**UK COVID-19 INQUIRY, MODULE 2C**

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**Closing Submissions on behalf of the**

**Commissioner for Older People for Northern Ireland**

**Introduction**

1. The Commissioner for Older People for Northern Ireland’s office was established by the Commissioner for Older People Act (Northern Ireland) 2011[[1]](#footnote-1) with the principal aim of safeguarding and promoting the interests of older people in Northern Ireland, a group who as of the last census in 2021 represents approximately 23 percent of the total population[[2]](#footnote-2).
2. As the Commissioner outlined in his evidence to Module 2C:

*“As Commissioner, my principal aim is to safeguard and promote the interests of older people in Northern Ireland and part of this role, one of my roles is to advise government on older people's issues, to commission research into issues that I feel are of importance, make recommendations to government on issues that affect older people here and I've also legal powers in relation to investigations that I can conduct, formal and informal investigations, as well. And…part of my role is to constantly review the services that older people receive, and to influence policy, practice and legislation that affect the needs of older people in Northern Ireland.”* [**01/05/2024, 2, 17-25 & 3, 1-4**]

1. That group is not only projected to rise but to rise at a rate higher than that of the overall population of Northern Ireland[[3]](#footnote-3). For the purposes of the Act older people are defined solely by the fact they are 60 years or over and as such they represent a cross-section of society. Whilst there are very many who are healthy and should have a good quality of life for many years nonetheless, as a group, they are more highly represented in the Northern Ireland figures of those with disabilities, mental health issues, co-morbidities, and those on hospital waiting lists. As such they require not just health services but, most especially, social services. Significantly for this Module and others, a considerable number of older people require to live and be cared for in community placements, the provision of which is outsourced by their Health and Social Care Trusts to privately owned providers.
2. As the Commissioner commented in his evidence: *“…whilst there are lots of positives with ageing population and what it can provide to society, there are a lot of challenges that come with it that government needs to really address, and I think a lot of the issues that came up in the pandemic were reflective of some of the failings there have been in those issues”* **[01/05/2024, 4, 49]**.
3. None of this was new prior to the pandemic. It was well known to the Department of Health, the Department for Communities, and the Northern Ireland government as a whole. Accordingly, the Department of Health, as the lead Department on the government’s response to the pandemic, should have factored it into the planning and response to the pandemic. The government should have ensured that it was properly factored into the planning for its response to the pandemic, so that it was properly accommodated by that response. The evidence shows that it did not do so and that older people and others known to be vulnerable paid a terrible price for that failure and their families have been left living with its consequences. The Module 2C Impact Film provided a sobering and stark reminder of the human cost to the people of Northern Ireland of those failings.
4. The issue for the Commissioner is how and why that happened, which is the learning he hopes this Inquiry will identify, as well as what can be done to ensure that it does not happen again through the recommendations that he hopes the Inquiry will make, together with the attention that will be trained on what the government does with those recommendations.
5. The older people that the Commissioner represents now are largely those who directly experienced the consequences of the government’s planning and decision-making and survived. Many of them lived through life-changing events. They are seeking to make sense of what happened and to know what will change to ensure that other older people will not endure anything similar or lose their lives as so many older people did. Older people are clear that what is of paramount importance to them at this stage is what can and must be changed going forward.
6. The purpose of this written closing is to develop points made in the oral closing and highlight some of what the evidence has shown in relation to two principal issues: (i) the apparent absence of any consideration of section 75 of the Northern Ireland Act 1998 in planning and decision-making; and (ii) the areas for improvement.

**Section 75**

***Requirements***

1. Section 75 of the Northern Ireland Act 1998[[4]](#footnote-4) placed a statutory obligation on public authorities when carrying out their functions to have due regard for the need to promote equality of opportunity, which includes access to appropriate health and social care services, between what are known as the nine protected categories. Older people feature heavily in two of those nine ‘protected categories’, age and people with disabilities. They are also highly represented in those requiring health and social care.
2. By the beginning of 2020, when the prospect of a pandemic was beginning to be recognised and that steps would need to be taken to protect the public, the Department of Health and the Executive would have had decades of experience of applying section 75. Considerations in relation to the protected categories should have been embedded in the very DNA of the approach to all public sector decision-making, including civil contingency planning. Whilst the Commissioner and others had their concerns about the way in which the requirement on equal opportunity had from time to time been implemented in terms of age and disability, they had absolutely no doubt that it was generally accepted there was such a requirement and that it should determine the approach to decision-making.
3. The whole of Northern Ireland now knows the extent to which older people, including those with disabilities, were particularly adversely impacted by the government’s response to the pandemic. No matter how many times the numbers of them who suffered and died of Covid-19 is stated, they still have the capacity to shock and so they should. That 90 percent of Covid-19 deaths in the first wave of the pandemic were people aged over 65 and that around half of all Covid-19 deaths in Northern Ireland occurred in a care home[[5]](#footnote-5) will remain a lasting shame.
4. However, what the Module 2C hearings have exposed is the extent to which section 75 was not properly factored into the planning and decision-making of the government’s response to the pandemic. At times it seemed as though years of accepted practice on the implications of section 75 were ignored in the face of the looming pandemic, notwithstanding the knowledge that those whose lives were most at risk were in protected groups.
5. The evidence on this is stark. Jenny Pyper, the former Head of the Northern Ireland Civil Service, acknowledged that the *“extent of the impact of NPIs on different groups within society was not assessed in any systematic way”* **[02/05/2024, 201 12-14]**. She stated that *“the pace of decision making was such that it simply wasn’t possible to do the normal section 75 or EQIA reviews that would be a normal part of civil service process”* **[02/05/2024, 201, 18-21].** Whilst highlighting the time pressure existing at the relevant time, Jenny Pyper conceded that *“the Covid Taskforce to perhaps have an equality workstream that would have given some focus to the work that was being done in terms of stakeholder engagement but also the work that was being done by individual departments with their stakeholders”* **[02/05/2024, 203, 1-5].** She went on to acknowledge “*the benefit of having an equality workstream within the Covid Taskforce to look at those sources of information, to be a point of direct contact for Disability Action, for the Commissioner for Older People, a central point of contact as opposed to relying on sources of information held in disparate parts of the system”* **[02/05/2024, 215, 9-14]**.
6. Karen Pearson, Director, Programme for Government, Covid Strategy, Civil Contingencies, Northern Ireland in the Executive Office Northern Ireland, provided support for this contention in her evidence when she acknowledged that *“as regards almost all of those groups of people in society to whom extra consideration needed to be given as part of planning, that effectively Northern Ireland fell short at all stages”* **[03/05/2024, 94, 18-21]** and that *“we’re trying to do more in the civil contingencies space, and I would love to have the opportunity of talking to some equality groups in Northern Ireland about that, after the Inquiry of course”* **[03/05/2024, 93, 23-25, 94, 1-2]**.
7. Whatever the good intentions for the future may be, this did not happen in 2020 and there was general agreement on that from the witnesses. Karen Pearson also acknowledged that *“we could have done more, we should have done more, should have found a way to make time”* **[03/05/2024, 93, 18-19]** and in response to questioning as to whether it was a *“failure of planning, in the lead up, in months leading up to March, when it was known that there would be a pandemic, that time wasn’t used to think about the impact that there would almost inevitably be on a number of different people in society”,* she accepted that *“it should have been done”* [**03/05/2024, 96, 19-25]**. See too Dr Joanne McClean, Director of the Public Health Authority, who when asked whether there should have been any *“broader risk assessment role [for the PHA] about the particular vulnerabilities, for example, of disabled people in the community and helping to inform decision making”*, acknowledged it had not been looked at as much as it should and that it is a learning for the future **[03/05/2024, 166, 3-11]**.
8. Whilst frank recognitions of failure are helpful, they do not explain **why** there was such a glaring omission in planning, especially when the likely consequences of it for older people and the vulnerable were entirely foreseeable. Without an insight into and understanding of why it happened, it is difficult to exclude the possibility of it happening again. The closest explanation lies in the evidence on the role and focus of the Department of Health and its Chief Medical Officer. See for example the evidence of Edwin Poots MLA, the former Agriculture Environment and Rural Affairs Minister, who when asked whether he had *“received enough information about, older people, disabled people, young people”*, stated “*We didn’t take into account so many other things…the focus was almost entirely on our response to Covid-19 to the complete ignorance of everything else.”* **[09/05/2024, 72, 12-13]** He accepted that focus was driven by the Department of Health and that they got the balance wrong **[09/05/2024, 72, 18-19].**
9. It was a common view, and in any event the evidence makes clear, that the driver of that focus was Professor Sir Michael McBride the Chief Medical Officer.

***Planning***

1. The section 75 failure is just one instance of a wider failure in pre-pandemic planning and of decision-making throughout the duration of the pandemic.
2. Any planning for a Northern Ireland response to a health pandemic would need to take in the distinctive features of its structures and population.
3. Uniquely among the UK jurisdictions, Northern Ireland has an integrated health and social care system. The evidence of Richard Pengelly, former Permanent Secretary to the Department of Health, was that in the context of the pandemic that could be an advantage: *“When we get into the issue of care homes during the pandemic, the integrated nature would have been very helpful”* **[07/05/2024, 9, 6-8]**. He went on to address ways in which it should have provided greater oversight but ultimately, he had to concede that in reality the integration was more illusory than real and that he *“struggled to see the real manifestation of that it terms of tangible benefits for patients”* **[07/05/2024, 11, 2-3]**.
4. The Commissioner’s evidence was perhaps more direct. In his view it should have been an advantage, but those opportunities were wasted. He highlighted the failure to capitalise on the relationships fostered by the integrated system which, if properly utilised, could have led to the more effective sharing of expertise **[01/05/2024, 25, 22-25, 26, 1-6]**.Instead, it operated to the detriment of those in care homes because of the Department’s focus on protecting the NHS with the care home and social care sector left to *“really struggle”* **[01/05/2024, 24, 22-25, 25, 1-3]**.In this regard the Commissioner gave the particular example of the failure to equip care home providers and domiciliary care providers with personal protective equipment (“PPE”), as issue which his office advocated on, and which took several weeks to resolve **[01/05/2024, 25, 3-12]**.In many ways the social care sector was treated as the poor relation of the NHS during this time, which is how it had been treated historically and which formed part of the argument for reform. Robin Swann, the Health Minister, described his perception that the social care sector was the *“Cinderella service…undervalued and under-recognised”* **[13/05/2024, 185, 12-15]**. This had a demonstrably negative impact on older people, who are especially reliant on the social care sector.
5. The pre-existing weaknesses in the structure for delivering adult social care meant that older people who depended disproportionately on those services delivered by that sector were vulnerable from the very outset of the pandemic. In the context of a pandemic likely to hit them the hardest, they were heavily reliant on a sector to meet their needs that was likely to be given inadequate consideration by the Department of Health and the government.
6. Whatever the level of integration, in reality, Northern Ireland had an extremely fragile health and social care system**.** This was generally accepted during the hearing. Simply put there were insufficient funds and not enough staff for the proper delivery of health and social care services. Social care was particularly disadvantaged. It was heavily dependent on the private sector and was in urgent need for reform. The Commissioner and others gave evidence on the weaknesses of the system and the need for the reform of Health and Social Care as exemplified in the 2016 Bengoa Report ‘Systems not Structures: Changing Health and Social Care’[[6]](#footnote-6) and the 2017 Kelly and Kennedy report ‘Power to People: Proposals to Reboot Adult Care and Support in NI’[[7]](#footnote-7).
7. Again, none of this was new. Sir David Sterling, former Head of the Northern Civil Service, acknowledged in his evidence that it was well known that there was a radical need for reform, which had been an imperative before 2020, referring to his witness statement in which he *“set out an extract from Fiscal Council's report[[8]](#footnote-8), a sustainability report they did on the health service, and that actually itemises a number of strategic reviews which have been carried out on the health service going back…maybe 30 or 40 years, and there has been common theme to a lot of those reports: basically they are suggesting that the health service needs to be reconfigured, that there needs to be greater focus given to primary care, that there needs to be the collection of specialisms in specialised units”* **[01/05/2024, 83, 5-15]**.
8. Within that system the position of Northern Ireland’s Chief Medical Officer is particularly striking. It is not at all comparable to that of Professor Sir Chris Whitty, as his office is not functionally independent of the Department of Health. Rather the Chief Medical Officer is a member of the departmental board **[10/05/2024, 4-5]** of the Department of Health and he provides policy advice to the Minister for Health over the entire gamut of public health, quality, and safety, and research within health and social care. Whilst there is a Chief Social Work Officer, that office is also not independent of the Department of Health, furthermore the position lacks the prominence and influence of the Chief Medical Officer. That was particularly relevant in relation to the pandemic, where planning and decision-making was to have a considerable impact upon the delivery of social care.
9. There was considerable evidence of the failure to factor into planning the implications of the Health and Social Care system that Northern Ireland actually had, with all its structural weaknesses and its frailties.
10. Sir David Sterling claimed that the *“knowledge that the Bengoa report was sitting on the shelf waiting to be taken forward would have been at the front of…all ministers‘ minds in January/February 2020”* **[01/05/2024, 87, 7-10]** and that there would have been a recognition *“that the health service would be under particular stress”*, which would be *“exacerbated by the structural problems, which had built up over the years”* **[01/05/2024, 87, 23-24]***.* This view is shared by the Commissioner who highlights the particular weaknesses in the social care system[[9]](#footnote-9). But it was hard to see any tangible evidence of the ministers having any such thing on their minds, or that it provoked any appropriate response. This is particularly the case as the understanding of it apparently would not have *“crystalised”* until *“in and around the start of March”* **[01/05/2024, 88, 1-4]**.
11. Consequently, there would not have been time for much, if any, of that to have influenced pre-pandemic planning. Indeed, it seems clear that there was not, or at least that it did not.
12. The Commissioner’s evidence was that, even so, that could have happened subsequently: “*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 ... and their implications should have been appreciated and factored into planning to avoid potentially disastrous outcomes for older people*.” **[01/05/2024, 23, 16-22]**
13. Again, it seems clear that this did not happen, or at least not to any appreciable extent and to use the Commissioner’s words, older people were left *“horribly exposed”* **[01/05/2024, 24, 2]**.

***Care homes***

1. Whilst appreciating that there will be a further investigation of care homes in Module 6, the evidence received in the Module 2C hearings in relation to the preparedness to deal with the unique risk posed to those who were resident in care homes, cannot reasonably be omitted from any closing remarks in this Module. The Inquiry has heard sufficient evidence to conclude that there were stark failings in relation to care homes, to the detriment of the older population, which should have been entirely foreseeable to anyone involved in the decision-making processes and for which Northern Ireland was woefully unprepared.
2. A prevailing criticism in the hearings rightly centred around the Department of Health’s surge plans[[10]](#footnote-10). The discharge policy of March/April 2020 saw hospital patients discharged into residential care settings without any testing or the expectation of dedicated isolation facilities. No risk assessment appears to have been conducted to determine the extent to which care home providers were able to accommodate these discharged patients without exposing other residents and their staff to the virus. There was no evidence that, at the very least, there had been any real engagement with the care home owners who were to have the responsibility of protecting their vulnerable residents and their staff, about the discharge policy, its likely impact or what mitigating assistance the Department of Health could provide. There seemed to be little attention paid or significance attached to the extent to which care staff might also work in other community placements or provide domiciliary care to older people isolating in their homes. In a very real and practical way neither the Department of Health nor the government knew whether, when they were finalising the plans and publishing guidance, care homes would be able to manage and keep older people and care workers safe.
3. Unsurprisingly in those circumstances the ‘Covid-19: Guidance for Nursing and Residential Care Homes in Northern Ireland’, that was to inform and assist but which had been rushed through so that it could be published on St Patrick’s Day, was ill-thought and hopelessly inadequate[[11]](#footnote-11).
4. To put it in the words of Edwin Poots, *“So the urgency that was created to get all of these elderly people out of hospital and have these beds available, that didn’t materialise, but what did materialise was that the nursing homes were left in an absolutely perilous state*” **[09/05/2024, 80, 6-11]**.
5. A section of the statement by Lord Peter Weir of Ballyholme, former Minister of Education, was cited at the hearing[[12]](#footnote-12) which encapsulates the shocking position that, *“…as an Executive, we didn’t pick up on the extent and scale of the problem immediately, and the level of impact on care homes only really became apparent in a wider context to ministers, when the mortality rate through Covid started to escalate, and infections and deaths within care homes were seen to reach such a high percentage of the total”* **[08/05/2024, 108, 10-16]**.This comment epitomises the apparent lack of forethought about the risk to residents in care home settings, in those early decisions.
6. It is inexcusable that so little, if any, thought was given to engaging at the very outset with the Commissioner who had a statutory duty to *“keep under review the adequacy and effectiveness* *of services provided for older persons by relevant authorities”* and to *“advise the Secretary of State, the Executive Committee of the Assembly and a relevant authority on matters concerning the interests of older persons”*[[13]](#footnote-13). This was the very person charged to inform, advise and assist in relation to older people, and yet the first contact by the Department of Health on planning and guidance for Covid-19 was not made until 13th March 2020 when the Chief Medical Officer and other healthcare professionals provided a briefing on Covid-19. By this time of course the Chief Medical Officer and the Minister for Health had already attended COBR and SAGE meetings, the World Health Organisation (“WHO”) had declared Covid-19 a public health emergency and Northern Ireland had experienced its first case. The time for input to any pre-pandemic planning was past as the first case in the global pandemic was already here.
7. Even without the particular information, insight and assistance that the Commissioner might have brought to pre-pandemic planning, the other evidence heard by the Inquiry in Module 2C suggests that the lack of forethought was entirely unjustifiable. It was recognised at a very early stage in the pandemic that there was a unique risk to older people. In particular the updating briefing paper prepared by Bernie Rooney, Deputy Chief of Staff in the Covid-19 C3 Northern Ireland Hub, following the COBR meeting on 29th January 2020 warned *“at risk groups which currently thought to be older people and those with an underlying illness”[[14]](#footnote-14)*. Sir David Sterling himself had sent a message in early February 2020 which read, *“I guess the problem will be if (when) it hits care homes and hospitals”* **[01/05/2024, 184, 11-12]*.***
8. The potential for catastrophic risk to care homes was therefore foreseen by the Head of the Civil Service at the very outset. The unique risk to vulnerable categories, including older people, was also flagged to the Chief Medical Officer as early as 25th January 2020. The email of Professor Woolhouse of that date and Professor Sir Chris Whitty’s response to it[[15]](#footnote-15) was put to the CMO during the hearings, in which Sir Chris Whitty outlined a view that: *"I think there are two reasons we should be considering evacuating people who are older or have pre-existing health conditions from Wuhan and the surrounding area if they request it...This seems to be the group most affected by the novel coronavirus, and it is very difficult to determine level of risk as inevitably the data coming out is going to be behind the reality"* **[01/05/2024, 195, 5-14]**.
9. Furthermore, at the first meeting of the Civil Contingencies Group Northern Ireland on 20th February 2020 a presentation was delivered by Dr Chada, the deputy Chief Medical Officer, which stated that *“the elderly and those with existing health conditions will be disproportionately affected*” **[07/05/2024, 47-48]**.
10. It is incomprehensible to the Commissioner, and will be to many older people who listened to the evidence, that the early recognition of the particular risk to them did not translate to stringent measures to ensure that residents of care homes were protected.
11. Naomi Long MLA made reference in her evidence to the contrasting position between prisons and care homes. She stated, *“Within prisons, we quarantined all new committals for 14 days to ensure that anyone arriving in prison did not enter the general population until such times as they were symptom-free or Covid free. And I believe that learning that we had, which I shared with the Executive, would have been useful in terms of managing the care home situation”* **[09/05/2024, 37, 14-18]**.
12. It simply beggars’ belief that such measures were able to be thought of and implemented by the Department of Justice to protect prisoners but that such measures were not even considered by the Executive in relation to care homes. It is difficult to resist the conclusion that the risk to care home residents was known and recognised but simply ignored in favour of having beds available in hospital for younger and more able-bodied patients.
13. The Minister for Health accepted during the course of his evidence that *“we could have done more…in regards to the supply and the support of how we actually affected not just working – those in care homes but those working in care homes and those providing care, especially in domiciliary care, and those people working and supporting vulnerable people within their own homes as well*” **[13/05/2024, 189, 19-25, 190, 1]**. He eventually answered *“yes”* to the proposition that statistics revealed that the government response in Northern Ireland was starkly ineffective in protecting care homes **[13/05/2024, 190, 1-3]**.
14. This admission, in 2024, will be of scant consolation to those who lost loved ones as Covid-19 ravaged care and nursing homes.

***Timing***

1. So much for what should have been factored into pre-pandemic planning and government decision-making. That leads inevitably to the issue of when that should that have happened. The Inquiry’s own graphic clearly shows what did happen[[16]](#footnote-16):



1. Whereas the first wave in Northern Ireland was bad, the second wave was worse; it was higher and more prolonged. These waves and the concentration of deaths amongst older people and other vulnerable groups represents what the government should have sought to avoid, with early and appropriate information and its proper use to inform planning and decision-making.
2. However, the distinct impression from listening to the evidence over the eleven days of public hearing, is that there was a lack of urgency that is simply incomprehensible in the circumstances. At times it seemed as if those in the Department of Health, which was the lead Department for the government’s response, were watching the approaching pandemic on the news and yet they had access to information from COBR and SAGE meetings and the mounting concern of key officials and experts in the rest of the UK. The Chief Medical Officer, for example, gave evidence that *“we were all watching it on our televisions in terms of the situation in China”*, which drew the understandable response from Senior Counsel to the Inquiry: *“I assume that you accept, we might all and officials might have been able to watch this on the television, but you are the Chief Medical Officer to Northern Ireland, and one might expect you to have been the person giving the sort of clarion call that matters really had reached a point of some significance.”* **[10/05/2024, 114, 1-2, 121, 7-14]**
3. The timeline has shown that Northern Ireland’s Chief Medical Officer had his first engagement with other UK Chief Medical Officers on 24th January 2020, which was when the first COBR meeting took place. Thereafter, they occurred roughly weekly. The first SAGE meeting on Covid-19 took place on 22nd January 2020 and they then occurred very frequently thereafter. The Scientific Pandemic Influenza Group on Modelling-Operational (SPI-M-O), which is composed principally of infectious disease modellers, first met on 27th January 2020. Northern Ireland’s Minister for Health attended his first COBR meeting on 29th January 2020 and the next day the UK has its first confirmed case. On 4th February 2020 the WHO published guidance on scaling up country preparedness and response operations. The Minister for Health attended his first SAGE meeting on 6th February 2020 and the following day on 7th February 2020 the WHO declared Covid-19 a public health emergency.
4. A significant period then elapses, in the context of the speed of the pandemic, until the first case is confirmed in Northern Ireland on 27th February 2020. A period when preparation could have been ramped up, but it was not, with consequences that would prove tragic for older and vulnerable population of Northern Ireland who had every right to expect that their government was doing all that it could to protect them.
5. The information that the Department of Health obtained from these early meetings could have its officials in no doubt about the seriousness of the position and the implications for Northern Ireland given the state and capacity of its health and social care system. But the evidence suggests that it was not met with a commensurate degree of urgency either in the pre-planning phase and prior to the first wave, or after the first lockdown and prior to the second wave.
6. A striking illustration of that is the position of Professor Ian Young, the Chief Scientific Adviser. On 12th February 2020 he went on sick leave, seemingly without having made any contribution to pre-pandemic planning, but more importantly, without any replacement or even arrangements having been made for one. It appears little was done by way of modelling, or the provision of the scientific advice that he would have been expected to provide, until his return at the end of March 2020. The explanation was that there were insufficient ‘data points’ i.e. cases in Northern Ireland so, effectively, there was no basis from which to develop a model **[07/05/2024, 65-66]**.
7. However, and tellingly, the UK modelling group met **before** there were any confirmed Covid-19 cases. Also, Professor Young went on leave **after** a series of COBR and SAGE meetings that should have indicated the need for a Chief Scientific Adviser. Whilst at that time the rate of transmission in Northern Ireland was not known, there were worrying signs as to its potential rate and seriousness. It defies belief that in the face of the approaching pandemic that by February 2020 there was simply no preparatory work that could usefully have been undertaken or commenced. Yet there is no indication of what might have been done in his absence, even something as basic as recommending liaising with the UK modellers and/or their counterparts in Germany and Italy, which had already experienced cases, so that preliminary work could start on his return.
8. There is absolutely no explanation of why. This is especially so because at the time Professor Young left, he would have had no idea whether Northern Ireland could afford to wait until his return at the end of March 2020 before getting started on modelling
9. A lack of urgency and inconsistency typified the government’s response, whether it was getting vulnerable groups on to the list of priorities and action points following the CCG (Covid-19) meeting of 20th February 2020[[17]](#footnote-17), or not seeking to stand up the Northern Ireland Central Crisis Management Arrangements (“NICCMA”) until mid-March 2020 despite the risks to the population from the impending pandemic and notwithstanding the clear advice from SAGE. On 10th March 2020, when there were already 16 confirmed cases in Northern Ireland, the advice was *“special consideration be given to care homes and various types of retirement communities”*. Just three days later, on 13th March 2020 it was that *“the science suggests that household isolation and social distancing of the elderly and vulnerable should be implemented soon”*.
10. The lack of urgency is all the more difficult to comprehend given the knowledge of Northern Ireland’s overall lack of preparedness for a flu pandemic, a reasonably well understood virus let alone Covid-19, which was anything but. The evidence of Chris Stewart, the Chief of Staff for the Northern Ireland Civil Contingencies Hub laid bare the basis of that difficulty:

*“I would absolutely accept the point that our planning overall was very late in the day. Sir David said yesterday, and I entirely agree with him, we were not as well prepared as we ought to have been. We ought not to have been 18 months behind in our planning for an influenza pandemic. We got to where we got by mid-March by dint of extremely hard work by a small and under-resourced team over a very short period. That is not a satisfactory position to be in, and it is not a position that I would seek to defend. We ought not to have been in that position. We ought to have been better prepared.*” **[02/05/2024, 53, 24, 54, 1-11]**

1. The Inquiry has many examples from which it can conclude that there was also an unfathomable lack of urgency and indecisiveness in the period leading up to Christmas 2020. Restrictions were imposed, lapsed, and brought back in. It was the very antithesis of what planning during a pandemic should be.
2. The evidence from Baroness Foster, the former First Minister, on her response to the urgings of the Minister of Health and the Chief Medical Officer to implement a lockdown or circuit breaker as the situation in the autumn became far more serious than in March 2020, typified the approach that saw Ministers rely on personal experience and anecdotal accounts as a basis for decision-making, apparently ignoring expert advice. During this time the stakes could not have been higher. In that context, and given the known risks to older people in care homes, vulnerable people in the community and to hospital capacity, it is difficult to know what to make of Baroness Foster’s statement that *“for those of us who need to get our hair cut every couple of weeks, it was becoming a real issue”* **[15/05/2024, 129, 7-9]**, or that coffee shops had brought stock in the anticipation of re-opening *“and if we hadn’t allowed them to open for that week, all of that stock would be lost”* **[15/05/2024, 128, 4-6]**. Decision-making on something as serious as the protection of vulnerable lives seemed to descend into chaos.
3. The consequences were swift. With aspects of society allowed to remain open and available to people at a time of rising deaths, Northern Ireland was to experience in January 2021 its highest death rates during the entire period of the pandemic.

**What needs to be improved**

1. Older people and the public in general were repeatedly told ‘we are all in it together’. But they were not in any meaningful sense. Older people in care homes, the disabled and socially disadvantaged did not have an equal experience of either the pandemic or the impact of the government’s response to it. They suffered and died in disproportionately high numbers. The Commissioner hopes that recommendations can be made to inform planning for future pandemics and minimise the risk of that happening again.
2. Dr Joanne McClean identified that an important part of the problem lay with the health inequalities in the society, contributed to by socio-economic circumstances and education level. She acknowledged there is an onus on the *“Executive and on government to realise that these are unfair inequalities that need to be tackled, not just because they caused an issue in the pandemic but just because they can and should be tackled”* **[02/05/2024, 167, 19-22]**. Addressing that lies outside the scope of this Module. However, in the light of the evidence heard the Commissioner considers that the following would contribute to improved planning and decision-making in preparing and responding to a health pandemic:
3. Establishing a better structure for providing the Executive with timely, independent, specialist advice, including re-considering the roles of the CMO and CSA. The evidence showed that the CMO’s multiple roles could become blurred and his position as a departmental official deprived the Executive, and other departments, of a properly independent view. They had no basis from which to properly assess his advice.
4. Ensuring that greater significance is given to the role of Chief Social Work Officer. It was known that older people in care homes or in receipt of domiciliary care were likely to be disproportionately affected by the pandemic and many of the restrictions imposed, so the lack of reference to any significant input from the Chief Social Work Officer for planning is striking.
5. Developing a mechanism to better use the available experience and expertise of those in the third sector and statutory bodies such as the Commissioner. This would have improved the government’s planning and response and could have avoided some of the chaos that undermined public confidence and compliance. The offer by Karen Pearson to talk to ‘equality groups about doing more in the civil contingencies space’ and ‘developing a civil contingencies risk register that will force a consideration of vulnerability in section 75’ is a welcome start but what is required is a proper structure so that it is more than a commitment from an individual.

**Conclusion**

1. The Commissioner was hoping that the evidence in this Module would provide answers and an understanding of how and why older people, and many vulnerable others, were so badly failed by the Northern Ireland government’s response to the pandemic. Regrettably the answer to the ‘how’ question is deeply depressing and concerning, whilst the ‘why’ question has not been properly answered.
2. In the Commissioner’s view it will need to be. Not least to build the public’s trust and confidence in the government’s ability to adequately respond to the next pandemic so that their lives are protected. The evidence heard has done little to start that process. But it must happen as without such trust and confidence, the public may not respond with the necessary compliance to whatever measures are considered necessary and that will be to the detriment of everyone.

**Monye Anyadike-Danes KC**

**Bobbie-Leigh Herdman**

**Lara Smyth**

**Aislinn Brady**

**Bar Library, 6th June 2024**

**Instructed by Diane Rowan, Legal Officer**

**Commissioner for Older People for Northern Ireland**

1. INQ000239436 - Commissioner for Older People Act (Northern Ireland) 2011 [↑](#footnote-ref-1)
2. <https://www.nisra.gov.uk/publications/census-2021-main-statistics-demography-tables-age-and-sex> [↑](#footnote-ref-2)
3. <https://www.nisra.gov.uk/system/files/statistics/census-2021-main-statistics-for-northern-ireland-phase-1-press-release.pdf> [↑](#footnote-ref-3)
4. INQ000147489 - Northern Ireland Act 1998 [↑](#footnote-ref-4)
5. INQ000267978 - Witness Statement of Eddie Lynch, Commissioner for Older People for Northern Ireland, dated 06/09/2023 [↑](#footnote-ref-5)
6. INQ000267978 - Witness Statement of Eddie Lynch, Commissioner for Older People for Northern Ireland, dated 06/09/2023 [↑](#footnote-ref-6)
7. INQ000191268 - Power to People: Proposals to reboot adult care & support in N.I. [↑](#footnote-ref-7)
8. INQ000449440 - Witness statement of Sir David Sterling, dated 20/03/2024

 INQ000398445 - Report from Northern Ireland Fiscal Council titled Sustainability Report 2022 Special Focus Health, dated September 2022 [↑](#footnote-ref-8)
9. INQ000267978 - Witness Statement of Eddie Lynch, Commissioner for Older People for Northern Ireland, dated 06/09/2023 [↑](#footnote-ref-9)
10. INQ000239437 - Health and Social Care NI Summary Covid-19 Plan for the period mid-March to mid-April 2020 and INQ000250243 - Letter from Richard Pengelly (Permanent Secretary) to Chief Executives of ALBs regarding Covid-19: Preparations for Surge dated March 2020. [↑](#footnote-ref-10)
11. INQ000267978 - Witness Statement of Eddie Lynch, Commissioner for Older People for Northern Ireland, dated 06/09/2023 [↑](#footnote-ref-11)
12. NQ000408058 - Witness statement of Lord Weir of Ballyholme (Peter James Weir), former Minister for Education dated 23/01/2024 [↑](#footnote-ref-12)
13. INQ000239436 - Commissioner for Older People Act (Northern Ireland) 2011 [↑](#footnote-ref-13)
14. INQ000474210\_0003 - Extract of Paper from Bernie Rooney, TEO to PS/First Minister and PS/Deputy

 First Minister providing an update from the COBR meeting of 29 January 2020 re coronavirus – UK

 preparedness, dated 30/01/2020 (with comments from CMO, Professor Sir Michael McBride) [↑](#footnote-ref-14)
15. INQ000047559 - Emails between Michael McBride (Chief Medical Officer for Northern Ireland), Chris Whitty (CMO) and colleagues, regarding advice on assisted departure of UK citizens from Wuhan, between 24/01/2020 and 25/01/2020 [↑](#footnote-ref-15)
16. INQ000472397\_0002 - Slide pack prepared by the UK Covid-19 Inquiry titled Covid and excess deaths - Northern Ireland, prepared on 25/04/2024 [↑](#footnote-ref-16)
17. INQ000023220 - Minutes of the CCG Meeting, regarding identification of isolation facilities, legislation, excess deaths and storage, and readiness, dated 20/02/2020. [↑](#footnote-ref-17)