Witness Name:	Eddie Lynch
Statement No:	1 (for Module 3)
Exhibits:	EL/1 - EL/18
Dated:	27th March 2024

UK COVID-19 INQUIRY

WITNESS 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, will say as follows:

INTRODUCTION

1. I received correspondence dated 24 February 2023 on behalf of Baroness Heather Hallett, the Chair of the UK Covid-19 Inquiry ("Inquiry") seeking a witness statement ("Statement") and the disclosure of documents pursuant to Rule 9 of the Inquiry Rules 2006 for Module 3 ("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 3' and the Inquiry's 'Note for the Preliminary Hearing in Module 3 of the UK Covid-19 Inquiry', that Module 3 will consider, and make recommendations about, the healthcare consequences of how the governments and the public responded to the pandemic between 1 March 2020 and 28 June 2022. The significance of these dates ("the Relevant Period") for Northern Ireland is that they cover a largely settled constitutional period. The Northern Ireland Assembly had resumed on 11 January 2020 following its suspension on 9 January 2017 and remained in place until it met on 13 and 30 May 2022, after the elections, and it became clear it could not continue its business as a Speaker could not be elected. During that two-year period of 2020 to 2022 when the Assembly was able to conduct business, domestic Covid-19 restrictions were both imposed and lifted in Northern Ireland.

3. This Statement, including the documents exhibited to it, relates solely to the work being undertaken in Module 3. It constitutes my response to the matters to be addressed as set

out at Annex B and Annex C of the Rule 9 Request. I have also provided a statement and documents pursuant to a Rule 9 Request for Module 2C dated 11 November 2022. However, I have not assumed that the Inquiry team working on Module 3 has seen and considered my Module 2C statement and its associated documents, so I have included some matters and documents from it that I consider may be relevant to the issues in Module 3.

4. In providing this Statement, I bear in mind particularly that the initial lockdown for Northern Ireland was from 23 March 2020, that there were subsequent restrictions in the community, that care homes exercised the authority granted to them to act independently in making individual decisions on isolation, and that the World Health Organisation ("WHO") did not end its declaration of Covid-19 as a global health emergency until 5 May 2023.

5. This Statement is provided under four main section headings:
   I. Office of the Commissioner for Older People;
   II. Interaction with Government;
   III. Impact of the Covid-19 pandemic; and
   IV. Lessons Learned.

6. 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 or other website, through a link in a referenced appendix at the end of the Statement. Others are provided as exhibits to this Statement and included in an electronic file. 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

7. Age sector organisations, such as AgeNI and Age Sector Platform, campaigned for some time to have an Older People's Commissioner for Northern Ireland. Their vision was to

have an independent, adequately resourced voice who could protect the rights and interests of older people.[1]

8. The Northern Ireland Executive committed itself in its 2007 Programme for Government ("PfG") to providing a 'strong independent voice' for older people. 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] I regard this as an important context in which to consider my role and that of my office during the Relevant Period and the response of government.

a. Nature of the Office

9. The office of Commissioner is a statutory role, at arms-length from 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, is 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.

10. 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 four-year term, which started on 13 June 2020.

11. 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 as 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. This is a charity representing the interests of older people in Northern Ireland, supporting them to make their voice heard, and a

convener of the Northern Ireland Pensioners Parliament. I can only assume that when I was appointed it was because 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].

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

b. Statutory Functions and Responsibilities

13. 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

14. Almost all those duties were engaged during the Relevant 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. During the Relevant Period 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.

15. 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.

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

c. Size and Nature of the Sector

17. Older people are disproportionately highly represented in some of the areas to be investigated in Module 3, such as the clinically vulnerable, those having to isolate, those on NHS waiting lists for non-Covid-19 conditions, and those experiencing pandemic related long-term physical or mental health conditions. Taking waiting lists as an example, by 31 March 2021 a total of 114,950 were waiting for inpatient and day case admissions, whilst 347,518 were waiting for a first consultant led appointment. Those aged 60 years and older constituted 40.5 per cent and 34 per cent respectively of those totals. The figures for those aged 50 years and over were 58 per cent and 51 per cent respectively[5].

18. 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 was necessary to rely on section 25 of the Act to widen the scope of my powers to apply to people aged 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 of treatment for Covid-19 as priority is given to those under 50. I have in the past represented the over 50s in situations where they have been resident in nursing homes. In one case we successfully advocated for the withdrawal of an eviction notice for someone in their 50s. In another case we were asked to advocate on behalf of a patient in their 50s in relation to the provision of physiotherapy and other therapeutic interventions. These are all individual decisions and highly fact specific and similar scenarios were not brought to my attention during the Relevant Period.

19. Using the primary definition provided by the Act, as of March 2021 Northern Ireland had an over-60s older population of approximately 439,600[6]. 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 constituting some 31.5 per cent of the total population. 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 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. It is likely to be an important factor in planning the response for any future pandemic. The current size of this older population, and its characteristics, should have been an important factor in responding to the Covid-19 pandemic.

20. It is also important to factor in the families of older people. They too can require assistance and support. In any event, they are an important part of the information network established by my office ("COPNI") 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.

21. Older people are present in each of the five Northern Ireland Health and Social Care Trusts (Belfast, Northern, South Eastern, Southern, and Western), across a variety of settings: in their own homes; in residential care homes and nursing homes; in hospices; hospitals; and in prisons. The statistics for older people in these settings do not perfectly

align with the Relevant Period, nor are they necessarily consistent with each other. Nonetheless, the statistics that are available indicate 'orders of magnitude' and show older people are a significant demographic in a variety of settings: their own homes or in the homes of relatives; residential and nursing home care homes; hospital; and prison. The issue of better statistical data is an important 'learning point' from the pandemic, which disclosed the extent to which the authorities did not have accurate information on the numbers of potentially vulnerable categories of people, where they were and their circumstances. It is difficult to plan for a pandemic without up-to-date reliable information on the groups likely to be affected. This is particularly so where, as in the case of older people, they engage more than one sector, i.e., health and social care, housing, and criminal justice.

22. The Northern Ireland Statistics and Research Agency ("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]. During 2020, on average, 21,491 older people in Northern Ireland received domiciliary care to support them to live independently or with their relatives.

23. The number of older people living on their own and the loneliness and isolation some of them experience, was exacerbated by the pandemic, in particular 'lockdown'. It is difficult to obtain reliable figures for this. However, NISRA produced a useful study entitled *Loneliness in Northern Ireland 2019/20.* While 'loneliness' does not directly correlate to social disconnectedness, it is a convenient indicator of levels of social connectivity. This study 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 case of the older population it often limits their opportunities for social interaction. *The Poverty Bulletin: Northern Ireland 2019/20* produced by NISRA states that '18 per cent of pensioners were in relative poverty' and '14 per cent of pensioners were in absolute poverty'[2] .

24. '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]

25. 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 to enable discharge when they are deemed medically fit. In my experience stays in these 'institutional settings', particularly where they are prolonged due to a lack of appropriate placements or support, exacerbates any sense of disempowerment, and sometimes creates it where it was not previously present.

26. As of 30 June 2021, Northern Ireland has some 473 residential care homes[7] catering for the older population through about 11,400 care packages[8], 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 Health and Social Care Trusts ("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"). I have exhibited a sample regional contract at **[EL/1a, INQ000472350].**

27. In principle HSCTs and care home providers work collaboratively to assess the resident seeking placement and the extent of their specific needs. The placements are driven by demand and supply. No data is gathered or published in relation to their reasons for declining a placement. It is well-known and accepted that there has long been a 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.

28. As for the hospital admissions of older people, 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[9]. These showed that the 65+ age group had the largest proportion of the 2010 total hospital admissions (34.6 per cent) and that was replicated in each of the five HSCTs. Furthermore, 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[10]. Specifically, as regards Covid-19 admissions, for the 2020 to 2023 period, a total of 27,580 were admitted to hospital in Northern Ireland of which 19,203 were older people. If those aged 50 to 59 years are added, then that figure rises to 22,335[11].

29. The direct commissioning relationship between HSCTs and individual care providers came under severe strain during the pandemic, due to the combined effect of high numbers of older people in hospital, a lack of suitable discharge placements and the urgent need for hospital beds. 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 in particular the following two documents that are exhibited at **[EL/4, INQ000417091]**. The *Health and Social Care (NI) Summary Covid-19 Plan for the period mid-March to mid-April 2020* states in relation to 'Discharge Planning for Patients in hospital': "*In the weeks ahead it will be more important than ever for Trusts to implement effective discharge arrangements for patients as soon as they were well enough to leave hospital in order to release beds for newly admitted patients…Trusts will work to maximise and utilise all spare capacity in residential, nursing, and domiciliary home care.*" Whilst the letter on *Covid-19: Preparations for Surge* dated March 2020 states: *"The*

availability of our most valuable resources needed to counter COVID-19 – beds, our staff and equipment – will all come under increasing pressure."

30. 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 personal protective equipment ("PPE") in care homes. The surge plans did not explicitly take account of the predictable outcome of discharging patients not tested for Covid-19 into enclosed and locked down care homes.

31. In those circumstances some care home providers felt that the position they were put in by the HSCT's requirements meant that they nonetheless had to take in new residents discharged from hospital or risk a loss of future business. Considering around 98 per cent of care in Northern Ireland is delivered in the private sector, for some care home providers these placements from the Trusts constitutes their primary source of occupants and income. They feared that refusing patients being discharged from hospitals could lead to repercussions from the Trusts in terms of their future occupancy rates. Their business model is reliant on the homes being at or close to full capacity. These fears came to my attention in conversations with Pauline Shepherd Chief Executive of IHCP. Additionally, three care home owners raised with me directly their concerns about this coercive attitude and the risks they felt it held for the safety of their residents, in the sense that new admissions from hospital without adequate prior testing compromised their ability to minimise the risk of outbreaks and control the spread of infection within their homes.

32. Finally, in 2020-2021 the average total Northern Ireland prison population[12], excluding those on remand, was approximately 1,640, of which those aged 60 years and older accounted 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 also been growing significantly.

33. 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 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"*[13]. This 'huge impact' was not confined to the

first wave. The most recent figures for deaths from Covid-19 show that for the period 19 March 2020 to 3 March 2023 some 89 per cent of all Covid-19 deaths were aged 65 years and older. Obviously, that statistic is even higher if the age band taken is those over 60 years or those over 50 years[14].

d. The Team

34. I could not properly discharge my statutory obligations and duties without the COPNI 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.

35. In addition to my office of Commissioner and that of 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 main purpose and functions of these positions is set out in their respective job descriptions exhibited at **[EL/5, INQ000417092]**.

36. Nevertheless, it is worth highlighting some aspects of their respective roles in relation to Module 3. So, for example, the Chief Executive is tasked with 'Developing and managing programmes, and projects to achieve the Commission's objectives.' Both the Head 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 'Identifying, initiating, and developing 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 Relevant Period.

37. 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 combined experience of the COPNI team, including my own professional experience prior to becoming Commissioner, allowed us to address decision-makers with acknowledged authority.

38. COPNI's reputation for an authoritative voice on issues concerning older people was established through its commissioned research and reports long before the announcement by WHO on 11 March 2020 that it was characterising Covid-19 as a 'pandemic'[15]. I refer particularly to the reports exhibited at **[EL/6, INQ000417093]**, which 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*[16].

39. 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*[17] and the 2017 Kelly & Kennedy report *Power to People: Proposals to Reboot Adult Care & Support in NI*[18]. 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.

40. Similarly in 2018, again prior to the Relevant 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. The DOH was a 'relevant authority' for that investigation and was therefore aware of the evidence obtained and the

recommendations made. I published a follow-up report in 2019, *The Commissioner's view: A summary of the responses to Home Truths*[19].

41. 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 some of the matters it should consider in formulating its response to the pandemic. I was also able to highlight at the outset, from an informed position, the detrimental impact that elements of the government's response might have on that section of the older population who were in care homes.

42. 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 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 Relevant 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

43. In my role as Commissioner, I represent the interests of potentially over 600,000[20] 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 those constituents confined to prison[21] establishments. Statistics and lived experience would suggest that my constituents are uniquely vulnerable to experiencing long term physical or mental health conditions[22], loneliness[23] and to feel more significantly the physical and mental impacts of being required to shield[24].

44. To properly represent those interests and carry out my role effectively, I have established trusted lines of communication with: HSCTs; senior personnel in the 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.

45. In addition, and most importantly, my office engages on an almost daily basis with older people and their families. 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 Relevant Period, COPNI received complaints and requests for assistance from over 400 individuals and families about pandemic related issues.

46. 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 the COPNI 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 the first '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.

47. The Corporate Plan that was in force at the start of the Relevant 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, INQ000417094]. During that four-year period, I aimed to promote awareness of the many contributions older people make in Northern Ireland and 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 Relevant Period are exhibited at **[EL/8, INQ000417095]**.

48. 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 had borne the brunt of the impact of the pandemic[25]. 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 experiences of the impact 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 with increased protection against discrimination on the ground of age.

49. When necessary, I proactively target certain groups and bodies to ensure I receive and 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.

50. 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 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.

51. I also obtain important information from informal discussions with key stakeholders like AgeNI, the leading charity for older people, and the Independent Health and Care Providers ("IHRC") group, which represents about 50 per cent of the care home providers.

52. In addition, during the pandemic, I participated in weekly 'Four Nations meetings' that were established by the Older People's Commissioner for Wales. They took place every Friday and involved the Chief Executives of AgeUK ; 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 on our experiences and explore ideas.

53. However, we did release 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 ("Joint Statements"). There were at least three of these Joint Statements: *The rights of older people in the UK to treatment during this pandemic* dated 30 March 2020; *Protecting the rights of older people: Commissioner's joint statement on older people being pressurised to sign Do Not Attempt CPR forms* dated 6 April 2020; and *Relentless focus on protecting older people's rights needed as we deal with the next phase of the pandemic* dated 23 November 2020. These three Joint Statements are exhibited at [**EL/9, INQ000417337**] The types of issues that we had in common are exemplified in the following extracts from these Joint Statements:

    (i) *The media are reporting that governments across the world are developing ethical guidelines and decision tools to help their doctors to prioritise patients for hospital admission and treatment. The difficult work is designed to ensure that the*

incredibly tough decisions about who gets treatment at this time of crisis are made as fairly and effectively as possible by their doctors.

(ii) *As organisations and individuals dedicated to supporting older people and protecting their rights, we are joining together to say that if and when our own governments across the UK do similar work it is vital that they all continue to uphold fundamental human rights principles.*

(iii) *Any suggestion that treatment decisions can be blanket ones, based on age alone or with a person's age given undue weight as against other factors, such as their usual state of health and capacity to benefit from treatment, would be completely unacceptable…*

(iv) *In addition, the fact that someone is in need of care and support, in a care home or their own home, should not be used as a proxy for their health status, nor blanket policies applied – for example, over whether they should be admitted to hospital.*

(v) *We are seeing shocking examples where blanket decisions seem to be being made about the care and treatment options that will be available to older and vulnerable people, who have felt pressurised into signing Do Not Attempt CPR forms.*

(vi) *Whether or not to sign a DNA-CPR form is an individual's decision, and they have a right to make that decision without feeling pressurised…*

54. In my view it is the engagement programme, and the wider network COPNI has developed, 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 people.

II. INTERACTION WITH GOVERNMENT IN RELATION TO THE PANDEMIC

55. 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 centred on not only protecting older people as much as possible from contracting the virus but also working with many authorities to

support and keep safe the hundreds and thousands of older people who had to immediately shield.

a. Communicating with Government

56. Throughout the pandemic I had direct engagement on Covid-19 issues either personally or through the key members 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, Regulation and Quality Improvement Authority ("RQIA"), Public Health Authority ("PHA"), and the Patient and Client Council ("PCC"). 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/10, INQ000417335]** 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.

57. 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.

58. My meetings with Ministers and politicians were often carried out over the telephone or remotely by platforms such as 'zoom' in reaction to issues that 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. This will undoubtedly be a matter of learning for the future, as such 'unstructured and ad hoc communications' are not an ideal method of policy development or decision making. The subject of discussion invariably centred 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.

59. In addition to those telephone and remote meetings, I also had the usual communications through email, or letter. I did not participate in informal communication by text or WhatsApp message. Any emails from the Relevant 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.

b. Raising Issues with the authorities

Issues and summary explanation

60. I have been asked by the Inquiry to identify the specific issues I raised with the DOH, the Chief Medical Officer and the PHA that I believed would improve the response of healthcare systems to older people during the Covid-19 pandemic and the response received. Given the nature of some of my communications with those public authorities, it is not possible to now list every such issue that I raised with them. Also due to the pressures and urgency of the time, if I raised an issue, it was invariably because I did think it would improve the response of healthcare systems to older people during the Covid-19 pandemic.

61. More specifically, the motivation for the issues I raised was three-fold, to address the immediate impact on older people of the pandemic and government's response; to assist in improving policies and procedures for the medium term in the recognition that there may be subsequent waves of Covid-19; and to ensure that appropriate data and information was recorded by government to feed into the learning so as to ensure we are better prepared should there be another pandemic. The main specific issues I raised over the Relevant Period were:

i. The impact of lockdown on the older population and adverse impact on Human Rights, influencing public health policies such as the 'Care Partner Scheme' and 'Visiting with Care – A Pathway'[26]
ii. Lack of sufficient PPE in care homes[27];
iii. Regular testing and vaccination of residents and care home staff[28];
iv. Roll out of vaccination programmes for older people[29];

v. Deaths in care homes caused by the discharge of hospital patients to care homes[30];
vi. Ageist decisions taken by medical professionals regarding admission to hospital and the entitlement to ventilators[31];
vii. Impact of the discriminatory and ageist practice of 'Do not resuscitate forms' on older patients without consulting the patient or their families[32], together with the disproportionately high impact on older people requiring treatment unrelated to Covid-19[33];
viii. Failure to adequately record and disaggregate care home deaths and the need for it[34];
ix. Disproportionate number of deaths in care home settings compared to the community, particularly when compared to other areas of UK[35];
x. Importance of wearing face coverings to help protect the elderly following the loosening of lockdown restrictions[36];
xi. Ceasing of care home inspections[37].

62. Lockdown, which was the most dramatic response of the government, necessarily created a closed environment for older people in institutions as well as those in their homes. The significance is that it required a high-level of control over who entered the institution to prevent the almost free circulation of Covid-19 amongst such a vulnerable population. This was also the case with older people living in their own homes, particularly those who were shielding for health reasons but who relied on the external assistance of care workers and were therefore vulnerable to the transmission of Covid-19 by domiciliary carers. All this raised issues concerning:

i. Discharge from hospital of older people back to their care homes and new admissions to care homes of those who, often for Covid-19 related reasons, could no longer manage in their own home;
ii. Provision of adequate PPE to staff and residents;
iii. Regular testing and vaccination of residents and care workers, especially agency and domiciliary care workers who were also operating in the community or working in other care homes;
iv. Implementation of an effective mechanism of oversight and inspection;

v. Roll out of a vaccination programme for all older people given the high likelihood of them having to be transferred to a care home or admitted to hospital.

63. There were similar issues for nursing homes, hospices, and prisons, all which also had significant populations of older people.

64. The pressures on the scarce resources of hospital beds, equipment, and staff to cope with the care of those who contracted Covid-19, created a series of issues for older people. Firstly, there was an obvious potential to discriminate against them in accessing those resources, especially where it might be considered that sheer age, frailty, or co-morbidities could reduce their chances of a good outcome. In my view there was also an indirect discriminatory effect. The extent to which those scarce resources were devoted to coping with the pandemic, along with the recognition that in many instances hospitals were becoming hot spots of poorly controlled transmission, necessarily delayed the admission for treatment of conditions that were unrelated to Covid-19 in which older people were often disproportionately represented.

65. Finally, information concerning death rates became a highly charged issue that was playing out in public, particularly during those first few weeks of the relevant period, when I was advocating for a break down in the percentages to ascertain how many deaths were occurring in care homes. I believe the DOH did not deem this to be sufficiently important at that time as there was an initial resistance to my questions around the data. Additionally, this became a highly charged issue for family members of those in care homes, as it had the potential to highlight the inadequacies in the government's response and the extent to which some of the most vulnerable in society were paying the highest price for the government's failures. Yet it was precisely for that reason, as well as the contribution to improved planning during the pandemic and for the future, that the collection of relevant statistical data was required. The impact of this topic becoming so highly charged was that an issue of public mistrust arose that necessitated the publication and proper explanation of the data.

66. I have set out later in this Statement a more detailed justification for raising some of the issues, together with the relevant context or evidence, and the improvement I hoped

would result. In addition to that evidence, the important feedback I received from my engagement programme, discussions with key stakeholders, the Four Nations meetings and material from COPNI's own research, all contributed to the issues I raised with government.

67. I am conscious that I have also been asked to address the response I received to raising these issues. I have done that in a separate section, and some of the justification may be addressed in that section where if it is easier to do so.

Hospital admissions and discharge

68. The NICE guidelines of 20 March 2020, *Covid-19 rapid guideline: critical care in adults*[38], provide at paragraph 2.2. in relation to 'Admission to critical care':

> *Involve critical care teams in discussions about admission to critical care for a patient where:*
>
> - *the assessment suggests the person is less frail (for example, a CFS score of less than 5), they are likely to benefit from critical care organ support and they want critical care treatment or*
> - *the assessment suggests the person is more frail (for example, a CFS score of 5 or more), there is uncertainty regarding the likely benefit of critical care organ support, and critical care advice is needed to help the decision about treatment.*
>
> *Take into account the impact of underlying pathologies, comorbidities and severity of acute illness on the likelihood of critical care treatment achieving the desired outcome. [Amended 25 March 2020]*

69. The significance of *"likely to benefit"* is reinforced by section 4 on 'Clinical decision making', especially by 4.2 that cautions: *"Base decisions on admission of individual adults to critical care on the likelihood of their recovery, taking into account the likelihood that a person will recover from their critical care admission to an outcome that is acceptable to them."*

70. Whilst the likelihood of benefiting from critical care has always been a factor for the admission of anyone to the Intensive Care Unit ("ICU"), it is not difficult to understand the concern that this could be used to deny older people, thought to be suffering from Covid-19, access to such care simply because of their age or frailty. It is also not difficult to understand the fear that the reference in the guidance to "*and they want critical care treatment"* could lead to pressure on or encouragement to older people to sign forms stipulating 'do not resuscitate' ("DNR"), which would avoid the issue of a transfer to ICU altogether.

71. The guidance published by the DOH on 26 April 2020, *Guidance for Nursing and Residential Care Homes in Northern Ireland*[39], makes clear the intention that:

> *Trusts must continue to collaborate with all care home providers throughout the period of the COVID-19 pandemic. The Health and Social Care Board has sought approval to free up Trust resources in a number of areas to enable them to rapidly respond to, focus on and prioritise the needs and staff requirements associated with the impact of COVID-19.* (§2)
>
> *As part of the response to COVID-19, the care home sector will play a vital role in accepting those being discharged from hospital – to aid recuperation in non-acute settings, and to enable hospitals to have sufficient beds to treat those who are acutely ill.* (§25)

72. This guidance indicates the financial support that is to be provided to care homes, which may itself have affected the ability of care homes to refuse to accept transfers from hospital even when they did not necessarily consider it in the best interests of the existing residents or the person to be transferred:

> *Where, as a result of the COVID-19 outbreak a nursing or residential care home's income reduces by greater than 20% below the past 3 months' average then Trusts should block purchase 80% of the vacated beds at the regional tariff. The Trust should then fill these beds as required over the next three months, taking account of the factors set out in this guidance and provided it is clinically safe to do so.* (§12)

73. The most illuminating provisions are to be found in the section, 'Discharges from a hospital setting' at §§26-29, see in particular:

> 26. *Ideally, patients who are COVID positive or symptomatic, should not be discharged to a care home that has no symptomatic or COVID positive residents unless that home was the patient's previous residence.*
> 27. *All patients being discharged from hospital to a care home should be tested for COVID-19, ideally this test will be done 48 hours prior to discharge. In addition, those patients/residents who are entering a care home through another route (e.g. from home or from a supported living service) should be tested in advance of their entry in to the care home. Ideally this test will also be done 48 hours prior to entry into the care home.*
> 28. *HSC Trusts have responsibility for ensuring the testing of these specific patients, in advance of timely discharge. However, where a test result is still awaited, the patient should be discharged and pending the result, isolated in the same way as a COVID-positive patient would be. A risk assessment with the receiving care home may be required in some circumstances such as where a person has cognitive impairment and isolation may be challenging.*
> 29. *Some care homes will have been assessed by the RQIA as not having the ability to appropriately isolate individuals because of the configuration of their premises. In general, these will be smaller homes. This will only be a very small number of homes. However, discharges to those homes should not take place from hospitals. Residents may return to these homes after a hospital visit if the Trust and home are in agreement the return can be safely managed.*

74. Concerns and fears were raised with COPNI by older people and their families with specific regard to the spread of infection in care homes and potential refusal of treatment at hospital. Additionally concerns and fears arose over the possibility of the government's guidance, guidelines and policies on admission and discharge being used detrimentally against them, notwithstanding that they benefit from Article 2 and Article 8 of the European Convention on Human Rights ("EHCR"), i.e., the rights to life and to family life

respectively, just like everyone else. Whilst such practices would be difficult to determine, the concerns and fears were real.

75. Accordingly, my intention was to secure further and clear guidance over the interpretation of the government's guidance in relation to the hospital treatment and discharge of older people who are frail or who have co-morbidities and have been diagnosed with Covid-19 or it is suspected. Although this was my intention, I do not believe that any appropriate further guidance or clarification was ever issued in this respect. Whilst I cannot recall the specifics, I do believe that there were several cases where COPNI was informed about a critically ill older person who was refused admission to hospital and where COPNI intervened.

PPE

76. On 28 March 2020 the Chief Medical Officer issued *Personal Protective Equipment (PPE) – Update to Service,* stating that *"Covid-19 should no longer be classified as a HCID [high consequence infectious disease]"*[40]. This followed an agreement on 19 March 2020 among the four nations to that effect. Prior to that Covid-19 had been classified in the UK as an HCID from January 2020. The change was apparently prompted by an opinion from the UK HCID group and the Advisory Committee on Dangerous Pathogens[41].

77. The service update would have a significant impact on the PPE to be used by those not engaged in high-risk procedures, i.e., not *"delivering or assisting with an aerosol generating procedure (AGP) on patients with possible or confirmed Covid-19 including in ICU or the hot zone of an ED"*. The result was the PPE to be used by health care workers in care homes, community care settings and domiciliary care settings was, in large part, restricted to a fluid repellent facemask (i.e., not an FFP3 respirator), apron and gloves, with eye protection if there was a risk of splashing. Even for that level of PPE, care homes found themselves in competition with hospitals for what was at times a very scarce resource.

78. This change to the requirements for PPE use particularly affected older people, as their health care workers often moved between settings, from home to home or from

domiciliary care to a care home. When coupled with a lack of testing, this had the potential to enable Covid-19 to easily enter care homes as well as the homes of older people shielding but reliant on domiciliary care workers, and/or spread within them and so increase the chances of a high level of death among older people. It also put staff at risk, and they were an increasingly scarce resource, which in turn had implications for the care and welfare of older people.

79. There was a degree of mistrust over the motivation for the change in PPE specification, with the suspicion that it was being driven by resource allocation rather than 'the science'. This was not helped by care workers, some of whom were having to make their own PPE, seeing ambulance workers and undertakers arrive at the care home in full Haz Mat suits.

80. All of that prompted real concern, which was communicated to COPNI by the IHCP group as well as older people and their relatives. My intention was to draw all of this to the attention of government and seek to improve the guidance on the provision of PPE and secure adequate support for care homes and others working with older people in sourcing appropriate PPE.

81. In accordance with the Act, my principal aim was to safeguard and promote the interests of older people in Northern Ireland. For that reason, I was mainly concerned with the use of PPE in care homes as they had the largest concentration of vulnerable older people, but for the reasons already given, I was also concerned with its availability for care workers in hospices, nursing homes, and domiciliary settings.

Testing

82. The guidance issued by the Department, *Covid-19: Guidance for Nursing and Residential Care Homes in Northern Ireland* dated 17 March 2020 contained little on testing for Covid-19, which I considered to be an essential aspect of an overall strategy to keep older people safe. However, it did state at paragraph 21 that: *"The PHA will ensure that a dedicated team engages with the home, in the event of one or more residents testing positive for COVID-19, to help you to ensure that isolation arrangements are put in place to minimise the risk of the infection spreading."* This of course presupposes that testing

has been made available. It did not address the situation when members of staff note that residents are displaying the symptoms of Covid-19.

83. That seemed to contrast with the position in England where the testing of residents was, apparently, to be carried out where there are symptoms, as opposed to confirmed test results: "*Currently, only the first five symptomatic residents in a care home setting are tested to provide confirmation of whether there is an outbreak.*"[42] Furthermore, the PHA's website at that time stated that: *"Testing is currently limited to patients who are being admitted to hospital and some health care workers"*. This confirmed my concern that older people in care homes would only be tested if their symptoms progress to the extent that they were admitted to hospital, as there was no effective means for having them tested prior to that. There was resistance from officials from the DOH to the testing of staff and residents in care homes, which in my view meant that it was likely the Minister was being briefed that this was not necessary.

84. The Department's, *Covid-19: Guidance for Domiciliary Care Providers in Northern Ireland* dated 10 April 2020[43] provides more detail on testing at paragraph 45:

> *Care workers providing support in the community are able to access COVID19 testing to help ensure they remain available for work. This includes domiciliary care staff, including those who are self-isolating due to a family member being symptomatic. It is important to note that using a negative test result to allow someone to return to work is not completely without risk and will need to be carefully considered. The Department will provide further advice on accessing tests separately.*

85. The reference to *"able to access"* was of course not a guarantee that that they would be tested. It was precisely this sort of lack of specificity in the guidance provided at the time that caused so much concern. Domiciliary care providers needed to know that staff would get tested, as that was of vital importance to the management of the service they were providing. Their staff, the older people they cared for, and their families were all concerned. As for the testing of domiciliary care staff, there seemed to be very little information on that. The provision of Covid-19 testing for staff in care homes and those dealing with the elderly in the community was in my view being affected by the shortage

of such tests, across the board. The issues on testing that were continually and urgently raised with me were what staff would be tested and how often would they be tested. It seemed to me that it was a matter of where the government considered the priority lay and my communications with government, whether directly or indirectly, was to make the case for older people to be considered a priority.

86. Then on 15 April 2020, the Secretary of State for Health Matt Hancock made the following widely reported announcement on Covid-19 testing for care home residents and staff with Covid-19 symptoms:

> *The government will roll out Covid-19 testing to all symptomatic adult social care staff, their family members and care home residents, following mounting concerns about the coronavirus's impact on the sector.*
> *Tests will also be provided to all residents admitted, or readmitted to care homes, from hospital, and eventually from the community, health and social care secretary Matt Hancock said today, though he did not put timescales on the plan*[44].

87. The guidance for England, which was published that day, provided that *"we are testing social care workers and residents in care homes (with or without symptoms) … as part of a rolling programme to test all care homes"*[45].

88. By contrast the guidance for Northern Ireland that was subsequently published on 26 April 2020, provided only that symptomatic care home staff will be tested unless there is an 'outbreak'[46]. This more restricted approach to testing meant that suspected cases of Covid-19 in care homes were not always subjected to confirmatory testing.

89. I was concerned that the government's position on PPE coupled with that on testing, was contributing to the growing numbers of Covid-19 related deaths, principally in care homes but also in other care settings outside of hospital. It was my intention to press the issue to try and get a change to the testing regimen. In making the case for testing, my principal concern in accordance with my statutory duties under the Act, was to ensure that older people in hospital were tested and their results received before they were discharged. I was particularly concerned to ensure that such a regime was properly implemented in

relation to those being discharged to care homes and nursing homes as those care settings, with their concentrations of vulnerable older people, held the greatest danger for older people should those who were asymptomatic be allowed entry. In practical terms, not all of these settings were able to effectively quarantine their older residents, especially those who had a high number of residents with dementia and low Covid-19 related staffing levels. Furthermore, most care homes did not have access to the nursing or medical expertise to properly care for their older residents should they contract Covid-19.

Inspections

90. The RQIA is responsible for inspecting the availability and quality of health and social care services in Northern Ireland. It periodically inspects care and nursing homes, as well as conducting unannounced checks, and publishes its findings. Whilst I criticised its effectiveness in my *Home Truths* report of 2018 and its 2019 (particularly at section 4.5), I still considered it had an important oversight role and could provide an independent perspective on the health and welfare of residents.

91. Irrespective of its likely effectiveness in ensuring care and nursing homes maintained safe practices during Covid-19, its role was arguably significantly reduced when the Chief Medical Officer, sent a letter dated 20 March 2020 to the RQIA[47] stating:

> *We are all aware of the rapidly developing situation in respect of Coronavirus which will require RQIA to keep its operations under review.*
> *For this reason, I am issuing a Departmental Direction of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. The Departmental is directing RQIA to reduce the frequency of its statutory inspection activity and cease its non-statutory inspection activity and review programme with immediate effect until otherwise directed.*
> *I ask RQIA to continue to respond to ongoing areas of risk, such as where there are services currently in enforcement or where enforcement is being considered that RQIA will focus their activity where it is needed most to ensure safe care and act flexibly and proportionately.*

92. The RQIA website at that time stated: *"In response to the Coronavirus pandemic, we are changing the way we work. During this time we are not conducting routine inspections of the health and social care services registered with us."*

93. I considered this development, together with the restrictions on the visits of relatives and GPs, to be an important loss of 'eyes and ears' on what was happening in care homes and other settings with older people. I was acutely aware that it was predominantly the families visiting their loved ones in the Dunmurry Manor Care Home who had alerted me to matters of concern, which prompted my investigation into practices into the home and disclosed serious breaches in safeguarding and human rights. Consequently, many of the care homes, which were locked down, had neither the external eyes of the regulator, nor the presence of residents' families able to observe and note the nature and standard of care practice.

Certifying and recording Covid-19 deaths

94. On 7 April 2020 the Health Minister Robin Swann announced there *"are cases of Covid-19 in 20 care homes across Northern Ireland"*[48], which are being managed by the RQIA and PHA. He did not provide the number of residents who were affected in those 20 homes and therefore what number should be added to the *"97 new cases"* recorded for Covid-19 deaths in hospital to provide a more accurate figure for the daily toll of the virus. The position at that time was that the number of deaths occurring in care homes was not collated in the current surveillance report. According to NISRA, the PHA Covid-19 Daily Surveillance Bulletin is derived from the reports of clinicians together with those of virus and local laboratories of: *"Patients who have died within 28 days of first positive Covid-19 test result, whether or not Covid-19 was the cause of the death"*. NISRA produced weekly death registration statistics, which are derived from the *"formal process of death registration and may include cases where the doctor…diagnosed suspected cases of Covid-19…but no test for the virus was conducted [and]… all deaths that occur outside hospital"*[49].

95. The lack of a clear position on total death figures raised considerable concern, especially given the reports by care homes and relatives of the high number of deaths of older people. I had started to flag that concern with the DOH and PHA in late March 2020. The importance of including the figures from care homes was reinforced on 13 April 2020 by Professor Chris Whitty, Chief Medical Officer for England, who confirmed the rising numbers of deaths in care homes *"13.5% of the UK's care homes had a confirmed case of coronavirus among their residents, up from 9% last week, with 92 more homes detecting cases in the previous 24 hours"*. At the same time academics were warning that the spread of the virus and its lethality in care homes in five EU countries appears to be higher than that being reported and researchers from the International Long Term Care Policy Network ("LTCPN") found the most robust data was available in Ireland where recent centralised government figures showed that 54 per cent of deaths from Covid-19 coronavirus occurred in care homes[50].

96. The significance of that was picked up by the chair of the Northern Ireland Assembly's Health Committee, Colm Gildernew MLA, who commented on 14 April 2020 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."* In an interview on the same day the Chief Medical Officer acknowledged that it was not presently known how many residents in care homes had died from Covid-19. He stated that *"the process of registering deaths was complicated"* but that it was "*being investigated by the Northern Ireland Statistics and Research Agency."*

97. That simply highlighted the need to ensure the accuracy of death certification, which was the context that gave rise to my concern about the changes that had been introduced to the process.

98. The certification of death in Northern Ireland is governed by the Births and Deaths Registration (Northern Ireland) Order 1976 ("1976 Order")[51] and the Civil Registration Regulations (Northern Ireland) 2012 as amended by Part 1 s.18 and Part 3, schedule 13 paragraphs.17, 23-26 of the Coronavirus Act 2020 ("Coronavirus Act")[52], which entered

into force on 31 March 2020. Article 25 of the 1976 Order provides for certificates of cause of death:

> *(2) Where any person dies as a result of any natural illness for which he has been treated by a registered medical practitioner within twenty-eight days prior to the date of his death, that practitioner shall sign and give forthwith to a qualified informant a certificate in the prescribed form stating to the best of his knowledge and belief the cause of death, together with such other particulars as may be prescribed.*
> *(3) A registered medical practitioner shall not give an informant a certificate under paragraph (2) or give the registrar a copy of such a certificate if—*
> *(a) he or any other person has referred the death of the deceased person to the coroner under section 7 or 8 of the Coroners Act (Northern Ireland) 1959 [1959 c.15] or he intends so to refer the death*

99. It was this requirement for the 'signing of certificates of cause of death' that was amended by the Coronavirus Act. It permitted a medical practitioner to sign the certificate who had not treated the person irrespective of whether the deceased person had received treatment from a medical practitioner or not.

100. I felt those changes would probably not make much difference to those who died in hospital, as they were likely to have received some treatment from a medical practitioner within 28 days of their death and were also likely to have been tested for Covid-19 and/or will have available up to date medical notes and records from which to reliably assess the cause of their death and complete the medical certificate of the cause of death. In my view the real impact of the change was likely to be in relation to those who died in a care home or similar facility, as they may not have been treated by a medical practitioner within 28 days of their death and therefore the accuracy of the certification could be dependent upon someone who has no direct knowledge of them or has access to any test results for Covid-19.

101. The Chief Medical Officer issued his own 'Guidance on the New Arrangements for the Completion and Issuing of Medical Certificates of Cause of Death and Stillbirth Certificates' on 27 March 2020 ("CMO's guidance")[53]. Essentially, it summarised the

statutory change introduced by the Coronavirus Act, without adding any real detail to provide guidance to ensure that medical certificates were completed as accurately as possible, and that all Covid-19 deaths in non-hospital settings were properly captured.

102. In my view, given the magnitude of the change and the difficulties of access created by 'lockdown' and other restrictions, there was a real need for practical guidance. This was reinforced when the Medical Defence Union issued a recommendation on 6 April 2020 that in certifying deaths during the Covid-19 outbreak medical practitioners should "*review all the information available and keep a note about your reasoning for stating a particular cause of death.*" Subsequently on 7 July 2020, the Office for National Statistics issued a detailed *Guidance for doctors completing Medical Certificates of Cause of Death ("MCCD") in England and Wales* for use during the pandemic, which included worked examples, e.g., *"if before death the patient had symptoms typical of Covid-19 infection, but the test has not been received, it would be satisfactory to give 'Covid-19' as the cause of death…and then share the test result when it is available [and in] … circumstances of there being no swab, it is satisfactory to apply clinical judgment"*. I have exhibited this guidance in **[EL/11, INQ000417336]**

103. I was unaware of anything of that detail having been issued for doctors in Northern Ireland to assist them with the completion of the MCCD following the changes made by the Coronavirus Act. This material formed part of the context in which I was seeking improved guidance on all matters relating to the accuracy of the statistics relating to death. I considered accurate data collection was essential, not just to managing the pandemic but also to enable the appropriate lessons to be learned for improved pandemic planning for the future. Given my concern over the disproportionately high numbers of older people dying in care homes, I wanted proper data collected on where people were dying and in what circumstances.

104. The notification of deaths to the Coroner is governed by the Coroners Act (Northern Ireland) 1959 ("Coroners Act"), particularly under section 7 that provides for the duty to give information to the Coroner. Detailed *Guidance for Matters relating to the Coroner* was issued by the Department on 1 November 2018[54]. It sets out the deaths to be reported to the Coroner and included examples of *"other circumstances that may require*

investigation". It also states that: *"In general, if a medical practitioner has any doubts or concerns about the circumstances of a death, the death should be reported to the Coroner".* This was broader than the CMO's guidance.

105. On 27 March 2020, the same day the CMO's guidance was issued, the Coroners Service issued a letter to doctors *Covid-19 planning, Emergency legislation re Medical Certificate of Cause of Death and Coroners*[55]. It stated that *"deaths which are considered to be due to the Coronavirus are considered "**Natural**" and do **NOT** need to be reported to the Coroner"* (emphasis in the original). It went on to reflect the greater flexibility to the signing the MCCD that was in the then Coronavirus Act, whilst emphasising the delays and associated distress caused by the increased pressure on pathologists to provide post mortem services and urged doctors *"to carefully consider whether a report to the Coroner is necessary".*

106. There was also a reminder that it is possible for a death to be from natural causes and nonetheless warrant notification to the Coroner – pursuant to the provision "*in such circumstances as may require investigation"* in s.7 of the Coroners Act. That meant there were certain circumstances in which deaths from Covid-19 may yet be notified to the Coroner but there was no further guidance on that from either the Coroner service or the DOH.

107. Detailed guidance for England and Wales had been issued the previous day, *Chief Coroner's Guidance on Covid-19* dated 26 March 2020[56], referred to "*A death is typically considered to be unnatural if it has not resulted entirely from a naturally occurring disease process running its natural course, where nothing else is implicated"* and significantly:

> *Covid-19 is a naturally occurring disease and therefore is capable of being a natural cause of death. There may of course be additional factors around the death which mean a report of death to the coroner is necessary – for example where the cause is not clear, or where there are other relevant factors ...There may also be cases where an otherwise natural causes death could be considered unnatural.*

108. That was part of the basis on which I was seeking to have practical guidance issued for Northern Ireland, if only by referencing helpful parts of guidance issued elsewhere in the United Kingdom. In my view that might have gone some way to allaying concerns reported in the media, that Covid-19 deaths are unlikely to be subjected to the scrutiny of a Coroner's investigation[57]. I considered that such scrutiny may be relevant where there was a concern that a Covid-19 death directly or indirectly resulted from the lack of Covid-19 testing, PPE, admission to hospital or lack of respiratory assistance (whether oxygen, CPAP machine or ventilator). This would go to the requirement to determine *"how"* the deceased came by their death pursuant to rule 15(b) of the Coroners (Practice and Procedure) Rules (NI) 1963[58]. Furthermore, in such circumstances, scrutiny could well be required to comply with the obligation to conduct an 'effective investigation' pursuant to ECHR Article 2. It could also help with an understanding of the effectiveness of the government's response to the pandemic in terms of lives lost, which would assist with future planning.

Response

109. In my view I did not receive a timely or satisfactory response to the many issues that I raised with the government. This in large part explains my very considerable engagement with the media as detailed below, since it provided an alternative means of registering the seriousness of my concerns. I have exhibited a record of my media statements in **[EL/12, INQ000417082]**.

110. 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 the provision of PPE for care staff wherever they were operating and the testing of care home residents, together with providing timely, adequate, and practical communication in clear language.

111. 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 provided on the day of the meeting **[EL/13, INQ000417083]**. There was insufficient time to consider it properly and so much of the time was taken up with its content being explained.

112. 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 specifically raised and regretted. 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 in residential facilities, there was an 'air of unreality' about the possibility of that happening in Northern Ireland. The view expressed by PHA seemed to be 'that won't happen here, they have a completely different system over there'.

113. 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"*[59]. In my view that did not accurately capture the reality of the situation.

114. 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, the testing of care home residents, and the need to ensure adequate communication of the Guidance to the sector, would all have been addressed. For example, although the Guidance states at page 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 completely unsatisfactory. That was one of the issues that had been flagged as a concern at the meeting and with adequate time, for us to have either responded to the proposed guidance beforehand or to have properly discussed concerns at the meeting, it could and should have been addressed.

115. The problems that nursing and residential homes reported to us they 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. a lack of clarity over exactly what was required to demonstrate to the HSCTs that they were 'unable to source their own supplies'; and
iv. all this having to be done as soon as possible to prevent the transmission of Covid-19 and keep people safe.

116. 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, such as whether nursing and residential homes should close their doors, how they were to deal with visitors, how to manage quarantined patients, whether patients should be transferred to hospital and what the process would be for hospital discharge.

117. My impression was that the deadline for the issue of the Guidance was given more importance than the content of the Guidance itself. It was a missed, early, opportunity to put measures in place that would be truly effective.

118. Furthermore, it became clear that the lack of effective communication with the very sector targeted by the Guidance was an issue. This is acknowledged in 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, which 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"*. I have exhibited this letter in **[EL/14, INQ000417084]**

119. I recognise that Module 3 is not concerned with the granular detail of the content of the Guidance, however, I raise this issue to illustrate what I consider to have been a failure in the mechanisms available to the DOH to ensure that, in a situation where speed 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 settings extremely well known to COPNI.

120. 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.

121. It was clear at the outset of the pandemic that the government did not feel a track and test 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 happen in Northern Ireland in a care home setting[60]. My instinct was that a properly established testing programme would be an essential tool in the fight to control Covid-19. COPNI conducted research widely, including WHO statements, for examples of how other countries combatted pandemics. Whilst we did not hold ourselves out to be epidemiologists there seemed no credible basis for the position that older people in care homes and other similar institutions could be kept safe without instituting a programme of testing those with whom they were to come in contact.

122. At the same time the families engaging with COPNI were bringing me their own experiences and urging me to press for the testing of those in care homes. I was also receiving calls from providers who also wanted their staff and the residents tested. In all the circumstances, I found it difficult to see how the extent of the problem could be gauged and any realistic planning could be developed, let alone the necessary lessons learned, without an effective means of tracking those infected with Covid-19 and testing them. I tried on numerous occasions to make this case to government.

123. 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. In my view the hospitals were planning on a surge in the degree of intake and therefore adopted a ruthless approach on the need to discharge older people from hospital and an equally ruthless approach in managing that process.

124. Firstly, 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 of older

people in cohorted and quarantined settings before they were discharged from hospital, as a means of restricting the transmission of Covid-19. The numbers of lives of older people that were being put at risk due to the lack of testing, was the most dangerous thing, where 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. Secondly, there appeared to be a premature discharge process to unblock hospital beds before older people were sufficiently recovered to be safely discharged and therefore, they were at continuing risk and few good options; go back to their care homes that often did not have the expertise to care for them in their current condition; go to other facilities that they did not know and where they were unfamiliar to the staff; or go home and put further pressure on the scarce GP resources.

125. 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.

126. Despite that I felt it was necessary for me to continue to make the case for the introduction of a proper regimen of tracking and tracking the incidence of Covid-19 and recording the deaths. On 31 March 2020, just days after the publication of the Guidance, which I considered to be deficient, COPNI emailed the DOH seeking proper information on this 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?"* These emails are exhibited at **[EL/13a, INQ000472348** I also used the media to press for such a regimen, including in 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.*"[61] By this time I

had secured support from Colm Gildernew MLA, the Chair of the Northern Ireland Assembly Health Committee. Then on 24 April 2020 I wrote to the Minister of Health[62].

127. Subsequently, the government effectively performed a 'U-turn' on their initial testing policy, as reflected in a letter from the Minister of Health dated 26 May 2020 exhibited at **[EL/15, INQ000417085]**. It 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.

128. 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 was claiming hundreds of lives, especially those of older people where the response required a coordinated multi-agency response. What was ultimately accepted was something that I had raised very early on. It required sustained efforts to achieve but, with all the resources at the disposal of the DOH it should, in my view, have been capable of being addressed far sooner. The 'fragility of the care home sector' was well known before the arrival of Covid-19.

129. 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 there were adequate staffing levels within homes, and the need to provide Covid-19 testing for older people and those working with them, created a perfect and fatal storm in care homes. I had similar concerns 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 both informally through telephone calls and emails, especially when it became clear that care staff were getting ill, adversely affecting staffing levels, along with other issues listed below, which are all exhibited at **[EL/16, INQ000417086]**:

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.

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."*

iii. 08.10.20 Letter to the Minister of Health raising concerns re implementation of care home guidance and *"learning from the first wave."*

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.

v. 16.04.21 Letter to the Minister for Communities on the impact on older people of isolation due to Covid-19.

130. 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 think it would have been beneficial to have had a proper opportunity to engage with the DOH on them in a proactive way.

III. IMPACT OF THE PANDEMIC AND THE GOVERNMENT RESPONSE

131. I have already addressed certain aspects of the impact of the pandemic and the government's response. In this section, I deal with specific issues the Inquiry has asked me to address concerning GPs, DNACPR, shielding, stay at home messaging, and inequality in the access to health care.

a. Obtaining GP appointments and the incidence of remote GP appointments

132. I have already referred to the lack of GP visits to care homes and other similar placement in the context of death certification. I now address specifically the 'impact of the Covid-19 pandemic upon the way older people were able to obtain general practitioner appointments' and the 'incidence of remote GP appointments'.

133. During the Relevant Period many if not all GP surgeries largely moved to a remote means of operating. This involved the use of telephone appointment bookings or bookings using an app, and remote appointments, sometimes over the telephone or over the internet e.g., through zoom, other times involving taking photographs and sending them electronically to the GP. Actual face to face appointments, of the type that older people had enjoyed prior to the pandemic, although still possible if the GP considered it clinically necessary, were nonetheless rare.

134. From my own experience of the circumstances of older people, I anticipated that those types of changes in accessing a GP service was likely to be problematic. Unfortunately, my office was not able to conduct any systematic research into this important issue of the ease and effectiveness of access to primary healthcare by older people who are the part of the population most likely to require it. However, it is an issue that warrants proper research and consideration in Northern Ireland as it seems clear that some of the changes to making GP appointments and accessing GPs way well be here to stay.

135. I am not aware of the government carrying out any such research, although I am aware of studies carried out in England and the Republic of Ireland. For example, an early study carried out by The Health Foundation for England on GP appoints by type for the period April 2019 to March 2020 showed that the effect of government and guidance discouraging 'walk-ins' and encouraging the movement of as much care as possible to remote-only means had already produced a marked reduction in face-to-face appointment and an overall drop in people contacting their GPs of about 30 per cent[63]. A later, more detailed, study carried out by the BMA dated 3 June 2020, *Delivery of healthcare during the pandemic, BMA Covid Review 3*[64], showed during the 'first wave' of the pandemic, from March to May 2020, a similar pattern of a dramatic increase in remote means of making appointments and accessing a GP for diagnosis and treatment, which also served to highlight the limitations of IT infrastructure and internet difficulties, and an overall reduction in GP appointments of about 32 per cent.

136. A similar picture emerges from a survey conducted in the Republic of Ireland in February 2020 and June 2020 by the Irish College of General Practitioners. The results of which were published in the BMJ in 2021 *How Covid-19 has affected general practice*

consultations and income: general practitioner cross-sectional population survey evidence from Ireland[65]. They show that face-to-face GP appointments decreased markedly from 87.3 per cent to 41.0 per cent of all GP consultations. More particularly, a shift to telemedicine was observed from 10.5 per cent of all GP consultations and 17.6 per cent of practice nurse consultations pre-Covid-19 to 57.0 per cent and 32.4 per cent, respectively during the Covid-19 response. Of even greater significance for older people was that over half of practices saw decreases in non-Covid-19 related consultations from vulnerable patient groups, including non-Covid-19-related visits from patients over 70 years who receive free GP care and were usually being frequent users of health services. The decline for those patients over 70 years was 79.5 per cent.

137. We did receive reports from older people and their relatives, as well as from IHRC, I also had meetings with Dr Alan Stoute the Chair of the GP Committee of the BMA on the accessibility of GPs, all of which indicated to me that those changes had a 'massive impact'.

138. Whilst these changes may also have impacted other sections of the population, my concern and comments are confined to their application to older people. In my opinion these measures were only beneficial or appropriate for older people in the pre-vaccination period due to the very real fear of older people that visiting a GP surgery brought with it a high risk of contracting Covid-19. However, older people would have welcomed reverting back to traditional methods post-vaccination, as it became disproportionately difficult for them to navigate the new remote systems and secure appointments. It is notable that despite these measures being brought in at a time of emergency (without being equality tested) that they are still in place today and continuing to pose challenges for older people.

139. The experience of older people in Northern Ireland was very similar to that described in the studies dealing with England and the Republic of Ireland. During the pandemic most consultations with GPs took place over the telephone and sometimes with the benefit of an app that allowed patients to send in photographs as directed by GPs to assist in diagnosis and treatment. Whilst my office was unable to conduct specific research on this issue or collect hard data but anecdotally, I became aware that older people were finding

it more and more difficult to secure appointments with their GP. Many GP surgeries operated a system whereby a period was set aside in the morning during which patients were required to telephone the surgery to ask to be given a telephone appointment with the GP. Older people reported to me that they found themselves waiting in lengthy queues on the telephone just to try to get through to their GP's reception to request a virtual appointment. They were often unsuccessful and sometimes, when they did manage to make contact, they found that all the daily slots for telephone appointments were already full, and they were told to ring back the following day.

140. In my experience the pandemic drastically increased the occurrence of remote GP appointments, which made it more difficult for older people to obtain GP appointments due to increased demand and due to what became the common system for booking appointments. Indeed, its use was so widespread that **NR** from the Health and Social Care Board, Dr Laurence Dorman from the Royal College of GPs and Dr Alan Stout from the British Medical Association were prompted to send a message to reassure patients that they can still access GP treatment, advice, and prescriptions[66]. This date of this message is 7 September 2020 and it is exhibited at **[EL/16a, INQ000472349]**. Furthermore, in my experience older people tend to be less well-versed in the use of technology and I had concerns that the use of a telephone appointment system and/or an app would have been off-putting to many older people who may have felt uncomfortable with or incapable of engaging with such a system.

141. The use of such remote appointments was particularly difficult for older people in care and nursing homes. They were often far less able to manage securing an appointment and engaging successfully in a remote appointment that older people in the community. I received many reports from residents and their families and from the IHRP to that effect. Furthermore, GP visits to care homes were far less frequent during the pandemic, with appointments with GPs for residents commonly being carried out remotely requiring help from staff who were already pressured and often not clinically trained. Evidence on this was given to the Northern Ireland Assembly Committee for Heath over the period Spring to Autumn 2020 by me AgeNI, NI Hospice, Marie Curie, IHCP and others. This evidence is summarized in the *Inquiry Report on the Impact of Covid-19 in Care Homes* published in February 2021, which I have exhibited at **[EL/17, INQ000417096]**. The following, taken

from pages 91, 92 and 19 is indicative of the information that I received: *"GPs were not able to visit, care home staff had to take a photograph and send it to the surgery"*; *"the interface with residents' own GPs, who know them best, was almost non-existent"*; *"it was difficult to ensure a holistic approach given GPs increasing use of telephone consultations"*; *"reduced access to GPs for care home residents, specifically highlighting reduced opportunities for Advance Care Planning conversations"*; *"the pressure felt by some care home staff to lead these important conversations for which they felt further training and medical input was required"*.

142. Whilst the evidence provided to the Health Committee was important and it is helpful for future planning that it has been recorded in such a comprehensive report by the Health Committee, in my view it is no substitute for the systematic collection of hard data that can then be analysed, e.g., something as basic as the number of GP appointments. Furthermore, if remote operations are likely to be a feature of future pandemics, then it will be important to learn the lessons of ensuring that there is adequate infrastructure, equipment, and training so that it can be used effectively. At the very least infrastructural issues such as improved internet coverage and enhanced quality, should be being developed now. On a simpler level, it will be important to ensure that there are enough appropriately trained staff available to answer telephone calls. A common complaint that arose from older people, and one that is still being made, is the requirement to tell the local receptionist about the nature of their issues, which some may deem a breach of their privacy. The more difficult question to be posed is how telemedicine should be best delivered in any future pandemic to older people who are disproportionate to the rest of the population likely not to be sufficiently tele-literate.

b. Do Not Attempt Cardiopulmonary Resuscitation decisions

143. From early in the pandemic, I was concerned about what I feared were blanket decisions being made about the care and treatment options that would be available to older and vulnerable people about admissions to hospital, to ICU and the use of ventilators. This was heightened by the reports that I was receiving about older people feeling pressured into signing 'Do Not Attempt Cardiopulmonary Resuscitation' forms ("DNACPR"), sometimes referred to as 'Do Not Resuscitate' forms ("DNR"). These reports were

intelligence led and came directly from both family members contacting COPNI and asking if this was normal and from some care home managers contacting COPNI to express how uncomfortable they felt with it.

144. I was particularly concerned that in the early phase of the pandemic this often seemed to be happening without the knowledge, support, and assistance of their families. It was apparent to me that 'blanket' policies, the most obvious being DNACPRs, were at risk of being applied in terms of the treatment of older people who contracted Covid-19. This was based on an assumption that they would be less likely to benefit from hospital treatment for Covid-19 than younger people. I have already referred to this concern in the context of 'hospital admissions and discharges', with the shortage of ventilators and scarcity of ICU beds creating a risk of the reference to 'likelihood of benefit' in the NICE guidelines on admissions to critical care being interpreted to deny critical care to older people. An extension of that type of logic in rationalising scarce resources, especially when hospitals were under such severe pressure and strain, might be to persuade older people to sign DNACPR forms. Many older people were suggestible and could easily feel that it would be 'the right thing' not to take up scarce hospital resources in favour of 'making way for the young', or they were frail and particularly vulnerable due to co-morbidities or serious life limiting conditions and could feel that it was 'just easier all-round' to decline further care should the situation arise. This was all the easier with the distance from the reassurance and support of their loved ones brought about by care home lockdowns.

145. So far as I am aware, these policies did not originate from central instructions from any particular organisation but rather were the result of clinical decision-making or local behaviour and actions at the relevant time. The challenge came largely from the family, friends and the public as a whole who were vocal about valuing older people and wanting them to be disabused of any suggestion that it fell to them to make a 'sacrifice' to protect the health service. However, it would have been better to have had an early, strong message from government.

146. I was aware of several cases where DNACPR notices were being put in place in relation to certain residents coming out of hospital or going into hospital and that in some cases

instructions were given to care homes for staff to put DNACPR notices to older people. It was in single figures and spread across Northern Ireland, but nonetheless I considered it was enough to raise concerns.

147. Similar concerns were being expressed in the other UK jurisdictions and we discussed them at the weekly Four Nations meetings. We were all so concerned that we issued a *Joint statement on the rights of older people in the UK to treatment*[67] on 30 March 2020 signed by AgeUK, Independent Age, Anchor Hanover, Commissioner for Older People in Wales, Age Cymru, Scottish Care, AgeNI and Age Scotland, which refuted any *"suggestion that treatment decisions can be blanket ones, based on age alone or with a person's age given undue weight as against other factors, such as their usual state of health and capacity to benefit from treatment, would be completely unacceptable"*.

148. The issue in relation to DNACPR was also beginning to appear in the media. A piece by BBC Wales on 1 April 2020 that reported an apology by a GP surgery for sending a letter asking patients with life-limiting illnesses to complete a DNACPR form explaining: "*Completing a DNACPR will have several benefits. 1/ your GP and more importantly your friends and family will know not to call 999. 2/ scarce ambulance resources can be targeted to the young and fit who have a greater chance.*"[68] This was echoed by another BBC piece on 3 April 2020 referring to guidance sent by a Clinical Commissioning Group in England to all GP practices and care/nursing homes in the area stating that many vulnerable people may not be admitted to hospital for treatment if they contract the virus, and directing all homes to *"check they have resuscitation orders on every patient"* and the concern of a care manager that residents and families were being pushed to sign the forms[69].

149. I issued multiple public statements raising further concerns and awareness on this issue[70]. I also appeared on BBC Radio Ulster Evening Extra on 9 April 2020 to discuss this issue and the anxiety which I felt it was causing to older people and their families who were worried that a DNACPR might be applied to them or their loved ones. The reason I kept pursuing this issue was that I was receiving reports of real fear amongst older people in their families that they would be coerced into signing a DNACPR,

essentially so that they would not be a burden, or that they would inadvertently sign it not really understanding what it was and its implications.

150. Whilst I realized that it was not uncommon for residents in care and nursing homes to have in place DNACPRs as part of normal Advanced Care Planning ("ACP"), I felt it was essential that the resident or patient had an opportunity to think it through properly with the benefit of discussion and support from their family and appropriate consultation with staff and, if desired, a clinician. I have my own understanding of expertise in end-of-life care and what normal advanced care planning looks like so any misuse would have been easy for me to identify. DNACPR is normally a very individualised and time bound practice which requires informed consent. Proper practice should not be abandoned because of the exigencies of the pandemic. I wanted clear assurances from the government that proper practice would be maintained in this very difficult aspect of health and end of life care. I discussed with key people in government at the highest level received assurances from the very top of government that this would be the case.

151. I did not receive any direct public response from the DOH in this regard. It is important to reiterate that this behaviour was not coming from central instructions but rather local behaviour. It is also hard to capture the pace at which issues originated in the public discourse in the first few weeks of the pandemic, which meant that usual practices of written correspondence, meetings and minutes were not being strictly adhered to. I do not think a public statement would have been of benefit as much as a direct instruction from the DOH to social workers, colleagues, or Trust directives to stop using DNACPR as blanket or group instruments in the way they seemed to be doing. In my view the absence of any public statement from the DOH did not cause any delay on the part of older people seeking treatment.

152. I gave evidence on the issue to the Health Committee as part of its investigation on Covid-19 and care homes. This was supported by Marie Curie, Alzheimer's Society, AgeNI, and IHCP, all of which is discussed in the body of the report (referred to above and exhibited at **[EL/17a, INQ000417087]**), including the view that the "*Department of Health should clearly outline and communicate the rights of older people and families to support stating the sensitive conversation about end of life, at a time and place that suits the individual,*

family and their doctor with the wishes of the resident and family recorded." It is also reflected in Recommendations 34, 35, and 36 under the title 'Advanced Care Planning':

> *Recommendation 34: Advance Care Planning should be discussed with each care home resident, on an individual basis, ideally ahead of any crisis; it should be led by the clinician who knows the individual best, with the input of other relevant professionals; and reviewed as necessary.*
> *Recommendation 35: The Department of Health should clearly outline and communicate the rights of older people and families regarding end-of-life planning, and this should reference the approach to treatment and care planning recommended under NICE guideline NG163.*
> *Recommendation 36: Steps should be taken to ensure that relevant professionals have access to appropriate training in advance care planning.*

153. Despite the assurances that I had received and the recommendations of the Health Committee's report of October 2021, I was not entirely satisfied and felt it necessary to persist with the issue to have it included as part of a public inquiry into the government's handling of care home residents in the pandemic, with the intention of understanding how it had happened and ensure that such a practice did not reoccur in any future pandemics when there may be similar pressures on health care resources. I gave interviews and made statements, including a piece published in the Newsletter on 24 November 2021 that "*it was possible that some older people died during the pandemic due to a Do Not Resuscitate (DNR) notice being placed on their file, leading to life saving treatment being withheld - and their families still do not know that this is how they died."*[71]

154. A public consultation was launched by the Health Minister Robin Swann on 17 December 2021 inviting the public to *"have their say on a draft Advance Care Planning Policy for adults in Northern Ireland."*[72] I provided a response to that invitation in March 2022, *Advance Care Planning for Adults Policy*[73], in which I reiterated my concerns about inequalities in end-of-life treatment for older people citing the findings of a 2017 NHS report[74]:

A 2017 report by the NHS: "Involving people in their own health and care Equality and health inequalities" found that there was risk of inequalities in end-of-life treatment for those with protected characteristics. The report found that discrimination in relation to age may arise, where assumptions are made in relation to someone's capability to exercise choice and control over their health, care and wellbeing. In the case of older people, they may face discrimination due to assumptions made around their mental capacity, or because of digital exclusion where key resources are only available online.

155. On 19 October 2022, following on from the consultation, Professor Sir Michael McBride launched the *Advance Care Planning: For Now and For the Future* policy document for all adults in Northern Ireland. Whilst I welcomed this document, I was disappointed that it had taken quite so long to achieve. Well before the pandemic, in December 2017, Marie Curie submitted an updated DNACPR policy to the DOH for consideration and approval. Furthermore, and leaving aside my own efforts to draw attention to the issue and those in the third sector, the Care Quality Commission in England published in April 2021 *Protect, respect, connect: Decisions about living and dying well during Covid-19*[75], which concluded that since *"the start of the pandemic, there have been particular concerns that 'do not attempt cardiopulmonary resuscitation' (DNACPR) decisions were being applied to groups of people rather than taking into account each person's individual circumstances"* and that *"there was undoubtably confusion at the outset of the pandemic and a sense that some providers felt under pressure to ensure DNACPR decisions were in place [which] risks undermining public trust and confidence in the health and care system and demonstrates the need for better oversight of DNACPR decisions."*

c. Shielding

156. In March 2020 speculation was rife that 'lockdown' and social distancing measures would be imposed on the general population and, additionally, the 'clinically extremely vulnerable' would be asked to 'shield'. Prior to Northern Ireland going into 'lockdown' it was clear that those considered to be at highest clinical risk from Covid-19 would receive 'shielding letters' from their GPs. My immediate concern was for the mental health and well-being of older people. I was aware that older people were likely to be disproportionately represented in the 'shielding category' and that NISRA studies

consistently showed that older people were already disproportionately affected by loneliness[76].

157. On 16 March 2020 I went to see Deidre Hargey Minister for Communities to discuss my concerns about the impact on the mental health of older people asked to limit human contact during the Covid-19 outbreak and the need to make minimising adverse effects a key focus[77]. I advised her that from my contacts, older people in Northern Ireland were concerned about the threat posed by the virus, but also at the prospect of an extended period with limited human interaction. I asked for greater clarity on exactly what older people would be asked to do so they would know what shielding would mean *"in practical terms for older people and to make sure we are putting in the support and services required, so if we have to go down that route that older people are supported, that they are protected, they get their supplies and also that they are not shut off from society, that we look at ways at how we can keep them engaged and keep them in contact with one another."*

158. A detailed template for a GP shielding letter was published on 25 March 2020 by the DOH consisting of 6 pages, which in summary advised those affected not to leave their houses, attend any gatherings including those of family and friends, and avoid contact with anyone showing symptoms of Covid-19[78]. It specifically addressed 'planned GP practice appointments', 'planned hospital appointments', and 'urgent medical attention'. An estimated 80,000 patients were sent shielding letters and I understand that the HSCB developed a central database of all those individuals who had been asked to shield by their GP[79]. This should have made it possible to conduct research on that cohort, but I am unaware of any studies carried out that would allow the impact of shielding on the ability of older people in Northern Ireland to access healthcare to be properly assessed. The DOH did request the Patient and Client Council ("PCC") to conduct a consultation into shielding experiences to assist in determining what could be done for those shielding in the immediate future and to plan for the winter and a possible second wave.

159. The PCC sent out a 'Shielding Survey' in June 2020 and then in August 2020 it sent a survey for those shielding in nursing homes, residential care homes and supported living arrangements *Understanding the Impact of Shielding Restrictions in Group Living*

Environments[80]. The report *Exploring the experiences and perspectives of clinically extremely vulnerable people during COVID-19 shielding*[81] was published in December 2020 based on 3,515 responses, of which 52.5 per cent were from the age groups 55 years and over. None of the conclusions or recommendations deal properly and specifically with the impact on access to health care. Although the report did distil several themes from the responses, two of which concerned 'HSC support' and 'Access to services', in respect of which the PCC provided Recommendation 3 *"Increase effort from Health and Social Care to 'check in' with clinically extremely vulnerable people"* and Recommendation 4 *"Provide easier access to food deliveries or to guaranteed priority supermarket slots Designate space/time for clinically extremely vulnerable people to go outside, visit shops, leisure centres, GPs, etc. without the perceived risk of coming into contact with the general public."*

160. From the contacts my staff and I had with older people on the issue of shielding, I am of the view that it did adversely impact them, not so much on their ability to access healthcare, but rather on their willingness to do so. The messaging on the risks of Covid-19 convinced many who were advised to shield, that it would be unsafe for them to go to hospital or other places to access healthcare services, even when this might have been warranted. This was also true of some older people who, whilst not being designated 'clinically extremely vulnerable', nonetheless either regarded themselves as being vulnerable or were simply not prepared to take the risk of contracting Covid-19.

161. That disinclination by some was also coupled with the fact that healthcare, certainly through GPs, was routinely being provided remotely and, as has already been discussed, this brought its own difficulties for older people in obtaining GP appointments and assistance.

162. It is worth noting that the PCC report on the results of the survey concluded that:

This fear of Covid-19 and the risk it represents to clinically extremely vulnerable people was a central concern. There was a sense from many respondents that this fear would prevent them from changing their shielding behaviour even when shielding advice changed. It was often accompanied by a perception that the rest of the world had gone

back to 'normal life' and that going out in public therefore posed too much of a risk until such times as a Covid-19 vaccine becomes available. Concerns about contracting Covid-19 may help explain why the proportion of respondents voicing frustrations or hopes around accessing routine or necessary healthcare was relatively low, although this still equated to a large number of people.

163. In addition to the issue of access to health care, I believe that it is important to appreciate the devastating social and emotional impact that shielding had upon many of the older population. In my view this was entirely foreseeable, and the imposition of lockdown and strong shielding advice should have factored that into the planning of those measures form the outset. To try and mitigate the loneliness and isolation many older people felt, COPNI conducted meetings with AgeNI to develop the 'Check in and Chat' telephone service free of charge for the over 60's to offer reassuring calls and help for the elderly feeling lonely or anxious[82]. Specifically, COPNI engaged with government on the provision of funding for the service and became involved with taking 'Check in and Chat' calls, which helped further inform and develop COPNI's knowledge of the impact of the pandemic and the government's response.

164. From my experience the overall messaging on shielding was strong but the details of its application could have been more clearly explained. It was a dramatic and unique intervention in people's lives in a crisis and in those circumstances greater clarity on the details would have helped alleviate concerns and frustration. The feedback that I was receiving on this from older people is in keeping with the findings in the PCC's report, which noted recurring themes of *"Guidance regarding shielding not being clear or timely"* and *"Insufficient information provided regarding resources for people shielding"*. It also concluded that:

Many people shielding in Northern Ireland due to Covid-19 appeared to prioritise being kept informed above other areas of unmet need. There was a strong desire to be given clear guidance on what they should and should not do. There were also clear messages that people wanted to see and understand any available information on Covid-19 infection rates – ideally at as localised a level as possible – and on the actual risk posed to them as individuals. Respondents expected that having access to this

information would empower and support them to make their own informed decisions about whether and how to emerge from shielding.

165. My greater concern about messaging was that much of the communication from the government was by periodic announcements on the TV media and through the internet. Whilst there were daily TV briefings on Covid-19 in England and Scotland, the same was not true in Northern Ireland and people needed to clearly understand the guidance as it applied here.

166. I was also concerned that there was an assumption that everyone would have access to the internet to get the most up-to-date and accurate information on shielding and pandemic-related rules and regulations generally. I raised these issues with the DOH.

167. Nevertheless, I also resorted to the COPNI website and social media to share news that I felt was particularly relevant to older people and their families, creating a specific section containing daily updates and explanations of relevant changes in rules, regulations, and guidance. However, in doing so I was aware of the limitations of many older people in terms of the internet and made a point of ensuring that print media and radio were also included in the ways in which COPNI communicated information. I was conscious that these forms of communication, particularly the radio, may have a wider reach for older people than the internet. I also encouraged telephone call-ins. I made representations to the DOH to the Department of Health on what I considered to be an over reliance of the internet to the detriment of those who either did not have ready access to it (whether for cost or other reasons) or did not feel able to navigate their way through the government websites, and urged other the use of other means of communication to ensure that information was reaching everyone who needed it. As part of those representations, I called for a specific telephone helpline tailored to the needs of older people. The DfC initially resisted this suggestion, but I understand that this idea ultimately fed into the funding of the 'check in and chat' service.

d. Government messaging to 'Stay at Home'

168. There was a very public government message to 'stay at home'. An issue for the Inquiry is the extent to which that may have contributed to older patients who needed treatment delaying in seeking it. I have dealt with this in part in addressing 'shielding' and its impact on old people's willingness to access healthcare from outside of their homes.

169. It is my view that the 'stay at home' message undoubtedly led to older patients delaying seeking medical treatment. It was my experience that the 'stay at home' message and the concept of shielding, while designed to protect the physical health of vulnerable people, also engendered much fear. From the anecdotal information that I have, I would suggest that older people's fear of seeking treatment and exposing themselves to illness was often greater than their fear of delaying treatment. There was a lot of media attention on the chaos and overcrowding of hospitals and many older people were afraid that they could easily contract Covid-19 while seeking medical help for some other condition and opted not to take such a risk. Some did not want to burden the health service further and chose to support it by staying away.

170. In the absence of research or data on this issue I cannot comment further on the extent of that, save that it was sufficiently significant for health and social care professionals to urge those experiencing ill health or social care problems not to delay seeking help from GPs, hospitals, or social care services and for Robin Swann Health Minister to give interviews urging people not to refrain from seeking health care if they need it, e.g., *"I understand that some people may think it is best not to attend their GP or ED when they know the service is under such pressure and I recognise people are making every effort to allow the health services to focus on COVID -19. However, if people are feeling unwell or worried about their symptoms, they should seek medical advice without delay."*[83]

e. Statement on the rights of older people to access healthcare and inequality in the access to healthcare

171. On 30 March 2020 a *Joint Statement on the rights of older people in the UK to treatment during the pandemic* ("Joint Statement") was issued, which is signed by me and the senior executives of AgeUK, Independent Age, Anchor Hanover, Commissioner for Older People in Wales, Age Cymru, Scottish Care, AgeNI and Age Scotland. I have been asked

by the Inquiry to explain my reasoning, as Commissioner, for participating in that Joint Statement.

172. The Joint Statement was issued at the time when death rates were rising alarmingly particularly amongst older people, there was intense competition for essential respirators and PPE that were in scarce supply, together with a shortage of hospital beds and a real fear that the sector would reach 'breaking point' with no viable vaccine in sight. The UK had just gone into 'lockdown' and thousands of clinically vulnerable people, many of them older people, had been advised to shield. The seriousness of the situation for health and social care was repeatedly emphasised, most prominently in a letter sent by Boris Johnston as Prime Minister on 28 March 2020 to every UK household that included the 'strap line' of the time for everyone to *"stay at home, protect the NHS and save lives"*. This was derived from:

> *If too many people become seriously unwell at one time, the NHS will be unable to cope. This will cost lives. We must slow the spread of the disease, and reduce the number of people needing hospital treatment in order to save as many lives as possible.*

173. In those circumstances I was concerned that in the allocation of essential but scarce health and social care resources, decisions might be taken that would disproportionately and adversely affect older people. I was particularly concerned about the influence of stereotypes about older people's clinical resilience based on their chronological age or place in a care home, that might encourage blanket decisions being made with age given too much weight rather than on a case-by-case consideration of individual circumstances, hence the inclusion of:

> *Any suggestion that treatment decisions can be blanket ones, based on age alone or with a person's age given undue weight as against other factors, such as their usual state of health and capacity to benefit from treatment, would be completely unacceptable. For many years we have known that chronological age is a very poor proxy for an individual's health status and resilience – something we all see among*

the older people in our lives. To ignore this and to revert to an approach based solely or mainly on age would be, by definition, ageist, discriminatory and morally wrong.

174. At the time of the Joint Statement, I was aware from UK-wide network meetings that ethics committees were working on policies on Covid-19 and that age was part of the criteria being considered for decisions including on admissions and CPR. By way of example only, around this time the BMA published, *Covid-19 – ethical issues: A guidance note*[84], that included:

A simple 'cut-off' policy with regard to age or disability would be unlawful as it would constitute direct discrimination. A healthy 75-year-old cannot lawfully be denied access to treatment on the basis of age. However, older patients with severe respiratory failure secondary to COVID-19 may have a very high chance of dying despite intensive care, and consequently have a lower priority for admission to intensive care.
Although a 'capacity to benefit quickly' test would be indirect discrimination, in our view it would be lawful in the circumstances of a serious pandemic because it would amount to 'a proportionate means of achieving a legitimate aim', under s19 (1) of the Equalities Act – namely fulfilling the requirement to use limited NHS resources to their best effect.

175. It was the decision-making around the *'capacity to benefit quickly'* where I felt older people might be particularly vulnerable. My main purpose in making the statement was therefore two-fold. Firstly, to ensure that older people knew their rights within the context of the unprecedented health crisis and reassure them that it was not legitimate for their care to be side-lined simply based on their age. Secondly, to seek to influence government decision-making.

176. As to the evidence for 'blanket-based decision-making', I became concerned about the risk of the application of 'blanket' policies through my work and experience that elderly people with severe Covid-19 symptoms were rarely being transferred to hospital for treatment and I was hearing reports of DNACPRs being applied to elderly patients without a proper consultation process with them or their families. From an early stage in the pandemic, and before I believe anyone had collected 'hard data' on the position in

Northern Ireland, I sought to act proactively to try and prevent such a risk becoming a reality.

177. As will be appreciated, I was also concerned about the broader issue of age-based discrimination of older people. I specifically raised the disadvantaged position of older people in Northern Ireland in relation to discriminatory practices that were enabled by the Equality Act 2010 not extending to Northern Ireland[85]. Whilst I had no 'hard evidence', I was aware from reports by older people's families and IHRP and there seemed to be fewer admissions of older people with severe Covid-19 symptoms from care homes to ICUs where both beds and ventilators were in short supply, and I felt it important to signal that age or care home residency should not become a 'screening tool' for access. There was similar anecdotal evidence about the use of DNACPRs, which may in turn have been at least partially influenced by the short supply of ventilators and the idea that a ventilator might be better used to assist a younger person 'who had their life ahead of them'.

178. I also expressed concern at the cancellation of surgical lists in multiple HSCTs across Northern Ireland, including orthopaedic surgery lists and the cancellation of some cancer surgeries. This was prominently reported in the media at the time[86]. I felt that the cancellation of such procedures was likely to impact more significantly on older people than on younger people and could therefore constitute indirect discrimination. This was particularly the case as I was aware Robin Swann Minister for Health indicated in a letter to me dated 19 July 2021 indicated that 40 per cent of people on waiting lists were aged 60 and over. This letter is exhibited at **[EL/18, INQ000417088]**. Also, I received reports from older people and their families that the deferment of treatment continued even after the pandemic to be a significant issue for older people, with untreated conditions manifesting themselves in more acute conditions later on and pre-existing waiting list issues being exacerbated by the cancellation of surgical lists. I was so concerned about the potential effect of this deprivation of required health care on the physical and mental well-being of older people, together with their quality of life, that in 2020 I intervened in Judicial Review proceedings brought by two women, one of whom was 75 years, challenging the waiting lists in Northern Ireland for elective surgeries. I sought to highlight the disproportionate impact of waiting lists for elective surgeries on older people and the exacerbation of this problem due to the pandemic, with the intention of persuading the

government to act. It is worth noting that the Judge considered that the resolution of the waiting list issue in these cases *"clearly involved high level political decisions in relation to resources and also in relation to structural reform of the health service"*[87].

179. In my view older people in Northern Ireland are more at risk of discriminatory treatment in respect of provision of healthcare than in other parts of the UK as Northern Ireland is the only part of the UK or Ireland where older people are not protected against discrimination in the provision of goods, facilities, and services. Both I and my predecessor have continually called for Age Discrimination (Goods, Facilities and Services) Legislation as a matter of upmost importance for many years. Tackling ageism is an overarching priority in the current COPNI corporate plan, *Right Here, Right Now*. In my view the pandemic has highlighted many stark examples of ageism within our society, and the exposure to this type of discrimination has played a key part in shaping the focus and intention of this corporate plan.

IV. LESSONS LEARNED

180. 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 Relevant 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 the response being not just swift but appropriate.

181. 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 correct 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. I have set out in my statement for Module 2C certain lessons that might be learnt in relation to those topics, some of which I consider are also relevant to issues covered by Module 3.

a. Understanding the Lay of the Land

182. Given that it was known that older people were uniquely vulnerable to Covid-19 and that significant numbers of them lived in nursing and residential care homes[88], in hospices or alone in their own homes with domiciliary support, an appropriate starting point before any response was formulated, should have been a rapid assessment of any structural weaknesses in the sector likely to be most relevant, together with the numbers of readily available staff and the nature of the facilities. This basic information was available, but it was likely to be held across several government departments particularly the DOH and DfC, as well as other public bodies such as the HSCB, PHA, HSCTs, and the RQIA. In my view the government was not sufficiently on top of this most basic first step, and it would have significantly assisted its approach to its response to the pandemic in relation to healthcare issues.

183. 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, not only had a statutory duty to assist but 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

184. 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 and placements where they lived. Whilst the plan was to consult us on the Guidance that 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. This was equally true of subsequent guidance on specific healthcare issues, for whilst COPNI was not a specialist

in healthcare it did have considerable knowledge and expertise about the circumstances of the older people on whom it would impact. In the future the government should seek to make best use of COPNI as a resource, together with the other Commissioners and those in the 'third sector'.

185. 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, which was appreciated, 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

186. There was an acknowledged need for reform of the sector and long-standing issues of insufficient beds and workforce shortages. Many of the care homes, and other settings in which older people were 'locked down' during the restrictions imposed by the government or through periods of isolation imposed by individual facilities, were neither equipped nor trained to care for the medical needs of older people should they contract Covid-19. Unless and until appropriately reformed, the government's response to any future pandemic needs to be framed with this in mind so that it can address the practicalities and be as effective as possible. 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 that undermined their trust in the ability of the DOH and the RQIA to keep the older people safe. In my view, the building of trust is a key task if people are to have the necessary confidence in the responses of the government to any future pandemic and to faithfully adhere to the restrictions imposed.

187. There were also 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:

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 and/or the deployment of resources, that were potentially ageist, such as admission policies which 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 older people off from their families, significantly reducing the extent and range of activities that were important for health and well-being and accelerating 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.

188. Those were all risks that a well-developed and appropriately used network could have helped to avoid or minimize before any measure was 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 Northern Ireland having an integrated health and social care service.

189. Some of the problematic issues only really emerged in operation, for instance: identifying the appropriate PPE and how limited stocks should be allocated; managing hospital admissions and discharges to make best use of scarce NHS resources; developing a programme for the tracking and testing of Covid-19 to protect vulnerable sections of the population; the wide-spread impact of imposing lockdowns; and the delegation of responsibility to individual residential and nursing homes to determine their own isolation and closure policies.

190. When I had reliable evidence of issues arising, I sought to draw it to the attention of the relevant authorities, usually personnel in the DOH. I am aware that others did so too. However, no effective mechanism was established for this, 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.

191. I would have preferred to have been able to use my interaction with the media in a more supportive way and for my engagement with older people, their families, and the sector as a whole to have been used more as a means of translating, explaining, and reinforcing the government's policies and guidance.

d. Dealing with the aftermath

192. A legacy of the government's response to the pandemic has been a loss of public trust and confidence in its competence. This loss of trust and confidence needs to be addressed, as belief that the government can manage a crisis appropriately is fundamental to compliance with its measures. A step to doing so would be to demonstrate that lessons have been and are being learned.

193. It is 4 years since the first lockdown was imposed and many older people are still living with not only the impact of Covid-19 but also with the consequences of the government's response to the pandemic. The Care Partnership was introduced by the government for families and care homes in part as a means of addressing some of the issues raised by the need to find a balance between the protection of older people and the maintenance of meaningful contact with their families, especially for those older people whose conditions meant they had a rapidly diminishing 'window of recognition'. The government had also allowed care homes to largely develop their own responses to the challenges of lockdown and the spread of Covid-19, which produced a range of initiatives such as the provision of outside 'visiting pods'. Consideration should now be given by government to reviewing the operation of the Care Partnership and the individual care home responses to assessing what might be standardised and supported across the sector to maximise

their benefits in this 'aftermath period' when isolation and periodic 'lockdowns' are still being imposed by individual care homes to deal with the Covid-19 that remains in the community.

194. There remain high levels of loneliness, depression, and fear amongst older people resulting from their experiences of the pandemic, together with despair about the ability of the health care system to respond to their needs, given the impact of the pandemic on a health care system that was already under strain. This is most obviously seen in, for example, the continued use of remote engagement with GPs and the increasing length of waiting lists that the recent Judicial Review shows can only be addressed by political decisions on resources and a degree of structural reform of the health service. These are issues that need to be grappled with in any event as whilst they disproportionately affect older people, they do affect others also. At present little is being communicated on the government's plans to help address, in particular waiting lists and more broadly the legacy of the pandemic, which would assist older people and others who are still struggling with the psychological and emotional impact of the pandemic.

CONCLUSION

195. 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 people for whom I was statutorily mandated to act as a champion, and 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, along with others whose organisations worked with older people, to try and convey to the government the urgency with which it needed to move and the practical issues that needed to be addressed for that to be effective.

196. 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 Relevant Period I had nearly 4 years in office, I

had developed a 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 and the likely efficacy of the government's proposed response to Covid-19, and the impact of the measures and guidance introduced to implement the government's policy.

197. 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*."[89] He was correct, it was clear, but a 'protective ring' was not thrown around the Northern Ireland care homes. Sufficient protection was not given to older people, even though they were foreseeably most likely to be vulnerable to Covid-19, nor was sufficient consideration given to how lockdown and other aspects of the government's response to the pandemic was likely to affect their opportunities to access the healthcare they required and to maintain their well-being.

198. Rather, a false narrative of lockdown in care homes was allowed to perpetuate, giving a misleading impression of the safety of those within the care homes or shielding elsewhere. Families were isolated from residents, some of whom were vital to their mental health and overall well-being, on the pretext that such isolation was essential to keeping the older people as safe as possible. In reality, care home staff and domiciliary care staff were unvaccinated, not tested for Covid-19 and yet able to come and go more or less as they please into care homes and older peoples' homes.

199. By the time the joint article was published in May 2020, there had been a total of 269 registered deaths in care homes alone from Covid-19[90], let alone older people more generally. Even then 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' ambition. Since the best available evidence, and the view of government itself, was that there was likely to be at least a 'second wave', in my view it was certainly

worth learning the lessons from the first wave and taking steps preparing to ensure a better outcome in any subsequent waves.

200. By June 2020 the requirements for lockdown had been eased and the very high death rate amongst older people in care homes was 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[91]. I thought it was time for the government to have an urgent inquiry into its response to the pandemic in relation to care homes, so that lessons could be learned for the further wave of infection that many believed was likely to follow the resumption of face-to-face interaction. Unfortunately, that did not happen. Instead, there was a more limited investigation by the Health Committee into the impact of Covid-19 in care homes, which I welcomed but which I made clear at the time was in my view not a substitute for a broader inquiry into the government's response. The government's preferred course was to participate in this Westminster instituted public Inquiry and whilst I also welcome it and look forward to its recommendations, I had in mind something specifically concerned with the position in Northern Ireland that might produce speedier outcomes, would be of demonstrable benefit to Northern Ireland in the outworking of this pandemic, and which could assist with the task of the authorities in Northern Ireland in preparing for the next one.

201. By 19 February 2021 there had been 983 deaths of care home residents in Northern Ireland, the overwhelming majority of whom died in the care home itself and not in hospital[92]. It is unclear how many older people died of Covid-19 during the pandemic. It is also not clear how many older people died of conditions for which they were unable to obtain treatment due to the focus of the scarce NHS resources on dealing with the pandemic or saw those conditions worsen. Many families feel their relatives suffered considerably during lockdown and the repeated periods of isolation imposed by their care homes or shielding in their own homes. There was a lack of social contact and a frequent deterioration in mental and physical health. Many residents in care homes were restricted to their own room and denied the opportunity to socialise with other residents who lived under the safe roof. Some of them are still living with its effects. For a number of people in care homes, that was the last year of their life. They had a very limited quality of life. They have very restricted access to family, perhaps with no physical contact. Families

were not allowed to visit loved ones until the last hour of end-of-life care. The process of bereavement was very disrupted.

202. Older people were undoubtedly significantly and disproportionately adversely impacted by the Module 3 issues, and their combined experiences capture something of the breadth of the impact of the pandemic. However, from my perspective the true issue for Module 3 is the extent to which in formulating its response to the pandemic, the government gave insufficient or inadequate consideration to the likely impact on the health, wellbeing, and survival of older people. The government should have better considered their circumstances, in particular the implications of Northern Ireland's integrated health and social care sector and the structure by which older people's care packages are provided. Therefore, any recommendations that may be made under Module 3 to improve the management of the response to any future pandemic, is likely to be of considerable importance to this section of the Northern Ireland population.

STATEMENT OF TRUTH

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

Signed:

Personal Data

Dated: 27th March 2024

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