk to men who had sex with men, given the fact that until just a few years before, that had been illegal?

A. Yes, probably it would have been a little bit more controversial in the Northern Ireland situation because of the more conservative attitudes to those issues.

Q. How did that impact on the messages that you were trying to get out there?

A. Well, I don't think it did impact. I think the message had to be got out, and there was no point in trying to be too subtle about it, because the message wouldn't have got across. So I think we appreciated that it probably ruffle a few feathers, but I think it didn't materially affect the line that was taken in the advertising.

Q. Now we saw you contributing in the ministerial meeting to the fact that the national advertising campaign hadn't been, you thought, very successful in Northern Ireland. Can you recall whether you took any

steps to remedy that fact within this group? Or at all?

A. Well, obviously the issue we're discussing at the moment, of the local advertising campaign, would have had an impact there. I mean, if it was felt that the national advertising hadn't really hit the mark, then it was all the more important to have a local campaign that would do so.

Q. How effective would you say that the campaign and the information dissemination was during your time there?

A. I do recall that we did have an evaluation of the campaign, and I am pretty sure that as a result of that, we adjusted it as we went along, and I think the overall feeling was that it was successful, we were getting the message across, and it was affecting behaviour.

Q. In fact we can see, I think, some of that if we turn over the page, the "UK Public Education Strategy", and you -- there's a reference to a paper there about the HEA's UK advertising package which was designed to increase general awareness, and the point was made it's targeted at heterosexual populations and the younger age groups:

"TV and press advertisements were being used but difficulties had been experienced with the use of the advertisements in cinemas."

Then it says this a little bit further down:

"Dr Horner indicated that there was evidence from patients attending the STD clinic at the RVH that the middle class groups were changing their sexual behaviour but there was no similar change apparent amongst lower socio-economic groups and he suggested that it was important to target the latter group in particular."

Then he makes the point that:

"... although the number of STD patients ... remained high AIDS and HIV did not seem to be a reason for this."

So is that the sort of information you were talking about, the sort of, as you go along, evaluating and working out what changes need to be made?

A. Exactly, yeah.

Q. Do you recall whether your group took into account or had any information from the Expert Advisory Group on AIDS operating out of London?

A. You mean the group chaired by Mr Hayhoe?

Q. No. It's a different group, not the ministerial group. The Expert Advisory Group on AIDS. Does that ring any bells with you?

A. Is that the one that arose from the ministerial group? No?

Q. No, it's entirely separate.

A. Doesn't ring a bell to me at all.

Q. Now we've heard evidence in the Inquiry that AIDS wasn't seen as a significant problem in Northern Ireland because levels of transmission were low. Would you agree with that?

A. The levels were low, but I don't think we were complacent. I think we were aware that it was a looming problem, and that action needed to be taken.

Q. Did you -- or were you involved in any links with the Republic of Ireland during that time?

A. Yes, there were -- there were meetings between the ministers north and south on a few -- at least one or two occasions, I can recall, just comparing the approach, and, again, it's conceivable that we'd maybe learn things from that would have influenced our approach as well, and perhaps vice versa.

Q. Were you aware of the stigma associated with HIV and AIDS during this time?

A. Oh yes.

Q. Were there any steps being taken by the Department to try to combat that to ensure that people were coming forward to be tested and accessing services, and so on?

A. Yes, I think that would have been part of the campaign, to try to counter that sort of attitude. Definitely.

Q. What strategies were put in place to try to do that?

How do you go about doing that? How did you go about doing that?

A. Well, I can't honestly remember the details of that, but, I mean, it would have been simply stating the facts as they were. For example, the fact that AIDS can be contracted by heterosexuals as well as homosexuals and, therefore, you know, the targeting of a particular group would be inappropriate.

MS SCOTT: Sir, those are the questions that I had. I wonder whether we could take a break so that Core Participants can suggest further questions to me.

SIR BRIAN LANGSTAFF: Certainly. Well, we're just about ready for our morning break, a little bit early, possibly, but we'll take a break for half an hour now, and then come back and hope that that gives long enough for those who want to suggest questions to you to do so.

Let me explain to you, Dr McQuiston, that there are a number of Core Participants in the Inquiry represented by legal representatives, whose representatives have a right on their behalf to put forward questions to counsel to ask you. Plainly, that might reflect the evidence you have given, which they'll be thinking about as you've been giving it, so we have to give them time for that.

But, in any event, it's probably time for a coffee

break or a comfort stop, and we'll come back no earlier than 11.30. It may be a little bit later if some late questions or a large number of questions come in. I can't tell you how many that will be, and I can't tell you quite how long that will take, because it depends upon the questions, obviously.

This being a break in your evidence and your evidence being on oath, what you mustn't do is talk about any of the evidence which you've given to anyone, whoever that person is.

I'll see you not before 11.30.

(11.03 am)

(A short break)

(11.30 am)

SIR BRIAN LANGSTAFF: Yes.

MS SCOTT: I have a few more questions for you, Dr McQuiston. Was -- how far was -- how far was your division involved in providing health promotion work to the army stationed in Northern Ireland at the time?

A. I'm drawing a blank on that, I have to say. I wouldn't have been surprised if that had been handled from London.

Q. Or potentially by officials from the Northern Ireland Office?

A. Possibly, possibly. I don't recall anything about that

at all.
Q. You told us that the differences or one of the differences between the national and local AIDS campaigns was that there was less emphasis on the dangers of infection through drug misuse.
A. That's right.
Q. What did that mean in practice? Did that mean that it was not set out as a risk in the information that was being disseminated?
A. Um, it would not have been given prominence, it possibly would have been referred to briefly, but the emphasis was very much on the dangers from unprotected sexual contact, and as I mentioned earlier, particularly in relation to businessmen and travelling overseas.
Q. And was thought given to the fact that people travelling abroad may need to know about the risks from drug misuse?
A. Yes, that's what I was saying. They very much were one of the target groups.
Q. But in relation to the risk of unprotected sex rather than drug misuse?
A. Yes.
Q. And the question is, was thought given to the fact that they may -- that those travelling abroad may need to know the risk of AIDS from drug misuse?

A. Well, I mean, we weren't silent on the issue. It was simply a case of a degree of emphasis. So I mean the message would have been there at a sort of less prominent level. I don't recall re-emphasising that issue for travellers, no.
Q. Did the Northern Irish Chief Medical Officer issue any public health guidance or anything about HIV or AIDS during your tenure at the Department?
A. I'm sure he did. I would imagine. I would be very surprised if he didn't. You know, that would be one of his roles: to issue those kinds of -- bits of advice. He certainly would have on AIDS, yes.
Q. But you're not able to help us now with the details of that?
A. Not on specifics, no. I'm afraid not.
Q. Then the last question is this: can you help us in understanding how the Northern Irish Health Service budget was set in Whitehall or within the Northern Irish Office?
A. Well, as in the case of the other territorial departments, it would have been based on the Barnett formula, so whatever expenditure was identified for England, there's -- a calculation is done to produce the equivalent figures for Northern Ireland, Scotland and Wales. So that would be the basis of the block grant

for Northern Ireland.
Then within Northern Ireland, it's the usual public expenditure survey, there's the usual round of haggling.
First of all, at Departmental level, the different divisions would be making their bid to the Finance Division. Then our finance division and all the other departmental finance divisions would be putting in their bid to the Department of Finance and that's the way it was developed.
There would be then from time to time one-off or special areas of expenditure that weren't really foreseen. I imagine the AIDS information programme would be one such and, again, whatever amount of money was earmarked for that, we would have got our share of that in addition to the block grant or to add to the block grant.
Q. And your role in that process was to put in your bid for your division to the finance team in the Department; is that right?
A. Yes, that's right.
MS SCOTT: Sir, those are the questions I have from Core Participants.
THE WITNESS: Thank you.
MS SCOTT: I don't think there are any questions -- no, no

questions from Dr McQuiston's legal representatives.
Do you have any questions?
SIR BRIAN LANGSTAFF: Just one, really. You've spoken about the problems caused by travellers from Northern Ireland returning to Northern Ireland who might be infected during their travels. What was the sense in the north about the extent of sharing drug -- of needle drug use in the Republic of Ireland, in centres like Dublin?
A. It was quite a problem in the Republic at that stage. More akin to the situation in England as I recall.
SIR BRIAN LANGSTAFF: So does it follow that there would be something of a possible problem of those from the north who travel to the south --
A. Yes.
SIR BRIAN LANGSTAFF: -- within the island of Ireland?
A. Yes and, indeed, advice would have been developed to include that possibility. Yes.
SIR BRIAN LANGSTAFF: So do you recall anything specific being said about that?
A. I don't really, I don't really, but certainly -- whenever I mentioned earlier that we emphasised the dangers to the people travelling out of the province, that would include travelling over the border to the Republic.
SIR BRIAN LANGSTAFF: Yes.

A. I don't remember anything specific.
SIR BRIAN LANGSTAFF: Well, thank you very much. That's all that I ask.
MS SCOTT: Dr McQuiston, is there anything you would like to add?
A. No. I hope it's been helpful to some extent. I know that my position or location within the Department maybe wasn't ideal from the point of view of the issues that the Inquiry is addressing, but I hope, to the extent possible, I've been able to offer some help.
SIR BRIAN LANGSTAFF: Well, thank you very much. You're right that the extent of the help you can give is limited, but nonetheless, it's been useful to us to have the organisation of the Health Services in Northern Ireland set out for us in the way you have, and to understand the rather different context of advertising and campaigning to reduce the spread of AIDS in the north of Ireland compared to the other at the territorial parts of the United Kingdom. And that's been quite helpful. So thank you for that.
And that's, I think, the conclusion of our business for today. So shall we say goodbye to you and then I'm going to invite Ms Scott to tell me what those of us who will be here next week have to expect from the Inquiry next week.

Thank you very much.
A. Thank you very much. Thank you.
MS SCOTT: So we have the evidence of Dr Aileen Keel on Monday and Tuesday, she will be giving evidence remotely --
SIR BRIAN LANGSTAFF: Yes.
MS SCOTT: -- followed by the evidence on Wednesday of Jeremy Hunt; Thursday, Malcolm Chisholm; and Friday Susan Deacon.
SIR BRIAN LANGSTAFF: Yes. So a focus on Scotland and Jeremy Hunt?
MS SCOTT: Indeed.
SIR BRIAN LANGSTAFF: Very well. Ten o'clock on Monday.
(11.40 am)
(The hearing adjourned until 10.00 am on Monday, 25 July 2022)

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