UK COVID-19 INQUIRY WITNESS STATEMENT

STATEMENT OF EDDIE LYNCH

I, Eddie Lynch, the Commissioner for Older People for Northern Ireland whose office is at Equality House, 7-9 Shaftsbury Square, Belfast BT2 7DP, Northern Ireland, make the following statement in response to a request from the UK Covid-19 Inquiry.

INTRODUCTION

1. I received correspondence dated 11 November 2022 on behalf of Baroness Heather Hallett, the Chair of the UK Covid-19 Inquiry ("Inquiry") seeking a witness statement and the disclosure of documents pursuant to Rule 9 of the Inquiry Rules 2006 for Module 2C ("Rule 9 Request").

2. The Inquiry was established on 28 June 2022 to examine the UK's response to, and impact of, the Covid-19 pandemic, and to learn lessons for the future. It is being conducted in modules and it is my understanding, from the Inquiry's 'Provisional Outline of Scope for Module 2C', exhibited at **[EL/1 – INQ000239424]** and the Inquiry's 'Note for the Preliminary Hearing in Module 2C of the UK Covid-19 Inquiry' exhibited at **[EL/2 – INQ000239435]**, that Module 2C will consider, and make recommendations about, the decision-making by the government in Northern Ireland in relation to the Covid-19 pandemic between 11 January 2020 and 15 February 2022. The significance of these dates ("the Specified Period") is that they mark the period from which the Northern Ireland Executive was re-formed for the first time since January 2017 until domestic Covid-19 restrictions were lifted in Northern Ireland.

3. This Statement, including the documents exhibited to it, relates solely to the work being undertaken in Module 2C for which I have been granted Core Participant status. It constitutes my response to the matters to be addressed as set out at Annex B and Annex C of the Rule 9 Request. The Statement is provided under four main sections:

I. Office of the Commissioner for Older People;
II. Involvement in Government's Pandemic Response Efforts;
III. Interactions with the Northern Ireland Assembly; and
IV. Lessons Learned.

4. I refer to numerous documents in this Statement. I have provided those that are publicly available, such as legislation and other documents available from a government website, through a link in a referenced appendix at the end of the Statement. Others are provided as exhibits to this Statement. In ease of the Inquiry, I have erred on the side of caution and exhibited a document where it is especially significant, or I consider it would be more convenient to have it readily to hand in the form of an exhibit.

I. OFFICE OF THE COMMISSIONER FOR OLDER PEOPLE

5. Age sector organisations, such as Age NI and Age Sector Platform, had been campaigning for an Older People's Commissioner in Northern Ireland for some time. Their vision was to have an independent, adequately resourced voice who could protect the rights and interests of older people.[1]

6. The Northern Ireland Executive committed in their 2007 Programme for Government ("PfG") to providing a 'strong independent voice' for older people and in December 2007, the First Minister and Deputy First Minister announced their intention to establish a Commissioner for Older People. In a statement by the Committee for the Office of the First Minister and Deputy First Minister ("OFMDFM"), the Committee 'recognised the disadvantages experienced by many older people' stating that it would be engaging with OFMDFM *"to ensure that the powers and responsibilities of the Commissioner are capable of delivering real benefits for older people"*.[2] This is an important context in which to consider the role of COPNI during the Specified Period and the response of government.

[1] 'We agree: Partnership campaign between AgeNI and Age Sector Platform at - https://www.ageuk.org.uk/northern-ireland/get-involved/campaigns/commissioner-for-older-people/

[2] 'Committee for OFMDFM welcomes the announcement of a Commissioner for Older People' at - http://www.niassembly.gov.uk/news-and-media/press-releases/archive-press-releases/press-releases-2007-2008/committee-for-ofmdfm-welcomes-the-announcement-of-a-commissioner-for-older-people/

a. Nature of the Office

7. The office of Commissioner is a statutory role, at arms-length of government. My office is set up as a non-departmental public body sponsored by the Department for Communities ("DfC") but, critically for the work I do, operationally independent. It was established in accordance with the Commissioner for Older People Act (Northern Ireland) 2011[3] ("the Act") with the principal aim, as enshrined in section 2(1), of safeguarding and promoting the interests of older people in Northern Ireland. Whilst the Act is available on the government website, it is exhibited for convenience at **[EL/3 - INQ000239436]**.

8. I first took up office as Commissioner on 13 June 2016, the inaugural Commissioner being Ms. Claire Keating who completed her term of office in November 2015. I was subsequently appointed for a second term four-year term that started on 13 June 2020.

9. My role is essentially to act as an independent champion for older people, who safeguards and promotes their interests. My determination to do precisely that would have been well understood I have spent much of my working life dedicated to championing the rights of older people and immediately prior to my appointment I was Chief Executive of Age Sector Platform, a charity representing the interests of older people in Northern Ireland, supporting them to make their voice heard, and convener of the Northern Ireland Pensioners Parliament. I can only assume that when I was appointed it was intended to put in office, as acknowledged at the time by the First Minister and Deputy First Minister, a 'fierce advocate for the interests of older people with a wealth of knowledge and experience'[4].

10. The Act affords me promotional, advisory, educational, and general investigatory duties and powers. Their purpose is to enable me to champion the rights and interests of older people throughout Northern Ireland.

[3] 'Commissioner for Older People Act (Northern Ireland) 2011' at - https://www.legislation.gov.uk/nia/2011/1/contents
[4] 'New official Eddie Lynch to be voice of the elderly' at - https://www.belfasttelegraph.co.uk/news/northern-ireland/new-official-eddie-lynch-to-be-voice-of-the-elderly/34532570.html

b. Statutory Functions and Responsibilities

11. The mandatory duties of the Commissioner are outlined in section 3 of the Act:

(1) The Commissioner must promote an awareness of matters relating to the interests of older persons and of the need to safeguard those interests.

(2) The Commissioner must keep under review the adequacy and effectiveness of law and practice relating to the interests of older persons.

(3) The Commissioner must keep under review the adequacy and effectiveness of services provided for older persons by relevant authorities.

(4) The Commissioner must promote the provision of opportunities for, and the elimination of discrimination against, older persons.

(5) The Commissioner must encourage best practice in the treatment of older persons.

(6) The Commissioner must promote positive attitudes towards older persons and encourage participation by older persons in public life.

(7) The Commissioner must advise the Secretary of State, the Executive Committee of the Assembly and a relevant authority on matters concerning the interests of older persons—

(a) as soon as reasonably practicable after receipt of a request for advice; and

(b) on such other occasions as the Commissioner thinks appropriate.

(8) The Commissioner must take reasonable steps to ensure that—

(a) older persons are made aware of—

(i) the functions of the Commissioner.

(ii) the location of the Commissioner's office; and

(iii) the ways in which they may communicate with the Commissioner.

(b) older persons are encouraged to communicate with the Commissioner.

(c) the views of older persons are sought concerning the exercise by the Commissioner of the Commissioner's functions.

(d) the services of the Commissioner are, so far as practicable, made available to older persons in the locality in which they live

12. Almost all of them were engaged during the Specified Period and are relevant to the Rule 9 Request. Of particular significance is my statutory mandatory duty under section 3(7) to *"advise the Secretary of State, the Executive Committee of the Assembly and a relevant authority on matters concerning the interests of older persons"* as I consider appropriate. I regularly highlighted my concerns over the position of older people in relation to the government's response to the pandemic, and provided advice to the relevant Assembly Committee, Departments and senior officials in the health and social care sector.

13. The general powers of the Commissioner are outlined in section 4 of the Act:
    (1) The Commissioner may undertake, commission or provide financial or other assistance for research or educational activities concerning the interests of older persons or the exercise of the Commissioner's functions.
    (2) The Commissioner may, after consultation with such bodies or persons as the Commissioner thinks appropriate, issue guidance on best practice in relation to any matter concerning the interests of older persons.
    (3) The Commissioner may, for the purposes of any of the Commissioner's functions, conduct such investigations as the Commissioner considers necessary or expedient.
    (4) If the Commissioner so determines, Schedule 2 is to apply in relation to an investigation conducted by the Commissioner for the purposes of the Commissioner's functions under section 3(2) or (3).
    (5) The Commissioner may—
    (a) compile information concerning the interests of older persons;
    (b) provide advice or information on any matter concerning the interests of older persons;
    (c) publish any matter concerning the interests of older persons, including—
    (i) the outcome of any research or activities mentioned in subsection (1);
    (ii) the outcome of any investigations conducted under subsection (3);
    (iii) any advice provided by the Commissioner.
    (6) The Commissioner may make representations or recommendations to anybody or person about any matter concerning the interests of older persons.

14. Similarly, my general powers to publish and make representations, under section 4(5)(c) and (6) were particularly important during the Specified Period and I resorted to them repeatedly.

c. Size and Nature of the Sector

15. Under section 25 of the Act, subject to subsections (2) to (4) "older person" is defined as a person aged 60 or over. In some exceptional circumstances and where I consider it appropriate to do so, I am entitled to direct that for the purposes of the Act "older person" means a person aged 50 or over and to apply my powers under the Act accordingly. I did consider the pandemic to constitute an exceptional circumstance, however during the pandemic I did not encounter a set of circumstances where I felt it necessary to rely on section 25 of the Act to widen the scope of my powers to apply to persons ages 50 or over. An instance where I might have considered doing so during the pandemic, would have been if an individual in their 50s advised my office that they were not admitted into hospital for treatment for Covid-19 as priority treatment is given to those under 50. I have also represented the over 50s in the past in situations where they have been resident in nursing homes. In one case we successfully advocated for the withdrawal of an eviction notice. In another case we were asked to advocate on behalf of a patient in relation to the provision of physiotherapy and other therapeutic interventions.

16. Using the primary definition provided by the Act, as of March 2021, Northern Ireland had an over-60s older population of approximately 439,600[5]. This represented some 23 per cent of its total population. If the broader definition of aged 50 years and over is used, the total figure rises to approximately 600,000. Furthermore, the latest census shows that the long-term population trend is significant growth with the recent period of growth representing the fourth highest in any intercensal. Importantly, the percentage increase in that period is considerably larger for older people over 60 years than for any other age band. All of this points to an aging population. The significance of this for the health and

[5] Census 2021 population and household estimates for Northern Ireland | Northern Ireland Statistics and Research Agency (nisra.gov.uk) at–https://www.nisra.gov.uk/system/files/statistics/census-2021-population-and-household-estimates-for-northern-ireland-statistical-bulletin-24-may-2022.pdf

social care sector, in the allocation of its resources and the challenges of providing appropriate care whilst respecting the independence and dignity of older people, is well recognised.

17. It is also important to factor in the families of older people. They too require assistance and support. They are an important part of COPNI's information network as they are very often the first to raise an issue, which not only affects their loved one, but on closer examination can be seen as a systemic problem of wider impact.

18. The NISRA bulletin, Northern Ireland Household Projections (2016-based), notes that the 'older population predominantly live in one or two adult households'.[3] There is an increase in the number of smaller households in Northern Ireland, with people aged 65 plus representing 41 per cent of all people living alone in 2016, projected to rise to 48 per cent in 2041[4] .

19. While 'loneliness' does not directly correlate to social disconnectedness, it is an indicator of levels of social connectivity. A NISRA study *entitled Loneliness in Northern Ireland 2019/20*, reports that older people experience comparatively high levels of loneliness (2020, p.6). Respondents in both the 65-74 and 75 plus age groups reported being 'more often lonely' at levels above the Northern Ireland average,[5] with 43.2 per cent of those in the 75 plus category being 'more often lonely'.[6] Furthermore, my experience indicates that this is likely to be exacerbated by poverty, as in the older population it often limits their opportunities for social interaction. *The Poverty Bulletin: Northern Ireland 2019/20* produced by the Northern Ireland Statistics and Research Agency (NISRA) states that '18 per cent of pensioners were in relative poverty' and '14 per cent of pensioners were in absolute poverty'[2] .

20. 'Self-efficacy' is a concept describing a person's beliefs about their capability to produce results or effects, and their ability to exercise influence over events that affect their lives. The Executive Office's report, *Wellbeing in Northern Ireland, 2020/21*, records low self-efficacy among many in the 75 plus age category.[7] The occurrence of low self-efficacy among 18.4 per cent of those aged 75 plus (compared with 12.8 per cent of those in the

25 – 34 age group) indicates an increased sense of disempowerment in this older demographic.[8]

21. Whilst many older people live in their own homes supported by family or through domiciliary care packages, a significant number live in residential care homes or spend long periods in hospital. Their admission to hospital and the length of their stay in hospital is often a combination of the state of their health and the lack of appropriate placements or care packages to enable discharge when they are deemed medically fit.

22. The Department of Health ("DOH") report 'Health Survey (NI) First Results 2020/21 records 69 per cent of those having a long-term health condition were aged 75 plus. Furthermore, the 2012 Annual Report of the Director of Public Health was accompanied by 'additional tables' on older people published on June 2013[6], showed that the 65+ age group had the largest proportion of 2010 total hospital admissions (34.6 per cent) and that was replicated in each of the 5 Health and Social Care Trusts ("HSCTs"). More specifically, for the 2021 to 2022 period, a total of 510,834 people were admitted to hospital in Northern Ireland of which 16,234 were under the elderly programme of care, 4,593 were under mental health and 56 under learning disability[7]. The scarcity of appropriate placements in Northern Ireland, whether for short-term placements to enable rehabilitation and a resumption of independent living or to provide an alternative home where that is no longer possible, is well known. Prolonged stays in hospital takes a heavy toll on their health and social well-being, as well as adding to the pressure on their families trying to care for them.

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[6] Older People: Additional tables to accompany the 2012 Director of Public Health Annual Report, June 2013 at - https://www.publichealth.hscni.net/sites/default/files/Older%20people%20-%20data%20to%20accompany%20the%20DPH%20report%20-%20June13.pdf

[7] Hospital Statistics: Inpatient and Day Case Activity NI 2021/22 NISRA & DOH https://www.health-ni.gov.uk/sites/default/files/publications/health/hs-inpatient-day-case-stats-21-22-accessible.pdf

23. Northern Ireland has some 473 residential care homes[8] catering for the older population through about 11,400 care packages[9], not including those for domiciliary care. Nearly all these care packages are commissioned from the private sector with the contract for the placement of residents being between the HSCTs and the care home providers pursuant to the Commissioning Plan developed by the Health and Social Care Board ("HSCB") in partnership with the Public Health Agency ("PHA").

24. The direct commissioning relationship between HSCTs and individual care providers gave HSCTs a powerful influence over them. It came under severe strain during the pandemic and its potential weakness was exposed by aspects of the government's response to the pandemic to the considerable detriment of older people. This was most evident in the earlier phase when there was a real fear that hospitals would become overwhelmed and HSCTs were under pressure to discharge patients as quickly as possible and speed up placements to care homes who would then be responsible for their health and social care. That pressure is illustrated by the 'surge plans' developed by the DOH. The 'Health and Social Care (NI) Summary Covid-19 Plan for the period mid-March to mid-April 2020' and the letter on 'Covid-19: Preparations for Surge' dated March 2020 are exhibited at **[EL/4 - INQ000239437]** and **[EL/4a – INQ000250243]**. All this was happening at a time when there was a lack of testing on those being discharged from hospitals and those to be admitted to care homes, coupled with a shortage of PPE in care homes. In those circumstances some care home providers felt the HSCTs requirement that they nonetheless take in new residents or risk a loss of future business, compromised their ability to minimize the risk of outbreaks and control the spread of infection within their homes.

25. The disproportionate impact of Covid-19 on older people in Northern Ireland cannot be denied. The Northern Ireland Minister of Health acknowledged: *"The COVID-19 pandemic*

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[8] Regulation and Quality Improvement Authority – Social & Healthcare Services Directory Northern Ireland | Regulation and Quality Improvement Authority (rqia.org.uk) at - https://www.rqia.org.uk/what-we-do/register/services-registered-with-rqia/rqia-register/all-care-homes-(including-rqia-service-id)/

[9] Statistics on community care for adults in Northern Ireland 2020/21 | Department of Health (health-ni.gov.uk) at - https://www.gov.uk/government/statistics/statistics-on-community-care-for-adults-in-northern-ireland-202021

has had a huge impact on older people: 90% of COVID-19 deaths in the first wave of the pandemic were in people aged over 65. Around half of COVID-19 deaths in Northern Ireland occurred in a care home"[10].

26. However, the true issue is the extent to which in formulating its response to the pandemic, the government gave insufficient or inadequate consideration to the likely impact on older people given Northern Ireland's integrated health and social care sector and the structure by which older people's care packages are provided.

d. The Team

27. I could not properly discharge my statutory obligations and duties without my team. They have been crucial in ensuring that I can represent the interests of the older people of Northern Ireland and give them a voice. The team comprises essentially nineteen full-time staff, who are all highly motivated, hugely experienced, and absolutely dedicated to the welfare of older people.

28. In addition to my office of the Commissioner and the Chief Executive, who are the key office holders, there is a management team. Following a re-structuring in August 2021, that management team comprises: Head of Legal and Advocacy Services, Head of Policy, Head of Corporate Services and Head of Communications and Engagement. The key purpose and functions of these positions are set out in their respective job descriptions exhibited at **[EL/5 - INQ000239438]**.

29. Nevertheless, it is worth highlighting some aspects of their respective roles in relation to Module 2C. So, for example, the Chief Executive is tasked with 'Developing the Corporate Plan and annual Work Plan for COPNI, ensuring the appropriate financial procedures, controls and structures are in place to deliver them' and 'Developing and managing programmes, and projects to achieve the Commission's objectives'. Whilst both the Head

[10] 'Older people and Covid-19' at - https://www.bgs.org.uk/sites/default/files/content/attachment/2020-11-02/Letter%20to%20Robin%20Swann%20from%20British%20Geriatrics%20Society%20Nov%202020%20for%20website.pdf

of Legal and Advocacy Services and the Head of Policy are responsible for 'Developing the means to influencing the policy agenda of Government, political parties, commissioners, providers, and various decision makers across Northern Ireland on issues affecting older people' and to 'Identify, initiate, and develop relationships with key policy makers and opinion formers at senior levels'. In addition, the Head of Policy is tasked with 'Managing a programme of policy advice and research that informs the Commissioner's work as an advisor to government on a broad spectrum of matters relating to older people'. These are all areas of work that took on particular significance during the Specified Period.

30. Despite the modest size of the COPNI team, throughout the pandemic and during its aftermath, they ensured that a spotlight was shone on the issues uniquely affecting older people. More importantly, COPNI's extensive network of contacts and the experience of the COPNI team, including my own professional experience prior to becoming Commissioner, allowed us to address decision-makers with acknowledged authority.

31. COPNI's reputation as an authoritative voice of issues concerning older people was established through its commissioned research and reports long before the announcement by the World Health Organization ("WHO") on 11 March 2020 that it was characterizing Covid-19 as a 'pandemic'[11]. I refer particularly to the reports exhibited at **[EL/6 - INQ000239439] and [EL/6a – INQ000250244]** that are of relevance to the work of this Inquiry as they highlighted serious concerns over the provision of care to older people and identified recommendations for reform: 2014 'Changing the culture of care provision in NI'; in 2015 'Prepared to Care? Modernising Adult Social Care in NI'; and in 2017 'CMA Care Homes Market Study'[12].

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[11] On 30 January 2020 the World Health Organization declared a 'Public Health Emergency of International Concern' in relation to Covid-19, and on 11 March 2020 characterized the outbreak as a 'pandemic' at - https://www.who.int/europe/emergencies/situations/covid-19

[12] 'Changing the culture of care provision in Northern Ireland: Commissioner's Advice to the Minister of Health, Social Services and Public Safety' at - https://www.copni.org/media/1122/changing_the_culture_of_care_provision_in_northern_ireland_pdf.pdf
'Prepared to Care? Modernising Adult Social Care in Northern Ireland at - https://www.copni.org/media/1121/prepared_to_care_modernising_adult_social_care_in_northern_ireland.pdf
'CMA Care Homes Market Study: Evidence from the Commissioner for Older People for Northern Ireland' at - https://assets.publishing.service.gov.uk/media/5981ebe8ed915d0228000048/the_commissioner_for_older_people_ni_response_to_update_paper.pdf

32. The weaknesses in the system were clear from those reports and from subsequent work, such as the 2016 Bengoa Report 'Systems not Structures: Changing Health and Social Care'[13] and the 2017 Kelly & Kennedy report 'Power to People: Proposals to Reboot Adult Care & Support in NI'[14]. Therefore, when the transmission rate of Covid-19 started to rise markedly and a government response was required, those weaknesses in the structure for delivering adult social care of sector and their implications should have been appreciated and factored into planning to avoid potentially disastrous outcomes for older people.

33. Similarly in 2018, again prior to the Specified Period, COPNI published the results of its year-long investigation into a care home, 'Home Truths: A Report on the Commissioner's Investigation into Dunmurry Manor Care Home'. Approximately 60 per cent of the requests for individual assistance to my Office relate to health and social care and highest amongst the issues raised are those in respect of care homes. This study sought not only to investigate the quality and delivery of care at that home, but to examine the extent to which there were lessons to be learned of broader applicability. I published a follow-up report in 2019, 'The Commissioner's view: A summary of the responses to Home Truths'[15]. As a result of that investigation, which was informed by leading independent experts on older people's nursing care, the regulation, inspection, and commissioning of care, safeguarding of older people and human rights, I was particularly well-placed to identify for the government the matters it should consider in formulating its response to the pandemic. I was also able to highlight, from an informed position, the detrimental impact that elements of the government's response might have on the section of the older population who were in care homes.

34. The expertise and commitment of my team was invaluable during the early stages when the government was seeking to respond to the demands of the pandemic and we were

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13 'Systems, Not Structures: Changing Health & Social Care' at - https://www.health-ni.gov.uk/sites/default/files/publications/health/expert-panel-full-report.pdf

14 'Power to People: Proposals to reboot adult care & support in N.I.' at -https://www.health-ni.gov.uk/sites/default/files/publications/health/power-to-people-full-report.PDF

15 'Home Truths: A report on the Commissioner's Investigation into Dunmurry Manor Care Home' at - https://www.copni.org/media/1478/copni-home-truths-report-web-version.pdf and 'Home Truths: One year update' at - https://www.copni.org/media/1604/207625-home-truths-one-year-on-update.pdf

trying, as a matter of urgency, to ensure that the vulnerabilities and needs of older people were not overlooked but were factored into whatever plans were being developed. It continued to be crucial for the rest of the Specified Period as the high number of deaths amongst the older population became clear and we highlighted the disproportionate impact on older people of some of the policies and sought to bring about necessary changes to the government's response.

e. How COPNI goes about its Work

35. In my role as Commissioner, I represent the interests of potentially over 600,000[16] older people and their families in Northern Ireland. This includes people experiencing a broad spectrum of personal circumstances. As Commissioner, I deal with and represent individuals living in their own homes, those living at home but reliant on domiciliary care, those living in supported living or in residential care homes as well as those in hospitals and hospices and even some constituents confined to prison[17] establishments. Statistics and lived experience would suggest that my constituents are uniquely vulnerable to experiencing long term physical or mental health conditions[18], loneliness[19] and to feel more significant physical impacts of being required to shield[20].

36. To properly represent those interests and carry out my role effectively, I have established trusted lines of communication with HSCTs and Social Care Trusts, senior members of the

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[16] Including his statutory power under Section 25 of the Act to raise issues in respect of the over-50 population.

[17] In 2020-2021 the total Northern Ireland prison population, excluding those on remand, was approximately 1,640, of which those aged 60 years and older account for about 8 per cent and if those aged 50 to 59 years are added, the percentage rises to 18 per cent. This demographic has been growing significantly. The Northern Ireland Prison Population 2021/22 (Sept.2022 rev) NISRA at https://www.justice-ni.gov.uk/sites/default/files/publications/justice/Northern-Ireland-Prison-Population-2021-22-revised.pdf and UK Prison Population Statistics, Georgina Sturge, House of Commons Library (25 Oct 2022) at https://researchbriefings.files.parliament.uk/documents/SN04334/SN04334.pdf

[18] 'Health Survey (NI): First Results 2020/21' at - https://www.health-ni.gov.uk/sites/default/files/publications/health/hsni-first-results-20-21.pdf

[19] 'Loneliness in Northern Ireland: Factors associated with feeling Lonely in Northern Ireland 2019/20 at - https://www.nisra.gov.uk/sites/nisra.gov.uk/files/publications/Loneliness%20in%20Northern%20Ireland%20201920_0.pdf

[20] 'Lived Experience: Voices of older people on the Covid-19 Pandemic 2020' at - https://www.ageuk.org.uk/globalassets/age-ni/documents/policy/lived-experiences-brochure-final.pdf

DOH, the Chief Social Work Officer and the Director of Mental Health, Disability and Older People. My office also regularly submitted responses to Government consultations in respect of proposed policy and legislative reform.

37. My office also engages on an almost daily basis with older people and their families and during the pandemic this increased dramatically as people struggled to understand the information on Covid-19 and the government's response to the escalating transmission rate. They were also desperate to have their concerns about what was happening to them taken to the government to bring about change. Over the Specified Period, COPNI received complaints and requests for assistance from 409 individuals and families about pandemic related issues.

38. COPNI's work is carried out under a four-yearly Corporate Plan with a budget approved and funded by the DfC, a department of the Northern Ireland Executive, from part of its 'Block Grant' allocation. The Corporate Plan, which is published on our website, is developed following consultation and direct engagement with older people. The delivery of that Corporate Plan is worked out through annual Business Plans, which include a wide programme of regular proactive and reactive engagement with older people and groups that I intend to pursue. These include public sector groups and charities to review the adequacy and effectiveness of services provided for older people by the relevant authorities. This type of engagement often involves collaborating in campaigns and providing endorsement through comment in the media, such as the support given to the Patient and Client Council in developing a Bereavement Charter for Northern Ireland as part of the NI Bereavement Network. During the period of 'lockdown' in Northern Ireland from March to May 2020 when it was not possible to conduct face-to-face meetings, we had to rely more heavily on remote interactions to maintain engagement.

39. The relevant Corporate Plan at the start of the Specified Period was for the period 2016 – 2020. It is titled 'Respect, Value and Protect', and focused on respecting the autonomy, rights, and diversity of Northern Ireland's older people. I have exhibited it at **[EL/7 - INQ000239440]**. During that four-year period, I aimed to promoted awareness of the many contributions older people make in Northern Ireland and working to protect older people

from all forms of abuse. In the ordinary course of events, a new Corporate Plan would have been published in late 2020 for 2020 – 2024 to coincide with the new term of the Commissioner. However, the year 2020 - 2021 was largely dominated by issues for older people arising from the Covid 19 pandemic crisis. Accordingly, I extended the period of the Corporate Plan and used the system of annual Business Plans to set out how I proposed to deal with those challenges. The Business Plans for the Specified Period are exhibited at **[EL/8 - INQ000239441]**.

40. I also work with the other commissioners in Northern Ireland on issues of common interest. By way of example only, during the early stages of the pandemic I liaised with the Commissioner for Human Rights to jointly publish an article highlighting the extent to which older people have borne the brunt of the impact of the pandemic[21]. More recently I worked with the Commissioner for Children and Young People during International Intergenerational Week, which brought together children and older people to discuss their personal impacts of Covid-19 and eliminate negative stereotypes of older people. I have also collaborated with the Equality Commission on the reform of age equality legislation in Northern Ireland to provide older people have increased protection against discrimination on the ground of age.

41. When necessary, I proactively target certain groups and bodies to ensure I maintain equal gender representation and inclusion of ethnic minority and LGBTQ+ groups as well keep abreast of the views and issues resulting from older people's different cultural and geographic circumstances. I also use the engagement sessions to share with regional councils, ideas and initiatives that have been developed in response to information received from older people and their families. I engaged with local councils in Northern Ireland to promote the need for 'Warm Hub' schemes to aid the cost-of-living crisis.

42. I place a high priority on these engagement sessions as they ensure that my work reflects the real experiences of older people living here and enables me to develop a better sense

[21] 'Article by Commissioner for Older People for Northern Ireland and Chief Commissioner Northern Ireland Human Rights Commission at - https://www.copni.org/news/2020/may/article-by-eddie-lynch-commissioner-for-older-people-for-northern-ireland-and-les-allamby-chief-commissioner-northern-ireland-human-rights-commission

of what is happening 'on the ground'. Additionally, the commissioned research and investigations carried out by COPNI provide me with a solid basis of knowledge and direct experience from which to discharge my statutory duty to advise government, it is the engagement programme that gives me a particular authority when advising Ministers, the Executive Committee of the Assembly and relevant authorities on matters concerning the interests of older persons.

II. INVOLVEMENT IN GOVERNMENT'S PANDEMIC RESPONSE EFFORTS

43. My duties are to promote and safeguard the rights of older people in Northern Ireland and to do this by keeping under review the adequacy and effectiveness of law, practice and services relating to older people. This very much remained my focus during the pandemic. From the outset, my attention was centered on not only protecting older people as much as possible from contracting the virus but also working with many authorities to support the hundreds and thousands of older people to had to immediately shield to help them stay safe.

a. Getting Information and Assessing Impact

44. I started hearing about a coronavirus disease (subsequently named Covid-19) in January 2020 from the news and through the news I learned about its rapid spread out of China leading to the WHO declaring a global health emergency on 30 January 2020. The following day the first two cases were confirmed in England. However, what particularly concerned me for Northern Ireland were the news reports of the rapid rise in cases in Europe, particularly Italy, were there were reports coming in of deaths amongst the elderly, a lack of PPE, and the extreme pressure being placed on hospitals. I was immediately concerned about the potential vulnerabilities of older people in Northern Ireland, particularly those in care homes.

45. The first case of Covid-19 in Northern Ireland was confirmed on 27 February 2020 and the following day amendments were made to the Public Health Act (NI) 1967 by the Public Health Notifiable Diseases Order (NI) 2020 to make Covid-19 a notifiable disease[22].

46. At the beginning of the pandemic, my priorities for COPNI's work shifted to a Covid-19-specific workload in the context of emergency crisis management. My office began to receive a large volume of complaints from older people, providers, families and Independent Health and Care Providers on a range of concerns. The early weeks and months were dominated by issues such as lack of Personal Protective Equipment ("PPE") for staff working in our care homes and how it was to be provided, the required admission of new residents without adequate testing, prevalence of infection in care homes, and the testing of staff and residents for Covid-19. Specifically, I was receiving calls during March and April 2020 from care home managers and providers expressing concern and frustration about what they saw as a requirement by their respective HSCTs to admit new residents from hospital without adequate testing for Covid-19. In some cases, tests were not carried out until after admission to the home, in others the tests had been carried out but the results, which could take up to 48 hours, were pending. The concerns this caused is illustrated by a piece published by BBC NI on 21 May 2020, 'Coronavirus: Care home owner 'threatened' to take untested elderly'[23].

47. The main discussion within COPNI at that time was what steps we could take to ensure that older people were properly protected and were given the best chance to survive the pandemic. Given all that I knew about the sector, I feared that if Covid-19 entered care homes, then the disproportionate number of older residents who were mentally frail or who had co-morbidities, together with the low ratios of clinically trained staff to care for them, would result in a very challenging situation, potentially producing high fatalities.

48. There was an obvious need for the government to act quickly to protect the population, especially older people who were particularly vulnerable due to the high proportion that

[22] 'The Public Health Notifiable Diseases Order (NI) 2020 at - https://www.legislation.gov.uk/nisr/2020/23/made
[23] 'Coronavirus: Care home owner 'threatened' to take untested elderly' at - https://www.bbc.co.uk/news/uk-northern-ireland-52762820

were frail or had co-morbidities, which were risk factors for poor outcomes should they contract Covid-19. However, in the early days of the pandemic I found that there was no single point of contact for me, or anyone from my office, to enable us to provide specialist information or guidance on what I feared would become a critical position with older people.

49. In the early days of the pandemic, when we recognized that speed was of the essence and in the absence of any established mechanism for obtaining information and providing feedback, my office was urgently trying to work out who or where to go to for support. COPNI relied on contacts within the DOH that we had used previously, for example, Mark Lee (Director of Mental Health, Disability and Older People), Sean Holland (Chief Social Worker) and, of course, the Minister Robin Swann. Whilst I acknowledge the difficulties faced in those early days, I did have an expectation that a single point of contact would be developed as the pandemic was advancing. Care homes, families and older people were using my office as a point of contact to raise issues and concerns. An important example of this was the issue around the provision of PPE and the difficulties experienced for care homes. In the absence of a designated point of contact, my ability to get in touch with the right people was curtailed. This caused inefficiencies and delays and often unnecessary escalation to the Minister.

50. My office also needed to be able to readily relay issues of concern that were brought to us in relation to older people. To respond to them effectively, I needed a means of raising their queries and concerns on emerging issues to seek reassurances from the DOH on how aspects of the pandemic were being managed and the plan moving forward. An example of this was the issue of testing in care homes. There seemed to be no proper forum for me to be able to present the concerns I had on this issue, and the feedback given to me by older people and from my contacts in the care home sector and discuss them constructively. As a result, I raised the issue with the media. It was a period of intense media coverage on the issue, in which I remarked that there was a lack of urgency on the part of DOH, that led to me being contacted by the Deputy First Minister Michelle O'Neill and a meeting set up with her and the First Minister Arlene Foster for assurances to be given that the matter would be picked up. Whilst I was grateful for their input, the system for communication was not quick, efficient, or ideal. It is certainly not how I wanted to proceed and would have been avoided had a proper system been instituted.

51. Furthermore, when draft guidance to be issued by the DOH was sent to COPNI, the response time was often so short as to preclude meaningful consideration and communication over what was required to help keep older people safe and alive. The following are just three examples, the documents in respect of which are exhibited:

    i. On 13 March 2020 I received an email at 12:31 from Mark Lee, which attached a letter to be issued to Registered Providers and HSCT Chief Executives together with 'Interim Guidance for social or community care and residential settings on Covid-19 at 12/03/2020'. These documents, which had already been emailed to HSCTs and the Regulation and Quality Improvement Authority ("RQIA") the previous day at 17:36, were being sent for a meeting later that day on the basis that: *"Not sure who's attending the meeting at the Department later today but thought it might be worth making sure you've seen"* them. The email from Mr Lee also stated that *"an update to this is being worked on as we speak"*. **[EL/9 - INQ000239442];**
    ii. On 16 March 2020 my Chief Executive, Evelyn Hoy, received an email at 08:51 from Mark Lee providing the current version of the new 'Covid-19: Guidance for Domiciliary Care Providers in Northern Ireland' for a meeting that day re-scheduled from 16:00 to 13:30. **[EL/9a- INQ000250245]**
    iii. On 3 December 2020 my Chief Executive received an email at 00:02 from Mark Lee providing a draft of guidance 'Care Homes- Christmas family visiting (23rd-27th December) to be shortly issued along the lines of the English 'Guidance: Making a Christmas bubble with friends and family'. Mr Lee stated that he would "appreciate any views from the Commissioner" and explained that it was hoped to "get it up to the Minister late tomorrow" and sought "any quick views" from me. **[EL/9b – INQ000250246]**:

52. There also seemed to be a high level of reliance on what was being published in England in relation to the NHS, and I was concerned that insufficient time opportunity was being provided to consider the implications of its effectiveness when applied to Northern Ireland's the very different system of health and social care.

53. I am statutorily required under section 3(1) of the Act to promote awareness of matters relating to the interests of older people and the need to safeguard and promote those interests. Equally, I am required under section 3(7) of the Act to advise the Secretary of State, the Executive Committee of the Assembly and a relevant authority on matters concerning the interests of older persons either upon receipt of a specific request or on any such other occasion as appropriate. I considered that the emergence of Covid-19 in Northern Ireland and the risks it posed to older people engaged those obligations. It was essential, therefore, to find an effective means of obtaining information on the needs of older people arising out of the pandemic (especially early on), assessing the impact the government's response to the pandemic was having on them, and highlighting what was required to properly protect older people.

54. This became particularly important when in or around 19 March 2020, DOH directed the RQIA to reduce the frequency of its statutory inspections of care homes and cease all non-statutory activity until directed otherwise[24], meaning that important insight into what was happening in care homes at this challenging time was lost.

55. I actively engaged with older people and those caring for them through a variety of measures, all adopted in recognition of the need for urgency and accessibility. In the early phase of the pandemic, we literally manned the 'telephone and took to social media. I reached out through the COPNI website and had meetings using the internet. The COPNI team organized surveys, PR campaigns, and updates through my Newsletter. An example of a survey commissioned by COPNI is the 'Impacts of Covid-19 on Older People' carried out on my behalf by Perceptive Insight Survey over 1 – 14 September 2020. The results of this survey were not published but were used to inform my views. It disclosed the following in relation to older people:
    i. 32 per cent experienced increased loneliness;
    ii. 20 per cent found it quite or very difficult getting shopping and other household necessaries during Covid-19 and lockdown;

[24] 'Senior Department of Health officials were warned of potential media attention if the Regulation and Quality Improvement Authority (RQIA) reduced inspections of care homes as preparations were under way for the Covid-19 surge', Local Democracy Reporting Service, https://viewdigital.org/care-homes-ni-health-chiefs-were-warned-that-halting-rqia-inspections-could-attract-media-attention/

iii. 18 per cent were reliant on friends, neighbours or community support to get goods and services from shops and supermarkets;
iv. 21 percent felt unsafe going to shops and supermarkets but felt that they had no option but to do so;
v. 25 per cent found it harder than previously to access medical services such as doctor's surgeries.

56. I also conducted hundreds of interviews with local and regional media outlets. There were approximately 300 recorded in the first year of the pandemic alone. Although much of this interaction was with older people and their families, it was not exclusively so. COPNI also had contact the care workers and social workers with whom they had established networks in the ordinary course of our work, met with the Independent Care Home Providers ("IHCP") group and AgeNI, as well as engaged with campaign groups that were being formed, such as 'Care Home Advice and Support Northern Ireland' and 'Covid-19 Bereaved Families for Justice'. I also sought briefings from individuals with specialist knowledge, such as in the School of Medicine, Queens University Belfast.

57. The purpose of all this was to find out what was happening with older people in Northern Ireland, inform them of what the government was doing and obtain feedback on how they were being affected by that and, more usually, hear their views of the impact of what the government was not doing. In combination, I regarded this as providing me with as speedy and reliable a basis as possible to engage with government on policy.

58. I subsequently developed a broad package of measures to obtain information on the government's pandemic decisions and assess their impact, to enable me to engage on the issues of concern to older people more effectively. The most valuable elements of that package were:
    i. Maintaining regular, frequent contact with older people, and more often, their families;
    ii. Maintaining contact with care providers both in primary care settings and in the community;
    iii. Regularly monitoring Health Committee meetings;

iv. Reviewing and monitoring confidential briefings from the PHA, facilitated directly by PHA, which provided updates on current and recent care home outbreaks;
v. Reviewing and monitoring confidential briefings from DOH on Care Home PPE levels, Workforce Training, Staff Metrics and Resident Metrics;
vi. Reviewing the results of the 2020 study carried out by Perceptive Insight on 'Impacts of Covid-19 on older people in Northern Ireland', a copy of which is exhibited at **[EL/10 - INQ000237823]**;
vii. Reviewing the regular internal-house research/briefings provided to me on wide range of issues by the COPNI Policy Team, including those reflecting the results of commissioned work such as on care staff PPE and testing in NI and ROI, older people and lockdown, and Covid-19 mortality in care homes;
viii. Regularly monitoring Northern Ireland and UK media.

b. Tapping into a Wider Network

59. There was so much urgency to assess the impact of measures and make proposals that would protect older people, which was fast becoming my primary concern, that I was not content to rely just on my local network but reached out to bodies and organization in the rest of the UK. This was initially to understand what they were doing but it quickly became a means of generating greater influence.

60. I participated in weekly 'Four Nations meetings' that were established by the Older People's Commissioner for Wales. They took place every Friday and in addition to us as Commissioners, they involved the Chief Executives of: Age UK; Independent Age; Older People's Commissioner for Wales; Chief Executive Age Cymru; Chief Executive Care Scotland; and Chief Executive Age Scotland. The purpose of these meetings was to allow us to share information from our individual nations on issues such as vaccination programmes, testing, lockdown experiences and learn how the devolved administrations were responding to the pandemic in comparison to the Westminster government. There was no agenda for these meetings and no formal minutes were taken as we wished to encourage open debate. We were keen to discuss our experiences and explore ideas.

61. As a group, we also released signed joint statements on key areas where we had a shared concern and on which we were seeking to make progress in our own jurisdictions. We considered not only gave greater prominence to an issue of concern but was also a means of increasing our individual leverage. These joint statements include the following, which are exhibited:
    i. The rights of older people in the UK to treatment during this pandemic; **[EL/11 - INQ000237824];**
    ii. Protecting the rights of older people: Commissioner's joint statement on older people being pressurised to sign Do Not Attempt CPR forms; **[EL/11a- INQ000250247]** and;
    iii. Relentless focus on protecting older people's rights needed as we deal with the next phase of the pandemic. **[EL/11b- INQ000250248]**

c. Communicating with Government

62. Throughout the pandemic I had direct engagement on Covid-19 issues either personally of through the key office holders in the COPNI team, with the Minister of Health, the Chief Medical Officer, DOH officials, The Office of the First and Deputy First Minister, DfC, Age NI, RQIA, the Northern Ireland Human Rights Commission ("NIHRC"), PHA, Patient and Client Council and Independent Health and Care Providers. In particular, confidential briefings were emailed to COPNI on a weekly basis from PHA on current and recent care home outbreaks and from DOH on care home PPE levels, workforce training, and on staff and resident metrics. I have exhibited at **[EL/12 - INQ000237825]** a chronological list of meetings with Ministers, politicians, and civil servants in relation to the response to the pandemic in which I have highlighted those of particular relevance to non-pharmaceutical interventions ("NPIs") and or similar key decisions, and a sample of the confidential briefings.

63. The purpose of that engagement was to enable me to use the information I had from older people, their families and those working on issues concerning older people, together with my own knowledge and experience of the weaknesses in the health and social care sector, to contribute to improving the response of decision-makers to the pandemic.

64. My meetings with Ministers and politicians were often carried out over the phone or by zoom in reaction to issues which were happening on the ground. The reactive and ad hoc nature of these meetings and interactions meant that no agenda was set, and no minute was taken. The subject of discussion centered around the most prominent issues on that day. I never recorded any meeting or noted the dissent or disagreement between participants. That is not to say they were not noted by other participants, but if that was the case then they were not circulated to me.

65. Any communication would have been by phone, remote meeting, email, or letter. I did not participate in informal communication by text or WhatsApp message. Any emails from the Specified Period are likely to now be archived on our remote server, I am willing to engage in any search that the Inquiry would consider appropriate and proportionate at this stage.

d. Raising Issues with Government

66. The first communication from the DOH to COPNI on the issue of planning and guidance for Covid-19 was on 13 March 2020 when the Chief Medical Officer and other healthcare professionals provided a briefing on Covid-19. I understood that guidance was to be issued and that they would be consulting with COPNI beforehand. I presumed they considered our knowledge and expertise would be relevant. By that time COPNI had already been distilling from the feedback we were getting what we thought were the important matters to cover in any guidance to ensure that older people were safe, particularly those in care homes. COPNI had also been conducting informal discussions to obtain the views of key stakeholders like AgeNI, the leading charity for older people, and IHCP group, which represents about 50 per cent of the care home providers. As a result, COPNI was clear about the issues that any guidance should cover and where assistance was likely to be required. In summary and at that stage, these included:
    i. Provision of PPE for care staff, wherever they were operating;
    ii. Testing of care home residents;
    iii. Timely, adequate, practical communication in clear language.

67. COPNI was invited by the Chief Medical Officer to meet with the DOH on 16 March 2020 to discuss forthcoming guidance for care homes. COPNI's Chief Executive Officer went to the meeting as I was attending other meetings at Stormont. She informed me that it was attended by the Chief Medical Officer, the Chief Scientific Advisor, the Chief Social Worker, the Director of Mental Health, Disability and Older People and officials from PHA. In addition to COPNI, the Chief Executives of AgeNI and IHCP group were also present. A draft of the guidance was not provided in advance of the meeting and so much of the time was taken up with telling us what was in it.

68. The officials were unable to address many of the issues COPNI raised and it soon became clear that that some of these issues had simply not been considered before, nor had sufficient thought been given to the practical outworking of the guidance. Importantly, the lack of consultation with the sector was raised. I, and indeed my team, regarded the draft guidance as unrealistic and impractical. In our view it required consultation. More significantly, COPNI was informed that there was simply not enough time to address the points being made as the guidance had to be issued the next day, which was St Patrick's Day. My Chief Executive reported orally to me after that meeting that despite her drawing attention to the high numbers of elderly in Italy who were contracting and dying of Covid-19, there was an 'air of unreality'. The view expressed by PHA seemed to be 'that won't happen here, they have a completely different system over there'.

69. Both she and I were very worried about that meeting and what it indicated for the future. We had expected that the DOH would wish to make use of COPNI's acknowledged expertise and experience and we had attended the meeting informed and ready to assist. We had expected a consultation, but that is not what happened. We were told, rather than engaged with, and not given the opportunity to make much if any difference. The final 'Covid-19: Guidance for Nursing and Residential Care Homes in Northern Ireland' was published the following day on 17 March 2020 ("Guidance") and states: *"It has been developed in consultation with a number of representative bodies"*[25]. If they had been

[25] 'Covid-19: Guidance for Nursing and Residential Care Homes in Northern Ireland at - https://www.publichealth.hscni.net/sites/default/files/2020-03/GUIDANCE%20FOR%20RESIDENTIAL%20CARE%20PROVIDERS%20-%20COVID19.pdf

consulted, then I should have thought I would be included, given my statutory responsibilities and the experience of COPNI.

70. Furthermore, had there been a proper consultation, then I would have hoped the issues COPNI raised during the meeting on 16 March 2020, such as PPE for care staff to avoid further loss of staff leading to support for the elderly residents falling to dangerously low levels, testing of care home residents, and the need to ensure adequate communication of guidance to the sector, would all have been addressed. For example, although the Guidance states at p.9 that *"Trusts will continue to work with nursing and residential homes on the provision of appropriate PPE, where they are unable to source their own supplies"* members of the IHCP group who sought to make use of that provision found it unsatisfactory. The problems reported to us that nursing and residential homes were encountering included (i) having to initially compete with the HSCTs for PPE, a scare resource and rapidly rising in price; (ii) having to show they were 'unable' to source their own supplies in circumstances where there was a clear conflict with the HSCTs; (iii) what exactly was required to demonstrate to the HSCTs that they were 'unable to source their own supplies'; and (iv) all of this having to be done asap to prevent the transmission of Covid-19 and keep people safe. These practical considerations could and should have been anticipated. So far as I was concerned and from the feedback I was receiving, the published Guidance seemed to simply ignore the realities on the ground resulting in significant omissions. Basic questions that would have answered some of the fundamental issues were ignored and it appeared that the deadline for the issue of the Guidance was given more importance than the than the content of the Guidance itself. It was a missed, early, opportunity to put measures in place that would be truly effective.

71. Furthermore, it became clear that the lack of effective communication with the very sector targeted by the Guidance was indeed an issue. A letter dated 30 March 2020 from the Chief Social Work Officer to registered care home providers and HSCT Chief Executives to provide the 'update' on PPE and access to testing issued on 28 March 2020 states: *"The update does not change the position set out in our guidance on domiciliary care and on care homes, both published on 17 March, but does note that the current guidance on PPE is being further reviewed with the aim of making it clearer to frontline staff"*.

72. I recognise that Module 2C is not concerned with the granular detail of the content of the Guidance, however, I raise this issue to draw attention to what I consider to have been a failure in the mechanisms available to the DOH to ensure that, in a situation where speedy was of the essence, it was able to make best use of all the practical experience available to it in formulating effective guidance to be applied in a settings extremely well known to COPNI.

73. I became aware that a task force had been put together to focus on Covid-19 and I found it incredibly frustrating, and disappointing, that the DOH seemed unable to find a way to enable COPNI to meaningfully contribute to its work before a policy became hardened and the guidance published. The result of this was very often a delay in the introduction of crucial initiatives. To try and avoid that, I found myself having to engage directly with the Minister of Health and other officials, often by telephone, so that I could properly explain the issue and its significance. On many occasions I resorted to the media to make the case and published numerous statements providing my assessment of the impact of the current policy and what I thought was necessary in the interests of older people. A good example of this is provided by the issue of Covid-19 tracking and testing.

74. It was clear at the outset of the pandemic that the government did not feel a test and trace type approach was suitable for care home residents. The Chief Medical Officer gave evidence before the Northern Ireland Assembly on 23 April 2020 confirming the government's stance that testing would not happening in Northern Ireland in a care home setting[26]. However, from information garnered by COPNI from a wide range of sources including WHO statements, examples of how other countries combatted pandemics and from the media, I very quickly formed the view that testing would be an essential tool in the fight to control Covid-19. This was reinforced by engagement with families who wanted the older people in care homes tested. In addition, I was receiving calls from providers who also wanted their staff and residents tested. In my view, without proper testing and an effective means of tracking those infected with Covid-19, it would be extremely difficult to

[26] 'Covid-19 Disease Response: Minister of Health and Chief Medical Officer at - http://data.niassembly.gov.uk/HansardXml/committee-22034.pdf

gauge the extent of the problem, engage in any realistic planning, let alone learn necessary lessons.

75. I had previously met with the Minister of Health on the issue but there seemed to be a failure of the DOH to grasp the urgency of the matter and the numbers of lives of older people that were being put at risk if staff, including those domiciliary staff working in the community, and residents, including those discharged from hospital, were able to freely move about care homes without a means of determining their Covid-19 status. I felt it necessary to come out strongly in the media to make clear I felt the government needed to increase the pace of decision making to introduce testing in cohorted settings. I was then contacted by the Deputy First Minister to ask if I would agree to a telephone meeting with her and the First Minister. I welcomed the opportunity to discuss my concerns and frustrations and had a meeting with them on 27 March 2020, which is included in the exhibited chronology of meetings. They told me they would raise my concerns with the Minister of Health at their next meeting.

76. I felt it necessary to continue to make the case for the introduction of a proper regimen of testing and tracking the incidence of Covid-19 and recording the deaths. On 31 March 2020, just days after the publication of what I considered to be the deficient Guidance, COPNI emailed the DOH seeking proper information on that issue, including: "*How are Covid tests in resid / care home settings being administered, recorded and tracked?"* More queries were emailed on 8 April 2020, including: "*Given the recent ramp-up in testing sites, what plans are there for prioritizing testing of care home workers and domiciliary care workers?"* On 24 April 2020 I wrote to the Minister of Health on these issues. I also used the media to press for such a regimen. An example is an interview I gave the following day on 9 April 2020 in which, in addition to the need for testing I also made the point that: "*It's important that all deaths are reported in terms of identifying where there might be outbreaks in homes so that all action possible is taken by the authorities to try and protect the remaining carers and residents.*"[27] I obtained support from the Chair of the Northern Ireland Assembly Health Committee ("Health Committee"), who the previous day, reported

[27] 'Call for care home coronavirus deaths in Northern Ireland to be disclosed as fears of 'clusters' grow https://www.belfasttelegraph.co.uk/news/health/coronavirus/call-for-care-home-coronavirus-deaths-in-northern-ireland-to-be-disclosed-as-fears-of-clusters-grow/39114871.html

in the same piece, called for dedicated teams to be set up to identify and deal with Covid-19 clusters in care homes and on 14 April 2020 stated in the media that it was *"important that decision-makers have the best evidence to inform their actions"* and the *"gaps in data between recorded cases and the true number of cases could be detrimental now, and in the future, with regards to understanding the impact of Covid-19"*[28].

77. Subsequently, the government performed an effective 'U-turn' on their initial testing policy, as reflected in a letter from the Minister of Health dated 26 May 2020 exhibited at **[EL/13 - INQ000237826]**, which acknowledged that the *"pandemic has drawn particular attention to the fragility of the care home sector"*, and notified an expansion of testing to all care home residents and staff and the work being done to roll out a programme of testing for all care home staff.

78. Whilst that was helpful and I remain grateful for the access I was given to OFMDFM and the Minster for Health, my concern is that this was not an efficient way to address something as serious as an ongoing pandemic that is claiming hundreds of lives, especially those of older people, and where the response required the coordinated multi-agency response. What was ultimately accepted was something that I had raised very early and required sustained efforts to achieve.

79. In my view the government's failure to properly grapple in its policy and guidance with the lack of PPE, the imposition of lock down without ensuring that there were adequate staffing levels, and the need to provide Covid-19 testing of older people and those working with them, created a perfect and fatal storm in care homes. There were similar concern for older people locked down or isolating in their own homes and reliant on domiciliary care. Yet these were all issues that I continually raised with the DOH, along with other issues listed below, both informally through telephone calls and emails, as well as through more formal correspondence such as the following, which are all exhibited:

[28] 'Coronavirus death toll will include care homes' at - https://www.irishnews.com/news/northernirelandnews/2020/04/15/news/coronavirus-32-care-homes-in-northern-ireland-affected-1902523/

- i. 24.04.20 Letter to the Minister of Health concerning the ongoing situation with testing for Covid-19 in care homes and my call for universal testing in care homes. **[EL/14 -INQ000237827];**
- ii. 11.05.20 Joint letter with NIHRC to the Minister of Health *"to seek assurances, in the absence of physical inspections in care homes at this time, that there are alternative measures in place that will ensure that the standards of care and treatment expected in care home settings is being provided."* **[EL/14a- INQ000250249]**
- iii. 08.10.20 Letter to the Minister of Health raising concerns re implementation of care home guidance and *"learning from the first wave."* **[EL/14b- INQ000250250]**
- iv. 24.03.21 Letter to the Minister of Health concerning the implementation of the DOH's guidance to care homes to permit limited, safe visiting of residents, and the provision of care partner status to specific family members and carers. **[EL/14c- INQ000250251]**
- v. 16.04.21 Letter to the Minister for Communities on the impact on older people of isolation due to Covid-19. **[EL/14d- INQ000250252]**

80. Whilst I do not of course claim that I had all the answers, I do believe that I was asking the right questions and I do think it would have been beneficial to have had a proper opportunity to engage with the DOH on them in a proactive way.

III. INTERACTIONS WITH THE NORTHERN IRELAND ASSEMBLY

81. By June 2020 the requirements for lockdown had been eased and the very high death rate amongst older people in care homes was popularly, and rightly, regarded as a scandal. The figures from NISRA showed that by 29 May 2020, there were 328 deaths in care home settings accounting for almost half the total number of deaths[29]. I thought it was time for the government to have an urgent inquiry into its response to the pandemic in relation to

[29] 'Weekly Deaths in Northern Ireland' at - https://www.nisra.gov.uk/sites/nisra.gov.uk/files/publications/Historical%20Weekly%20Deaths%20Bulletin%20-%20Week%20ending%2029th%20May%202020_0.pdf

INQ000267978_0030

care homes, so that lessons could be learned for the further wave of infection that was likely to follow the resumption of face-to-face interaction. I was not alone in this, as around this time the Health and Sport Committee of the Scottish Parliament was calling for evidence on the preparedness of care homes to respond to the pandemic and how they have been supported and equipped to deal with its effects, and the House of Commons Public Accounts Committee was preparing to hear evidence on readying the NHS and social care for the Covid-19 peak.

82. However, the position of the Minister of Health Department, who was facing calls and pressure in the media for a full public inquiry and Judicial Review[30], was that whilst there was a need for a full review 'this was not the right time as the DOH's focus was on re-building service'. In my view it was precisely the right time for a proper investigation to learn what lessons we could now. The pandemic was far from over and there was a real opportunity for such 'lessons' to make a material difference. I actively engaged with the media and members of the Health Committee to try and bring about a proper investigation, making the case that it would be crucial to ensuring there was appropriate planning for the future and mistakes were not repeated.

a. Proceedings before the Health Committee

83. As part of the basis for my call for an investigation, I provided a briefing to the Health Committee on 4 June 2020 on the handling of key Covid-19 issues and my concerns going forward, which I have exhibited at **[EL/15 - INQ000237828]**. I was accompanied at that briefing by COPNI's Chief Executive and its Head of Legal and Advisory Services.

84. The key issues addressed at this briefing included general Covid-19 planning and preparation, PPE shortages, accurate reports of Covid and testing issues. The authorities were advised that there was a need to address staffing issues along with extra support required to deal with the stress of the pandemic. There was an acknowledgement that the government had implemented better reporting on victims of Covid-19, as deaths in care

[30] 'Covid-19: NI families renew calls for care homes inquiry' at - https://www.bbc.co.uk/news/uk-northern-ireland-52999112

homes were not reported initially, however further improvements on reporting could still be made.

85. Testing had not been rolled out at the time of this meeting and I made renewed calls for a rolling program of universal testing. Whilst the Minister of Health had announced plans to start such a program, I felt that more urgency was required. I was able to acknowledge that progress appeared to have been made on many issues, but emphasis the point that it was all taking too long.

86. My principal focus during that briefing was two-fold: (i) to obtain a roll-out of a proper testing program, and (ii) to draw attention to the potential impact on older people as society emerges from lockdown and eases measures. Other issues aired at the briefing included concerns over discharge from hospital without testing and also concerns among constituents over 70 years of age who were in good health, away from a care home, that they no longer wishes to be forced into lockdown. This point identified the range of issues my office received from older people in the community. The meeting concluded with the acknowledgement that we were in stage one of a pandemic and lessons must be learnt from all if there is to be a second or third wave.

87. I explained that it was a constant and uphill battle to get the necessary support for the care home sector on a range of those issues.

b. Evidence to the Health Committee's Inquiry

88. Based on all the evidence it received, the Health Committee decided to conduct an inquiry on the 'Impact of Covid-19 in Care Homes' that would produce recommendations to the Assembly on its findings. The terms of reference, which I have exhibited at **[EL/16 - INQ000239431]**, were issued in early September 2020, were that the Health Committee would:
    i. Identify the key issues impacting care homes as a result of the COVID-19 pandemic;
    ii. Identify domestic and international examples of best practice in arrangements to protect and care for residents of care homes during the pandemic;

iii. Report to the Assembly on its findings and recommendations by 13 November 2020.

89. Whilst this was not a public inquiry, I did consider the terms of reference provided an early and important opportunity to assess what had happened and learn lessons. I readily agreed to provide evidence orally and in writing. I gave evidence to the Health Committee on 13 October 2020, accompanied by COPNI's Head of Legal and Policy Advice, which I have exhibited at **[EL/17 - INQ000237830]**.

90. My oral submissions were essentially a follow-up to issues I shared at the briefing on 4 June 2020. I highlighted that there were some 14,000 older people in care homes in this jurisdiction and the government had a duty to protect their human rights. No one should be discharged from hospital and placed in a care home without a negative Covid test. Access to PPE was still not adequate for many independent providers. Furthermore, testing in general was still a big issue, it was either not happening, or it was taking too long between tests being performed to function as a useful tool to manage the spread of infection. I informed them that we had received reports that it was taking 4 - 8 days for some test results to be returned. I also made the point that financing in general for care home and care providers needed to be addressed as their costs of responding to the pandemic and implementing the government's guidance had increased markedly. Other concerns that my office had, which I flagged, included families' concern that those in care homes were being left isolated from their loved ones and experiencing a lack of social contact, that was having a detrimental effect.

c. Written Submissions to the Health Committee's Inquiry

91. I used the opportunity to provide written submissions, which I submitted on 19 October 2020 and have exhibited at **[EL/18 - INQ000237831]**, to highlight in a point format, the issues I raised during my oral submissions and which I still felt required to be emphasized. This included my concern about the policy on discharge from hospital to care homes without testing prior to discharge and issues of isolation for residents within care homes. Also, access to PPE remained a significant concern, both in terms of cost and access to

supplies, and testing in care homes needed to be conducted in a timelier way to improve the management of residents' health and welfare in the care homes.

92. Another issue I wanted to reiterate was the funding of care homes as I was concerned that rising costs, without appropriate support, could have a detrimental impact on care. I was aware from my investigation 'Home Truths' just what that could mean for some residents. Maintaining efficient staffing levels and effective pay and conditions for staff needed to be addressed before the problem deteriorated further. These issues could have serious consequences for the quality of life for older people as well as the sustainability of the sector in the long run. That possibility was exacerbated by the loss of confidence in the RQIA that families and staff were raising with COPNI. They queried RQIA's independence and concerns about the suspension and restriction of RQIA's inspections since the commencement of the Covid-19 outbreak.

93. Finally general points were raised as to concerns over the ability of the HSCTs and care homes ability to deal with future stages of Covid-19, together with the limited scope of the Health Committee's inquiry, which did not deal with other matters of concern such as 'Do Not Resuscitate' and amendments to the death certificate and their potential impact on the accuracy of death figures attributed to Covid-19. I advised the government that this inquiry was of very considerable public interest in terms of learning from what happened and is happening in care homes and from the large numbers who have been and are affected by it. However, I also stated that it should not be considered as a substitute for any full public Inquiry that may be warranted under ECHR and Human Rights Act 1998.

d. Health Committee's Inquiry report to the Assembly

94. The Health Committee's report and recommendations were finalised on 21 January 2020 and then published for their debate in the Assembly on 1 February 2021[31].The report recognised the context of long-standing issues of workforce shortages and an accepted

[31] Committee for Health 'Inquiry Report on the Impact of COVID-19 in Care Homes' at - http://www.niassembly.gov.uk/globalassets/documents/committees/2017-2022/health/reports/covid-19-and-its-impact-on-care-homes/report-and-images/health-committee-inquiry-report-on-impact-of-covid-19-in-care-homes.pdf

need for reform, in which the pandemic impacted care homes. It also acknowledged the commitment of the Minister of Health to reform and his initiatives to deal with the pandemic, including the beginning of the roll out of a vaccination programme. The report dealt in detail with a number of issues, including:

i. Care home visiting, which it accepted was closely linked to issues around Covid-19 testing and PPE, and that there were resource implications;
ii. Covid-19 testing and the concern that care homes do not necessarily have all the required equipment, or adequately trained staff, to undertake symptom-monitoring in line with government guidance;
iii. Discharge policy involving the discharge of Covid-19 positive patients to care homes and the struggle that some care homes had with imposing isolation whilst maintaining the well-being of their residents;
iv. Access to PPE and the longer-term issue about procurement and payment;
v. Funding and staffing issues, in particular the need to adequately support care homes whose increased costs exacerbated the pre-existing financial strain on the sector, and to address the very significant problem of inadequate staffing levels that were only worsened by the high infection rate.

95. Cutting across those specific issues, was a general concern about poor communication and, linked to that, a lack of consistency around the implementation of the Guidance.

96. Much of the evidence I gave to the Health Committee on those issues was accepted and is reflected in the report and included in the recommendations that were provided to the Assembly for debate on 1 February 2021. In ease of the Inquiry, COPNI has prepared a comparison document of the main recommendations of the report and my submissions, which I have exhibited at **[EL/19 - INQ000237832]**. The principal reason for doing so being to indicate the issues that might have been addressed at the outset, had there been an appropriate mechanism for the DOH to harness the knowledge and practical experience of those working with older people and recognised the importance of properly communicating its policy and guidance to the very people that were required to implement it.

97. The report was approved by the Assembly, which resolved that the Minister of Health *"implement the recommendations contained in the report as part of the ongoing response to protect care home residents during future surges of the pandemic"*[32].

IV. LESSONS LEARNED

98. I acknowledge that the government did 'learn lessons' about the deficiencies in its planning during the initial phase of the pandemic and that it did adapt and change its response over the Specified Period. However, in my view, it should not have been necessary for it to do quite so much learning and developing 'on the hoof' especially when so many lives and futures depended on it.

99. Whilst a pandemic such as Covid-19 may come 'out of the blue', the context in which the government responds is not unknown nor are the resources at its disposal to formulate and implement any response. In my view, this is the perspective from which to consider the efficacy of the government's response and identify what might be improved for any future pandemic. My contribution to the lessons that can be learned relates to the position of older people.

a. Understanding the Lay of the Land

100. Given that it was that older people were uniquely vulnerable to Covid-19 and that significant numbers of them lived in nursing and residential care homes[33], an appropriate starting point before any response is formulated, is a rapid assessment of any structural weaknesses in the sector likely to be relevant, together with the numbers of readily available staff and the nature of the facilities. This basic information was available, but it would have been urgently required was likely to be widely held across government departments particularly the DOH and DfC, as well as other public bodies such as the

[32] Northern Ireland Assembly, Minutes of Proceedings at - http://www.niassembly.gov.uk/assembly-business/minutes-of-proceedings/session-2020---2021/monday-1-february-2021/

[33] The number of over 60s in the Northern Ireland population was approximately 439,000 and roughly 16,000 of them were in a nursing or care home – see the NI census population and household estimates and the 'surge plan' referenced below

HSCB, PHA, HSCTs, and the RQIA. In my view the government was not sufficiently on top of this at the outset.

101. An important lesson is how the government can ensure this process is more speedily and accurately carried out. In addition to its own resources, it had a range of external sources with proven experience and capability to draw on, some of whom, like COPNI, had provided reports and briefing papers commenting on those very issues. There is a lesson to be learnt about how best to make use of that resource, which is an issue that also arises in relation to the formulation of the response itself.

b. Establishing a Network of non-Governmental bodies and Organisations

102. The government recognised early on that, from the perspective of older people, COPNI and organisations like AgeNI and the IHCP group were likely to have specialist sector-specific knowledge. Between us we brought the news and views of older people and their families as well as the knowledge of the capacity and requirements of the homes. Whilst the plan was to consult us on the Guidance that I understood was being developed specifically for the nursing and residential care home sector, in my view that occurred too late in the process for any meaningful change to result, so that the draft provided to us at the meeting was essentially the version that was issued, and which would determine much of what happened in the early phase.

103. There is a lesson to be learned about when best to consult and about what, but a prior lesson concerns the extent to which the government would have been better assisted if early on it had established a reliable network to draw on. Whilst the government did establish information channels for me and others, it all seemed a little ad hoc and had more thought been given to what information network to establish and how to use it most effectively, much time would have been saved and all our efforts could have been better directed.

c. Making Best Use of the Network

104. There was an acknowledged need for reform of the sector and long-standing issues of insufficient beds and workforce shortages, many of whom were neither equipped nor trained to care for the medical needs of older people should they contract Covid-19. There were also persistent serious failings in the management of registered facilities that were well-publicised but, in any event, were known to the DOH. For many families this had resulted in trust in the ability of the DOH and the RQIA to keep the older people safe. All of this produced real and practical challenges for the successful implementation of the Guidance, but the government seemed to have no one who was either willing or able to address the practicalities despite having them highlighted by COPNI and others. This is an important lesson to be learnt.

105. Also, there were important issues to consider and address to ensure there was no avoidable infringement of older people's basic rights or that their best interests were not unnecessarily compromised such as with:

i. Practical arrangements for allocating PPE and establishing Covid-19 testing, which were scarce resources and essential not just for hospitals, but also care homes who had a much higher staff to resident ratio;
ii. Introduction of policies or the deployment of resources, which were potentially ageist, such as admission policies that could be interpreted to exclude older people from access to hospitals and ventilators, whilst ignoring the lack of nursing expertise in many homes;
iii. Introduction of 'lockdown', which cut them off from their families, significantly reduced the extent and range of activities that were important for health and well-being and accelerated the decline of many who many who were cognitively impaired;
iv. Authority given to individual homes to determine their own isolation and closure policies, which enabled them to introduce policies that did not have the best interests of the residents at heart and led to inconsistent approaches across the sector.

106. These were all risks that a well-developed and appropriately utilised network could have helped to avoid or minimize before any measure was actually published and put into

operation. Indeed, I certainly drew attention to many of these 'design flaws', but there appeared to be little if any contingency planning. Fundamentally, there seemed to be little thought given to the likely implications of policies and guidance that seemed to prioritise health over social care, despite having an integrated health and social care service.

107.Some issues may only emerge in operation. This was the case with the most pertinent issues faced, for instance: the allocation of PPE; establishing testing in nursing and residential homes; the introduction of ageist policies in respect of the deployment of resources and admissions to hospitals; the introduction of lockdown and other non-pharmaceutical interventions; and the delegation of responsibility to individual residential and nursing homes to determine their own isolation and closure policies. When I have reliable evidence of this, I sought to draw the attention of the DOH and government to it. I am aware that others did so too. However, there was no effective mechanism for doing so and I was left to largely escalate concerns up to Ministers and take to the media. This is neither efficient nor ideal. It is not conducive to the trust and confidence in government that is particularly required during a pandemic for serious criticism to have to be made so publicly of the government's policies and guidance and to see resultant 'U-turns' and changes.

108.I should have preferred to have been able to use my interaction with the media in more supportive way and for my engagement with older people, their families, and the sector to have become an instrument for translating, explain and reinforcing the government's policies and guidance.

d. Retaining and Developing what Worked

109.There were things that worked and also measures and initiatives approaches that were less successful. In my view the gains from that period should not be lost. Indeed, the surge plan, 'Covid-19 Regional Action Plan' that the government developed for the period for

September 2020 and onwards is an illustration of building on the lessons learned, particularly in relation to section 3 on 'Resilience (service Continuity)'[34].

110. However, in my view an important lesson learned would be how to build on the communication channels that were developed with the non-governmental bodies, so that should a pandemic occur in the future it can perhaps be approached in a more planned way and those who have a proven ability to contribute can properly assist where required.

CONCLUSION

111. In early 2020 I watched the news coming out of Italy about a coronavirus in almost disbelief. Yet by 27 February we had our first official case and just over two weeks later our first confirmed death. It is easy to forget the situation we faced in that early period before there was any prospect of assistance from a vaccine. Things were frenetic, even chaotic, with the spread of Covid-19 moving at a fast pace.

112. Even so, it was clear to me right from the outset that it was older people who were amongst the most seriously at risk. Almost every aspect of what was happening and the government's response to it threatened the very people for whom I was statutorily mandated to act as a champion, whose interests I was charged with safeguarding and promoting. I was acutely aware of the risks to their lives if the safeguards the government was incorporating into its response to the pandemic were deficient. It was my task, with others whose organisations worked with older people, to try and convey to the government the urgency with which we needed to move and the practical issues that needed to be addressed for that to be effective.

113. I was not an expert, but I knew the structure of the sector and its weaknesses as, of course should the government, and I understood in a very practical way how it operated 'on the ground'. Additionally, over my professional career, especially in my role as Commissioner, and by the start of the Specified Period I had nearly 4 years in office, I had developed a

[34] 'Northern Ireland Covid-19 Regional Action Plan for the Care Home Sector' (surge plan) at - https://hscboard.hscni.net/download/PUBLICATIONS/covid-19/COVID-19-Care-Home-Sector-surge-plan02.pdf

very extensive network of contacts and a reliable means of keeping in touch with older people. This meant I had a wealth of up-to-date information on the position of older people in relation to Covid-19, the likely efficacy of the government's proposed response to it, and the impact of the measures and guidance that were introduced to implement the government's policy.

114. In my view what was required, as I said in the article I published jointly with the Chief Commissioner of the NIHRC on 6 May 2020, was to create *"a ring of steel to protect care homes from the virus with effective PPE and priority testing"*. Within days of that being published the Secretary of State for Health Matt Hancock stated during a Downing Street press conference that: *"Right from the start, it's been clear that this horrible virus affects older people most. So right from the start, we've tried to throw a protective ring around our care homes."*[35] He was correct, it was clear, but a 'protective ring' was not thrown around the Northern Ireland care homes. Indeed, by the time the joint article was published there had been a total of 269 registered deaths in care homes from Covid-19[36].

115. Nevertheless, I considered that the government could do more to protect older people, particularly those in care homes, and I did not regard it as too late to deliver on the 'ring of steel'. The best available evidence, and the view of government, was that there was likely to be at least a 'second wave'. I exploited every available channel of influence available to me to try and achieve that that 'ring'. However, by 19 February 2021 there had been 983 deaths of care home residents in Northern Ireland, the overwhelming number of whom died in a care home not hospital[37].

116. From my perspective, the issue of the government's response to the pandemic is essentially two-fold. Firstly, the efficacy of the mechanisms government developed to inform its policy and measures for responding to the pandemic. Secondly, the extent to

[35] Coronavirus press conference 15 May 2020 at - https://twitter.com/SkyNews/status/1261329991708684294
[36] 'Weekly deaths in Northern Ireland at - https://www.nisra.gov.uk/sites/nisra.gov.uk/files/publications/Historical%20Weekly%20Deaths%20Bulletin%20-%20Week%20ending%208th%20May%202020_0.pdf
[37] 'Weekly deaths in Northern Ireland at - https://www.nisra.gov.uk/sites/nisra.gov.uk/files/publications/Weekly%20deaths%20bulletin%20-%20week%20ending%2019th%20February%202021.pdf

which government was prepared to pay attention to information about the impact of those measures and speedily adapt its response. My experience throughout the Specified Period is that there were deficiencies in both those of elements from which real lessons can be learned to improve the outcomes of any future pandemic.

STATEMENT OF TRUTH

The contents of this witness statement are true and accurate to the best of my knowledge and belief. So far as I am aware, I have produced all the documents to which I have access and which I believe are relevant to the Inquiry's request.

Signed:

Personal Data

Date: 6th September 2023