Northern Ireland Assembly

Committee for Health

OFFICIAL REPORT (Hansard)

Public Health Notifiable Diseases Order (Northern Ireland) 2020

27 February 2020

NORTHERN IRELAND ASSEMBLY

Committee for Health

Public Health Notifiable Diseases Order (Northern Ireland) 2020

27 February 2020

Members present for all or part of the proceedings:
Mr Colm Gildernew (Chairperson)
Mrs Pam Cameron (Deputy Chairperson)
Ms Sinéad Bradley
Ms Paula Bradshaw
Mr Gerry Carroll
Mr Alan Chambers
Ms Jemma Dolan
Mr Alex Easton
Ms Órlaithí Flynn

Witnesses:
Mr Nigel McMahon Department of Health

The Chairperson (Mr Gildernew): I advise members that the Department is proposing to make a statutory rule to make illness arising from coronavirus a notifiable disease. The order is proposed to come into operation on 29 February 2020 and is subject to negative resolution. Given the urgent nature of the statutory rule, an official is here today to brief the Committee and answer any questions members may have.

I welcome Mr Nigel McMahon, chief environmental health officer in the Department of Health. Nigel, you can go ahead and brief the Committee, please

Mr Nigel McMahon (Department of Health): I sincerely thank the Committee for the opportunity to look at the statutory rule at very short notice this afternoon. I know that you have a very busy agenda. These are exceptional times, and the Committee will be well aware of the challenges being faced as a result of the spread of coronavirus disease — now known as COVID-19 — to an increasing number of countries. It is a rapidly evolving situation, as I am sure you are aware, and the Department is seeking to take all necessary steps to minimise the risk to the public.

The proposed statutory rule for consideration this afternoon, the Public Health Notifiable Diseases Order (Northern Ireland) 2020, would extend the list of notifiable diseases specified in schedule 1 to the Public Health Act (Northern Ireland) 1967 to include coronavirus disease/COVID-19.

The existing schedule of notifiable diseases includes 33 diseases, running alphabetically from acute bacterial meningitis to yellow fever, and it includes some relatively common illnesses, such as chickenpox and food poisoning. The primary effect of making COVID-19 disease notifiable under the 1967 Act is to require medical practitioners to share patient information with the Public Health Agency if they become aware, or have reasonable grounds for suspecting, that a person who they are

attending has coronavirus disease/COVID-19. This should also remove any uncertainties that there may be about the legalities of sharing such information under those circumstances. In turn, this information will be vital in alerting the Public Health Agency to cases or suspected cases of COVID-19, to ensure that the health and social care system as a whole can respond quickly, and for surveillance and tracking of the spread and epidemiology of the disease should we get cases here in Northern Ireland.

I am sure that you would agree that most people who believe or advise that they may have, or may have been exposed to, an infectious disease will be willing to follow medical advice by subjecting themselves to medical examination and diagnostic tests and to allow themselves to be admitted to hospital for treatment should that be deemed necessary. In such cases, it is unlikely that somebody who is ill would attend school or go to work. However, in relation to a notifiable disease, the Public Health Act (Northern Ireland) 1967 provides additional powers that would, under certain circumstances, allow the Public Health Agency to seek an order from a district judge to require a person to undergo medical investigation or to be removed to hospital and, if necessary, detained there for a specified period.

These powers have always been available in respect of all the existing notifiable diseases since the 1967 Act was introduced. However, they have very rarely, if ever, been called upon. It is also an offence under the Act for a person who knows that they are suffering from a notifiable disease to go to work. The Public Health Agency may serve a notice on a person excluding them from attending work, excluding children from attending certain places of entertainment, or on a person caring for a child directing them that the child should not attend school for a period. There is a range of additional measures in the Act relating to things like disinfection of workplaces, hotel rooms, houses, caravans, laundry, library books and so on. There are also requirements relating to the handling of the body of a person who dies from a notifiable disease.

The Republic of Ireland made COVID-19 a notifiable disease by introducing the Infectious Diseases (Amendment) Regulations 2020 on 20 February. COVID-19 was made a notifiable disease in Scotland under the Public Health etc. (Scotland) Act 2008 on 22 February. Similar amendments are being considered by England.

On next steps, subject to the Committee's approval, the rule together with the explanatory memorandum will be laid at the Assembly Business Office, and the Business Office will submit copies to the Assembly. It is planned to bring the order into operation on Saturday 29 February 2020.

The Department is conscious that this is a rapidly evolving global situation regarding the spread of coronavirus disease. Unfortunately, that has meant that there has been insufficient time to consult with the Committee and other interested parties in the way in which we would have liked. The designation of coronavirus disease/COVID-19 as a notifiable disease will be part of a wide range of measures intended to support efforts to protect the people of Northern Ireland by seeking to contain its spread should we have cases confirmed here.

I thank the Committee once again for facilitating the request to have the matter considered today. I am happy to take your views on the proposal and any questions that you may have.

The Chairperson (Mr Gildernew): Thank you, Nigel. I recognise that there are many conditions and diseases in this Act, but when and how do you expect these powers to be used?

Mr McMahon: The primary effect, which is a notification, would come into force straightaway. That is why we are keen to get this on the books as soon as possible. That is not to say that notification is not happening at the moment, but it would be good to have the legislative underpinning for it and to help raise awareness that it is, in fact, now a legal requirement to share that information. The statutory rule that we are looking at, of course, does not do anything other than add COVID-19 to the list, but I thought that it was important that the Committee was aware of the other powers available in the parent Act. As I said in my opening lines, to my knowledge, those powers have not been used. They are a matter of last resort. You would expect that most people would comply with medical advice or possibly even the threat of further legal action. I think that it is extremely unlikely that the additional powers in the Act would actually be used.

The Chairperson (Mr Gildernew): OK. In relation to the European surveillance system, my understanding is that that does not include COVID-19. If we were to make it notifiable here, would that mean that we would feed that into the European surveillance system?

Mr McMahon: I do not know the answer to that. If that is something that you would like us to check and get back to you, we can do that. This would purely be domestic legislation around requiring local notification to the PHA.

The Chairperson (Mr Gildernew): OK. Finally, from me, before I go to members, there is a range of issues that could be dealt with, such as access to schools and access to leisure centres. Is that generally something that would be used in a staged or phased way? How is it implemented in a specific case?

Mr McMahon: There are different requirements for different parts of the legislation in seeking these orders. Regarding checks and balances, in general terms, the PHA would have to go to a district judge to request that such an order be made.

With regard to evidence, again, there is a variation between the different sections, but, broadly speaking, the evidence to support the making of an order would have to come from the director of public health in the Public Health Agency. They would have to state that they felt that the person either had the disease or was likely to be carrying the disease and that whatever action was proposed was in the interest of the person, possibly their family or the wider public for the judge to make that decision.

The Chairperson (Mr Gildernew): There is a recognition, and it is very relevant, that the legislation has been amended in the South. The Department and the Minister are in regular contact, and I believe that, as we live on an island, it is very important that we have a joined-up approach and that we are working with the same advice and that there is clear and consistent advice being given to the public in a timely way.

Mr Chambers: I just want to confirm that the new statutory rule only comes into play when somebody has been clinically confirmed to have the disease. If someone was just suspected or was going through the process of having it confirmed, does that Act come into play at that point, or does it have to be clinically confirmed before the Act comes in?

Mr McMahon: The statutory rule that we are considering today merely adds COVID-19 to the list. On the wider powers of the Act, effectively, the person would need to be ill or, at least, the medical practitioner would need to have evidence to suggest that they were, maybe through a presumptive test or something like that. They would need to have reason to believe that they were infected with the disease.

Ms S Bradley: To elaborate on your point about the European model, if we add this on, and it is a matter of record, is it the same with the South? If you have a recordable appearance of an illness, do you share that data with public health in the South? I am just thinking of border regions or people who travel across the island. How fluid is the sharing of information?

Mr McMahon: The two Departments are in touch with each other, so if either jurisdiction were to get cases, there would be information shared, I would imagine. Obviously, we are not in that scenario yet, but I do not think that details of individuals would be shared, for obvious reasons.

Ms S Bradley: I am trying to understand at what stage GDPR would override it or vice versa. There is a vested interest in understanding an individual's connections in the instance of a diagnosis. I am not talking about the reasonableness of judging that they may have it, but if a diagnosis were made.

Mr McMahon: If a diagnosis is made, the Public Health Agency would engage in its normal contact tracing. It would interview the person, investigate where they have been, who they have been in close contact with and take details from those people. If there is cross-border movement, it may well be appropriate to share that information with the other jurisdiction.

Mr Carroll: Thanks for your presentation. Just to clarify, is the power of detention in the Act or it is contained in the statutory rule as well?

Mr McMahon: It is in the main 1967 Act. It has always been there. The statutory rule simply adds COVID-19 to the list of diseases to which the Act applies.

Mr Carroll: Therefore, it would extend to COVID-19 if the SR is accepted?

Mr McMahon: Yes.

Mr Carroll: It is very serious and important, but are there concerns that, as you say, if a general practitioner or other health professional has reason to believe that somebody could have the virus, is that a document or an investigation, or how does that come to pass?

Mr McMahon: I am not a medical doctor, so it is difficult for me to answer that question, but one scenario that I could give you might be if an initial laboratory test were a presumptive test, subject to a further test to confirm, then the attending doctor might feel that would be sufficient evidence to assume for the time being that the person did, in fact, have the illness.

Mr Carroll: Just quickly, Chair, if I can, we had a briefing around the Mental Capacity Act, and there were some suggestions about potential human rights challenges. There was a court case in England. Public health is obviously fundamental and a priority for containing the virus, but is there a concern from a human rights perspective that that could potentially be abused? Has that been suggested or investigated by the Department?

Mr McMahon: The first thing that I will say is that we are not aware that it has been used in the past, and we deem it very unlikely that it would be used in this scenario. It is obviously important for the Committee to know that it is there.

On the wider issues and the issues that you raise around human rights, the jurisdictions across the UK and in the South are all talking to each other about it. There are obviously different legislative landscapes, particularly since devolution, in all the countries, so we are seeking to take a consistent approach where that is possible. We are trying to iron out the differences in the legislation. Ours, being from 1967, as you say, precedes much of the modern human rights legislation, and it is probably fair to say that if you were rewriting it now, it might look slightly different. However, there are certain checks and balances built into it, and we are confident that if ever it were applied, it would be applied appropriately.

The Chairperson (Mr Gildernew): OK, Nigel. Thank you for your assistance.

Are members content that the Department makes the statutory rule?

Members indicated assent.