FROM: NR

DATE: **26 February 2020**

TO: **1. Dr Michael McBride (cleared by Dr Chada 26/2/20)**
2. Minister Swann

BRIEFING FOR COBR MINISTERIAL MEETING ON 26 FEBRUARY 2020 - 2019 COVID-19

ISSUE:	Briefing for Ministerial COBR meeting - COVID-19
TIMING:	Wednesday 26 February – 15:00
PRESENTATIONAL ISSUES	Media interest in this issue remains high. Press Office is working closely with PHA on an agreed comms approach and media handling. Press Office will continue to monitor the situation closely. Cleared by Press Office 25/02/20 PC
FOI IMPLICATIONS	Fully disclosable
FINANCIAL IMPLICATIONS	Potential implications in terms of planning & preparation including: equipment costs, consumables and remedial capital works, training/overtime. By way of indication, the Department bid for £55m in 2009 to meet additional expected costs emerging from H1N1 (Swine Flu) in 2009/10. A similar cost (revenue and capital) in responding to Covid-19 may arise in the reasonable worst case scenario during the mitigation phase.
LEGISLATION IMPLICATIONS	None.
EQUALITY/HUMAN RIGHTS/RURAL NEEDS IMPLICATIONS	None.

RECOMMENDATION:	You are invited to note the briefing including speaking notes and lines to take (**Tab A**), the agenda (**Tab B**), managing the deceased in the UK paper **(Tab C)** and SAGE return to CCS on risk of public disorder paper **(Tab D)**

Introduction

1. The Ministerial COBR meeting will discuss the outbreak of COVID-19 on Wednesday 26 February at 15.00. **You will be accompanied by the Deputy Chief Medical Officer, Dr Naresh Chada and Doreen McClintock from Department Of Justice**.

Situation update

2. As of 25 February at 12:30, DHSC has reported 80,250 confirmed cases of Covid-19 worldwide. 77,658 of these are in China. There have been 2,700 deaths to date. 2,663 of these were in China. A total of 37 fatalities have occurred outside of Mainland China (Iran (Islamic Republic of) (12), Republic of Korea (10), Italy (6), cases on Diamond Princess Cruise ship (3), Hong Kong SAR (2), Japan (1), Taiwan (1), France (1), Philippines (1)

3. Based on the advice of the UK CMOs the risk to the UK currently stands at moderate. This allows Governments to plan for all eventualities.

4. Based on the scientific advice of SAGE the UK Chief Medical Officers have extended the travel advice to include Iran, parts of northern Italy and several other areas. A CMO letter advising the HSC system of the details was issued on the 25 February.

5. Across the UK, public health professionals are carrying out enhanced monitoring of direct flights from these areas. Passengers will be told how to report any symptoms they develop during the flight, at the time of arrival, or after leaving the airport.

6. These areas have been identified because of the volume of air travel from affected areas, understanding of other travel routes and number of reported cases. This list will be kept under review.

7. There has been a lot of media interest regarding school parties that have returned from ski trips in Italy. Guidance to schools was issued on the 17 February and this will now be updated to reflect the latest advice.

8. The latest scientific modelling forecasts indicate that a peak is likely to occur in China in March, and in the UK as early as April.

9. In the UK, as of 25 February, thirteen people have tested positive for COVID-19, all of which have been in England. All the patients were transferred to specialist NHS centres (eight have since been discharged as of 25 Feb), and robust infection control measures are being used to prevent any possible further spread of the virus.

10. It is understood that in the most recent cases, the virus was passed on in the Diamond Princess cruise ship and the patients were transferred from Arrowe Park to HCIDs.

11. From 10 February, 12 centres across the UK are now capable of carrying out tests for COVID-19. This includes a facility in Belfast at the Regional Virology Lab (RVL).

12. In Northern Ireland, as of 25 February, 50 tests have been carried out which were negative. PHA now releases an update every Wednesday on the number of tests completed in NI.

Patient transfer to a high consequence infectious diseases (HCID) unit

13. The current protocol for a first case in each UK country is to transfer to a HICD unit in England. The HSCB is currently working with Woodgate, the air ambulance charity, and with NIAS to consider what options would be available prior to engaging MoD. HSCB has also discussed the possibility of transfer to Dublin, however this does not currently look like a viable option owing to lack of suitable resources there.

14. While patient transfer is awaited, any confirmed case, i.e. presumptive diagnosis based on Belfast RVL test result, the patient will be admitted to the

Regional Infectious Disease Unit, ward 7A Belfast RVH if 16 years and over or RBHSC if the patient is under age 16.

Reasonable Worst Case Scenario planning

15. Cabinet Office is currently working to the 2019 National Security Risk Assessment pandemic flu planning assumption as the Reasonable Worst Case Scenario (RWCS).

16. This assumes that the first wave of the pandemic will last approximately 15 weeks with over 50% of the population falling ill and up to 20% off work during the peak weeks. This would lead to a huge surge in demand for health and social care services which would have a knock-on impact on current provision.

17. Besides very severe levels of stress on HSC, the level of excess deaths would stretch capacity in organisations involved in the management of deaths. In NI, DoJ, in partnership with other government departments, local councils and funeral directors, is responsible for managing excess deaths. DoJ is currently developing an Excess Deaths Framework and exploring body storage options.

18. TEO convened a multi-agency meeting through the Civil Contingencies Group to assess sector resilience on 20 February. Officials from DoH and PHA were in attendance.

The Health Protection (Coronavirus) Regulations 2020 and Coronavirus Bill

19. DHSC announced The Health Protection (Coronavirus) Regulations 2020 on 10 February. The Regulations are designed to provide a range of measures to prevent the further transmission of COVID-19, including powers to detain an individual on public health grounds for the purposes of isolation and screening. These powers will apply to England only.

20. The primary public health legislation in NI is the Public Health Act (Northern Ireland) 1967 LPP LPP Equivalent primary legislation would not be taken through the Assembly in as quick a time as using the UK-

wide Coronavirus Bill, even if the accelerated passage procedure were to be invoked. Therefore the draft Coronavirus Bill will be the most suitable vehicle for creating powers in primary legislation for the NI Assembly to make emergency regulations equivalent to the Regulations for England.

21. Officials are working with colleagues in the NI Office of the Legislative Counsel to develop clauses pertaining to the above requirement to be included in the draft Coronavirus Bill. This work is well advanced.

22. Working closely with the Cabinet Office, policy leads in DoH have assessed existing legislation against the proposed UK-wide draft Coronavirus Bill and have drafted five additional NI clauses where existing additional legislative powers or flexibilities are required to ensure NI preparedness in the event of a pandemic.

23. You gained Executive agreement to consent to Westminster legislating on our behalf by way of the Coronavirus Bill at the Executive meeting on 17 February.

24. In addition to measures previously agreed for the Coronavirus Bill, Whitehall Departments have now identified a number of areas where they do not believe they have the necessary statutory or common law powers to respond to fully respond to a COVID-19 outbreak.

25. The list of areas where further legislation might be needed has been developed on a UK-wide basis. The needs identified vary between the different jurisdictions of the UK (reflecting the different legal landscapes). Officials in the relevant NI Executive Departments are currently reviewing these areas for any impact on NI and if further Clauses are required for drafting for NI.

26. The Bill will be brought forward on a time-limited basis. The powers being sought are proportionate to the challenges we will face in responding to a severe pandemic and will only be enacted for the duration of any pandemic after which the legislation would be withdrawn by way of a 'sunset' clause. The exception to this may be the emergency public health powers, including regulation-making powers for isolation. We have asked Cabinet Office to consider not applying a sunset clause to these provisions as these powers are

currently not available under any other NI legislation but are available to the other UK countries.

27. You will return to COBR (M) at the beginning of March for final agreement on the full content of the Bill and to agree whether to introduce the Bill and provisions, based on the latest scientific advice.

28. As regards cross-border differences, in RoI the equivalent legislation for holding patients in isolation is the Irish Health Act 1947 – S38. It makes provision for detention, but only for named infectious diseases (equivalent of a notifiable disease). RoI added COVID-19 to its statutory list of infectious diseases on 20th February and Scotland did the same on 22nd February. We have considered the public health merits of adding COVID-19 to the list of notifiable diseases under the Public Health Act (NI) 1967 and you approved a recommendation to take this forward as soon as is reasonably practicable on 25 February. The Health Committee are to consider an SL1 proposing the making of an Order to add COVID-19 to the Schedule of Notifiable Diseases on 27 February. If the Committee approves the making of the Order, COVID-19 could become notifiable as early as Saturday 29 February.

Excess deaths

29. The DoJ has responsibility for developing a detailed operational/activation plan to help manage the impact of an excess deaths scenario in NI. The operational plan will focus on NI's capability in respect of burials/cremations, mortuary capacity, and body storage. We have been liaising with Cabinet Office on this issue and our colleagues in the Devolved Administrations (DA's) regarding developing an approach that is consistent with the rest of the UK. The recent outbreak of the Coronavirus has resulted in a renewed focus across the UK in terms of planning for the impact of a pandemic.

30. The reasonable worst case scenario outlined in the current National Risk Assessment (for pandemic influenza) indicates that up to 50% of the population may experience symptoms resulting in a mortality rate of 1.25% of the UK

population over a 15-week period with potentially half of fatalities falling over a 3-week peak. We are therefore planning on the basis of 6,000 – 9000 deaths in NI.

31. In England, Scotland and Wales there is approximately a ratio of 70% cremations compared to burials. However in NI the situation is reversed as there is only one crematorium, which is already working at full capacity.

32. We have been working on the basis of a body storage facility with refrigerated / freezer capacity. Cabinet Office guidance up to this point has been to avoid shared burials. However at a meeting on 25 February they indicated that shared burials should not now be ruled out.

Public Order

33. PSNI are well practised in dealing with public order situations in Northern Ireland. However public order issues resulting from COVID-19 has the potential to put additional strain on resources, particularly if PSNI is facing staff shortages due to personnel having contracted the virus or needing time off for caring duties.

34. In addition we will need to be mindful of the marching season and the potential for the spread of the virus when so many people are gathering in the same place. Any attempt to stop parades and prevent mass gatherings would have the potential to lead to public disorder.

Recommendation

35. You are invited to note the briefing including speaking notes and lines to take at (**Tab A)** and the draft Agenda at (**Tab B),** managing the deceased in the UK **(Tab C)** and SAGE return to CCS on risk of public disorder paper **(Tab D).**

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TAB A

SPEAKING NOTES AND LINES TO TAKE

- I remain very grateful for the advice and guidance being provided by officials in DHSC and PHE and for their ongoing support.

- To date there have been no confirmed cases in Northern Ireland.

- We now have a facility at the Regional Virology Laboratory in the Belfast Trust capable of carrying out tests for COVID-19. This is one of the 12 centres operating across the UK. To date there have been 50 tests completed in NI.

- I am aware that DHSC announced the Health Protection (Coronavirus) Regulations 2020 on 10 February. These are designed to provide a range of measures to prevent the further transmission of Covid-19, including powers to detain an individual on public health grounds for the purposes of isolation and screening. I note that these powers will apply to England only.

- My officials are working with colleagues in the NI Office of the Legislative Counsel to develop clauses to provide powers to make similar regulations to this requirement to be included in the draft Coronavirus Bill which is due to be taken through Westminster. This work is well advanced.

- Working closely with the Cabinet Office, my officials have assessed existing legislation against the proposed UK-wide draft Coronavirus Bill and have drafted five additional NI clauses where existing additional legislative powers or flexibilities are required to ensure NI preparedness in the event of a pandemic

- In addition to measures previously suggested for the Bill, Whitehall Departments have now identified a number of areas where they do not

believe they have the necessary statutory or common law powers to respond to fully respond to a COVID-19 outbreak in the UK.

- The list of areas where further legislation might be needed has been developed on a UK wide basis. The needs identified vary between the different jurisdictions of the UK and The Executive Office is working with Officials across the NI Executive Departments to establish any impact or additional requirements to the Bill for NI.

- The powers being sought are proportionate to the challenges we will face in responding to a severe pandemic and will only be enacted for the duration of any pandemic after which it would be withdrawn by way of a 'sunset' clause. The exception to this may be the emergency public health powers, including regulation-making powers for isolation, where we have asked Cabinet Office to consider not applying a sunset clause as these powers are currently not available under any other NI legislation but are available to the other UK countries.

- I will return to COBR (M) at the beginning of March for final agreement on the content of the Bill, and to agree whether to introduce the Bill and provisions at this time, based on the latest scientific advice.

- In the Republic of Ireland, the equivalent legislation for holding patients in isolation is section 38 of the Irish Health Act 1947. It makes provision for detention, but only for certain 'infectious' diseases. Ireland added COVID-19 to its statutory list of infectious disease on 20th February 2020. My officials have considered the public health merits of adding COVID-19 to the list of notifiable diseases under the Public Health Act (Northern Ireland) 1967 and I have asked that this be implemented at the first available opportunity in order to provide a degree of legislative support for our efforts to prevent further spread of the disease.

- There may be significant financial implications for dealing with COVID-19 in terms of prudent planning & preparation. By way of indication,

my Department bid for £55m in 2009 to meet additional expected costs emerging from H1N1 (Swine Flu) in 2009/10. A similar cost (revenue and capital) in responding to Covid-19 may arise in the reasonable worst case scenario during the mitigation phase.

- My Department, the Public Health Agency and the Health and Social Care Board continue to work closely with the relevant authorities and public health organisations across the UK and the Republic of Ireland to ensure Northern Ireland is well prepared to deal with the situation as events unfold.

- Internationally, and in the UK and the Republic of Ireland, we remain in the Containment phase of our response as we seek to prevent sustained community transmission. At the same time we must plan to mitigate the potential consequences for the health of the people of NI and the impact on our health services, other public services and wider society. My priority as Minister is to ensure effective measures are in place within Northern Ireland.

LINES TO TAKE

- We are still very likely to see further confirmed cases in the UK over coming days and weeks. We have agreed mechanisms for managing this situation, including early notification of any confirmed case and ensuring our general public remain appropriately informed and reassured to the actions being taken, as appropriate.

- The powers being sought in the UK-wide Coronavirus Bill are proportionate to the challenges we will face in responding to a severe coronavirus pandemic. These clauses will allow NI the additional legislative powers and flexibilities required to enable a rapid and effective response including public health legislation to contain the future spread of the novel coronavirus in Northern Ireland.

- My Department, along with the PHA, remains in regular contact with the relevant authorities across the UK and the Republic of Ireland to ensure any necessary precautions are in place in Northern Ireland in response to this situation.

- The devolved administrations are continuing to take part in daily teleconferences, 7 days a week, hosted by DHSC to ensure the whole of the UK is appropriately prepared and a consistent approach taken. DHSC are also continuing to hold meetings of officials from Communication teams of the four UK health Departments daily, to ensure a consistent approach is agreed across the nations.

Excess deaths

- We currently have body storage capacity for approximately 280 bodies, over and above the normal arrangements.
- We are actively seeking to increase that capacity and have identified a location where containers to store the bodies could be housed.
- We are working closely with a range of organisations to find the most acceptable solution.
- We are actively sourcing refrigerated / freezer containers which could be used to store the bodies.
- There are significant financial implications.
- Will funding be provided to the Devolved Administrations to provide a body storage solution?

Public Order

- There are no indications at this time that there is likely to be an upsurge in public disorder.
- PSNI have plans in place to deal with any issues that may arise.
- If needs be, resources will be diverted from other activities in the first instance.

TAB B

Covid-19 (Novel Coronavirus) - UK Preparedness
COBR (M)

1500, Wednesday 26th February 2020

PROVISIONAL AGENDA

1) Current situation update

a. Situation Report

b. Health advice for travellers and schools

c. International response

d. HMG preparedness

2) Public order

3) Communications

4) Next steps

TAB C

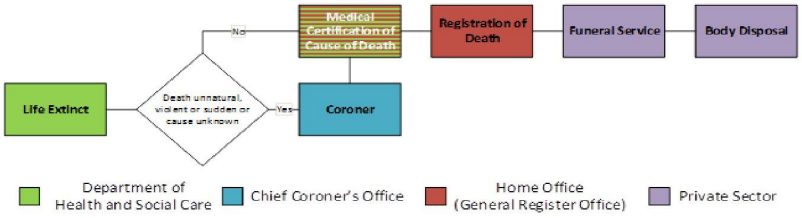
Covid19 - Managing the deceased in the UK

Purpose

This note sets out the challenge presented by the number of deaths which may result from Covid19 Reasonable Worst Case Scenario (RWCS) and outlines an emerging strategy for dealing with them in an effective and respectful manner.

Background

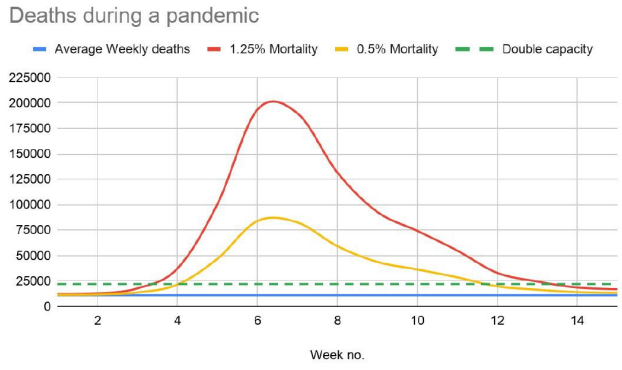
2. The capability to manage deaths is derived from local facilities, statutory processes and practical issues. This includes arrangements to certify and register deaths, the means to transport bodies, storage facilities, and the means to dispose of bodies. The capability is delivered locally by a combination of public, private and faith organisations. There is an average of around 11,800 deaths per week across the UK. The planning to significantly augment death management capacity is commonly referred to as excess deaths planning.



3. The current advice from the Scientific Advisory Group for Emergencies is that preparations to manage the deceased during a Covid19 outbreak should mirror those for the Reasonable Worst Case Scenario (RWCS) for an influenza pandemic. For managing deaths, the planning assumptions are:

- Up to 1.25% of the population dying from the pandemic (c820k) with c50% of those deaths (470k) occuring during a three-week peak. These are in addition to non-pandemic deaths during the same period; and
- Up to 50% of workers are unable to work for up to two weeks during the 15 week period of the pandemic. With up to 20% off at any one time the peak(s) of the pandemic.

4. Following the experience of Swine Flu in 2009, ministers agreed in 2011 that local responders should plan for managing a local additional mortality rate up to 0.5% (of the local population). This approach was based on the premise that, at the point at which modelling of a pandemic suggests the number of



excess deaths look likely to exceed this range, central government would look to deploy measures to augment or enhance local capability. Against the RWCS, from the point of community transmission within the UK (which could happen in the few weeks), there are potentially then only five weeks before deaths are approaching 100,000 per week (mid-April onwards).

Local capacity to manage deceased

5. Measuring overall local capacity to manage excess deaths is notoriously difficult and what data there is, is incomplete for many areas. An initial review of selected LRF excess deaths plans by the Ministry for Housing, Communities and Local Govt suggests that, while most have plans, they will struggle to do more than double local capacity (ie. up to c23,000 deaths per week) in the face of business continuity challenges associated with a pandemic. This will take time to put in place as, while there may be basic plans on paper, the necessary capabilities or revised processes do not generally exist on the ground. To field meaningful capabilities will depend on both access to funding (eg. to secure extra storage capacity) and legislative easements to increase throughput (from the point of death through to final disposition) and address concerns over competition law in a sector where the private sector plays a significant part and is under close scrutiny by the Competition and Markets Authority. All of this will take time to put in place given the range of stakeholders involved across the public, private and faith communities. Inevitably, there will be wide variations in practice and knowledge and given the challenges and sensitivities in this space, local planners are looking to central government for direction.

Updated Excess Death planning guidance for England

6. Existing (2013) guidance for local planners on managing excess deaths has been updated recently to reflect legislative and organisational changes and clarify the options planners may wish to consider. This work was started before Covid19 outbreak and there is demand from local planners for it to be issued. The intention is to issue this in a low key way to local stakeholders via a closed extranet (Resilience Direct) as soon as final comments are in from relevant experts (later this week or early next).

7. There would be no proactive public communication, although defensive lines - focusing on prudent contingency planning against a reasonable worst case and not a forecast - would be available if needed. The MHCLG would handle any initial media queries with individual departments picking up on specific points within their areas of responsibility (eg. Ministry of Justice for coroners, Home Office death registration, Dept of Health and Social Care for death certification).

Decision - Are ministers content for the updated guidance to issue to local planners?

Central response measures

8. Departments have identified a range of easements to increase local excess deaths capacity. These include the relaxation of regulated processes such as death

certification and aspects of the coronial system, as well as guidance to alter non-statutory procedures. A number of these will be included in the Covid19 Bill. These will help local responders make more effective use of resources and alleviate some bottlenecks in the death management process. However, these alone, are not expected to enable areas to meet the requirements of a 0.5% mortality rate as there are crucial pinch points around the ability to conduct funeral services and the limited number of faith and non-faith leaders to undertake these roles, often alongside their many other duties, as well as time slots for church and crematoria services (traditionally these are weekdays between 10 and 4pm).

Body storage

9. Body storage has the potential to ease some of the pressure but can not solve the problem. Health and Safety Executive guidance states that bodies should be frozen if stored for longer than four weeks as they start to breakdown requiring specialist treatment and handling. As a rough calculation, a four week maximum stay requirement would cap refrigerated storage at around 50,000 bodies (in addition to the normal background level). Initial work by Crown Commercial Services has identified some modular units that could be deployed alongside existing mortuaries where space permits, and which would meet some (c16,000 bodies) of this need - the balance would need to be accommodated in existing refrigerated storage units. Extra storage beyond this number would require frozen storage capacity, which is very limited within the UK and mostly located within larger refrigerated storage facilities. Lead times are likely to mean some contracts will need to be placed in the next few weeks if capacity is to be ready in time.

10. While it might be possible to meet the requirement under the lower (0.5% mortality rate) planning assumption in this way, it appears impractical to go beyond this unless the curve is flattened and lengthed significantly.

Other options to cope with mortality rates beyond 0.5%

11. Work to date suggests that the only practical way to address the large numbers envisaged over a short period in the upper range of the planning assumption, would be to drastically reshape the body disposal process in those areas under greatest pressure. This may disproportionately affect cities and those areas with the largest proportion of elderly people (eg. coastal towns).

Next Steps

12. A dedicated excess deaths workstream has been established led by the Cabinet Office to develop proposals to maximise the use of local capability and make provision for the shortfall centrally, whilst treating the bereaved with care and compassion and upholding their wishes for the deceased as far as is possible. A three pronged pan-UK approach approach is being adopted:

1) drive and support local planners to augment their capacity to manage 0.5% mortality;

2) develop options for auxiliary body storage and transport through national procurement of mobile and fixed capacity to augment local efforts; and
3) explore other body disposal options.

13. To achieve this separate working groups will focus:

I. on ensuring there are measures in place to manage deaths in the community (from confirmation of life extinct through to body storage);
II. Establish commercial options for body storage;
III. Explore other options for body disposal.

In parallel, advice is being sought from SAGE on refining the planning assumptions as our understanding of the virus grows, and from and faith groups to inform our thinking.

Civil Contingencies Secretariat

25 February 2020

TAB D

SAGE return to CCS on risk of public disorder paper

250220 SPI-B HO return on public dis