Witness Name: Marion Reynolds

Statement No.: 01

Exhibits: 5

Dated: 26.02.2024

UK COVID-19 INQUIRY

WITNESS STATEMENT OF MARION REYNOLDS

---

1. I am Marion Reynolds, a group member of NI Covid Bereaved Families for Justice, who has been selected to provide a Corporate statement on behalf of the Group in response tothe Inquiry's Rule 9 request for Module 2C.

2. NICBFFJ is a branch of the UK-wide CBFFJ Group. It was established with the purpose ofcoordinating activity in Northern Ireland, coordinating involvement with the UK-wide inquiry into the handling of the pandemic and leading calls for a separate NI Public Inquiry.

3. NICBFFJ was started in or around January 2022, that is, just before the end of the specifiedperiod identified as being covered by Module 2c which runs until 15th February 2022.

4. Prior to that, a number of our members were involved in engaging with state entities andpublic representatives throughout the pandemic, or were involved in other memorial groups.

5. Those in our group who did engage with state agencies and entities did so in an attempt to highlight issues and safeguarding concerns arising due to the pandemic, or to address

detrimental impacts arising from failures to implement effective policies, including those intended to benefit the most vulnerable. The aims were to gain access to residents and patients, improve the quality of care for those young and older adults and those with a disability living in nursing and residential care, and to engage with those in authority on government policies, operational decisions and guidance that was not working at both ground and operational levels.

6. In a group of this nature, the expertise and experience of the group will naturally be broad, as we are a group of individuals who have been brought together by the circumstances of the pandemic and of our respective bereavements. This breadth of experience, which includes my own, provides a strength to the group, ensuring a varied and representative range of experience and knowledge.

7. In my working life I was a practitioner and manager in Family and Child Care Services, and was then employed by the Department of Health as a Social Services Inspector responsible for inspecting and providing professional advice on children's social services. After 14 years in post I moved to the Eastern Health and Social Services Board as Deputy Director of Social Services for Children and Family Services. Following the Review of Public Administration in 2006 I took early retirement from the Board and worked for the next 13 years as an Independent Social Worker. I believe this gives me an in depth understanding of how the health and care systems work or ought to work in this jurisdiction. It also ensured that I was better placed to navigate these than many members of our group. As will be apparent from my account below, although I was armed with this knowledge and experience of the HSC((NI), it was not sufficient to help my aunt, who sadly passed away in November 2020 after contracting Covid.

8. A key purpose behind the establishment of the Bereaved Families for Justice Campaign Group was therefore formed to support one another. Some members would almost have

provided a counselling service to others within the group. It also allowed groups of peopleto come together with a shared loss, and many formed their own support networks with others they had met in the group. Whilst members were very supportive to one another, the group was very informal and the support and assistance provided was not structured,but was ad hoc. Practical support would have included members of the group helping others by writing letters of support or making comments about letters or avenues to achieve particular results.

9. This links to a second reason for the formation of the Group, which was to challenge decision makers and policies and to seek accountability given the efforts of engagement during the pandemic with sadly little or no change. NIBFFJ therefore grew organically, with the purpose of campaigning for change, partly as a response to bereavement, but also as a response to the failings that many individuals had experienced and wished to both share with others in order to prevent reoccurrence in the future.

10. NICBFFJ aims to:

a) Apply pressure to ensure that there is accountability and transparency on the UKand NI Government's past actions, response to the Coronavirus Pandemic and their ongoing approach.
b) Provide a collective voice for bereaved families and a supportive space for them to connect.
c) Ensure families are well-informed on their rights and options for seeking accountability in relation to their loved ones' deaths.
d) Lobby for proper support for families bereaved during the Covid-19 pandemic including but not limited to psychological, emotional and practical support, and for statutory services to take the needs of families bereaved by Covid-19 into account.

e) Make sure that families who have been bereaved by Covid 19 are involved in the commissioning of Covid 19 memorials, and that the National Covid Memorial Wall is made permanent.

11. NICBFFJ represent and are made up of members who have lost loved ones, both young and old, to Covid-19, in a variety of circumstances including in care homes, hospitals and in the community. Since its inception NICBFFJ have campaigned, in conjunction with CBFFJ, for improved accessibility for bereavement support, post bereavement financial support and policy reviews to prevent avoidable mistakes from being repeated.

12. NICBFFJ continues to empower members to hold the Government and public bodies to account to ensure that the circumstances leading to the deaths of their loved are avoided in the future. NICBFFJ's membership reflects a broad demographic of Northern Irish society who are united by the aim to learn lessons and save lives in this and future pandemics.

13. The group supports a full judge led public inquiry into the UK government and the Northern Ireland Executive handling of the pandemic, including decision making and funding at all levels during the pandemic.

NICBBFJ and views on the Devolved Response

14. As the history above suggests, many of the individuals who make up our group were involved with engagement with a variety of state entities and mechanisms from before the pandemic due to the fact that their relatives were vulnerable and reliant on healthcare or social care. Many were also involved in campaigns and activities which sought to establish answers and/or ensure accountability in relation to the circumstances of the death of their loved ones in the pandemic. Their activism was directed at key decision makers from an early stage in the pandemic in the hope that lessons could be learned as

soon as possible to prevent other families from suffering as they have. Group members also coalesced around specific groups aimed at informing the response to Covid-19 in Northern Ireland.

15. Many therefore engaged with such entities from the outset of the pandemic. Those engaged with included senior officials from the Department of Health (DOH) and its Arm's Length Bodies (ALBs) in NI: Public Health Agency (PHA), Regulation and QualityImprovement Agency (RQIA), Patient and Client Council (PCC), senior management representatives from various Health and Social Care Trusts who are responsible for providing services at various health facilities (hospitals, care homes), the Commissioner for Older People (COPNI), the Northern Ireland Human Rights Commissioner's office and public representatives including local MLA's, devolved Ministers and even the UK Prime Minister.

16. Our members, collectively and some individually, also have in depth knowledge and experience of how the NI health and social care systems operated in practice, including knowledge obtained prior to the pandemic. My own experience serves to demonstrate this in practice. As a result of that knowledge, we have significant concerns relating to thedevolved response for a variety of reasons which I will address below.

17. Aside from these experiences of engagement with state bodies and entities, it is also relevant to note, when considering broader thematic issues of concern, that a strikingly large proportion of our group are made up of bereaved relatives of some of the most vulnerable in our society, including those who were elderly or in poor health, and relianton care assistance or requiring essential healthcare interventions. An important aspect ofassessing the response to the pandemic involved taking effective steps to ensure that thereare adequate measures in place to protect the most vulnerable in society. That is not just the view of our group, and a matter of plain logic, but was repeatedly emphasised in civilcontingency planning documents. Consequently, when assessing the response to the

pandemic, one important factor to consider is whether the most vulnerable were in fact protected. Looking at the lived experience of our membership in relation to their loved ones in care homes, or who were seriously ill, or elderly and/or living with dementia, andindeed the statistics detailing those who died in the pandemic, the simple answer is that the most vulnerable in our society were not adequately protected. Concern at this is heightened as the impression was given to many of our group that the authorities either abandoned those loved ones, or were fatalistic about the possibility of protecting them.

18. I understand that these issues were raised on behalf of NICBFFJ in previous Modules, including in relation to Preparedness and Resilience. Whilst we as a group consider that many of the flaws in the response find their origin in the lack of preparation and resilience, many were also evident through the inadequacy of the government response when the pandemic hit.

19. In order to identify the flaws in the devolved response to the pandemic, NICBFFJ consider it is important for the Inquiry to consider some aspects of the lived experience of membersof our group, as this serves to identify a significant number of issues, many of which suggests that there were systemic flaws in the response to the pandemic.

20. Many of our members lost loved ones very early on in the pandemic, in circumstances which suggest that the lack of speed, and the ineffective nature of the initial response, wasa factor in their deaths. Other members lost loved ones many months and even years after the onset of the pandemic. The circumstances of many of these deaths reinforces the conclusion that either there were significant failures in the course of the immediate response, and that lessons learned from the initial wave were not properly acted upon.

21. The reason we as a group believe that these individual experiences are significant and should inform the inquiry is that the problems identified are inherently relevant to this Module, whilst the apparently systemic nature of these issues suggest that there were

significant failings in the response to Covid 19 in the specified period. As noted in previous Rule 9 responses provided by the NICBFFJ, it is also important to remember thatthe concerns about the response which the Inquiry is investigating are not abstract concerns, but do relate to traumatic and distressing experiences that real individuals haveexperienced, and which has led us as a group to identify these common themes.

22. We have identified a significant number of these issues in our response to previous Rule 9 requests for Module 1 and witness evidence for Module 2. Those experiences are also inherently relevant for Module 2C. For ease of the inquiry, and to reduce the need to crossreference between different responses, I have included those that we consider key for Module 2C here, but also propose to append those documents with this statement for completeness.

Issues of Particular Relevance for Module 2c

23. I would identify the following additional issues as being matters of particular importanceto our members for the purposes of Module 2C.

Vacuum in Governance

24. In previous statements on behalf of NICBFFJ concerns have been raised about the impactof the vacuum in governance which continued from January 2017 until January 2020. Thedetrimental effect of this vacuum in governance on a wide range of matters has been verywell publicised. It is inevitable that this 3 year vacuum in governance had a significant and detrimental impact on the coherence of the pandemic response from January 2020 onwards, not least because a number of new Ministers had been appointed with no previous ministerial experience, including the Minister for Health.

25. It is also relevant that the political vacuum in the jurisdiction included the lack of a devolved legislature. That suggested that a backlog of legislation required from the

Assembly had built up. The concern would be that this hindered the pandemic response where legislation was required.

26. Moreover, as the Inquiry has heard, our health and social care system was already in a dire state having suffered from years of under-funding, stagnation, and lack of much needed reform. This combination of a lack of political leadership and a health and social care system that could barely cope with routine pressures much less the extraordinary pressures of the pandemic meant that the residents of Northern Ireland were particularlyat risk from this pandemic and in need of a focused, clear and immediate Government response.

27. By contrast, we believe that the evidence in this Module will expose a devolved responsethat was slow and late to react to the pandemic, and failed to act in properly informed and sufficiently protective ways for the benefit of all residents of Northern Ireland, and particularly the most vulnerable.

28. It is a particular concern that many of the reactions of our political representatives were motivated not primarily to protect the lives and human dignity of all those in the jurisdiction, in particular the most vulnerable, but were significantly informed by politicalposturing, depending on a preference either to look south to the Republic of Ireland or tolook east to the UK Government, in an effort to seek vindication for views on the nationalquestion. This of course makes no sense when deciding on the most appropriate responseto a pandemic, which does not respect borders or political persuasions.

Herd Immunity

29. The concerns of many of our members about a policy of 'herd immunity' is linked to the apparent lateness of the UK lockdown, and the fact that high profile events, including a football match between Liverpool and AC Milan, and Cheltenham Festival, were permitted to proceed despite the known risks from the virus, including from asymptomatic transmission. The issue was particularly apparent as those events took

place on a different island to this jurisdiction, and raises questions as to whether effectiveaction could have been taken at that stage, including to restrict travel. There is also a concern that these events were permitted to proceed as the UK was following a strategy of herd immunity, and therefore wanted the virus to circulate. Whilst these issues were considered in Module 2, we consider that they are also relevant in considering the devolved response, and whether any rules, regulations or advice should properly have been implemented in this jurisdiction notwithstanding the approach of the Londongovernment at this point in time.

Failures in a Northern Ireland focused response

30. Related to the apparent lateness of a UK lockdown are concerns that our elected representatives stalled for too long while waiting for the UK government to take action. The evidence heard in Module 2 exposed the dither and delay at the heart of the UK Government but those delays did not only come to light in retrospect. They were evidentin real time as the pandemic approached. Many of our members recall a sense of frustration that our elected representatives stalled for too long before taking action in early2020 and thereafter they allowed Westminster to take the lead in decision making notwithstanding that the impact of Covid in Northern Ireland was always going to be different given our unique features including our geographical reality, our population density, the fact that statistically we were consistently a number of weeks behind Englandas the pandemic hit, as well as the dire state of our health service.

31. A further issue repeatedly raised by our members is that confusion arose from thedifferences in decision making between NI and Westminster, either because different decisions were taken by both without the reason for this being clear, or because the samedecisions were implemented across the UK in circumstances where this failed to take intoaccount the different circumstances that applied in this jurisdiction.

32. The inquiry will be aware of the nature of these concerns from the evidence of Catriona Myles in Module 2, however this is also an important feature of the issues under investigation in this Module, as the devolved administration bears some responsibility forhow this was addressed.

33. Catriona Myles' evidence made clear that the lived experience of many of our members was that the Westminster government appeared to be the real driver of decision-making in NI, and the impression was given to many of our members that NI was a mere afterthought. A further aspect of this is that there appeared to be a failure to appreciate and address the fact that NI was on a separate island, and shared a land border with another state. That meant that even a whole UK approach would not eliminate confusionarising from mixed messaging, as those living in border communities were required to consider the rules or guidance imposed from Dublin as well as from Westminster or Belfast. Where all three took differing approaches the potential for such confusion was magnified.

34. It therefore appeared to a number of our members that there was a lack of a coherent approach to ensuring a consistent and therefore an effective approach was taken for this jurisdiction. That concern was heightened by the fact that rules appeared to be implemented by all three jurisdictions without regard to the fact that some peoples' livesstraddled the border, and that this required to be taken into account when determining the rules that should apply. This also makes it difficult to see how a response could havebeen coherent, given the fact that the virus itself did not respect political boundaries. It was, or should have been, a matter for the devolved executive to identify the detrimentalconsequences that the differences in approach caused, including any resulting confusion,and to take steps to remedy these. It is not clear that they did so.

35. Our members also harbour concerns about the differences in international travel restrictions in the UK as compared to the Republic of Ireland. It was well known during then pandemic that international travellers (from these islands and from abroad) opted

for different travel routes via either Dublin or Belfast airports depending on the respectiverestrictions imposed at that time.

36. For completeness we would identify that a number of our members considered that the confusion about what rules applied was arguably heightened when the reasons for thesediverging approaches were not entirely clear to the public. These are not abstract concerns. They are raised, among others, by Frances Doherty whose mother Mary Magdalene Mitchell tested positive for Covid on 21st March, before any lockdown was imposed. She died on 25th March 2020. She believes that the cost of the delay in imposinga lockdown can be counted in lives lost, including the life of her mother. She queries the reason for the delay in lockdown in this jurisdiction as compared to the Republic of Ireland.

Families with little to no contact with vulnerable individuals while they were in hospital/care settings

37. A significant number of our members feel very strongly that the limits imposed on socialinteraction and the associated extent of the limitation on contact with vulnerable relatives in care homes/hospital settings was punishing and damaging.

38. One obvious and repeated aspect of this is was the social isolation that was imposed to prevent the spread of Covid. It is accepted that these measures were introduced with thegeneral aim of protecting health and life, however the manner in which these measures were implemented was often suggestive of a failure to consider or to adequately take intoaccount the importance of social interactions for mental health, particularly for some of the most vulnerable in society.

39. This was a stark reality for many of our members who could maintain little or no contactwith vulnerable loved ones who were in a Hospital/Care Home setting, even after

vaccination and testing was widespread, and even after government guidance supported a conclusion that such contact should be facilitated. The accounts of our members includebereaved family members constantly imagining the pain and suffering of their loved ones'final days/hours as they died cut off from family members, in many cases without any comprehension as to why contact had ceased. These accounts repeatedly identify the horror of this, leading to continuing trauma. Many of our members are still struggling to pick up the pieces from this clinical estrangement in the final phase of life.

40. A number consider that this contributed to the deterioration in their loved ones and mayhave been a factor in their deaths. Others are concerned that vulnerable relatives would have been confused at the lack of contact or would have been left alone, isolated and frightened when they were dying.

41. Agnes McCusker for example believes her mother, Bridget Halligan, went downhill aftervisits to her Care home (Dunlarg Care Home in Keady) were stopped on 18 March 2020. Her family had visited her every day up until this point. They then rang the care home daily for an update. Bridget tested positive for Covid 19 around 7 April 2020, and passedaway on 12th April 2020. The family were not permitted a visit. As there were few staff members on duty in the home the night she died she passed away alone. Agnes still doesnot know at what time her mother died.

42. Nuala Scullion died of Covid 19 at the Causeway Hospital on 24 February 2021, aged 58 years. She was taken away in an ambulance 5 weeks and one day before she passed away.Her family never spoke with her again. Although they were permitted a zoom with her before she died, Nuala was already unconscious. Her children are members of NICBFFJ and determined that their mother will not be forgotten.

43. Terry Whyte's mother Margaret had been in Ard Na Va home on the Falls Road when thepandemic hit. Although his mother had a sharp mind, the whole family noticed her

mental and physical health deteriorating once family visits were stopped. Although one family member (Terry's brother) was permitted a visit by appointment, this took place through a window and was difficult. On one occasion when he visited a staff member hadclosed her blinds and Terry's brother could not even see their mother. They were concerned at her treatment as they had seen staff giving her medication without appropriate PPE, but given the restrictions on accessing the home the family believed there was little they could do but complain to the home. This happened a number of times.Margaret passed away on 27th January 2021

44. The concern at the impact of social isolation on the vulnerable is not merely raised by members of NICBFFJ. The Social Care Institute for Excellence recognizes identifies that psychological and emotional abuse may include "*Enforced social isolation-preventing someone accessing services, educational and social opportunities and seeing friends", and "Preventing stimulation, meaningful occupation, or activities. Types of organizational or institutional abuse they identify include "Discouraging visits or the involvement of relatives or friends*".

Wakes and Funerals

45. Whilst there is significant concern at the treatment of the most vulnerable during their life,a related concern which has been repeatedly expressed by our members is that there was a failure to appreciate the importance of social interaction at the end of life, and as part ofthe grieving process.

46. The cultural and religious importance of wakes and funerals in Northern Ireland should not be underestimated. However, one important aspect of the limitation on social interaction is found in the repeated issues with the denial or severely limited restriction on rituals in the form of wakes and funerals. The Inquiry has heard and will continue to

hear harrowing accounts from many of our members about the denial of funeral rightsand the long term impact they had on the trauma and the grief of many people.

47. Many of those who were bereaved in the early stages of the pandemic in particular describe the treatment of their loved ones after death in stark terms, including Rhonda Tate, who states, "*My mother was treated as if she was toxic waste*".

48. Anne Elliott describes how she was told her brother's funeral could not go ahead and wasdelayed as the undertaker had no death certificate. Eventually the funeral took place at 2hours' notice. She says simply "*There was no wake. We never saw Basil again.*"

49. Our members believe that this denial of ritual and social interaction has prolonged the grieving process and prevented many bereaved from coming to terms with the death of their loved ones.

50. This again supports a conclusion that there were systemic failings, including in failing torecognise the importance of social interaction in the response to the pandemic. We consider that this is relevant for the issues to be considered by the inquiry in Module 2C,including to identify whether this was due to inherent failings in the pandemic response,and therefore for identifying steps that should be taken in the future.

Failures in Political Leadership

51. The concerns about restrictions on funerals takes on particular significance in this module,given the controversy over the circumstances of the funeral of Bobby Storey. Given the strength of feeling about the denial of funeral and grieving rituals, many of our membersstill report a lasting sense of outrage at what occurred with Bobby Storey's funeral. It is important to emphasise that these concerns stand alone from any view about the deceased

or the political representatives who were involved. The issue was that it was importantthat everyone be under the same restrictions, and be subject to the same laws.

52. The spectacle of other families being kept outside Roselawn Crematorium, while waiting on the Bobby Storey cremation service which appeared to be given preferential treatment, was cruel and disgraceful. Although it may be said that it was a matter for Belfast City Council as opposed to the devolved executive, ultimately our group considers that responsibility and leadership stems from the Executive and the parties on Belfast City Council mirror those in the devolved executive.

53. I do not personally know if there was a difference in adherence to Covid restrictions following the Bobby Storey funeral, but in terms of public confidence I fear that significantdamage was caused. People felt that their loved ones were treated with less respect and less dignity, and their grief was not considered to be as important. As a group we believethis sent the wrong message and was a slap in the face to many of the Covid bereaved. There was an absence of First and Deputy First Minister briefings for many months due to the political fallout associated the Bobby Storey funeral and this was another consequence of this.

Inaction/quietude of politicians in the devolved administration

54. The Inquiry has heard and will no doubt continue to hear accounts from bereaved familiesabout their difficulties in trying to communicate with or seek clarification, assistance or support from agencies and statutory bodies to whom they reached out to during the pandemic. There are many common themes and experiences, most of which centre on a lack of communication, inadequate communication or confused responses to requests forclarification during the pandemic. In the context of Northern Ireland, those complaints and concerns also extend to our locally elected politicians.

55. A number of our members identify that, feeling like they had nowhere else to turn, they reached out to locally elected politicians in their desperation about their relatives but did not get help or even a response. For example, Hazel Gray, an only child, describes how she tragically lost both her parents to Covid 19. George Little died in December 2020, while her mother passed away on 17th January 2021. They had been in hospital together for a time. Hazel describes visiting her mother after being told she was unresponsive, only to find her responsive though parched. She has concerns about the treatment of both her parents, including concerns that her mother was administered inappropriate medication in light of her medical conditions. She describes contacting Minister Swann and Dame Arlene Foster with her concerns but never receiving a response.

56. As noted above, Ingrid Johnstone describes her belief that her father, Robert Gallagher, was given up on and treated as a unit, and that Midazolam was used to accelerate the end of his life. He passed away in Sir Samuel Kelly Care Home in Hollywood. Ingrid describes sending an email to Michelle O' Neill raising her concerns about the fact that her father had few or no funeral or ceremonial rights and contrasting this with the funeral of Bobby Storey. In response an aide confirmed that Ms O' Neill did attend Mr Storey's funeral but did not say much more. Ingrid's sister Lesley also describes writing to Sir Jeffery Donaldson and Naomi Long, but received no reply from either. They describe how they felt abandoned by their elected representatives.

57. . Trevor Hazley describes how he found the PCC to have been of particular assistance when seeking to obtain answers in relation to the care of his father Lesley. However he does identify that this positive experience was isolated, and contrasted poorly with other entities, identifying that he had made a complaint to RQIA about his father's nursing home without success, and further that he had made a complaint to Social Services, who subsequently advised that the complaint had not been progressed as it had been forgotten about. Trevor also describes contacting Minister Swann's office, but describes him doing nothing.

Lack of Post Mortem examinations by a GP

58. A number of our members also express concern that the absence of post-mortem examinations during the pandemic, particularly where they had concerns about the treatment of their loved ones. This was also a concern of my own in relation to the death of my aunt, not because there was anything in relation to the death itself but rather because the circumstances of her death and the issuing of her death certificate confirmedto me that this amounted to the removal of an important safeguard for the elderly and vulnerable. In order to fully understand the overlapping nature of this concern, and manyother concerns above, I believe it will assist to consider the treatment of my aunt in fullerdetail.

My own experience and the death of my aunt

59. I am acutely aware that the case of my aunt is not the only one in which members of our group have identified overlapping concerns. I outline aspects of what happened to my aunt and my own experience of trying to care for her during the pandemic not because I believe this deserves greater recognition than any of the many other tragic cases during the pandemic, but because this demonstrates in practice significant weaknesses in the pandemic response, which appear to have been overlapping and systemic. Her experience, and my inability to protect her or to access support highlights a number of thesystemic features identified by our group, as noted above. I appreciate that a number of these issues may be considered in greater detail in other modules. However I believe herown case identifies a number of systemic issues which may be relevant for the Inquiry toconsider in this Module. These include:

    i) My aunt contracted covid in Hospital, an entity that was supposed to care forher, many months after the first wave of the pandemic, suggesting lessons had

not been learned and measures taken to protect those who had to attend hospital;

ii) The measures introduced to combat the pandemic did not have sufficient flexibility to respect the needs of individuals and the most vulnerable, such as my aunt's reliance on lip-reading;

iii) The care package proposed for her was clearly in adequate, particularly during the pandemic, and this issue appears to have been systemic. Despite this there was still a drive to discharge her from hospital. That suggests that the response to the pandemic did not respect the rights of the most vulnerable;

iv) My aunt was vulnerable and isolated in the Care Home, having been denied access to professionals who would normally visit such establishments as well as myself and her family. It should have been appreciated that safeguards to ensure the maintenance of quality care in such care homes were strengthened. Instead RQIA suspended their visits.

v) Steps taken by the Department of Health as part of the Covid response, to mitigate the detrimental impact on some of the most vulnerable in society, were inadequate in practice, being based on Guidance which was then not implemented by the Care Homes or enforced by the Trusts. Those such as myself who should have been informed about this Guidance were not.

vi) Safety mechanisms, including civil society, such as the Human Rights Commission, the Commissioner for Older People, the Law Centre, individuals in positions of responsibility with the health and care sectors and entities such as the RQIA did not operate effectively. They did not seem to change anything in practice. As will be apparent from the above, my own experience is not an isolated case, though it may be even more striking given that I knew many of the individuals I reached out to after having interacted with them in my professional career. It could be expected that I was more familiar than most with who to reach out to and what they were capable of achieving in practice. In reality this did not help my aunt. The safeguards did not work.

vii) The change in process for certifying the cause of death was a significant concern, given the importance of this as a safety mechanism to protect the livesof the most vulnerable in society.

viii) The restrictions on funerals and grieving rituals has caused lasting damagefor many in the grieving process.

60. I raise those concerns because of my aunt's experience as outlined in greater detail now.

61. In March 2020 my aunt, Marie Reynolds, injured her hips, requiring hospital treatment. Marie lived alone, was profoundly deaf, was five foot nothing and weighed only around8 stone. Despite her small stature she feared nobody and was sharp as a tack. Tragically this did not save her once or ensure she benefitted from proper care when she became ill.

62. One issue that caused me concern on her admission to hospital was that, despite the fact that she was deaf and relied heavily on lip-reading for communication, staff would still wear a mask when caring for her. In the isolated situation which prevailed in the health and care sectors, this must have isolated her still further. I had raised this with individualsin authority, and the Public Health Agency had recognised that this was a problem, but still nothing was done for my aunt or many others who were reliant on lip-reading for communication. Those who were so reliant must have felt abandoned by those in authority and those caring for them due to the use of masks. One factor of particular concern is that this occurred not at the immediate outset of the pandemic, in early 2020, but after the summer, when these issues should long have been apparent and steps could and should have been taken to ensure mitigation for those such as my aunt.

63. In September 2020 my aunt was readmitted to hospital with pneumonia where she contracted Covid. The risk of Covid was well known by this stage. I do not see how she could have contracted Covid if adequate safety measures were followed. This again suggests a systemic failing in response to Covid. It is not clear to me to what extent the

Devolved Administration considered nosocomial infection as a feature of rising case numbers throughout the pandemic, or the extent to which effective steps were taken to reduce such infections, however as will be apparent from the accounts above, a significant number of our members describe their loved ones contracting covid in health or care facilities, including late into the pandemic.

64. I myself had contracted Covid in and around the same time as my aunt. Together with my brother, I had been heavily involved in caring for my aunt as her care package was inadequate in itself. Despite this, and despite her condition having deteriorated following her hospital admission, I received a phone call to advise me that Marie was being discharged from hospital to her home with effectively the same care package that had been in place before her hospital admission. The only difference was that she was in significantly poorer health and I was now too sick to help care for her myself. The proposalitself was cruel and inadequate to protect her from harm let alone to care for her. When Imade this clear I was informed that a male patient in a similar condition had just been released with a similar care package. I do not believe that this strengthened the case thatI should accept an inadequate care package for my aunt, however I do believe that this reinforces the conclusion that there were systemic failings at this stage in how vulnerableindividuals were being discharged from hospital during the pandemic. If I had not been ill I would have made a formal complaint about the social worker who was responsible for this suggestion given the obvious inadequacy of the proposal, and the extent to whichI considered it risked my aunt's health and dignity. I appreciate that failings of this naturemay have been present prior to the pandemic, however it is also clear to me that the fact of the pandemic reduced oversight mechanisms, and therefore exposed the most vulnerable in our society to inadequate treatment.

65. My aunt was then transferred to Downe Hospital. She was not eating or taking her tablets.She had struggled with eating all her life, but would eat with encouragement, however I believe that by this stage she felt totally abandoned. The transfer between hospitals took

place when it seemed very obvious to me that my aunt was very weak, on a dark cold wetnight. I am sure she was confused and scared, and do not believe it could have been appropriate to transfer her in her state of health at that time and in those conditions.

66. Marie was subsequently discharged from Downe hospital to Comber Care Home, in or around October 2020. I was told that we were not allowed to visit her in person. We therefore had to travel to a patch of grass outside her window and just wave at her. I travelled to see her with my aunt's 86-year-old sister. There were no extra facilities provided outside the window to facilitate such visits, and my 86-year-old aunt had to stand, with me, on wet, slippery grass in the cold in October/November to wave at her sister. Marie could not properly see or hear us, and she could not lip-read at that distancethrough the window. She kept waving us to come in and clearly did not understand whatwas going on. The whole manner in which the visit took place makes the word cruel seeminadequate.

67. I would bring buns and lemonade when I visited her, but I was not allowed in so would leave them with staff. I fought to get into the home given my concern for my aunt and myunderstanding that she may not eat or drink without proper encouragement and I was not sure she was getting such attention. I tried the staff in the home, then a whole varietyof bodies, a number of which had personnel who I had dealt with professionally when I was working. I tried the Eastern Board, the Chief Nursing Officer's office, the NI HumanRights Commission, the Law Centre, the Patient Client Care Council, and the Commissioner for Older People. Although everyone I dealt with sounded sympathetic and listened to me they didn't help in any practical sense.

68. I had noticed when I visited the home that another resident was permitted a visitor, but nobody could tell me how this was permitted. I later discovered that the department had introduced Guidance in September 2020 that Care Homes should work to introduce CarePartners, who would have played a prior role physical or mental health needs were met,

and who would be permitted access to the individual in the home for this purpose. The underlying purpose was to mitigate the harm on the health, wellbeing and rights of the individual caused by the measures to protect against transmission of Covid 19. Nobody from the Care Home told me about this Guidance despite the extent of my efforts to visitmy aunt in the home.

69. When I finally did get access to the home it was apparent to me that Marie's condition had deteriorated to such an extent that she was near death. She had not been eating and was very dehydrated. Despite being transferred to the home with bags of her own clothesshe was wearing someone else's clothes, with her own still in plastic bags in the cupboardin her room. There was nothing on the walls to look at. I had been aware of this before I was permitted into the room and had sent down a TV, and whilst this had been placed inher room, it was not even plugged in. The boxes of cakes and buns and the lemonade thatI had brought down just sitting there, piled up. Some of them were now out of date. My aunt was dehydrated. I had brought a flask of tea with me and she gratefully drank the whole flask. My aunt had always needed encouragement to eat or drink and it was clear to me that, for whatever reason, there was inadequate attention paid to this in the home, with the result that my aunt was dehydrated, emaciated and dying before my eyes.

70. I raised my concerns with the person in charge. She said the matter would be investigated.I said that my aunt was close to death. I was told that the doctor had not thought this when he had last seen her. Unfortunately I did not enquire when this was, but I would say it was obvious to me that my aunt was near death. I imagine I have less experience ofseeing individuals at this point in their lives compared to staff in Care Homes, and it is amatter of concern to me that they could not see how unwell she was.

71. My aunt was in the home for around three weeks before she passed away, on 20November 2020. She had no underlying health problems, and after her hip operation shehad made a great recovery. Had she not ended up in that care home, or had people given

her the time to encourage her to eat and drink within the home, I believe she would be here today.

72. For completeness I append a number of items of correspondence I engaged in about the treatment of my aunt, as this serves to support with contemporaneous evidence some aspects of this account. This includes correspondence with the NIHRC, exhibited at **[MR/1 – Email to NIHRC]** the Commissioner for Older People, exhibited at **[MR/2 – Email to Eddie Lynch]** Linda Johnston from the South Eastern Trust, exhibited at **[MR/3 – Email to Linda Johnson SE Trust]** the Chief Nursing Officer, exhibited at **[MR/4 – Email to Chief Nursing Officer]** and Age NI, which is exhibited at **[MR/5 – Emails with Age NI].**

73. Whilst I accept that many care homes are under-staffed, and that this was exacerbated during the pandemic, I believe that the treatment of my aunt was so inadequate that it resulted in cruel treatment and ultimately caused her death. My concern is not only the inadequate care, it is the manner in which the covid response itself in some ways enabledthis. Prior to the pandemic there would have been relatives visiting the home, but also a variety of professionals, including GPs, but also chiropodists, therapists, and RQIA inspections. There would have been a variety of professionals in the home who I believe would have raised concerns at the inadequacy of her treatment and the risk to her life. Asa result of the pandemic these safety mechanisms were removed. There was no-one to sound alarm bells at such treatment. There was no oversight or safeguards. Some of the most vulnerable in society were simply abandoned.

74. That concern is reinforced by the watering down of another safety mechanism, in relationto the certified cause of death. After her death I telephoned my aunt's GP to tell him she had passed away. I am sure that he had not seen her since her readmission to hospital with pneumonia in September 2020. He asked what the cause of death was. I am not a medical professional and have no medical qualifications, but for what it was worth I gavemy own view, including that it was partly fragility of old age, partly her hip fracture and

partly Covid. When I received her death certificate it simply repeated what I had said, including the phrase "fragility of old age", which as far as I know is not a medical term which should appear on a death certificate. I am not raising this to criticise the GP. We know each other well, I respect him very much and understand that he trusts me and no doubt felt he could rely on what I had told him. My concern is that if this process was permitted in my aunt's case, then it may have occurred in many other cases, where the individual reporting the cause of death may not have been so trustworthy, or where the GP did not have a similarly trusting relationship with them, but also had no opportunity in practice to verify the cause of death. That is a real concern in circumstances where manyof these vulnerable individuals had been denied access to their families up until their death, and where they had died isolated and alone.

75. My understanding of medical certificate's identifying the cause of death is that this is a safeguard, particularly in the case of elderly or vulnerable individuals. I understand thatthe importance of such a safeguard was highlighted, for example, in the recommendationsof the Harold Shipman Inquiry. It is therefore a matter of concern that such an importantsafeguard was so severely weakened during the pandemic.

76. My aunt had already made her own plans for her funeral, including ordering the Order of Service to be printed, requiring only that the date of her death to be added. She was oneof a large clan, one of ten siblings, and had a wide circle of friends. Despite this we were required to have a comparatively small funeral and no reception afterwards. I appreciatethat what we were permitted was still greater than what many others were allowed at different stages of the pandemic, however this has left a lasting sense of sadness that we were deprived of the opportunity to give her the funeral she deserved.

Recommendations for the Future

77. A number of overriding impressions can be gained from the accounts and experiences of our members.

78. The first is that there appears to have been a consistent failure to protect the most vulnerable in society from the virus, including in care homes and hospitals, many months after the outset of the pandemic. That suggests a failure to learn how to addressthe risk posed by the virus and to take effective steps to protect the vulnerable in particular. It is difficult to divorce these concerns from the concern that the devolved response was simply overwhelmed and many of the most vulnerable were simply abandoned to their fate.

79. There also appears to have been inadequate regards to the needs of the most vulnerablewhen determining the appropriate pandemic response. Although many of our members relatives contracted covid in health and care settings, they were then denied significantcontact.

80. In one sense it may not be surprising that there were failures in the pandemic response. What is of particular concern is that the mechanisms that would normally be identifiedas being avenues through which change could be achieved, or safety could be assured, failed when they were needed most. In many cases this resulted in the most vulnerablebeing abandoned to their fate.

81. We consider that the following lessons must be learned for future pandemics:

    (i) Prolonged vacuums in governance or political posturing in governance shouldnot be permitted to hinder a pandemic response. There should be clear and ongoing pandemic planning for Northern Ireland, taking into account its unique political and geographical situation, with protecting lives and livelihoods at the heart of this planning.

(ii) In any future pandemic response there must be emphasis on protecting the health and lives of the most vulnerable in our society in practice. That means not only from the pandemic, but from any detrimental consequences arising from the steps taken to combat the pandemic.

(iii) The health and social care systems must receive adequate levels of funding, and have appropriate oversight mechanism to confirm that funding is used effectively, to ensure they are capable of responding effectively to any future pandemics. This must include that they are capable of protecting the rights and lives of the most vulnerable in our society in a pandemic. Never again should an impression be given that the most vulnerable in society have been abandoned to their fate in a pandemic, or have suffered in the pandemic due to their very reliance on the healthcare system which is supposed to protect them.

(iv) Related to (iv), state entities must be capable of acting quickly on up-to-date guidance about the risks posed by any future pandemic, and able to respond in an informed and effective way to those risks.

(v) The importance of communication in a pandemic, including not just between agencies responding to the pandemic, but also communication with family members and those affected by the pandemic, must be considered a priority inthe future.

(vi) The importance of informed consent for medical interventions, including DNRs, should be protected, by additional legislation if necessary;

(vii) In the future, there must be an acknowledgement of the importance of mental health in response to a pandemic. This should mean emphasis on the importance of being able to maintain social interaction, particularly for those who are vulnerable or otherwise isolated and/or cannot understand why they have suddenly been left isolated. This should also include acknowledgement of the importance of social rituals, such as church attendance, wakes and

funerals, for those who have suffered from such pandemics as a fundamental part of the grieving process.

(viii) Consolidating legislation to identify the rights and obligations owed to users of the health and social care systems, and to provide or simplify appropriate mechanisms to effectively protect and allow those users to vindicate those rights in practice. Relevant safeguards to protect the most vulnerable should be strengthened, not weakened, in a pandemic.

(ix) Consistent with (ix), steps should be taken to ensure that where Government policy is issued, particularly where this is to protect the rights of health and social care users, it is implemented in practice. To the extent there is a power imbalance between the Department and the Care Homes which permits this itrequires to be addressed and rectified. Never again should independent care homes be permitted to effectively ignore guidance published by the Department of Health for the purpose of protecting the rights of vulnerable people and their families. Such an outcome is not consistent with a coherent oruser-friendly system.

(x) Where laws are infringed, (including human rights laws) that protect life, or prohibit treatment that is inhuman or degrading treatment, there should be mechanisms to identify which can operate effectively, even in a pandemic, andthose responsible for such infringement should be held to account. Thatincludes not just the individuals who have infringed these laws, but also thosein supervisory roles who have permitted this to occur. This is required to ensure that the law is implemented and effective in practice. This is also required to prevent any appearance that there is tolerance of acts which amount to life-endangering behaviour and/or may have resulted to death.

.....

.....

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand thatproceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: _____ Personal Data

Dated: 2/26/2024