

Thursday, 24 July 2025

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(10.00 am)

LADY HALLETT: Ms Carey.

MS CAREY: Good morning, my Lady, may I call our first witness, please, Professor Sir Michael McBride.

PROFESSOR SIR MICHAEL MCBRIDE (sworn)

LADY HALLETT: Thank you for coming back to help us, Professor McBride.

THE WITNESS: My Lady.

Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 6

MS CAREY: Professor, your full name, please.

A. Michael Oliver McBride.

Q. You have been the Chief Medical Officer now since September 2026 (sic), so not long off your 20th anniversary in that role.

A. That's correct.

Q. Can I ask you, please, a little about the role of Chief Medical Officer. And can I say at the outset, Professor, I'm aware that you've given evidence in other modules, we are going to try not to have too much repetition but inevitably there are people involved in this module that won't have the familiarity with the other modules and so I would like to cover some things in a little detail with you.

The role of the Chief Medical Officer I think you

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safety in relation to policy.

I also had policy responsibility for research and development within the department.

Q. Thank you. Well, I'm just focusing now perhaps on the remit of Module 6. I think you say nonetheless you are accountable to the Health Minister and your role is to provide independent professional advice to the minister.

You have a number of qualifications, Professor, and I won't go through them all, but you do say in your statement that you had no professional or technical expertise in relation to the social care sector, and you said you do not have expert knowledge of the care sector, but clearly over your time as CMO you will have gained some knowledge.

Can you help us as to how that knowledge developed in the run-up to the pandemic.

A. Well, perhaps to expand upon that, as a practising doctor, of course, I had direct responsibility in both my undergraduate training, my post-graduate training, my time as a consultant physician, of interfacing and working very closely with adult social care services. So from that point of view I would have knowledge and experience.

In terms of -- and my role as medical director within a trust, similarly I would have interfaced with

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set out at your paragraph 2.4, and you say:

"[You] hold roles in relation to the Department's general direction and oversight of [the health and social care] organisations ..."

Would you be able to expand on that a little, perhaps in more layman's terms as to what actually it is you do as the CMO?

A. Well, as was the case during the pandemic, I had a wide range of both professional and policy responsibilities. Those professional responsibilities included providing professional advice across all areas of the department, in terms of departmental policy. It also involved providing professional leadership to the medical profession in Northern Ireland and communication with the medical profession.

And from a policy perspective, I had responsibility for all of the domains of public health. So that would have included the actions that we took both within the department, across government, to improve the health and wellbeing of the population. So action around obesity, around alcohol and drugs, suicide prevention, and also policy responsibility around screening programmes, prevention programmes and, particularly of interest to this module of the Inquiry, was policy responsibility for health protection and also aspects of quality and

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the director of social work within the trust, director of nursing within the trust. And then working within the department as Chief Medical Officer, I would have worked very closely with the Chief Social Work Officer, the Chief Nursing Officer, and would have provided professional and technical advice which was important to particular important elements of policy that they were progressing in the adult social care sector.

So, you know, I think it was important to say that I was involved in providing input and advice, but I'm not a specialist in adult social care.

Q. Yes. Thank you. And was there anyone in the CMO's Group that did have the specialist knowledge and experience in adult social care?

A. No, that -- although we were fortunate in that we have an integrated health and social care system and the department has responsibility across health and social services, that we had the Chief Social Work Officer, who is obviously a social worker by background, we had the Office of Social Services and the professional social work advice that was available to the department and also to other government departments. And then you had the teams within the Chief Social Work Officer's group who had responsibility for a wide range of adult social care, everything from care home sector through to

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supported living, et cetera.

So in that way we had, I had access to and understood the key priorities within adult social care and we had a very effective and close working relationship in those issues in the department.

Q. Thank you. I think you say early on in your statement that you're not directly involved in work to develop care home guidance or, indeed, the visiting guidance, but you say you did support engagement with a number of other stakeholders and you were involved in the implementation of the visiting guidance; can I ask you, is that a reference to the Care Partner guidance or is it wider than that?

A. It's wider than that, and I just want to highlight that the work that was taken forward primarily by the Chief Social Worker and the Chief Nursing Officer were hugely important aspects of work, but as in the pandemic, there were so many priority areas that we had to brigade our resources and knowledge to those who were best suited to progress particularly aspects of the pandemic response and some of the mitigations. And the responsibility for leading on that work was primarily with the Chief Social Work Officer supported by the Chief Nursing Officer in relation to visiting, but I met with them on an ongoing basis, and we agreed, for instance, the prioritisation

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a weekly basis?

A. It's very difficult to put a number on that. I think that there would have been regular and frequent engagement. I mean, at that time we were working extremely long days, you know, 16 to 18 hours a day, seven days a week. So there was frequent and regular engagement and the pace, the complexity of issues is now even difficult to adequately describe, but because of that, my Lady, it did require us to work very, very closely as an integrated team, and I think part of the -- our ability to respond to the pandemic was predicated on those very strong interprofessional relationships that we had, and the interface that we had with the respective policy teams.

But also the long-established relationships we had with our colleagues in the Public Health Agency with the Health and Social Care Board. And I would have to say with respect to the adult social care sector, the long-established relationships that the Chief Social Work Officer and his team had with representatives of the sector. So again, there was very regular and frequent engagement.

Q. Right. Can I go back, though, to February 2020. And you say that on 17 February, you asked to see the integrated surge plans from the Health and Social Care

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of the Care Partner scheme.

Q. Yes.

A. We discussed regularly our ability to scale up and offer testing to visitors, and we communicated jointly in correspondence with the sector on a number of occasions, and indeed had joint meetings with the sector, where we both, all three of us, would have provided updates on work that we were progressing, and seeking to understand some of the challenges and difficulties in the sector in progressing those policies.

Q. Clearly you had -- you've told us there about your work with the Chief Social Care Officer; do you mean Mr Sean Holland?

A. Sean Holland, yes.

Q. And Chief Nursing Officer, I think was Charlotte McArdle, certainly in the initial stages of the pandemic. There were three over the course of the two years that the Inquiry is looking at, I think there was Fiona McQueen as well.

A. (Witness nodded)

Q. And was that Maria McIlgorm?

A. Oh, Maria McIlgorm, yes.

Q. Thank you.

Can you give us an indication of how often would you liaise with Mr Holland? Are we talking a daily basis,

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Board because you wanted to know the details and, indeed, the scope of the current planning, and I think you gave the board about a month to provide those plans, it didn't take them that long but you said that on receipt of the initial surge plans, you identified gaps in the surge plans relating to the adult social care sector.

Could you help, Professor, what were those gaps?

A. Again, from memory, as I've reflected in my statement because I haven't been able to locate the original versions of the plans that were submitted, planning at that time was difficult because we didn't have robust modelling in terms of what the consequences and impact of the pandemic was actually going to be. We knew it was going to be severe. But to actually ensure effective planning and mitigation required us to have better modelling, which would allow for a more effective operational planning.

The initial plans that came in, from my memory, in relation to the adult social care sector were primarily based on the understanding that there would be high levels of sickness absence, which was correct. I mean, that was a very, very sensible assumption, and indeed I had communicated that at the time to colleagues.

The gaps that I noticed in the plan related

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1 primarily to areas around prevention of infection,
 2 mitigation measures that we would put in place to manage
 3 effectively individuals in care homes who had Covid, the
 4 interface between the care home sector then and the
 5 acute sector, the primary care sector, and the clinical
 6 support that would be required to be provided, and also
 7 how we were to make care homes themselves more
 8 resilient.

9 So I'll say the initial plan was more about staffing
 10 pressures, where, in my view, what was required was
 11 a much more comprehensive plan.

12 Q. Yeah, I think in your statement you say they lacked
 13 specificity.

14 In relation to staffing pressures, did the plan set
 15 out what would happen if there was a 10% absence, a 20%
 16 absence, a 30% absence?

17 A. From memory it did, up to and including a 50% absence
 18 rate. And again, that was really important because
 19 obviously it was vitally important that individuals in
 20 living in care homes had the care and support that they
 21 needed. So that was a vital part of the planning but it
 22 wasn't, to my mind, the only part of the planning, and
 23 there were other elements that needed to be addressed.

24 Q. Did you ask at all why the plans lacked the specificity
 25 that you thought they should have?

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1 care, community care, right the way through to critical
 2 care.

3 As I recall, considering the trust plans,
 4 individually they were robust. There were, as I recall,
 5 some issues with some of the plans, but what was
 6 required was an overarching integration of those plans.
 7 So for instance, each organisation had its own plan but
 8 what I needed to see was that there was an overarching
 9 coordination of the plans within all of the trusts. So
 10 for instance, if there were acute pressures in one
 11 particular trust in terms of beds or ICU beds, how would
 12 that be managed regionally?

13 There was an assumption, I thought implicit in the
 14 plans, that that regional coordination would be
 15 happening and I did not see then that robust mechanism
 16 whereby that regional -- (overspeaking) --

17 Q. If I can perhaps bring it to Northern Ireland level,
 18 there were particularly pressures in Belfast, for
 19 example --

20 A. Yes.

21 Q. -- a more heavily populated area. Are you saying that
 22 the surrounding trusts were not necessarily geared up
 23 for helping Belfast out in the event that they became
 24 under significant pressure?

25 A. In essence, I think that's a very helpful summary. And

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1 A. No, with the passage of time, I don't recall having that
 2 conversation or making that ask, but I then did take
 3 steps to have the plans, I suppose, a second eye
 4 consider the plans and to have those quality assured and
 5 to ensure that any gaps were addressed.

6 Q. Right. I'm going to come on to that because I think
 7 you're referring to the report that you commissioned in
 8 July 2020, but before we get there, can I ask you this:
 9 there was also a health and social care plan from
 10 mid-March to mid-April that was published and we
 11 understand from Mr Holland that sitting under them were
 12 plans at health and social care trust level; have I got
 13 that right?

14 A. That's correct, yes.

15 Q. And I think you say in your statement that you reviewed
 16 the health and social care trust level plans. Are you
 17 able to give us an overview now of what kind of planning
 18 there had been at trust level in relation to the adult
 19 social care sector?

20 A. There had been extensive planning, and anticipation of
 21 where the pressures would be. I mean, the letter that
 22 I had written in February, which you alluded to, on
 23 17 February to the Health and Social Care Board and the
 24 Public Health Agency had asked for comprehensive plans
 25 across health and social care, everything from primary

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1 I think that it was that regional coordination, to my
 2 mind, which needed to be much more robust.

3 Q. Now you asked, as you just alluded to, for work to be
 4 done to quality assure some of the plans, and you said
 5 you commissioned work in the care home sector and you
 6 report was delivered on 1 July 2020, and I ask because
 7 I'd like to know how the work that you commissioned in
 8 July affected the pandemic response as we entered the
 9 winter of 2020.

10 If it helps you, Professor, we can look at the
 11 report.

12 It's INQ000459860_8 or it might be 9 -- back one
 13 page, please. Thank you.

14 This was the review of the trust surge plans, and if
 15 we go down to paragraph 5.6, I think we'll see there the
 16 point that you were just making about the wide variation
 17 in the trust plans and the regional approach that we've
 18 just spoken of. The review found that:

19 "Arrangements for practical hands-on support was not
 20 always clear in plans, nor was the supportive
 21 infrastructure to provide clinical and in particular
 22 nursing support into the sector."

23 A. Yes.

24 Q. Can you give us a sort of practical example of what the
 25 review there was talking about.

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1 **A.** Yes, and just to go back a little bit, that, yes, the
 2 quality assurance did inform the plan for that winter,
 3 but actually we didn't wait until 1 July -- or 10 July
 4 I think this paper was published -- to basically
 5 implement the learning from the external quality
 6 assurance. That was an ongoing process of engagement
 7 with the trusts, with the independent care home sector,
 8 facilitated workshops which were alluded to within the
 9 report, and then that was built into the plan that had
 10 been published, that you alluded to earlier, on
 11 19 March, the health and social care Covid-19 summary
 12 plan, and actually, the 13 March, then, social care plan
 13 for children and adult services.

14 So, as I say, it was an iterative approach, but this
 15 was the final document which summarised all of the
 16 extensive work and engagement that had taken place
 17 during that period.

18 **Q.** All right. I wasn't suggesting it was -- there was only
 19 one plan and then only the July review, but thank you
 20 for telling us about the other iterative approach that
 21 Northern Ireland took. I was actually asking there,
 22 Professor, about the arrangements for practical hands-on
 23 support, which was not always clear. What was driving
 24 that? Can you help?

25 **A.** Yes, that was in relation to if indeed a care home had
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1 were in a consistent way, nor was there a mechanism,
 2 once those pressures were identified, to escalate them
 3 in a consistent way to ensure that those pressures were
 4 flagged to the relevant teams within trusts, to ensure
 5 that there was an appropriate response.

6 **Q.** I ask you these questions to really try to find out
 7 what, then, the product of this was that was of
 8 practical assistance come wave 2.

9 And can I ask for page 78 of this document be put up
 10 on screen, because there was an appendix to the review,
 11 which perhaps gives a little more detail, but can you
 12 give us an overview, Professor, of appendix 8 and how it
 13 practically helped, come winter 2020?

14 **A.** Well, this was, you know, a plan on a page, this was
 15 a schematic, this was a mechanism that the external
 16 reviewers used to engage with the trusts, with the
 17 Health and Social Care Board, and with the PHA, having
 18 engaged with the sector. And basically, what it was --
 19 and in very simple terms, was putting care homes at the
 20 centre of the preparation and planning, and basically
 21 all of the subsidiary services in the context of care
 22 homes, whether that's GP Covid hubs, you see up in the
 23 top left, clinical district support services, just below
 24 that, a range of other services that would reach into
 25 care homes, and I think if we flip to the next -- sorry.

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1 an outbreak, what was the support that would be provided
 2 in practical terms, in terms of clinical support,
 3 clinical services, access to general practice input, you
 4 know, in -- access to respiratory -- expert respiratory
 5 care advice, the arrangements then for admission of
 6 individuals from care homes into trusts?

7 But it also was around managing some of the sickness
 8 absence that the care home sector was undoubtedly going
 9 to see, and what were the mechanisms whereby care homes
 10 could identify the pressures in terms of staffing that
 11 had the potential to impact on the quality of care that
 12 those living in care homes were experiencing, and what
 13 were the mechanisms to escalate that and then to respond
 14 to address that?

15 **Q.** Right, we'll come on to that. Can I just go over to
 16 page 10 in the document. The review also found there
 17 was: an initial focus on supporting care homes with
 18 outbreaks but less so on protecting and shielding the
 19 Covid-free care homes; data sets differed; and the
 20 process of monitoring was unclear in trust plans.

21 That last bullet point there, Professor, what was
 22 unclear about the monitoring and who should be, in fact,
 23 monitoring?

24 **A.** I think it was both aspects. I think that there was not
 25 a established mechanism to identify what those pressures
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1 **Q.** Before we go to the next page, may I just ask you about
 2 some of the actions down the right-hand side of this
 3 document. One can see in the top box there's actions
 4 related to care homes, and -- thank you very much --
 5 "Expanded capacity -- 390 probable from dormant and
 6 planned expansions" --

7 **A.** Yes.

8 **Q.** -- is that 390 extra homes? 390 extra beds? What was
 9 this document telling us about?

10 **A.** That was about -- the first element was about maximising
 11 the bed capacity in the care home sector.

12 **Q.** Right. The plan doesn't actually say how or who is
 13 responsible for finding an extra 390 beds.

14 **A.** Yeah.

15 **Q.** Can you help, how was that, then, in fact achieved?

16 **A.** I suspect -- I mean, from memory, I don't think that
 17 additional capacity was achieved, but it was to inform,
 18 in a fairly straightforward way, conversations with
 19 trusts, PHA, and the board as to how that might be
 20 achieved and what the options were there to perhaps
 21 purchase more capacity, identify more capacity, in the
 22 system.

23 Again, it relates to probably, you know, points 2
 24 and 3 there as well.

25 **Q.** I was going to ask you about point 2.

16

1 A. Right.

2 Q. Point 2 says:

3 "Providers collaboration with hotels (440+

4 [presumably rooms or beds] identified to date)"

5 What was the action that was envisaged that would

6 require people who might need care home assistance to

7 be, what, housed in a hotel?

8 A. Well, this was at an early stage in the pandemic, and as

9 a consequence of this, that -- given the concerns that

10 there were about discharge from hospital, because

11 obviously we didn't have enough tests at that point in

12 time, and there had been advice from 3 April that

13 individuals who were discharged, even though they had no

14 symptoms, should be isolated for 14 days.

15 Q. So was this a step-down facility, effectively?

16 A. Well, step-down in health service terms, is different.

17 Q. I see.

18 A. This was an arrangement which a number of trusts to put

19 in place to ensure that the isolation period for

20 individuals who were being discharged was completed when

21 their clinical care was finished within the acute

22 sector, and the risk was that by staying in the acute

23 sector, they may be exposed, as we were anticipating

24 significant numbers of people coming into hospital with

25 Covid, and this was a step-down in the sense of

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1 setting into their own home, and whether it would be

2 similarly utilised. I'm sorry, I don't recall the

3 detail of that.

4 Q. Can I ask you then, please, about page 80 of this

5 document and this is what's called a care home trigger

6 matrix, which deals with surge status and various

7 pressures, whether it's numbers of residents that have

8 got Covid, workforce pressures, et cetera.

9 And we can see there green, amber, red, RAG ratings,

10 to use that phrase. What I was trying to understand was

11 how the plan set out what the response would be if

12 a care home did have a high number of residents and

13 perhaps inadequate staff to not meet the care needs

14 today/overnight. Where does the information sit about

15 how it was to be dealt with?

16 A. I think it's probably on the page just before that, but

17 this was information that was shared with the Health and

18 Social Care Board at Health Silver, but it was also

19 information that was shared with the department and it

20 was shared with the individual trusts. So this is the,

21 I suppose, the intelligence, live intelligence would

22 have been provided by the -- and that's something which

23 I presume we will cover perhaps later -- the Service

24 Support Team, who basically acted as the conduit between

25 the care home sector, having identified the degree of

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1 individuals who were well enough and it was appropriate

2 to complete their isolation in a facility that wasn't

3 a care home.

4 Q. It's my fault. I did mean isolation rather than

5 step-down, but thank you for clarifying that.

6 Do you know, in fact, the kinds of numbers of people

7 that were discharged from hospital that ended up going

8 into a hotel to complete their isolation?

9 A. I don't know the numbers. I know there were at least

10 four facilities that were used in that way. But again,

11 I don't have the detail of the numbers.

12 Q. Right. Can I just ask you about the "Care at home" box

13 which is on the bottom of our page 78. Clearly there,

14 point 1 is "Prioritisation of vulnerable clients" but

15 the hospital provision of short-term -- sorry, "hotel

16 provision of short-term placement -- proforma for

17 admission", what was envisaged for people who would be

18 requiring care at home to be isolated in a hotel?

19 A. I don't recall that level of detail at that time.

20 I think certainly -- I mean, obviously the individuals

21 would only have been discharged from hospital as part of

22 that discharge process, if they were well enough and

23 fit, medically fit, to be discharged from hospital.

24 I honestly can't recall whether that considered those

25 individuals who would be discharged from an acute

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1 surge and pressures across those areas, status areas

2 that you've mentioned on the left, the big box on the

3 left, and then there was an assessment made of the level

4 of support that was required. For instance, that

5 support could have fallen into operational support, in

6 terms of with PPE, with equipment, but equally, up

7 towards the top box, it could have required clinical

8 support from the care home support teams --

9 Q. I see.

10 A. -- within the trusts, and particularly, in the third row

11 down, palliative care teams in terms of those

12 individuals who it was deemed and -- who, for instance,

13 may have had an advanced care plan and who were

14 approaching the end of life and escalation into an acute

15 care environment was not required, but however, their

16 palliative care needs needed to be met within the care

17 home environment.

18 Q. Can I take a step back and we can see there now some

19 detail that is emerging following the review of the

20 trust plans. Was this kind of detail absent from the

21 pre-pandemic trust plans that you looked at?

22 A. Yes.

23 Q. And do you know now whether the pre-pandemic planning in

24 the event of a future pandemic descends into this kind

25 of detail that we see on our screen?

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1 A. That work is ongoing at present. This is the sort of
 2 detail that we do need to have in place and, in my view,
 3 in the future, emergency planning across health and
 4 social care needs to be fully integrated with the adult
 5 social care sector. There is -- and also business
 6 continuity planning, both in healthcare, needs to be
 7 fully aligned with the adult social care sector. The
 8 interdependence, you know, the -- there is no -- I mean,
 9 we have an integrated health and social care system in
 10 Northern Ireland but at times it's not as integrated as
 11 it could be, and this, I think, is a really important
 12 mechanism to build on in terms of future pandemic
 13 preparedness to make sure that we not only are able to
 14 provide the clinical care and support that's required to
 15 the sector but also that we're rapidly identifying what
 16 the operational needs of the sector are to provide
 17 appropriate clinical care and support.

18 Q. Can I move on to the discharge policy, please, and you
 19 say in your statement that you did not provide specific
 20 advice or guidance on patient discharge, and clearly,
 21 whether a patient is clinically fit for discharge is
 22 a matter for the doctor and clinicians reviewing the
 23 patient, but you were involved, I think, in the -- sent
 24 a draft of the 17 March guidance for care homes, albeit
 25 you say you were not involved in the development itself

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1 particular about how staff are going to be provided with
 2 PPE.

3 Two questions. Do you recall ever looking at the
 4 17 March guidance and realising there was potentially
 5 a lack of guidance about how PPE was to be provided?

6 A. Again, it's very difficult now, having considered so
 7 many documents, to remember what I knew at a particular
 8 point in time and what I now know. From memory, the
 9 core of the 17 March document was around cooperation
 10 between the care sector and trusts in relation to
 11 workforce. I think they did specifically cover issues
 12 such as PPE and the trusts supporting the care home
 13 sector with the supply of PPE and it covered a wide
 14 range of issues.

15 I would say that that document is very much
 16 a high-level document, but beneath that there would have
 17 been the operational engagement between the Public
 18 Health Agency and the Health and Social Care Board with
 19 the sector itself. And as I say, that was the --
 20 I understand -- as I recall, that was probably the third
 21 update there had been to that guidance prior to its
 22 being updated subsequently.

23 Q. Were you aware of concerns that the Department of Health
 24 seemed more focused on getting the guidance out than
 25 making the content itself perhaps more practical and

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1 of the guidance. Were you essentially asked to review
 2 the 17 March guidance?

3 A. It was sent -- the 17 March guidance was sent. I mean,
 4 again -- and it's not that this was not a very important
 5 piece of guidance, it was a fact that I had so many
 6 other competing pressures and demands at that time, and
 7 to my assessment, all of the relevant people who needed
 8 to be involved in the development of the guidance were
 9 involved.

10 You that the Chief Social Work Officer and his
 11 policy team, who had an intimate and detailed knowledge
 12 of the adult social care service, you had the Public
 13 Health Agency and the experts in infection prevention
 14 and control, they're both medical and nursing providing
 15 input into that. And you had the Chief Nursing Officer
 16 and her team who were supporting the infection
 17 prevention and control team and the PHA. And it --
 18 unlike -- most probably may have been considered by my
 19 Deputy Chief Medical Officer, but certainly I didn't
 20 provide any personal input into the document.

21 Q. Right. Can I ask if you were aware, though, that -- the
 22 Inquiry has heard that the Commissioner for -- the
 23 office of -- Older People in Northern Ireland, and
 24 indeed the IHCP, the independent health care providers,
 25 had concerns about the 17 March guidance, and in

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1 helpful for the providers and the sector in general?

2 A. I think -- I can't now recall -- I'm certainly --
 3 whether I was aware of it at the time. I suspect
 4 I probably must have been aware that there were some
 5 concerns around engagement with the distribution of the
 6 guidance. However, to my mind, the priority --
 7 I mean -- well, firstly, it was always accepted that the
 8 guidance, again, would be developed and there would be
 9 further refinement of it.

10 Secondly, the immediate issue, and the most urgent
 11 issue, was to get guidance to the sector, which could be
 12 updated, because our primary objective was to ensure
 13 that the information was within the sector as to how we
 14 best protect those most vulnerable people in care homes.

15 I think that, yes, could we have consulted more
 16 widely? Could we have engaged more widely? However,
 17 that would have been at the expense of the timely
 18 dissemination of the guidance. And as I recall, within
 19 a week of the guidance going out, we had a significant
 20 increase in outbreaks in care homes.

21 The other important thing about the guidance was
 22 that the guidance wasn't just about guidance; it was
 23 also about ensuring that we were skilling up the staff
 24 working in the health and social care sector. So there
 25 was a section within the guidance that said "These are

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the available resources to increase knowledge and skills around infection prevention and control", and it pointed to various sources of online training. Importantly, also it alluded to online training that was going to be provided for health and social care workers in the sector, particularly those who had no previous experience of working with individuals who had significant respiratory problems, and required care.

So it wasn't just about getting out guidance; it was about ensuring that there was awareness of how the guidance should be applied and all of the training that was required to go along with that. And, you know, the Chief Nursing Officer and her team engaging with Northern Ireland Social Care Council, engaging with the Clinical Education Centre, provided -- working with, again, the PHA and trusts, provided a significant amount of training to enhance the skill base within the sector, which, again, I think is an important learning point for the future in terms of that skill base within the health and social care sector.

Q. In the week that the guidance came out, I think you have seen a statement from COPNI, if I can use the shorthand, where COPNI describes attending a meeting or something -- the chief executive attended a meeting where there was an "air of unreality", to use their

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seriousness of this.

So this was about communicating to the system in Northern Ireland, not just health and social care, but right across other government departments, as well, what we were about to face into. So I mean, I really don't understand any sense of unreality or lack of urgency.

I mean, I would add that the context of this, as you highlighted earlier, was that I had already met, on 11 February with the Health and Social Care Board asking them to draw up plans for surge, which I was fully anticipating. I'd written to them on the 17th. We were in the midst of that plan. I was attending meetings of COBR, meetings with the UK Government, attending meetings of SAGE. There was no sense of unreality in terms of what we were facing into at all.

And within days, we had introduced, on 16 March, social distancing, working from home, advising people not to go to pubs and restaurants. So I really don't understand that reflection.

Q. Right. You say in your statement that in due course you became aware, in general terms, of concerns in relation to the hospital discharge and although you can't recall now the source or when you became aware, what I'd like to know is what were the actual concerns that were being raised with you?

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phrase, about the possibility of scenes from Italy of old people dying happening in Northern Ireland. And COPNI's statement says that the view expressed by the Chief Medical Officer, and indeed the Chief Social Worker, seemed to be: that won't happen here, they have a completely different system over there.

Indeed, Mr Lynch told us yesterday that his general impression in March was that there was the air of unreality that it wouldn't happen in Northern Ireland.

Was there a sense, from your perspective, that what we had seen happening in Italy wasn't going to reach the shores of Northern Ireland?

A. I fail to understand those comments, if I'm really honest. And in the context of events at the time, I think the -- a meeting that's referred to was not actually the meeting of 16 March, it was an earlier meeting that I engaged with the Commissioner for Older People, in Evelyn Hoy, and that was on 13 March, and that was part of a series of meetings which reflected the seriousness of the impending situation.

So in that series of meetings that day I met with all the trade unions, I met with primary care representatives and secondary care representatives. I met with the Department for Communities and local government and explained the evolving situation and the

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A. I think certainly, from memory, from early on, there were concerns, and understandable concerns and concerns which I think that were very frustrating and they impacted very significantly on some of the policy decisions and operational decisions we were making around lack of testing capacity. And there were concerns, and they were reasonable concerns that in the absence of testing, that discharging people from hospital risked introducing infection into care homes.

My recollection was that that was the nature of the concerns.

Q. Right. You go on in your statement to refer to a report called the "Rapid analysis of the possible growth of respiratory outbreaks in ... Care Homes in Northern Ireland". It was a report from April 2020, which suggested that by the end of May there may be between 160 and 300 outbreaks in care homes of respiratory infection and that there may be a rise from around three nursing home outbreaks a day to around 14 outbreaks a day, assuming that none of the non-pharmaceutical interventions happened?

I just want to understand, who commissioned that report, and what effect did it have on pandemic planning and, perhaps, even planning into surge 2?

A. I mean, I think that the plan -- sorry, the, I

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suppose -- now, I think it's probably unwise to describe it as modelling, because what it was, was an extrapolation from if we continue to see the same rate of growth in infections in the care home sector by, you know, by the end of May, we may see X, as you've described. And the difficulty with that was that it didn't take into account the fact that there had been very significant non-pharmaceutical interventions, restrictions, introduced in terms of reducing population and social contact and social mobility.

And at the time that that report was received, the R number, which was the, in Northern Ireland was between .75 and .8, so all of the trajectory of the pandemic at that time was actually downwards, and contrary to the report which was actually shared with myself and shared with the Chief Social Work Officer, it -- the envisaged scenario at the end of May did not transpire, care home infections peaked in early May, on 7 May, remained stable and started to fall throughout May, the latter part of May and June, and in early August, I think it was the end of the first week in August, we had only two confirmed outbreaks in care homes.

So I think what it -- it demonstrated, I think the important thing in that report and in the email associated with it, it demonstrated the series of

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community surveillance. There was actually, even though we were detecting very small numbers of cases, those were only the symptomatic cases that we were detecting, and there was clearly an extensive degree of asymptomatic transmission occurring, which we were unaware of at the time, and actually hadn't the ability to identify the extent of that, because we simply didn't have the tests.

So I think that's what contributed to the very sharp rise and --

Q. Can I just pause you there because I just want to make sure I understand that.

A. Yes.

Q. Is essentially what you're saying is that although you can't say for certain, you consider it's possible that there was a rise in infections in care homes in May because there was a high prevalence of Covid in the community?

A. Of which -- to the extent to which we didn't know.

Q. Yeah. Understood. All right.

I interrupted you, Professor, but I just wanted to be clear about that was essentially where you got to, albeit that you can't say that with any evidential certainty because of the lack of testing.

A. I mean, a good example, you know, on 2 March, the

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actions which the Health and Social Care Board and PHA at Silver were doing in terms of planning for any eventuality whereby there were significant care home outbreaks. It summarised the actions that were already taken, and also indicated that there was, as I would have expected to have been happening at that time, ongoing engagement between Health Silver and trusts in terms of planning and preparing for a range of eventualities.

Q. Can I ask you about the peak in early May.

A. Yes.

Q. Because we've heard evidence that there were particular supply issues in March and April, but they ameliorated as time wore on. There was, by early May, testing of hospital discharges, and indeed of some of the staff, at least, working in care homes. Do you know or does the department know why there was a peak therefore in early May?

A. I think that, you know, looking back on it now, and again, you know, there isn't -- it is undoubtedly the case that across the UK we had a very rapid rise in the first wave. That was because we didn't know the extent to which there had been multiple seeding of infection from other parts of our European neighbours, and because we weren't testing at a community level, there was no

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minister, the then minister provided a statement to the Executive, indicating that we had carried out 150 tests, and one had been positive.

Now, that was not what was happening. It did not reflect the reality of how the pandemic was spreading or how rapidly it was spreading. And I suppose it reflects the fact that in many respects, we were running to catch up.

Q. Can I ask you, then, to look, perhaps, at your paragraph 6.8, Professor, because you say that -- it's dealing with May still, there was a care homes report that came out on 14 May and you summarise it in your statement at paragraph 6.8, and you say:

"On the issue of transmission mechanisms between and within Care Homes there was a sense that [Northern Ireland] was performing relatively well in this area, probably due in part to its integrated health and care system and the small number and size of Care Homes."

And I wanted to know in what sense that Northern Ireland was performing relatively well was based?

A. It was based on comparative analysis of the numbers of outbreaks in care homes and the -- at that point in time, the relative numbers of deaths that were in care homes. Now, I mean, I think that the impact on care homes and the number of deaths in care homes was

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1 profound and, you know, it was a question of doing less
2 badly rather than doing less well.

3 I think that it's very difficult to understand --
4 I mean that was in the context of a paper that was
5 discussed at the Strategic Intelligence Group --

6 **Q.** Yes, it was.

7 **A.** -- which actually looked at data, so it was -- the group
8 itself, I can't recall the exact data that we were
9 considering, but we would've, at those meetings, been
10 reviewing that paper and we would've been looking at
11 the relative numbers of outbreaks across the UK.

12 Now, we were doing that comparison analysis to
13 identify if there was anything that we should be doing
14 that others were doing that was -- actually could make
15 the care homes more secure and prevent more outbreaks.

16 I mean, subsequently, there has been international
17 comparison around care homes, care home deaths, across
18 a range of countries, and I think that there is clearly
19 a huge range in variation in terms of the impact in care
20 homes, and I think trying to understand the differences
21 in terms of the provision of adult social care in
22 different countries, the structure of it, the workforce,
23 how those who support the workforce are trained,
24 recognised, remunerated, I think there is a rich
25 comparative analysis and research to be undertaken as to

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1 **A.** Was I surprised, I -- I mean, I wasn't involved in the
2 commissioning of the report or its methodology. I was
3 aware of the report. I did get a presentation on its
4 findings. I think that, you know, the review had
5 limitations, and, you know, there is absolutely no doubt
6 that there were multiple routes of transmission -- or,
7 sort of, multiple routes of entry of Covid into care
8 homes. Discharge from hospital was one, but there were
9 many, many others. And I think it would be unwise to
10 attribute undue significance to one mode of entry into
11 a care home without the evidence base for it.

12 So I think this was a descriptive piece but there
13 were limitations in terms of the study. I mean, the
14 main one being that there was very limited testing going
15 on at that time, and the only individuals that were
16 being tested were those with symptoms.

17 **Q.** Well, that's what I was going to ask you. Do you think
18 there should have been more work done once testing
19 became available to check whether there was a link
20 between the hospital discharges and the infections in
21 the care homes?

22 **A.** I mean, obviously that -- we were reliant in Northern
23 Ireland on a lot of that work that was being carried out
24 and those research studies that were being carried out
25 in the rest of the UK. We had access to those research

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1 understand why some of those differences existed.

2 We were looking at it from the point of view of
3 identifying what more we could do.

4 **Q.** I think it's, Professor, the phrase "performing
5 relatively well"; "Compared to what?" many people may be
6 asking. Because you've told us about the peak of
7 infections in care homes. There'd been, I think,
8 297 deaths in care homes by 15 May. In what sense was
9 it -- Northern Ireland performing relatively well?

10 **A.** It was in comparison -- and I can't remember the detail,
11 but it was in comparison to what we were seeing in terms
12 of the impact in the adult social care sector, and
13 particularly care homes, in Scotland, England and Wales
14 at that time.

15 **Q.** We know that in Northern Ireland there was specific
16 research into the relationship between discharges and
17 outbreaks by November 2020 in the Herity report, and
18 we've looked already at the two weeks of testing that
19 was carried out -- sorry, the two weeks that were looked
20 at in the report, noting there was no testing in week 1
21 and limited testing in week 2, and it showed outbreaks
22 more closely correlated with hospital admissions than
23 discharge, but there were relatively low numbers of
24 links between hospital discharges and infections.

25 Were you surprised by those results, Professor?

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1 studies from SAGE, Vivaldi, the Easter 6 study. So that
2 information was readily available to us. The findings
3 of those research studies would have been discussed at
4 the Strategic Intelligence Group. And in truth, as
5 well, we would not have had the capacity to replicate to
6 the scale that those studies provided really rich
7 information that actually demonstrated how we might
8 reduce the risk in care homes and those factors that
9 increased the risks in care homes.

10 So we didn't -- to answer your question, we didn't
11 do further research in that area.

12 **Q.** Right. You've mentioned a couple of times there that
13 there perhaps needs to be research undertaken, not just
14 into that route of ingress but to comparisons between
15 why there's outbreaks in either one country or another,
16 or even more at a local level.

17 Can you help from the Northern Irish perspective,
18 acknowledging that there's perhaps not the resources
19 that some of the other nations have, what capability is
20 there in Northern Ireland, though, to carry out this
21 kind of research?

22 **A.** There is capacity. We do have a health and social care
23 research strategy, our Chief Scientific Adviser is also
24 the head of the HSE R&D division, which sits within the
25 Public Health Agency. So there is good quality research

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carried out in Northern Ireland. Now, in terms of local to Northern Ireland, it's on a smaller scale, but Northern Ireland does punch above its weight in terms of contributing to multi-centred studies, trials, UK-wide research, and indeed international research.

I think that -- in relation to further research in this area, I think the National Institute for Health and Care Research I think is the most and best placed body that could be commissioned to look in more detail at the many, many complex factors that underpin and could potentially act as mechanisms to reduce risks. So that -- yes. I can elaborate if it would be helpful, but maybe not --

Q. No -- well, it brings me on to what I want to finally ask you about the discharge policy, and you say in your statement that whilst there was attempts to reduce the risk of Covid getting into the care homes, it remains the case that the hospital discharges into care homes did connect two high-contact environments, and reducing the risks should and must remain a priority in similar pandemics.

It may be that many people would not disagree with that sentiment at all, but how, Professor, do you say there could be work done to try to reduce the risk between those two high-contact environments?

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So what we actually really need is more robust data, not just in relation to care home residents, but also more robust data in terms of those staff working in care homes, the staff that interface between the acute sector and care homes, and it's only whenever we have that data and that data is joined up between the acute sector, the adult social care sector, primary care, that we can begin to understand those complex interfaces, and actually identify strategies that might interrupt and potentially break the potential chains of transmission.

Q. You refer there to staff inadvertently being a vector of transmission, and in your statement you acknowledge the tension that in limiting staff movement, there is still nonetheless the need to provide a safe level of care for the residents. Do you have any views on how best to achieve the need to restrict staff movement but also the need to provide the level of care in Northern Ireland?

A. And is this during a pandemic?

Q. During a pandemic.

A. I think we did attempt to do that during the pandemic. So, for instance, resources were made available to the adult social care sector and care home sector to block book agency staff, for instance, to prevent agency staff, who would be working on a part-time basis, moving between one care home and another. I think that was an

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A. I think it's about understanding how, for instance to -- and it's back to the last question -- how do we make care homes more -- for want of a better word, more Covid secure?

So that will -- really it looks at -- that requires us to look at of the infrastructure, the structure in terms of care homes. If we were -- you know, bearing in mind that care homes cover a wide range of facilities, some very small, some extremely large, some purpose built, some repurposed buildings, I think it's important that we look at both issues such as design, building control, the -- how we design the potential to cohort individuals within care homes so that, for instance, there are smaller numbers of individuals in smaller units within a care home, that we are not having staff moving between care homes.

I think there's also, in terms of that connection with hospitals, it's about having mechanisms whereby we can track and monitor the movement of health professionals between the trust-based facilities and into care homes. For instance, if we had an outbreak, it would -- we would basically be starting from a very low base in terms of identifying all of the intelligence which would identify those staff movements and putting together a picture of how infection got into care homes.

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important piece of work, and that happened very early, actually, in March of 2020.

I think that the other important aspect that we introduced early on was the introduction of sick pay for staff, because, whilst many care home providers did provide sick pay, many did not, and from a behavioural science perspective, it is really important that individuals, often who are very lowly paid, are assured that if indeed they are symptomatic and should be self-isolating, that it is not going to have a detrimental impact on their income.

So I think that was an important practical step that we did.

I think that there were other things that we did, and I could elaborate but I think the important thing in terms of your question is, there are a range of things which I think we can identify that -- I've listed two, which would reduce the risk of staff moving between care homes, and other mitigations that we couldn't put in place, and we put many of those initiatives in place at the time, but we shouldn't be waiting till the next pandemic to actually plan and prepare and write those important aspects into future pandemic preparedness at planning.

We need to be planning for those interventions now,

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1 and we need to have those written in to our plans, and,
 2 you know, as we move into Exercise Pegasus in the
 3 autumn, I think the -- there are clearly important areas
 4 that we need to test with respect to adult social care.

5 **Q.** Do you consider that it would have been of assistance to
 6 have brought in legislation limiting staff movement in
 7 Northern Ireland during a pandemic?

8 **A.** I'm not an expert on legislation. I think that it's
 9 very tempting to reach for the lever which says, "Make
 10 something mandatory and it will happen". That isn't
 11 always the case, in my experience.

12 I think that we -- I think that there are several
 13 things we can do to limit staff movement, something
 14 which I emphasised repeatedly during the pandemic,
 15 something that we were aware of and something that we
 16 tried to address. It's about reducing the drivers for
 17 staff movement. Why --

18 **Q.** I follow that.

19 **A.** Oh, sorry.

20 **Q.** No, no, and I follow that because you've outlined
 21 a number of the ways --

22 **A.** Okay. The limitations in terms of introducing
 23 legislation were: could we have introduced that
 24 legislation in a timely way? I think, although I'm not
 25 an expert, there would be a lot of employment law

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1 know what, if any, special work was done to try and
 2 limit ingress into those larger care homes?

3 **A.** Special work over and above the general approach?

4 **Q.** Yes.

5 **A.** I think that the guidance at the time, and I do recall
 6 discussions with colleagues and the Chief Social Worker
 7 and the Chief Nursing Officer in respect of teams, about
 8 cohorting of individual residents in care homes, and
 9 actually cohorting the staff within those care homes to
 10 ensure that staff were not moving between caring for
 11 individuals who had Covid and individuals who hadn't
 12 Covid.

13 I think the other advice that we provided, and the
 14 PHA re-emphasised this during the Omicron wave in early
 15 2021, was the issue of staff movement. I think that
 16 staff movement between larger care homes is a particular
 17 issue, because they are often part of chains, and staff
 18 will often work, and may work, across a number of care
 19 homes, particularly where there are pressures.

20 Now, as I say, I'm not an expert in the area.

21 I think that -- I'm not aware of any particular
 22 additional measures over and above those general -- the
 23 general advice that we provided to larger care homes.

24 **Q.** Okay. Can I just ask you briefly about testing. We
 25 know that in the first interim protocol for testing

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1 importance occasions. If we were to take an equality
 2 impact assessment point of view in terms of the impact
 3 that it would have, it would probably disproportionately
 4 impact on low-paid workers.

5 **Q.** Yep.

6 **A.** It would disproportionately, perhaps, in terms of the
 7 demography of the population, may impact on female
 8 workers in the sector. I think there are huge potential
 9 downsides with taking a legislative approach.

10 The approach we took was to place it into guidance,
 11 but I think underpinning that, what we need to have, if
 12 indeed, to what extent that continues, if we do not
 13 address the sort of underlying issues around
 14 remuneration, recognition, then I think we need to have
 15 a mechanism whereby we can readily track those staff
 16 movements, which we couldn't do during the pandemic
 17 other than directly interviewing individuals to find out
 18 where they had worked.

19 **Q.** Right. I ask you about staff movement because in your
 20 statement you make reference to the fact that larger
 21 care homes were more badly affected with outbreaks of
 22 Covid-19 reflecting, no doubt, the greater number of
 23 people entering into the home, and the greater risk of
 24 staff movement. There are, I think, at least 144 care
 25 homes in Northern Ireland with 40-plus beds. Do you

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1 which came out on 19 March, frontline clinical workers
 2 were included in the priority for being tested but not
 3 care home workers at that stage. Can you help us,
 4 Professor, why weren't care home workers put in as one
 5 of the priorities for frontline testing in the first
 6 interim protocol?

7 **A.** Frankly, we didn't have enough tests.

8 **Q.** It was simply that?

9 **A.** It was simply that. We had just moved from the
 10 "contain" to the "delay" phase on 12 March. We had
 11 stopped contact tracing because we didn't have enough
 12 tests to continue that and we had to prioritise what
 13 tests we had for those people who were in hospital
 14 either requiring ventilation, who had pneumonia, the
 15 management, and tried to protect individuals who may
 16 have been in contact with them in hospital and to ensure
 17 that we were able to support those staff who were
 18 providing care for them.

19 So it wasn't anything other than the fact that we
 20 simply did not have the tests that were needed.

21 **Q.** The Inquiry has heard some evidence that there were
 22 concerns that some staff were refusing to be tested.
 23 Were those concerns brought to your attention as CMO?

24 **A.** Yes, and I think this was, again, pretty early on in the
 25 phased rollout of the regular testing programme.

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I think early May, concerns were brought to my attention. At that stage I was keen to understand what the -- what lay behind that. What was flagged to me at that time was that there were significant concerns around sick pay, and that that would address, in a significant way, the issue, that sick pay was subsequently provided both in domiciliary care and in to care workers.

I also flagged at that time, the importance for PHA trusts to ensure that there was a clear understanding of why testing was so important, and that regular programme of testing, and that required both education and information in terms of the difference that would make in terms of protecting very vulnerable people in care homes.

I think it was a -- I don't think it was a widespread issue, I think it was fairly localised, and again, as we saw, then, subsequently we had a very high uptake of testing by healthcare workers working in the sector. And by -- you know, by 10 July we had tested 17,000 health and social care workers working in adult social care and 13,000 people living in care homes. That was from the start of the rollout of the programme from 12 March.

So -- and that report, which was a PHA report on
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that certainly in March there wasn't PPE available. And I'm trying to understand how you can say with some confidence "there was no occasion where we weren't able to provide it", and yet there are a number of examples that we have seen where care homes were being told that there isn't the PPE.

A. I mean, there are two aspects to that. I mean, I wasn't in the lead in terms of PPE or its distribution. I did have responsibility for the pre-pandemic stockpile in terms of PPE, so I approved releases of that stock to supplement the supply held by the Business Services Organisation, who then supplied PPE to trusts and then on to the care home sector.

So at the strategic level, there was not an occasion where we ran out of supply of PPE. At various points, we had very, very short supply of stock on some key items, so at various instances, we may have had a week's supply, at a Northern Ireland level. Everyone worked very hard to purchase additional PPE. There was mutual aid across the UK where we shared PPE to even out some of the demands, because obviously some of the peaks and surges in demand were different across the UK nations.

I think the point that you're referring to was the fact that at the outset of the pandemic, while the department was saying, "Trusts, share your PPE that you
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whole care home testing on 10 July, demonstrated, week on week, increases in the uptake of testing by care home staff.

So I think that that was due -- down to improved education and awareness of the importance of it, but I think, primarily, also, about addressing the sick pay concerns.

Q. You referred there to domiciliary care staff and in your statement you say that the second version of the interim protocol included testing of frontline care staff in the community, and in fact Mr Holland had to issue a letter a couple of days later explaining that included staff working in domiciliary care. Can I ask you the same question: was there any reason why domiciliary care was not -- care working staff were not included in the first protocol or is the answer the same, there just simply wasn't the capacity?

A. There wasn't the capacity.

Q. Right. Can I, perhaps before we take our mid-morning break, just deal with one topic briefly with you.

You say in your statement in relation to PPE that to your knowledge "there was no occasion where we were not able to provide appropriate PPE to health and social care staff, including care home staff". The Inquiry has heard, though, a number of pieces of evidence suggesting
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have with the care home sector, because it is not your PPE," as Sean Holland said on Monday, "this is an integrated health and social care system, this is about protecting individuals who are vulnerable, it's about protecting staff."

But what we did not have at that time, and I think this is a really key learning point for the future, we did not have a robust mechanism whereby the PPE pressures in care homes could be identified, that could be escalated, and that trusts could then move to address that. So we subsequently fixed that, in terms of --

Q. Can I pause you there, because I'm going to come on to your suggestions for fixing it, but you're right, there's an issue here between what was going on at Northern Ireland level and what was going on on the ground.

A. Yes.

Q. One of the Northern Ireland care homes that the Inquiry asked to provide a statement says that: the management were going to ask local businesses, schools and skilled people within the community to make masks and face protection. The home owner themselves travelled hours to collect PPE from other home owners. The owners stressed on many occasions in the early days to the trusts and the community that they were vulnerable, but
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1 it always seemed to them that the hospitals seemed to
 2 get the PPE first before the care homes.
 3 So there clearly is a disconnect, to use that
 4 phrase --
 5 **A.** Yeah.
 6 **Q.** -- between what was going on nationally and what was
 7 going on on the ground. One of the things you recommend
 8 was in your statement: a greater resilience of supply
 9 lines, including options to repurpose and scale up local
 10 manufacture.
 11 Can you help us with what has been done to increase
 12 that resilience that you consider is needed.
 13 **A.** I'm not aware that, in my offering my reflections, that
 14 there has been anything particular done in that space.
 15 I think that that probably needs to be at a UK level, in
 16 terms of -- you know, it's not just about the
 17 manufacture and production of PPE. We depend on very
 18 long supply lines for medicines. We depend on very,
 19 very long supply lines for diagnostics. You know, and
 20 part of the problems that we ran into during the
 21 pandemic were those long supply lines for reagents to
 22 have tests, and actually medicine supply chains.
 23 So, in terms of future pandemic preparedness, there
 24 has to be consideration to the extent to which we can
 25 be, to some degree, self-sufficient, but obviously that
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1 to change the system for PPE ordering, procurement, and
 2 supply.
 3 **MS CAREY:** Thank you.
 4 My Lady, would that be a convenient moment?
 5 **LADY HALLETT:** Certainly. You remember our breaks,
 6 Professor McBride. I shall return at 11.30.
 7 (11.15 am)
 8 (A short break)
 9 (11.30 am)
 10 **LADY HALLETT:** Ms Carey.
 11 **MS CAREY:** Thank you, my Lady.
 12 Mr McBride, can I ask you, please, about care
 13 partners --
 14 **A.** Yes.
 15 **Q.** -- and that aspect of visiting. And we know that on
 16 23 September the guidance came out with a view to
 17 implementation of the Care Partner scheme by 5 November.
 18 That guidance that came out said nothing at all
 19 about whether care partners were to be tested. Were you
 20 asked, in your capacity as CMO, about whether there
 21 should be testing brought in, whether there was capacity
 22 for care partners to be brought in?
 23 **A.** I would certainly recall discussions at that time about
 24 the capacity to, I suppose, provide further reassurance
 25 about the production of the Care Partner scheme. We
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1 comes with a price tag, and how much of an insurance
 2 policy are we prepared to pay to ensure that's the case?
 3 Reflecting on it further, I would probably go further
 4 than my observation in my statement.
 5 I do think that we need to look -- rather than care
 6 homes purchasing their own PPE, I do think we need to
 7 look at regional purchasing of PPE, whether that's in
 8 trusts in the acute sector or in the care home sector,
 9 I think that would be a much more robust way of ensuring
 10 that we have PPE procured for the health and social care
 11 system in Northern Ireland, and probably would be able
 12 to procure it at a much more effective cost as well.
 13 So I think that the -- you know, and again, this is
 14 not something I've tested with policy colleagues or
 15 departmental colleagues, but I do think we need to move
 16 away from a system which is dependent on primary care
 17 providers, dentists, adult social care, purchasing their
 18 own. I think one of the learning points from the
 19 pandemic for me is that we had to basically put in
 20 place, from scratch, a distribution and supply line
 21 which eventually, probably from, I think you're right,
 22 mid-April, ensured that there was robust supply chains
 23 and PPE getting into trusts. We shouldn't have to learn
 24 to do that again the next time.
 25 And I think the important learning point is we need
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1 were always clear that adhering to the guidance -- and
 2 obviously that guidance changed over time, in the
 3 regional principles, from 6 July -- that visiting should
 4 be facilitated and could be safely facilitated. That
 5 was clear at the outset.
 6 I think that, given the experience of many care
 7 homes of outbreaks in the first wave, there was clearly
 8 a real sense of fear and anxiety about the potential
 9 risk, and there were also, I was aware of, a range of
 10 views, indeed even amongst relatives, as to whether
 11 visiting could or should be facilitated. The difficulty
 12 at that time was we were heading into the second wave.
 13 You know, in the period -- just rolling back
 14 a little bit -- in the period of July, early July, in
 15 Northern Ireland, I mean, it seems quite remarkable now
 16 but we only had three to four people testing positive
 17 each day, so we had very, very low levels of community
 18 transmission. And as I said, we only had two outbreaks
 19 in early August in care homes. So transmission was at
 20 an extremely low level.
 21 However, on 10 September the Executive introduced
 22 postcode restrictions and then further restrictions on
 23 22 September, and then we were moving into that circuit
 24 breaker that was put in place in November.
 25 So essentially we were seeing a very rapid increase
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1 in demand for testing because of increased community
 2 transmission, and again it came down to the fact of not
 3 actually having the tests. So those discussions were
 4 had, but as I say, we just could not facilitate it at
 5 the time.

6 **Q.** And once the Care Partner scheme was implemented we know
 7 there was some testing, limited testing, brought in for
 8 care partners over the winter -- sorry, the Christmas
 9 period of 2020 into 2021, but do you think, upon
 10 reflection now, that there -- given you were allowing
 11 more people into care homes by virtue of the care
 12 partner, and there was increasing transmission, that in
 13 fact made it all the more important for the care partner
 14 to be tested?

15 **A.** Well, I think the -- you know, not to labour the point
 16 but there are -- I mean, the important point here is
 17 that testing was only ever an additional measure, an
 18 additional safeguard on top of all of the other measures
 19 around infection prevention and control that were in
 20 place to ensure that individuals could safely visit.

21 Now, I accept that the ability of certain care homes
 22 was more constrained than others because of the layout
 23 of the building, but we were always clear that, applying
 24 good infection prevention and control measures, that
 25 visiting could be facilitated, and that testing only

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1 course the department and you were listening to the
 2 families who desperately wanted to see their loved ones,
 3 there hadn't been sufficient concern taken account of
 4 the care homes, who were worried about that increase in
 5 footfall?

6 Do you think there was a lack of engagement with the
 7 actual providers who were going to be the ones
 8 implementing Care Partners?

9 **A.** My understanding was that there was engagement. I think
 10 that the origins of this, although I wasn't leading on
 11 it and I wasn't involved in the design or development or
 12 the implementation of the Care Partner scheme. It was
 13 led by the Chief Nursing Officer and her team. My
 14 understanding was that it arose out of the Rapid
 15 Learning Initiative which had been conducted in July,
 16 and the 10,000 or, sorry, I think it was 10,000 Voices
 17 engagement event which was listening to the experience
 18 of both health care workers but also relatives and their
 19 concerns on a range of issues, and it arose from that.

20 My understanding was there was engagement, certainly
 21 with families, and I understand, with some care home
 22 providers.

23 **Q.** Right.

24 **A.** I don't know the extent of that and, you know, it was
 25 envisaged, as you mentioned, that there would be further

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1 ever was an additional measure.

2 I do -- I mean, there are many things, looking back,
 3 that I would reflect upon. I do wish that we had had
 4 the additional testing capacity at the time to ensure
 5 that care partners were tested. I think that probably
 6 would have provided additional assurances to the sector.

7 And I think more generally, I wish that we'd had LFD
 8 tests earlier, because again, that -- again, that
 9 facilitated more general testing of those visiting care
 10 homes. And indeed, all of us testing on a regular basis
 11 to protect those most vulnerable.

12 So I think that looking back, I think the care home,
 13 sort of, partner initiative was an extremely innovative
 14 approach. I'm not certain that it was -- as I've said
 15 in my statement, that it was implemented as extensively
 16 and -- as it could have been, and looking back on it
 17 now, I wish we had done that earlier and I wish we'd
 18 been able to have testing to give confidence to the
 19 sector.

20 **Q.** Can I just ask you a couple of things about that last
 21 answer. I think you've seen correspondence, including
 22 a number of letters and emails from the IHCP, concerned
 23 that there was not enough prior engagement with the IHCP
 24 prior to the Care Partner model being rolled out. And
 25 in particular, they were concerned that, whilst of

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1 and extensive engagement from the date of the
 2 correspondence to the date of proposed implementation in
 3 early November.

4 **Q.** Can I ask you about a letter you wrote on 16 December.

5 Could we have on screen, please, INQ000256371_1,
 6 initially.

7 We're now 16 December and so, in theory, the Care
 8 Partner model should have been implemented across care
 9 homes. It makes the point there that:

10 "The decision to permit visitors into a care home
 11 and how this is organised is the responsibility of the
 12 ... manager ... [and indeed it] should be based on
 13 a dynamic risk assessment", assuming that that takes
 14 into account that there may be a care home with an
 15 outbreak who would need, therefore, to limit
 16 infection --

17 **A.** Yes.

18 **Q.** -- for example. All right.

19 But the letter goes on to say:

20 "... it is clear that there are a significant number
 21 of families who feel they have not been able to visit
 22 their relatives or set up care partner arrangements, in
 23 line with regional guidance. Some of the stories told
 24 by the families are deeply concerning."

25 And if we go over the page:

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1 "... the Department's position [second paragraph
2 down] that care home visiting and care partners can be
3 safely facilitated ...

4 "As the Minister has stated publicly, it is
5 difficult to understand how some care homes have been
6 able to facilitate visits while others have not."

7 Did you, as CMO, do any work to try to understand
8 why there was this variation in the Care Partner model
9 being rolled out?

10 **A.** No, I wasn't involved in any of that at all. As I say,
11 it was a matter which the Chief Nursing Officer was
12 leading on, working closely with the Chief Social Work
13 Officer and his team. I have to say, I did discuss the
14 scheme, as I mentioned earlier, before it was
15 progressed. I was hugely supportive of it --

16 **Q.** Yes.

17 **A.** -- but I wasn't directly involved in seeking to
18 understand what some of the concerns were.

19 But as I say, generally, I understood those
20 concerns. Given the experience of care home providers,
21 the deaths that had occurred in care homes, the risks of
22 potential further outbreaks, and here we were
23 introducing the Care Partner scheme at a time where we
24 were heading into a time of increased community
25 transmission.

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1 testing if, in fact, their risk assessment said there
2 needed to be a need?

3 **A.** I mean, what we were hearing at that time from some, but
4 not all, care home providers, was that -- and certainly
5 from families -- was that the absence of testing was
6 a barrier. And, you know, as it goes on to say, and
7 I think it's further down in that letter, we were
8 heading into Christmas period. You know, many of these
9 individuals are people -- very elderly, perhaps in the
10 latter months and years of life, and it was really
11 important -- the minister was very committed, as we all
12 were, to ensuring that visiting was facilitated. So it
13 was an additional reassurance, as it were, over and
14 above what we regarded as necessary in -- from
15 a risk-based approach, to provide those assurances to
16 the care home providers who still remained anxious about
17 the consequences.

18 But, you know, as I said earlier, they were at the
19 interface of managing relatives who didn't want any
20 visitors into care homes and also, you know, relatives
21 who wanted to visit.

22 So I don't underestimate the challenges that we're
23 facing. These were very, very finely balanced
24 judgements but we were seeking to both encourage and
25 do everything that we could that would remove any

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1 So there were legitimate concerns; they needed to be
2 addressed. That engagement, I understand, by the PHA
3 and by trusts did address some concerns some care homes
4 had around the Care Partner scheme, and then was
5 facilitated.

6 So there was a process of active engagement,
7 support, advice, and to my knowledge, where those
8 concerns were raised where individual families could not
9 access or make use of the Care Partner scheme,
10 I understand those were by and large addressed.

11 But again, as I say, I can't speak
12 to -- (overspeaking) --

13 **Q.** Can I ask you about page 3, please. And you say in your
14 letter:

15 "However, in recognition of the concerns felt by
16 many homes about visiting and care partner arrangements,
17 the Department is moving to provide further support and
18 assurance ... Should a provider, in order to enable
19 visiting to take place, perceive a need for additional
20 risk mitigation ... then COVID-19 testing will be made
21 available ..."

22 Given that you've already in the letter pointed to
23 the fact that there needed to be dynamic risk
24 assessments, why did you include there the need that
25 a care home might perceive a need for there to be

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1 residual concerns.

2 **Q.** Right. Can I move on to the changes that were made to
3 regulatory inspections, and we know that in your
4 statement -- and I'm at section 15 onwards, Professor --
5 that the joint chief executive officer of the Public
6 Health Agency and the Health and Social Care Board was
7 one person but they had announced their intention to
8 retire by the time of the pandemic, and we've heard from
9 Ms Briege Donaghy that you then advised that the CEO of
10 the RQIA should be appointed to the Public Health
11 Agency, and indeed there were, I think, three other
12 fairly senior members of the RQIA who ended up either
13 working in the CMO Group or the department.

14 Ms Donaghy told us that, from her perspective, the
15 loss of those four critical posts, leaving them with
16 significant under-experience in the RQIA, impacted on
17 their ability to perform their statutory functions. And
18 I suppose the question really is, why did you feel it
19 was absolutely necessary to remove those four posts,
20 thereby leaving the RQIA without their core experienced
21 members?

22 **A.** Well, it was the -- I mean, starting -- I didn't -- it
23 was not my decision to remove those four posts.
24 I certainly pointed out to the -- and highlighted, as
25 I correctly felt was right to do, that the fact that we

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were, in a very short period of time, not to have a chief executive in -- well, we didn't have a chief executive, a full-time chief executive in the Public Health Agency, the organisation that was coordinating the public health response to the pandemic, an organisation that already had significant vacancies, it's probably the smallest of all of the public health bodies across the UK and had capacity and capability constraints, that in my view the absence of senior leadership was a single point of -- or chief executive senior leadership -- was a single point of risk, not just within the organisation, but a system-level risk.

You had that then combined with the planned retirement of the chief executive in the Health and Social Care Board.

At that time there were also a significant number of vacancies in the department, as I had a vacant deputy CMO post at that time. And as you alluded to, with the agreement of the chief executive -- the then chief exec in the Public Health Agency, the -- an individual who'd extensive public health experience and health protections experience was seconded on an interim basis into the department.

An individual was seconded for a very short period of time from the PHA into the department, as you

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working across organisational boundaries because there were just so many complex, complicated tasks that had significant policy and operational interfaces that we set up a number of groups which included representatives from the PHA, the board and the department, working in an integrated and collective way.

I mean, I mentioned the Northern Ireland modelling group in my statement. We had the Care Home Task and Finish Group, the Expert Advisory Group on Testing, and that was the PHA and the Department, the RQIA, and other organisations working in an integrated and collective way, and of course, during that period we were also operating very much in a command and control environment, because the emergency response plan had been activated. And looking back on it now, I don't think those arrangements very much sat comfortably with the normal governance and accountability arrangements.

Q. No. Does it come to this, Professor, that you thought that at the time it was more important for there to be a chief exec in the Public Health Agency than it was for the department, the RQIA to have its senior more experienced leaders?

A. No, that -- I don't think that's -- there were risks to be balanced.

Q. Right.

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mentioned, from the business services role. That individual later returned to RQIA, but I understand then shortly after was seconded into the PHA. I was not involved, nor was the department involved, in that second secondment.

I think that none of those circumstances were ideal. We simply did not have the strength and depth across key organisations within the system at that time. And I provided advice to the then perm sec, who contacted the chief executive in the RQIA, who then subsequently agreed, she informed her chair of that approach. Regrettably, I don't think that conversation was communicated to other members of the RQIA board.

Q. Yeah.

A. But I think, you know, I would say that at that time, there was major realignment of every single service in Northern Ireland. Our trusts were realigning, adapting services. We were bringing in retired individuals to fill gaps, or to increase capacity in both trusts, in the Health and Social Care Board and the PHA. We were bringing in academic colleagues from the universities to support the PHA with epidemiology and analysis. We were bringing in business support colleagues.

And not only that, I think -- and this is a point which -- it wasn't just secondments, we were actually

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A. And there is -- undoubtedly the secondment of the RQIA chief executive posed a risk to RQIA. At that time, although I wasn't directly involved in the discussions, I understood that the deputy who was then appointed into -- sorry, the director who was then appointed into the interim role was an experienced individual who'd been with RQIA for a year, 25 years' experience in health and social care, and indeed, had been brought in to review the RQIA inspection methodology.

There were just a series of very, very difficult choices, and all of those choices carried very significant risk. As I say, I wasn't involved in the -- I was involved in supporting the perm sec in a conversation with the chair of RQIA but I wasn't involved in any other discussions with RQIA.

Q. We know that there was a direction, then, issued to the RQIA to reduce the frequency of their statutory inspections and to cease their non-statutory inspections, on 20 March. And we also know about the SST that was set up to provide support to the care home providers but, in essence, Professor McBride, do you consider that there was still the ability, nonetheless, for the RQIA to safeguard individuals in Northern Ireland who were in care homes?

A. Well, the straightforward answer to that is yes.

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I think that, you know, as the minister communicated to the COPNI and to the Northern Ireland Human Rights Commissioner, we recognised that there were some risks with this, but there were also significant risks with individual care home inspectors, who individually inspected 30 to 40 care homes, moving from care home to care home in terms of introducing infection.

So it was about controlling the risks that we could control.

I think the other important point to bear in mind is that it was also the case that RQIA does not normally inspect care homes during an outbreak for that very reason, because of the risk, both in terms of transmission between facilities but also risks to staff and certainly, I, looking back on it now, I still regard that the reduction in the frequency and to take an evidence, risk-based approach that was intelligence led, focusing RQIA's activity where it was needed most was the right approach to do -- or the right approach to take, and we had assurances from RQIA at that time that they could put in place alternative arrangements to ensure that whilst a reduced number of on-site inspections would occur, that they could rapidly put in place arrangements to ensure that there was a mixture of both on-site, remote, and hybrid inspections.

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which may be different with a different virus. And I --

Q. Can I ask you this, given that those care home providers were going to be under significant pressure to try to keep their environments Covid free or disease free, doesn't that make it all the more necessary for someone to go in and check that they are complying with IPC, that they're not using PPE that's not fit for purpose. There is a strong argument that perhaps you need more inspections in times of stress, not less.

A. Well, as I say, RQIA, in all likelihood, even had the inspections continued at the frequency which they did -- and bearing in mind that, statutorily, care home inspections in the regulations occurred twice a year, now, quite apart from the fact whether or not -- could RQIA have increased its inspection frequency during the pandemic? I doubt that very much, given the capacity that they have amongst inspectors.

Would increasing the frequency of inspectors created -- increase risk of the introduction of infection into care homes, given the movement of staff? I think probably yes. I don't know what -- what numbers of staff within RQIA, for instance, would have been self-isolating at a particular point in time, or indeed shielding because of underlying health problems.

So I think it's -- I think that undoubtedly, when,

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Q. And that's what I want to come on to ask you. In the event of a future pandemic, would you again support the decision to cease and reduce inspections in the way that we had in March 2020?

A. I mean, I thought long and hard about this, and I think that -- I don't think there is a sort of a yes/no answer to that. I think ideally one would want and wish to continue inspections, but again, I put that in the context that the primary responsibility for the quality of care resides with the provider of that care, and the second duty of quality in the 2003 order resides with the commissioner of the care.

So that's both the care home provider, the trust as the commissioner -- an inspection should only ever be an additional assurance. It is never and cannot be a substitute for the responsibility of a provider organisations to assure themselves of the quality of the care that's provided or trusts to be assured of the quality of the care they're commissioning.

In terms of the stopping or in terms of the non-statutory inspections, I think that was the right thing to do. In terms of reducing the frequency of the statutory inspections, I think it would depend on the circumstances of the individual pandemic, how it was transmitted, the risk to the population in care homes,

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as you say, the system is under pressure, you want to ensure that all of the safeguards are in place and effective, but I would also, in the wider context, say that we had very significant numbers of nursing staff, allied health professionals, in care homes during the pandemic supporting care homes because of staff absences or meeting the care needs of the population.

I mean, it's described very well in Natalie Magee's statement from the Belfast Trust where she describes what actually happened when a care home went down into outbreak, the fact that the care home's support team visited the care home to identify the care needs of those individuals, assessed those that needed to have either the support of the good care at home team, those that needed to be transferred into hospital, provided that hands-on advice and support.

I think that -- you know, from the -- up to the -- I think it was the -- I think probably October in that period of time -- sorry, I beg your pardon, it might have been the end of May, there was something like 27,000 hours of --

Q. Yes, you're talking about all the redeployment from the health and social care trusts into support the care homes --

A. Yes, so -- and we go -- and I've read in preparation for

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the Inquiry the fact that there were instances, and a number of instances, where staff did contact the RQIA and say "We have a concern", and inspections did take place and enforcement action was taken.

So -- and I'm not trying not to answer the question, but I -- I just think it's a difficult one to call, and I think it will depend on the individual circumstances. I think maintaining inspection capacity and capability is important, and I think it would need to be maintained as we asked that on a risk-based and a targeted basis and formed by intelligence.

Q. Can I just ask you this, finally on this topic, the British Association of Social Workers in Northern Ireland highlight that, in the absence of the regular and routine inspections, their members formed the view that elements of the RQIA's regulatory oversight had, in fact, informally been transferred to frontline social workers. Were you aware that the social workers were considering themselves now perhaps to be stepping in, my words, to perform what had hitherto been done by the RQIA?

A. I don't -- you know, again, I looked at the Health Committee reports. I think what -- and I'm not certain that's exactly what that section of extract says, although I appreciate it's shorthand, I think what the

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presumption that that responsibility would transfer to anyone else.

As a matter of fact I'm not sure how you can informally transfer a statutory responsibility or consider that it has been delegated.

Q. No one is suggesting, I think, from the statement that was before the Health Committee, that there was any kind of formal transfer but there was certainly a feeling or perception amongst the frontline social workers that they were stepping in to perform that role.

Can I move you on, Professor, to a different topic, please, and that of DNACPRs.

In your statement, you say that you became aware of concerns, and certainly the Department of Health became aware of concerns, in the summer of 2020.

You set out in your statement there was no policy in force from the department or indeed from you that advocated, allowed or in any way suggested that blanket use of DNACPRs was acceptable. In fact quite the opposite.

And you go on to say in your statement:

"There was no [blanket] use of DNACPR in NI at any stage and any such approach would have been morally and professionally unethical and unacceptable ..."

Professors Barclay and Sleeman, who have provided

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British Association of Social Workers were flagging was that some of their members seemed to be unaware, although the society itself was aware, that RQIA inspections were continuing, I think is the quote.

I think that it wasn't raised with me at the time.

RQIA issued a public statement on 8 April, you know, clarifying the work that they were still doing, and there was communication from the Chief Social Worker to chief executives in trusts around the enhanced role of RQIA in terms of the Service Support Team. That communication should have been cascaded within individual organisations and I would have expected any professional who had concerns of that nature to raise them, through their line management arrangements, to the directors of social care with individual trusts so that those would -- reassurances would be provided.

Now, I have to say that I absolutely recognise that communication with health professionals during particularly the first wave was challenging and it was difficult, given the speed and pace of events, and many professionals had concerns about how they would fulfil their professional responsibilities and their, you know, statutory responsibilities in this particular incidence.

But the matter of fact is that RQIA inspections were not suspended, and there was no informal arrangement or

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a report to the Inquiry, say there's been no systematic evaluation of the use of DNACPR forms in Northern Ireland and therefore query how it is you can state with certainty that there was in fact no blanket use, in the absence of such an evaluation.

What led you to say there was no blanket use of DNACPR in NI?

A. Well, I think what I've said in my statement, there was no blanket policy. There was certainly no -- there was nothing that was issued from the department, there was no --

Q. Can I stop you there. You say:

"There was no blank use of DNACPR in NI at any stage ..."

A. Sorry. There was certainly no information, no guidance, no advice, issued to the health service on this matter. It was quite the converse, the concerns that were being raised with me at that time by clinicians were that circumstances would arise whereby they were not able to afford people the treatment and care that they required, and that demand for services outstripped the capacity to deliver that, and what I did very early and moved very early to do, was to address those potential concerns and the psychological stress that professional staff were experiencing worrying about those eventualities.

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I established a Covid Ethics Forum which had its first meeting on 15 April, ensured it was connected into the Trust Ethics Committee and we, and I know, my Lady has questioned me previously about this, we published a Covid guidance and support framework on 5 June and then updated that in September, specifically to provide absolute clarity in relation to the professional codes of practice, GMC guidance, Resuscitation Council guidance, and actually, that all professionals must act within those standards, within that guidance, and, actually, within the provisions of the law.

So I think we moved very proactively within that space, and again, we took further work then around the development of advanced care planning.

Q. I'm going to come on to that.

Just one other matter. Professors Hatton and Hastings who provided the Inquiry with an expert report into learning disabilities say that they could not find any Northern Ireland material relating to DNACPRs on people with learning disabilities. Do you know whether there was any work done in Northern Ireland to see if there was a link between DNACPRs being imposed on people with learning disabilities?

A. I'm not aware of any such work. I'm not aware -- again, there were certainly concerns that were being raised in

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of those engagement sessions. We did an equality impact assessment, we engaged with the Human Rights Commission, we engaged with the equalities commissioners, the Commissioner for Older People, the children's commissioner, and we produced the policy document in October 2020.

Q. Yes --

A. But it has not progressed, I have to say, due to competing priorities and resources.

Q. I understand that, but there may be many in this room who say there was an advanced planning care policy approved for publication in October 2022. You, and indeed various other members of the Northern Irish witnesses that have come to give evidence, know the concerns of the bereaved about the DNACPR form. Why is it still, three years on, that the ReSPECT form is not written in stone in the advanced care planning policy?

A. I believe it should be.

Q. My question was: why isn't it?

A. Again, as I've answered just previously, it is a question of -- the policy responsibility no longer sits with me, unfortunately. I think myself and the Chief Nursing Officer are now taking forward work and have been over the last six months to make significant progress.

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other jurisdictions. I think there was a lot of fear and anxiety, but certainly, I was aware of no individual cases or concerns were brought to my attention in Northern Ireland.

Q. All right. And you have referred, just a moment ago, to advanced care planning. In your statement -- I'm at paragraph 14.8 onwards -- you say there has been development and use of regional DNACPR forms and a single integrated process now for advanced care planning with the ReSPECT form, with which her Ladyship is familiar, being introduced. Is use of the ReSPECT form now mandatory in Northern Ireland?

A. No, it isn't, and if I'm honest, we have not made the progress on advanced care planning that -- even since I last updated my Lady on that. I think that it's one of the most crucial aspects of the learning from the pandemic, that each one of us needs to communicate with those that are important to us about the things that really matter to us, both in terms of future planning, not just in terms of clinical matters, but financial matters, personal matters.

We did a huge amount of work around advanced care planning, you know, that started with a submission from myself to the minister in September 2020. Extensive engagement, Disability Action actually facilitated some

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Q. Who does the policy sit with?

A. It sits with a deputy secretary within the department, who I work very closely with, and again, we have agreed to prioritise this area of work. It is one area that I think needs to be significantly progressed. I do fear that we've lost some of the momentum, lost some of the engagement that we had previously built up, and I think we will need to reengage with the public as we did previously.

But, you know, I was heartened to see again, in Natalie Magee's statement from the Belfast Trust that advanced care planning had increased over the years, in advance of the pandemic, but it is not consistently applied, and I do think that whilst we have provided level 1 training, which has been accredited for healthcare professionals, that needs to be more extensively rolled out and implemented.

So it is a great frustration for me. I absolutely agree with you. I think it should be a subject of the contractual agreement between care home providers and trusts, that trusts, during their annual care plan reviews of individuals, ask about whether someone has sat down and had an informed discussion with an individual, their family, their GP, about their wishes and that that has been documented and that it's reviewed

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1 on an ongoing basis, and I actually think that it should
2 be written into the relevant standards in care homes and
3 I think it should be subject to inspection by RQIA,
4 against those standards.

5 **Q.** Can I ask you about two aspects of data, please. The
6 learning disabilities experts could not find any
7 evidence on Covid-19 mortality amongst adults with
8 learning disabilities for Northern Ireland. Do you know
9 whether there has been any collection of data on the
10 number of learning disabled people in Northern Ireland
11 that died from Covid-19?

12 **A.** I'm afraid I don't know the answer to that.

13 **Q.** Second point in relation to data. Clearly there was
14 work being done to try and ascertain how many residents
15 in care homes had died from Covid-19, and indeed, in,
16 I think, from 19 April onwards, NISRA published data on
17 deaths and suspected deaths.

18 But can I ask you about deaths relating to care
19 workers, because you say in your statement that the
20 Department wanted daily updates, and on 12 May you
21 issued correspondence to the trusts saying that they
22 should provide on a daily basis the number of health and
23 social care workers who had died with or from Covid-19.
24 Does it follow that before 12 May, that data wasn't
25 being collected.

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1 extent of which that is captured. I certainly don't
2 recall that information being collated and shared with
3 the department to the best of my knowledge.

4 **Q.** Just finally, please, Professor, you say in your
5 statement that, with hindsight, more could have been
6 done to protect the care home sector. Standing here --
7 or sitting here now, three years on, what do you think
8 could have been done better?

9 **A.** I think that -- we know the estimated projection of
10 growth in older people, which is a great thing, and it's
11 a tribute to public health and health science and
12 medicine, Northern Ireland will see the greatest growth
13 in older people by 2047 compared to any other part of
14 the UK. We will have an increase of 112% of people
15 living over the age of 85. And it's combined with
16 a significant reduction in -- 23% or something -- in the
17 younger population between 0 and 15.

18 The needs of older people are becoming increasingly
19 complex, and we've heard from a number of other
20 organisations giving evidence to this Inquiry.
21 Domiciliary care is more than -- not that it's not
22 important -- providing individuals with support with the
23 activities of daily life. Many, many, many complex
24 people are now living independently in their own homes
25 but require both significant medical and social care

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1 **A.** Well, it would have been collected within individual
2 trusts --

3 **Q.** But not communicated --

4 **A.** But not communicated to the department, and whenever it
5 was -- I mean, the minister had asked me because it was
6 an area he was very focused on, asked that I write out
7 to trusts. And it wasn't just deaths, it was actually
8 the number of individuals who were care workers who had
9 acquired Covid, the number -- and had been admitted to
10 hospital, the numbers who were intensive care, and the
11 numbers who had subsequently deceased as a consequence
12 of Covid.

13 **Q.** Did that data set include workers who worked for
14 independent providers or only those who worked for the
15 trusts?

16 **A.** Well, it certainly would have included those employed by
17 the trust. I don't know the answer to the second part
18 of the question, around independent -- (overspeaking) --

19 **Q.** Do you know whether there was any data collected in
20 relation to the deaths of domiciliary care workers in
21 Northern Ireland?

22 **A.** I don't know the answer to that. And -- although
23 I suspect, again -- well, I'm speculating. You know,
24 perhaps a source of that information would have been the
25 employing organisation. But again, I don't know to the

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1 support.

2 So there's a fundamental review for the model -- of
3 the model required, and there is a review of adult
4 social care under way. I do not think, sadly, that it
5 will progress rapidly enough because of, again,
6 resourcing pressures and constraints. And that's not
7 a lack of commitment on the department or all of the
8 partners in the social care collaborative; I think it's
9 just a reflection of wider pressures.

10 I do think more could have been done in the run-up
11 to the pandemic to improve the resilience of the sector.
12 We have a very low-paid workforce, no job security.
13 Again, sadly, not appropriately valued or recognised,
14 not regulated and the value added that comes with being
15 a regulated, recognised professional group.

16 I think that would have been an important asset to
17 have. I alluded to some of the challenges that we faced
18 initially around the skill base, particularly around
19 infection prevention and control. We had to very, very
20 rapidly skill up health and social care workers in the
21 sector, providing additional training, in terms of the
22 use of PPE, but infection prevention and control
23 practices.

24 So the sector is much more complex. Healthcare
25 workers will need to have increased skill dealing with

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greater complexity of clinical need, but also we should have been in a position where there was more enhanced IPC training in advance of the pandemic.

I think that -- and if we could ensure that that is part of the regular -- part of the contracting arrangement between the trust and the trust's -- and is built into the standards -- and the care home standards, the residential care standards, have been reviewed and my understanding is some of that detail is built in.

I do think that we could have and I wish we were able to have rolled out testing more quickly.

I do think that we need to radically look at partnerships with industry, in terms of the diagnostics industry, in terms of future pandemic preparedness and how we rapidly go from identifying the next cause -- or the next pandemic, to actually scaling up a rapidly deployable test, including those tests such as LFDs which made a complete difference, a rapid test that gave you a result in 15 minutes which was a good predictor of whether you were infectious or not. That was a sea change.

We almost seem to have forgotten that we were all doing that twice a week, you know, when we were going to visit our elderly parents or when we were meeting in our Christmas bubbles, that we all tested.

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the major difficulties in the sector is how diverse it is, the fact that 80% of Northern Ireland is provided by independent care providers, and they are very diverse groups.

I think that in -- when there is a national crisis and an emergency, we need to have a mechanism whereby we can rapidly switch to an arrangement whereby we almost have an arrangement whereby we move to almost a regional control and support. I mean, we've talked about some elements of the terms of the Service Support Team but much more than that is needed. There almost needs to be a command and control element of how the adult social care is responding.

I mean, the social care collaborative -- and I know Robin Swann is -- will be giving evidence later. I mean he has suggested perhaps putting the social care collaborative on a statutory basis. He has suggested having a social care trust.

I mean, I think those are all potential avenues that could be explored.

I mean, I -- obviously, if you have a social care trust which is an affiliation of independent sector providers and statutory providers in trusts, then you have a mechanism. And certainly in terms of directing and controlling, the department, for instance, holds

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So I think having that built in will be crucially important.

Q. Can I ask you, then, about one of the things you said there, and it builds on something that COPNI told us yesterday. He made a recommendation that in future planning there needs to be group of experts, but not just experts, private care home providers, staff, family members, maybe even residents, and he was surprised about how few experts were potentially in meetings, considering there ought to be essentially a sort of readymade body ready to stand up in the event of a future pandemic, to provide that expertise and all round experience.

Can I ask you, how feasible or practical do you think it would be to have such a body in the event of a future pandemic?

A. I think that body already exists. We had SAGE, we had various subgroups, we had the SAGE social care group. In terms of expert advice --

Q. Now, there are all of those bodies individually, but I think he had in mind more of a cohesive body, bringing together all of those different people?

A. Well, maybe if I can come back to something that I mentioned earlier, which is around pandemic planning, preparation, and business continuity planning. One of

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emergency direction orders for each and everything -- or organisation in the health service. But at times we didn't have all the levers that we needed to be able to pull, and we didn't have the existing data or we didn't have the -- I say, the robust support arrangements that were required.

So I think there is merit in exploring that concept, but perhaps in a much more developed way than it is described there. But it has to be in partnership with the providers themselves, and those who use the service -- (overspeaking) --

Q. I think that was the point he was driving at.

A. Yes.

MS CAREY: My Lady, they are all the questions I have of Professor McBride.

LADY HALLETT: Thank you very much, Ms Carey. Mr Wilcock. Mr Wilcock is just there.

Questions from MR WILCOCK KC

MR WILCOCK: (Microphone off)

Professor, thank you very much for attending. As you know, I represent Northern Ireland Covid Bereaved Families for Justice. In fact, Ms Carey King's Counsel has very helpfully already dealt with a number of the questions that I was planning on asking you, and so I'm going to try and avoid encouraging you to repeat

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yourself even though there are a few questions remaining that I wish to ask you.

I have four topics. The first one is about your involvement in the discharge policy, and this morning Ms Carey asked you about your involvement in the guidance on 17 March. I'd like to ask you about your involvement in specific subsequent stages of the development of the discharge policy.

And I'd like to start by saying that at paragraph 5.4 of your statement, you state that whilst you were aware of correspondence that the permanent secretary had sent in relation to the range of actions he was asking the trust to take at that stage to maximise surge capacity in hospitals on 26 March, you do not believe that you or your office provided policy or professional advice or input to that correspondence.

Now, you should know that in his statement to the Inquiry, the permanent secretary has stated that a draft of the letter seeking comments from the Clinical Advisory Group, which includes you and a number of other colleagues, was circulated, inviting views, because -- and the quote is important for the question -- "given the sensitivity and importance of getting it right".

The question is, given the sensitivity of this issue and the importance of getting it right, why didn't you

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discharged into nursing and care homes, published in April 2020. And I suppose the point of the question is, everyone appreciates the many other commitments you had on your time, but one of the aspects of the Northern Ireland organisation is the sort of vaunted inclusion of health and social care together. Why didn't you take advantage of that possibility by giving your advice, even though you knew that there were other experts who probably had more day-to-day dealings with adult social care than yourself?

A. I mean, you know, there's a combination of answers to that. Firstly, it was the wide range of issues I was covering and leading and coordinating, the principle of subsidiarity applied throughout the pandemic, those who were expert in an area from a professional or policy perspective led on those areas of advice and guidance, and the guidance was being led by the Chief Social Work Officer's team and particularly his Director of Mental Health, Disability and Older People's Services, but all of the right people were involved in developing that.

We had the Chief Nursing Officer and her team. We had the Health and Social Care Board, the Director of Community Services within the Health and Social Care Board, and we had the expertise of the Public Health Agency and their infection prevention and control team.

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provide your policy with professional advice as a result of the specific request from the permanent secretary at this stage?

A. Well, as the -- the perm sec's statement goes on to elaborate, there was nothing new in the letter of 26 March. It summarised in great detail all of the actions that were taken across health and social care, around the testing, around the support that needed to be provided to domiciliary care sector.

He references a number of exhibits within that and the reference to the Clinical Advisory Group is the Strategic Clinical Advisory Group, which I was not a member of, and the exhibits were seeking input from that Clinical Advisory Group, which I had established, and it contained a range of clinicians, respiratory physicians, those in intensive care. I was not a member of that group.

I don't and, having checked through the records, there was no input into that letter provided by myself. There were comments provided, and I was not able to -- I've been unable to locate any input from the strategic clinical advisory cell itself.

Q. Thank you very much. You go on in your statement to say that neither yourself or your office were involved in the guidance, including in relation to patients

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So the right people were involved with the right professional and technical skills and expertise, in the sector. In my view, now and then, it did not require additional input from me, particularly given the fact that there were others who were better placed to provide that input.

Q. Thank you very much.

Different topic, and this is what -- the Herity report that you again were asked questions about by Ms Carey. What I would like to do is, bearing in mind your answers, drill down a little into how this report was presented to the Northern Ireland public.

In your statement to this Inquiry, you carefully stated that the Herity report, quote, and I emphasise "did not support the suggestion that discharge of patients from hospital was a substantial cause" -- again, I emphasise the quote -- "of Covid outbreaks in care homes."

Now, you've already said, in effect, that you agree that the discharge from hospitals obviously made at least some contribution, even though people may disagree about the quantification of that.

A. Yes.

Q. You go on in your statement, don't you, to state that the Herity study examined two specific weeks in reaching

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1 its conclusions. And what I'd like to do, please, is
 2 have an extract from the report put on screen in order
 3 to try and explain the point I'm seeking to make.
 4 I've been given verbal permission and assurance,
 5 more to the point, this will happen.
 6 **A.** I have it, yes.
 7 **Q.** It's just not come up on my screen.
 8 **A.** I've got it here, so ...
 9 **LADY HALLETT:** I've got it on my screen.
 10 **MR WILCOCK:** Everyone but me. Anyway, I think I know what
 11 I want everyone to look at.
 12 If you look at the first three lines of that page,
 13 you should see, I hope, that the report explains why it
 14 is concentrated on the two weeks it looked at, weeks 11
 15 and 13.
 16 **A.** Yeah.
 17 **Q.** And then, if we go on to the table in the middle of the
 18 page, which I think you'll agree was later used to give
 19 the public a summary of the report's conclusions, do you
 20 agree that that was used to give the public a summary of
 21 the report's conclusions?
 22 **A.** That's my recollection, yes.
 23 **Q.** Yes. And we can see that the report stated that for
 24 weeks 11 and 13, which, if it matters were 9 and
 25 23 March, among the 465 people discharged, one tested
 89

1 community transmission and outbreaks in care homes.
 2 But I absolutely accept the fact that the limitation
 3 in this study is that we were not testing individuals
 4 who were discharged, who were asymptomatic at this time.
 5 **Q.** I read out the extract from your statement. Is there
 6 any reason why you did not bring this specific flaw to
 7 the Inquiry when you made your statement?
 8 **A.** Well, certainly, I mean, I answered the questions that I
 9 was asked about the -- by the Inquiry. I mean, I don't
 10 think I -- there was -- I wasn't involved, as I say, in
 11 designing the study, conducting the study, or designing
 12 the methodologies. So I mean, I would not wish to
 13 highlight -- I mean, it was no act of omission on my
 14 part not to highlight that. I think the general point
 15 I would make is that the findings of this, and as I've
 16 also said in my statement, and said on a repeated number
 17 of occasions, that there are many ways of which
 18 infection entered care homes and that included the
 19 movement of staff, all sorts of staff, health
 20 professionals, care home staff, visitors, and also the
 21 connection between two high-contact areas between
 22 hospitals and also care homes.
 23 And I've said unequivocally on a number of occasions
 24 that undoubtedly, in my view, it was highly likely that
 25 some care home outbreaks were caused by discharges from
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1 positive in the first week after discharge and four more
 2 tested positive in the second week after discharge,
 3 hence, in total, five, 1.1%, I think it's put in the
 4 table, tested positive within two weeks of discharge,
 5 and 460, 98.9%, did not. Very reassuring figures.
 6 But as I accept it -- you now accept it, before
 7 lunch (sic) --
 8 **A.** Yeah.
 9 **Q.** -- that the serious flaw in this statement is that
 10 routine testing of care homes had only been introduced
 11 on 24 March. And you have already accepted that?
 12 **A.** Yes.
 13 **Q.** So it's right, isn't it, that any suggested inference
 14 that 98.9% did not test positive during this period is
 15 inaccurate, because many of these people will not have
 16 been tested at all?
 17 **A.** It is absolutely correct, and I made that point earlier,
 18 that there were significant limitations in this study
 19 because of the limitations in testing at the time.
 20 I think that the primary point in this paper was the
 21 relationship between increased hospital admissions or
 22 the greater strength of the relationship between
 23 increased hospital admissions and care home outbreaks,
 24 and by inference, therefore, as we saw throughout the
 25 pandemic, the relationship, greater relationship between
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1 hospital, or some were exacerbated by discharge from
 2 hospital. So I have not -- I mean, I have been very
 3 upfront in terms of articulating that.
 4 **Q.** We have a history of all the letters that have been
 5 written in correspondence, I'm not going to ask you
 6 about it now.
 7 With her Ladyship's permission, can I just ask you
 8 this, though. Can you give any examples off the top of
 9 your head, or perhaps in writing afterwards, of any
 10 occasion where you drew this flaw to the attention of
 11 anyone to whom this report was disseminated?
 12 **A.** No, I wasn't asked to provide any commentary on the
 13 report. I didn't provide any commentary at the time and
 14 I haven't been asked to provide any commentary on it
 15 since.
 16 **Q.** Thank you. As I say, we have copies of the
 17 correspondence, and I appreciate your answer.
 18 Let me return now to a different topic. Again, one
 19 that, sadly -- you have answered a lot of questions we
 20 want to ask. I want to really round it up.
 21 You have, in your statement and in your oral
 22 evidence, described the swapping of staff from the RQIA
 23 and the PHA as effectively an indication of the ability
 24 of the CMOG to adapt and be flexible in a generally
 25 under-resourced situation. The question is really this:
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1 can you see why members of the group I represent, given
 2 that generally under-resourced situation, see your
 3 references to flexibility and agility as implying that
 4 this system was working the way it should have been,
 5 when in fact a more accurate description of what was
 6 happening was making and mending, panicking and
 7 disarray?

8 **A.** I wouldn't accept that at all. I think that's an unfair
 9 characterisation and does not reflect the commitment
 10 that I observed from staff within RQIA, within the
 11 Public Health Agency, the Health and Social Care Board,
 12 and in the department.

13 There was no panic. We were resolute. We were
 14 committed, and we had one purpose, which was to prevent
 15 deaths in severe disease and to use all resources at our
 16 disposal to do so.

17 So I don't accept that as an accurate description.

18 **MR WILCOCK:** I hope my question did not objectively imply
 19 that that was the case but, anyway, let's move on.

20 Final topic: DNACPRs.

21 My Lady, to be frank, the question I was going to
 22 ask has been asked --

23 **LADY HALLETT:** Go for it, Mr Wilcock. I trust you.

24 **MR WILCOCK:** I have a short question, which we hope is in
 25 the spirit of what we wanted to ask, and it's really

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1 worries, and their anxieties. And those stories, those
 2 Every Story Matters are very, very impactful. So
 3 I don't think anyone should be left with unanswered
 4 questions and I would encourage individual relatives to
 5 directly engage with clinical teams if they have
 6 concerns of that nature.

7 **Q.** Does it follow from that emphasis on individuals raising
 8 specific instances that there are no plans to conduct
 9 a systematic investigation?

10 **A.** I'm not aware of any plans. You know, that would not be
 11 a decision for me and I haven't been asked to provide
 12 any advice on that matter either.

13 **MR WILCOCK:** Thank you very much, Professor.

14 **THE WITNESS:** Thank you.

15 **LADY HALLETT:** Thank you very much, Mr Wilcock.

16 Ms Beattie.

17 Ms Beattie is over there, Professor.

18 **THE WITNESS:** Thank you, my Lady.

19 **Questions from MS BEATTIE**

20 **THE WITNESS:** Thank you, my Lady.

21 **MS BEATTIE:** Professor McBride, I ask questions on behalf of
 22 Disabled People's Organisations, and in Northern Ireland
 23 that's Disability Action. The question is concerning
 24 testing for domiciliary care workers.

25 In mid-August 2021 you advised that testing was now

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1 this: do you accept that, notwithstanding the official
 2 efforts you described to reassure people that there was
 3 no blanket policy about a DNACPR policy, such concerns
 4 still remain?

5 I just wonder whether you'd thought of this: in
 6 Module 3 Mr Swann observed that there was now an
 7 opportunity to retrospectively evaluate the use of
 8 DNACPR in regards to the recommendation of this Inquiry.

9 I just wondered whether you agreed, bearing in mind
 10 the comments we've had from the professors?

11 **A.** I think -- I mean, I also was asked this question in
 12 Module 3, and how I responded was that I would encourage
 13 individual families who had concerns of this nature to
 14 engage directly with care providers and with trusts if
 15 there were concerns that they had. Because I do think
 16 that's the most appropriate mechanism by which those
 17 answers can be provided and either assurance provided or
 18 not.

19 I think the wider question for me is whether such an
 20 approach would have been justified and proportionate,
 21 and potentially, the unintended harm and consequences of
 22 that, in terms of adding to distress and grief.

23 I did listen to, and read very carefully, the
 24 stories and experiences of those in Module 2C, who
 25 described in very vivid terms their concerns, their

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1 available to asymptomatic staff working in the
 2 independent domiciliary care sector. And I think you
 3 wrote a letter on 17 August 2021 to independent
 4 domiciliary care providers to that effect.

5 The Expert Working Group on Testing, which you've
 6 mentioned, and which you had established --

7 **A.** Yes.

8 **Q.** -- to advise on testing had flagged in October 2020,
 9 ten months previously, that domiciliary care workers
 10 were the number 1 priority and that there was evidence
 11 of significant transmission in domiciliary care,
 12 probably equivalent to what was seen in care homes.

13 Now, is it right that domiciliary care frequently
 14 involves personal care and close physical contact?

15 **A.** Yes.

16 **Q.** Yes? Is that right? Sometimes multiple times a day,
 17 for example, for someone who may need it morning,
 18 daytime and night; is that right?

19 **A.** It can do, and certainly with individuals with very
 20 complex underlying needs, yes.

21 **Q.** And also that domiciliary care workers would visit many
 22 different people in the one day to provide that close
 23 personal care; is that right?

24 **A.** That certainly can be the case, yes.

25 **Q.** And was it those features of domiciliary care that had

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1 indeed led the Expert Working Group on Testing to regard
2 domiciliary care testing as the number 1 priority in
3 October 2020?

4 **A.** Well, I think what you're referring to, and having --
5 I mean, I obviously didn't -- other commitments --
6 having established the group, I didn't sit on the Expert
7 Advisory Group on Testing. The section that you're
8 referring to refers to a readout from a UK -- England
9 policy identifier. It wasn't discussion that was within
10 the group, it was a readout of what other nations were
11 doing, and it was clearly indicating that this was
12 identified as a priority area that needed to be
13 advanced, given the fact that there was something like,
14 at a UK level, some 800,000 domiciliary care workers
15 delivering care to a million people.

16 So the conversations was about what was being
17 planned, and how that might be given effect to. And
18 I think if you read through the detail of that, it
19 demonstrates that it was still very much in the
20 exploratory stages about the feasibility of that, and
21 actually how it might be given effect. I mean, it
22 talked about perhaps individuals going to a central hub
23 to get a test, et cetera, et cetera.

24 So that was the initial discussions about it. It
25 was certainly a priority. It was also discussed again

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1 But that was trust-employed domiciliary care
2 workers. It did take significant effort on behalf of
3 the PHA to identify all of the domiciliary care workers
4 working in domiciliary care amongst the 300 providers in
5 Northern Ireland, and to onboard them onto the DHSC
6 system so that they could be registered for LFDs, and be
7 tested.

8 So it was a logistical challenge, and had we been
9 able to roll it out earlier, we would have done so. But
10 I think that -- I wouldn't want to create the impression
11 that we didn't regard domiciliary care workers, either
12 those employed by the trust or the independent sector,
13 as not a priority. I mean, we were the first part of
14 the UK to introduce symptomatic testing for domiciliary
15 care workers, whether they were trust employed or
16 independent sector employed.

17 So we were -- I mean, I think a point I would make
18 in closing is that we expanded testing as quickly as we
19 could but there were very significant logistical
20 challenges.

21 **Q.** So you've mentioned that the best test was the lateral
22 flow test rather than a PTR -- rather than a PCR test --

23 **A.** Well --

24 **Q.** Were PCR tests made available to -- (overspeaking) --

25 **A.** -- from the point of view of logistics, not in terms of

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1 at the Expert Advisory Group on 10 November.

2 And as I said earlier, we were in the midst of
3 the -- at that stage would have been the Alpha wave and
4 we had very significant pressures on PCR capacity. And
5 the decision at that meeting was that -- and indeed this
6 had been discussed at the four-nation UK ministerial
7 meeting on 8 October -- that the most effective way to
8 test particularly that large number of individuals on an
9 ongoing basis was to await the arrival of the new
10 testing technologies, the lateral flow devices.

11 I mean, PCR was not very suitable for the
12 circumstances that you describe, because if you take
13 a PCR test -- and you could be waiting sometimes --
14 well, ideally 24 hours, but up to 72 hours for test
15 results. So you needed something that was much more
16 rapidly deployable, that would actually give a more
17 immediate assessment of potential risk. And obviously,
18 as you've said, we did then, after a number of pilots in
19 January of 2021, roll out LFD testing to healthcare
20 workers. We made it available to domiciliary care
21 workers in March of 2021. And incrementally then we
22 rolled it out into the independent sector.

23 Now, I mean, there are several letters from me at
24 that time. One of 4 June which is saying: this is
25 available, you should already be doing this.

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1 sensitivity and specificity, but in terms of the
2 practicalities of somebody moving, you know, between
3 people's homes as you've indicated.

4 **Q.** Was any testing made available to that independent
5 domiciliary care workforce prior to August 2021?

6 **A.** Yes, through the Northern Ireland SMART programme, which
7 was established, which I, with the agreement of the
8 minister, established in March and I alluded to the
9 rollout to domiciliary care workers directly employed by
10 trusts from the March --

11 **Q.** And if I can just pause you there, I think you've told
12 us that 80% of the independent -- of the domiciliary
13 care sector is the independent sector; is that correct?

14 **A.** I don't think I mentioned that figure. I was talking
15 about the adult social care sector. I think the
16 percentage is probably around the same as --

17 **Q.** Yes, I think Mr Holland from the department --

18 **A.** Possibly.

19 **Q.** -- said 76% of domiciliary care contact hours are
20 provided by the independent sector; is that right?

21 **A.** Yes.

22 **Q.** So is it right, then, that that left the vast majority
23 of the independent sector without that provision even if
24 -- (overspeaking) -- rollout in March?

25 **A.** I think the other important point to make here is that

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1 we were, certainly from April, early April,
2 notwithstanding the communication to trust-employed
3 staff, LFDs were available to every single one of us
4 from April of that year, and we were all being
5 encouraged to undertake twice daily LFDs. So that was,
6 from memory, around 19 April. And under the Northern
7 Ireland SMART programme, which was really about
8 facilitating the rollout of LFD tests across a range of
9 sectors, by the mid to end of April, we had LFDs
10 available to all voluntary community sector
11 organisations or anyone employing more than ten
12 employees, or indeed with ten or more volunteers.

13 So there were various routes by which individuals
14 could already avail of LFDs, and we were advising the
15 population to use LFDs before visiting care homes. But
16 as you say, the formal communication was on 17 August
17 from myself and the Chief Social Work Officer, but LFDs
18 were available to domiciliary care workers prior to
19 that, to the best of my understanding.

20 **LADY HALLETT:** Thank you, Ms Beattie. I'm sorry we're going
21 to have to leave it there. We've got a lot to get
22 through today.

23 Thank you very much, Professor McBride. Whatever
24 findings I make, I don't think anybody disputes the
25 amount of pressure you and your colleagues were under
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1 and if I slow you down, please forgive me, but it's
2 important that everyone hears what you have to tell us.

3 **A.** Yes.

4 **Q.** You are the former Minister of Health in Northern
5 Ireland, I think you were appointed on 11 January 2020
6 until 27 October 2022; is that correct?

7 **A.** That's correct, yes.

8 **Q.** And I think, although not within the dates of the
9 pandemic, I think you were again the Health Minister in
10 February to May 2024?

11 **A.** That is correct.

12 **Q.** Right. In your statement you helpfully set out the
13 pre-pandemic situation where, you make no bones about
14 it, you considered that social care was underfunded and
15 in need of reform in Northern Ireland?

16 **A.** That's correct.

17 **Q.** And you went on to say, indeed, in Module 2C, that you
18 believed that the social care sector was exposed when
19 you took up your post. You said:

20 "... I perceived our domiciliary care, our social
21 work, to be the Cinderella service because I do think
22 they have been undervalued and under-recognised up until
23 that point ..."

24 And I suspect you still stand by those remarks
25 today?

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1 and the efforts you went to to try and protect as many
2 people as possible. So thank you very much for what you
3 did, and thank you very much for your help with the
4 Inquiry.

5 That, I'm assured, is the last time we'll be
6 burdening you or your department. So thank you very
7 much.

8 **THE WITNESS:** Thank you, my Lady, I hope my evidence has
9 been of assistance to the Inquiry.

10 **LADY HALLETT:** Thank you.

11 Very well, I shall return at 1.45.

12 **(12.45 pm)**

13 **(The Short Adjournment)**

14 **(1.45 pm)**

15 **LADY HALLETT:** Ms Carey.

16 **MS CAREY:** My Lady, may I call, please, Robin Swann.

17 **MR ROBIN SWANN (sworn)**

18 **LADY HALLETT:** Thank you for coming back to help us again,
19 Mr Swann.

20 **THE WITNESS:** My Lady.

21 **Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 6**

22 **MS CAREY:** Mr Swann, your full name please.

23 **A.** Robert Samuel Swann.

24 **Q.** And I dare say it won't be the last time but I am going
25 to ask you to speak slowly, please, if at all possible,
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1 **A.** Very much, yeah.

2 **Q.** So it's against that background, then, Mr Swann, that
3 I'd like to ask you some questions about the role you
4 played in the pandemic, and indeed in particular what
5 went well, what did not go so well, and what we might do
6 in the future, given now you're no longer in the
7 department, perhaps some reflections, many years on now,
8 about what could be improved should we have another
9 pandemic.

10 Can I ask you at the outset, did you, as minister,
11 know how many beds might be freed up by the hospital
12 discharge policy?

13 **A.** Not at the outset of that in regards to a specific
14 number, no.

15 **Q.** Right. Did you know the percentage of, or proportion of
16 discharges that might end up in care homes, of people
17 that might end up in care homes?

18 **A.** Not at that point but I do know from subsequent work
19 that there has been an analysis of that.

20 **Q.** All right. And do you know the percentage of people who
21 might require domiciliary care who were being discharged
22 from hospital?

23 **A.** No.

24 **Q.** You say there that you did subsequently come to know.

25 Can you give us an outline of the figures involved?

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1 A. Well, I think it comes from the Herity report, it
2 regards those, you know, non-elective ones that --
3 people who were discharged to both their own homes but
4 also to care home residents as well.

5 In the first two quarters of 2019, it was, on
6 average, 6% of those discharges that actually came from
7 hospital into domiciliary care homes, and that didn't
8 actually change in the first two quarters of 2020.
9 Actually in the second quarter of 2020 the percentage of
10 people being discharged from hospital to a care home
11 actually declined slightly.

12 Q. Do you agree with the decision to expedite discharges
13 without testing to care homes?

14 A. Well, the challenge at that point in time was the
15 availability of testing in regards to the quantity and
16 the quantum that we actually had in regards to that.

17 From what I've seen of the decision taken and the
18 steps taken, it didn't have that dramatic effect on the
19 numbers or the practice. Still very clear from the
20 practices that were involved that all those discharges
21 were made, actually, on a clinical assessment rather
22 than on any drive from a centralised policy that came
23 from -- a change of policy that came within the
24 department.

25 Q. From your perspective, who was it who took the decision
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1 were you made aware of concerns by particularly members
2 of families of people in care homes about the discharge
3 policy and whether infections were now being brought
4 into care homes?

5 A. It was brought to my attention, there were concerns in
6 regards to how that was being done and the perception
7 that was done. Some of the language around it, about
8 care homes being flooded by people being discharged from
9 hospitals wasn't reflective of the position or, indeed,
10 what was actually happening in Northern Ireland in
11 regards to that. The guidance actually coming from the
12 Health and Social Care Board, I think from around the
13 3 April, was about that 14-day isolation where possible.

14 Q. Before that isolation guidance came out, though, can
15 I ask about an email that was sent to your office,
16 please, and can we have on screen INQ000256495.

17 It's, in fact, two emails sent by Martina Ferguson
18 who is a member of the Northern Irish Covid Bereaved
19 Group, and she emailed your office on 30 March, so
20 before that isolation policy was in place. And she
21 explains in her bottom email that she is writing another
22 email to you as she is a desperate daughter.

23 She said:

24 "If someone has passed away in a nursing home since
25 the lockdown has taken place ... can they be tested for
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1 to agree with the expedited discharge policy?

2 A. Well, I'm not so sure it actually was a policy change in
3 regards to that, it was a reinforcement of what would
4 have been done at other clinical pressurised times,
5 should that be winter, or those winter pressures that we
6 had seen previously. The engagement mainly came, and
7 the correspondence came, that I was aware of and had
8 sight of before it was actually sent out to trusts
9 actually came from the permanent secretary. The
10 permanent secretary in Northern Ireland also carried the
11 title of Chief Executive of Health and Social Care, as
12 well, so it was a dual-titled role.

13 Q. The permanent secretary sent out the letters that
14 reinforced what you say was an existing policy, but --
15 so do we take it that it wasn't you, it wasn't
16 the department, or it was at Executive level, was there
17 any sort of overarching decision within Northern Ireland
18 to agree to the expedited discharges?

19 A. It wasn't something that I was asked to agree to, but it
20 was something I was aware of.

21 Q. All right.

22 Now, we know that initially there was no testing of
23 the patients that were discharged, and indeed,
24 initially, no requirements for the people discharged to
25 be isolated. Obviously that changed over time. But
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1 COVID-19? Can the government exercise all their powers
2 to ensure there is a ... test ..."

3 And she makes the point that there are very
4 vulnerable elderly loved ones and staff working in those
5 environments.

6 And a little later on that evening, she in fact goes
7 further and says -- she has asked you to stop all new
8 admissions into all the nursing homes in Northern
9 Ireland with immediate effect until the visiting
10 restrictions are lifted, and she says she wants to know
11 that "we are doing everything we can to help stop the
12 spread of Covid-19 and protect our vulnerable elderly".

13 Did you receive other emails setting out the
14 concerns that Ms Ferguson sets out in that email?

15 A. I'm not specifically aware of any emails but I am aware
16 of Martina Ferguson, and her emails and the passion that
17 she brought forward because I did meet her on a number
18 of occasions in regards to the issues and concerns that
19 she had.

20 Q. This was a few days in to the discharge policy being in
21 force. Did you consider it realistic to be stopping new
22 admissions as at the end of March 2020?

23 A. I didn't think it was something that would have been
24 practical at that time in regards to what the intention
25 of that, the discharges from hospitals into care homes
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1 was actually about in regards to that, because I was
 2 very clear in my understanding that it was only being
 3 based and done on a clinical assessment and what people
 4 were perceived fit to be discharged into care homes and
 5 it wasn't as was perceived, as people were worrying
 6 about that it was an emptying of hospital beds straight
 7 in a care homes without any care or attention being
 8 applied to it.

9 **Q.** We understand the decision made clear that there should
 10 only be discharges if clinically appropriate,
 11 I understand that, but the corollary of that is ensuring
 12 there are protections in place in the care home to where
 13 you are discharging the patient.

14 Yesterday, the Commissioner for Older People in
 15 Northern Ireland, Mr Lynch, told her Ladyship that
 16 certainly as far as he was concerned, in March 2020 the
 17 hospitals, to use his phrase, were pretty empty, and he
 18 queried why, perhaps, there was the need for those
 19 discharges in the early stages of the pandemic, why you
 20 didn't wait until there was more testing capacity.

21 Are you able to help with: was any thought given to,
 22 perhaps, delaying discharges until there was sufficient
 23 testing capacity?

24 **A.** My Lady, I think the perception of hospitals being empty
 25 wouldn't be a reflection that we had in Northern Ireland

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1 is some unoccupied beds within the hospitals which may
 2 be what Mr Lynch was talking about yesterday.

3 **A.** Yes.

4 **Q.** And I just want to understand, are you suggesting that
 5 this graph doesn't accurately represent what was going
 6 on in the hospitals?

7 **A.** It does, but it is from the start of April. The
 8 pre-data, you know, we're talking about those discharges
 9 were, you know, earlier on, we were talking about
 10 March --

11 **Q.** Yes.

12 **A.** -- in regards to that discharge policy at that point.

13 Sorry, if there's confusion in regards to --

14 **Q.** No, not at all, but we've seen other graphs that show
 15 a real spike in April of admissions of Covid people, and
 16 the like, but perhaps before that, there is still, on
 17 the face of this graph, some spare capacity with which
 18 he would say you could have kept people in hospital
 19 pending the availability of testing.

20 Was that something that any thought was given to,
 21 Mr Swann?

22 **A.** Not that I'm aware of and, again, in regards to those
 23 discharges from hospital to care home was done when
 24 people were deemed clinically fit and the support was
 25 there to return them to actually what, if they were to

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1 in regards to that, because our hospital occupancy was
 2 always over and above what was recommended in regards to
 3 the use of hospital beds, and sometimes in regards to
 4 that clinical assessment for people who were actually
 5 physically fit to be discharged to be maintained in the
 6 hospital is not good for them either, rather than being
 7 returned home.

8 If we had have been waiting until testing capacity
 9 was up to -- and again, I think, I covered it in the
 10 last module -- the perception of testing now isn't what
 11 it was then in regards to the ease through LFDs or,
 12 indeed, the quantity or the ease they were available
 13 even in turnaround times as of being able to access test
 14 results.

15 **Q.** Can I ask you about that last answer, and can we have up
 16 on screen, please, a graph INQ000485679_23. It, I hope,
 17 is going to be a dashboard. There we are.

18 If there's a misperception about occupancy rates,
 19 and the like, I'd like you to correct it, but this is
 20 general bed capacity. Indeed, in Northern Ireland you
 21 were monitoring ICU capacity, as well. You were also
 22 monitoring the number of Covid admissions as opposed to
 23 general admissions, but if we look at the graph on the
 24 right-hand side, with the blue and yellow and red on it,
 25 one can see there as at April, on the face of it, there

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1 return to their own care homes they had come from which
 2 would have been equivalent to being in their own home.

3 **Q.** Did you ask, Mr Swann, around this time about the
 4 capability of care homes to actually implement isolation
 5 facilities?

6 **A.** I'm aware there has -- there was work done in regards to
 7 the RQIA assessing there was 80 homes that were saying
 8 they had the facility to do that in regards to being
 9 able to isolate somebody to that standard in regards to
 10 that, but I think as Professor Holland explained on
 11 Monday, you know, that was a desktop exercise in regards
 12 to his understanding.

13 **Q.** Yes, he thought that might be an underestimate of the
 14 number of homes that were able to isolate, but at the
 15 time you were taking the discharge decision had you
 16 asked for any work done to ensure that there was
 17 capability within the care homes to isolate?

18 **A.** Not that I can recall at this stage.

19 **Q.** And at the time the discharge decision was being spoken
 20 about and was being rolled out, did you ask whether
 21 there may be any other isolation facilities that could
 22 accommodate discharges until such time as tests were
 23 available?

24 **A.** Well, I think the guidance that was in place in regards
 25 to that at that time was that if the care home that the

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1 individual was to be returned to didn't have capacity,
 2 they were still to remain, actually, within the trust,
 3 and the trust was to do that. So that would have been,
 4 I suppose the equivalent of them staying in a hospital
 5 facility if the trust couldn't find an adequate or
 6 a suitable place for them to be returned to.

7 **Q.** Professor McBride told us this morning potentially of
 8 the use of some hotels as effectively an isolation
 9 facility. But I ask you about this because the Health
 10 Committee in due course in Northern Ireland said there
 11 was a palpable sense of pressure amongst care homes to
 12 admit patients who may have been Covid positive, and
 13 indeed, a registered manager of a care home in Northern
 14 Ireland told Every Story Matters:

15 "At that point ... everywhere was so under pressure
 16 and we were ... told 'Well, they reside in your home,
 17 that's where they need to be, they're fit for discharge,
 18 we need the bed, you need to take them back'. So you
 19 didn't really feel like you could [say no]."

20 Putting those two pieces of evidence together, do
 21 you think it was made clear to care homes that they
 22 didn't have to accept Covid-positive patients?

23 **A.** I do in the guidance that was actually was -- actually
 24 was given out at that stage in regards to that. The
 25 care home always had that option to say no.

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1 Committee for Health decided in July to conduct an
 2 inquiry into the particular impact of the pandemic on
 3 care homes. And I think you're familiar with the
 4 report, Mr Swann, but I'd like to ask you about two of
 5 the Health Committee's recommendations which came out in
 6 January 2021.

7 Could I have up on screen, please, INQ000256510_12.

8 Thank you.

9 One of the recommendations, recommendation 15, was
 10 that:

11 "... no-one [should] be discharged from [a] hospital
 12 to a care home in which they are a resident, without
 13 having tested negative for COVID-19, unless the care
 14 home confirms that it has the staffing and facilities to
 15 ensure isolation for the required period; and that this
 16 is subject to monitoring and review."

17 And I think you responded to that recommendation,
 18 and were not in favour of agreeing with that
 19 recommendation. Could you set out why for us, please,
 20 Mr Swann?

21 **A.** I think, my Lady, we partially accepted that
 22 recommendation, if my memory is correct in regards to --
 23 I think it follows very much in the last --

24 **Q.** I don't want you to guess, Mr Swann.

25 **A.** Sorry.

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1 In regards to the support that we put in, we were
 2 also receiving, I suppose, counter to that, input from
 3 care homes who were concerned about their
 4 under-occupancy, as well, where actually I had to put in
 5 a financial support scheme in regards to homes to make
 6 sure they were economically viable at that point, in
 7 regards to that, so -- in regards to that specific
 8 quote, that's not something that was brought to my
 9 attention at that time.

10 **Q.** Did you get any sense when you were minister, perhaps in
 11 the March, April stages, that care homes did feel under
 12 pressure even though the guidance said they didn't have
 13 to take a Covid-positive patient, or was that not
 14 brought to your attention?

15 **A.** I don't remember in any of the engagements that I had,
 16 and I think even from -- from memory in regards to that,
 17 I don't think any care home ever contacted me or my
 18 office in regards to that to say: look, we're feeling
 19 pressurised, can you step in and give us support to say
 20 no?

21 I think the relationship should have been that
 22 between the care home and the trust who the contract was
 23 actually with to the ability to say: we're not
 24 comfortable.

25 **Q.** In your statement, the Northern Ireland Assembly

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1 **Q.** You set out your partial response to the recommendation
 2 at paragraph 134 of your statement, if it helps you.

3 **A.** Sorry, yeah.

4 My response, my Lady, in paragraph 134 is that we
 5 were:

6 "... '... concerned that refusing to admit a new
 7 resident without a negative test, regardless of the care
 8 home's ability to facilitate the required self-isolation
 9 period, would [actually] create undue pressures on other
 10 parts of the system particularly where the care home has
 11 the capacity to facilitate the required period of
 12 isolation.' [But] I also advised in the same response
 13 that [the] discharge was an area of policy that the
 14 Department continued to keep under active
 15 consideration ..."

16 **Q.** I just want to understand what you were saying there.

17 I think you're saying that if they could isolate,
 18 then you wouldn't want that to be a reason why
 19 a hospital bed wasn't freed up; do I understand that
 20 correctly?

21 **A.** That's correct.

22 **Q.** But what if the home couldn't isolate?

23 **A.** Well, then they could stay in the hospital for the --
 24 and that's why that -- that recommendation was partially
 25 accepted, and that was my understanding.

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1 Q. Thank you.
 2 Recommendation 16 was in a similar vein but not
 3 identical: that new residents, from wherever they were
 4 coming, ie non-hospital residents, should not be
 5 admitted to a care home unless they have tested
 6 negative.
 7 And I think you also indicated that you didn't fully
 8 agree with that recommendation and accept it. Could you
 9 help us with why you were not in favour of accepting
 10 that recommendation.
 11 A. And again it was for the same reason earlier: if the
 12 care home said they were able to or were able to
 13 facilitate a new resident who -- who may not have tested
 14 positive, could actually accept them into that facility,
 15 as well.
 16 Q. All right. The Committee for Health's inquiry report
 17 said in due course that many homes struggled to isolate,
 18 and they gave a number of reasons for that, perhaps
 19 facilities as one, staffing issues is another. And
 20 indeed, the residents themselves, who perhaps for their
 21 own cognitive state, were unable to abide by isolation
 22 rules.
 23 Was it brought to your attention, Mr Swann, that
 24 there were, before the Health Committee's inquiry
 25 report, problems with care homes being able to isolate?

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1 Q. Did you know, or was it brought to your attention, how
 2 many care homes were saying no?
 3 A. No, there was -- it wasn't brought to my attention at
 4 that stage.
 5 Q. And if there was the pressure that certainly the Health
 6 Committee and, indeed, some of the evidence that we have
 7 heard being brought to bear on the care homes, do you
 8 think the care home's ability just to say no was
 9 a sufficient protection?
 10 A. Well, if they needed to raise it as well, I think
 11 there -- as I said earlier, the relationship between the
 12 care home and the trust with the contractual arrangement
 13 should have been strong enough for them to say no. If
 14 it's not in future pandemics, it's something I would
 15 clearly be in favour of recommending, that there is that
 16 strength of a relationship where the ability, actually,
 17 for the home itself to say that.
 18 Q. This may be a difficult question to answer, but just
 19 standing back now, do you have any overall reflections
 20 on what could have been done better to protect care
 21 homes in Northern Ireland?
 22 A. Well, I think in the early stage, my Lady, I would
 23 always have been of the view that our strength within
 24 Northern Ireland was that we were an integrated system,
 25 but also from my comments, and I think even in the

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1 A. There was concerns, and I think that goes back to,
 2 I think, the evidence that Professor Holland gave on
 3 Monday in regards to that desktop exercise in regards to
 4 those homes that thought they were able to facilitate
 5 isolation in regards to that and I think as you've
 6 already indicated, he believed that was an
 7 underestimation.
 8 Q. Right.
 9 Just standing back for a moment about the discharge
 10 policy. Can I ask, from your perspective, what steps
 11 did you put in place to try to protect care homes, given
 12 that there was no testing, there was very significant
 13 concerns that PPE supplies were not getting to on the
 14 ground, you had recommended that staff try not to move
 15 between care homes, but what was in actual place to
 16 protect the care homes, Mr Swann?
 17 A. I think it was their ability to say no in regards to
 18 that transfer. And I know from, you know, previous
 19 comments in regards to that, you know, some care homes
 20 expressed a concern that they were being pressurised
 21 into that. That was something that I'd have been keen
 22 to ensure that they didn't feel pressurised, that it was
 23 only in the possibility there they were accepting
 24 someone who was deemed medical fit would be transferred
 25 into those homes.

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1 opening comments from counsel, I think there is also
 2 weaknesses in regards to that, because of that
 3 relationship between our adult social care sector being
 4 part of the overall budget of that single trust or the
 5 geographical trust that we have in Northern Ireland.
 6 So one of the recommendations that I've now -- and
 7 it is with hindsight and being able to step outside the
 8 role of minister being in there, of our five
 9 geographical trusts, adult social care was one of the
 10 delivery aspects that they had.
 11 So it would have had to compete with financial
 12 pressures, budgetary pressures, everywhere else. My
 13 concern, as well, is because that section of the care
 14 sector of that trust is so outsourced, when it comes to
 15 financial pressures, it's always one of those areas that
 16 when finance directors or trusts or boards are looking
 17 to balance a budget, it's one of those areas that often
 18 gets looked at first because it's the easy -- it's the
 19 easy budget line to start to remove. So the
 20 recommendation that I was actually bringing forward and
 21 part of response to, to the Inquiry, was that we take
 22 adult social care, actually, out of the five
 23 geographical trusts, and create a single trust for
 24 social care across the whole of Northern Ireland.
 25 My Lady, it's not as big a step -- well, it's a big

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1 step probably for some within health and social care in
 2 Northern Ireland, but the fact that we're a population
 3 of 1.9 million in regards to that, geographical size of
 4 Greater Manchester, population size of Greater
 5 Manchester, I don't think it's unreasonable to do. It's
 6 how our ambulance service already works as a sixth
 7 trust. So it takes all that functionality, all the
 8 budgetary control, all the pressures, and puts it into
 9 one overarching body.

10 **LADY HALLETT:** Sorry to interrupt. Wouldn't that then fight
 11 against what you says is one of the strengths, that it's
 12 an integrated system?

13 **A.** But it still would be. It would be a single adult
 14 social care trust still working within a section of the
 15 Department of Health under SPPG. So the same way that
 16 our Northern Ireland Ambulance Service actually supports
 17 the transfer of patients to EDs across every trust in
 18 Northern Ireland and has the ability to divert an adult
 19 social care trust that covered the whole of the
 20 geographical of Northern Ireland would then be able to
 21 have a consistency of approach, have a consistency of
 22 delivery, and should the future pandemic ever put those
 23 pressures again there could be the same level of
 24 support, trust, and input rather than having a central
 25 body, department, RQIA, or PHA, having to deal with five

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1 two-week period in March 2020 and did not support the
 2 hypothesis that hospital discharges were a substantial,
 3 I emphasise that word, cause of outbreaks.

4 Given the limitations of the Herity report, in that
 5 at least one of the weeks there was no testing at all
 6 and in the second week there was limited testing, can
 7 you help, Mr Swann, with why no other work was done to
 8 try and ascertain whether there was infection seeded in
 9 care homes from hospital discharges in Northern Ireland?

10 **A.** I think the Herity report reflected Northern Ireland
 11 work that was commissioned in Scotland and elsewhere
 12 which came to the same basis of conclusion: that
 13 although there was seeding to a level for the hospital
 14 discharge into care homes, it wasn't the main or the
 15 substantial source of infection at that time.

16 **Q.** Staying with the discharges but just a different aspect
 17 of it. Can you help with what steps were taken to
 18 protect domiciliary care workers who were now dealing
 19 with patients being discharged who may be Covid
 20 positive?

21 **A.** Again, the guidance went down through their employers
 22 because, again, as -- was said, a highly privatised
 23 contracted service in regards to that, it was the advice
 24 that was coming, should -- the PPE in regards to what
 25 support they were given, as well.

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1 different trust directors to explain what was needed,
 2 why it was put out, and how guidance was disseminated.

3 **MS CAREY:** It may be straying beyond the terms of reference
 4 of this Inquiry, Mr Swann, but can I just ask you, what
 5 do you perceive the benefit would be in a pandemic of
 6 having a one singular social care trust?

7 **A.** I think -- well, it actually comes back, I think, to
 8 a question that I know counsel has asked previously in
 9 regards to Professor McBride's evidence about how trusts
 10 or even hospitals could support each other or care homes
 11 could support each other. So if that was under one
 12 overarching umbrella, the ability to do that would be so
 13 much -- believe now so much easier, in regards to that.

14 Professor Holland, in his evidence, talked about, in
 15 regards to domiciliary care, about how some parts of
 16 Northern Ireland are more challenging in regards to
 17 those packages. My Lady, what we see is when trust
 18 boundaries often come to either side of a village in
 19 Northern Ireland, the level of access or the level of
 20 being able to access a domiciliary care package can be
 21 different, just depending on the postcode of where
 22 you live.

23 **Q.** We are familiar, in the Inquiry, with the conclusions of
 24 the Herity report which was published in November 2020
 25 and we know that that took data from a very early

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1 **Q.** One of the ways of potentially protecting care homes was
 2 to try and restrict staff movement. And we heard from
 3 Mr Holland that there was a pilot that was spoken about
 4 called Safe at Home, which envisaged staff working seven
 5 days on site, seven days off, with a period of isolation
 6 beforehand, and he told us why that pilot wasn't able to
 7 be got off the ground, but I think you were aware,
 8 Mr Swann, or certainly your office was, that some people
 9 were living in, as it were, and can I ask you please to
 10 have a look at an email INQ000586668_1, and actually the
 11 email below that please, if I may, thank you.

12 This is 27 May and an email to your office and it
 13 says:

14 "We have been contacted by [a resident] in relation
 15 to [a particular town]. When the lockdown started, the
 16 manager had to take leave due to her husband's health,
 17 requiring shielding and a new manager was placed in
 18 post. [They] took over and moved into the home so that
 19 she could guarantee a high level of care throughout the
 20 lockdown, she has remained there for 9 weeks. The lady
 21 called asked if the Minister could visit [and it was
 22 pointed out that wasn't going to be possible -- that was
 23 going to be difficult], even to talk to the manager from
 24 the car park. While this may not be possible perhaps
 25 a phone call would be appreciated (the home apparently

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1 has not had Covid)."

2 Did you ever arrange a call with either this person

3 or, indeed, someone in a similar position, and if so,

4 what did you learn from speaking to them?

5 **A.** My Lady, that was a direct contact to my constituency

6 office at that time. I think, inadvertently, the

7 response came up where I did go out, actually, and visit

8 the home, the staff, the manager, that we actually spoke

9 to, and her husband was in the car park. It was a car

10 park visit in regards to that stage, was able to speak

11 to some of the residents, indeed through the window.

12 So the care at home model that was suggested,

13 I thought was actually reinforced by this example that

14 we actually had in regards to that because of the

15 dedication of that individual, or the new home manager

16 that come in at that point.

17 **Q.** Can you remember now, Mr Swann, what were they telling

18 you in that car park about how life had been for them

19 and how the care home was managing to stay Covid free?

20 **A.** Well, it was specifically in regards to what was, I

21 suppose, envisaged through care at home, if the staff

22 was restricting the footfall in regards to coming in and

23 out. Now, some of the staff were, it was the manager

24 who actually moved in and stayed at that stage but it

25 gave her that hands-on response. She told me it was

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1 **A.** No, apologies, I was just going to -- at what time, at

2 what stage, I don't recall.

3 **Q.** What did you learn from speaking with the domiciliary

4 care providers?

5 **A.** Again, it was that -- from domiciliary care providers,

6 and especially in Northern Ireland, well, not especially

7 in Northern Ireland, my Lady, they see the people who

8 they come in on a regular basis and they get to know

9 them, they're more than just clients. They become

10 regular, regular visitors into homes, sometimes they

11 were the only visitors that were coming into some homes

12 in regards to that, so the domiciliary care providers

13 were, I suppose they were appreciative of the

14 acknowledgement in regards to going out and speaking to

15 them in regards to hearing some of the concerns as well,

16 but some of the steps that they were taking, you know,

17 spending that bit of extra time rather than just their

18 allotted paid 15 minutes in regards to that.

19 **Q.** So they were staying on with the people they were

20 looking after --

21 **A.** Yes.

22 **Q.** -- rather than a 15-minute visit or whatever the

23 position was?

24 **A.** Yes, they would just do that.

25 **Q.** Did they mention to you concerns about PPE in the

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1 challenging but she thought that was her duty to her --

2 I think she talked about her family, is how she saw

3 actually the residents in regards to that.

4 The husband to the manager who I spoke to said it

5 had been highly challenging to the family, the fact that

6 the wife had moved out, the mother had moved out for

7 nine weeks, as well, but were very much supportive of

8 what she was doing at that stage.

9 So that's why the care at home model was something

10 I feel it was attractive although, unfortunately, it

11 didn't come to fruition.

12 **Q.** Did you, just moving away from care homes, did you have

13 any personal engagement with people or agencies that

14 were providing domiciliary care?

15 **A.** To the same extent, I think it was one visit I did when

16 I went down, I think it was the Ards Peninsula, where I

17 actually went to, again, it was a car park of a GP

18 practice where domiciliary care providers were coming to

19 pick up their PPE from a centralised point, at that

20 stage, the trust, rather than them having to drive,

21 because, again, of the geographical area rather than

22 those care providers having to come in to a central

23 area, the trust actually took a facility out, so I took

24 that opportunity to go out.

25 **Q.** And what -- sorry, to interrupt --

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1 domiciliary care sector?

2 **A.** Well, that was the visit that actually, I spoke about in

3 regards to that. That's how they were picking up the

4 PPE at that stage. One of the points that, and again,

5 it came through the integrated sector, although we had

6 challenges at the beginning of the pandemic, because of

7 the supply lines and the contacts that we had between

8 the care -- the independent care home providers, the

9 domiciliary care providers, as well, that they

10 facilitated a point of contact within each trust, and

11 that the trust were the linkage to get that PPE directly

12 to them, the decision that we took was that they would

13 be supplied equally from storage when we had the ability

14 to do that and the quantities to do that.

15 **Q.** Can I return to where I started on this topic which was

16 the potential of the Safe at Home pilot. In your

17 statement you say that you:

18 [As read] "... consider the best way Covid could

19 have been prevented from spreading in care homes was by

20 the introduction of the Safe at Home pilot. You said

21 that trades unions' concerns could have been addressed

22 and measures put in place to ensure staff felt safe."

23 Why are you such an advocate for the Safe at Home

24 pilot?

25 **A.** Because I think from that visit in regards to the

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1 engagement we had where the staff were prepared to do
2 that, we had some care homes who wanted to look at it
3 but there was that general concern from trade unions'
4 side, and rightly so, that it was putting additional
5 pressures on staff (unclear) over and above what they
6 were expected to do and whether the staff member could
7 feel, actually, pressurised into doing it rather than on
8 a voluntary basis.

9 I know there was concerns raised, as well, within,
10 I think, on permanent secretary level about the cost and
11 the practicality of being able to do it, but I wanted to
12 explore as to if there were homes and staff willing to
13 do it, should we have been able to facilitate it? And
14 I'm disappointed that we weren't able to do that.

15 **Q.** Right. Do you still think that might be a model worth
16 pursuing?

17 **A.** I do, yes.

18 **Q.** Mr Holland told us on Monday, I think it was, that
19 looking back, he didn't think it was something that ever
20 could have been expanded in scale for various reasons.
21 Do you agree with Mr Holland?

22 **A.** I think that is, I suppose, validating my point, as
23 well, I think it is something that if homes wanted to
24 do, they should be possibly supported in doing that.
25 One of the things that we have in Northern Ireland, and
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1 unwell but to prevent that additionality of covering
2 a number of facilities.

3 **Q.** A number of witnesses from Northern Ireland have spoken
4 about the ability of care homes to block book agency
5 staff. Was there any specific funding put in place to
6 enable the block bookings?

7 **A.** There was. There was a number of financial packages
8 throughout the pandemic that were provided, and one of
9 the things that -- from the initial -- I think the
10 initial grant facilities that we gave in March was,
11 like, a stipend in regards to the number of beds, and
12 each --

13 **Q.** Yes, you're right, and I think it was 27 April that
14 there was 6.5 million allocated, and it was on a per-bed
15 basis, 10,000, 15,000, and 20,000. But that's end of
16 April, Mr Swann. Are you saying that if there was to be
17 block booking, it was to come out of that
18 6.5 million pot?

19 **A.** Well, not at that stage. That was a block grant which
20 was given to homes at that stage, so we could get
21 additional monies to them quickly. I'm not sure that
22 there was that strict of a spend profile put on it at
23 that stage, but as -- as we progressed, and additional
24 financial payments and support came throughout the
25 pandemic, it was through engaging with care home
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1 I think it has already been referred to, we have
2 a number of smaller homes where this, the Care at Home
3 facility could be easier facilitated rather than some of
4 the large-scale homes that we see elsewhere across the
5 country.

6 **Q.** More generally in relation to restriction of staff
7 movement, did you, at the time, give any thought to
8 whether there needed to be any legislation brought in to
9 try to prevent staff moving between care homes or care
10 settings?

11 **A.** I don't think it was ever raised with me in regards to
12 legislation to prevent that happening, but there were
13 steps that we did take, which I think have already been
14 covered, in regards to the ability for homes and
15 providers to actually block book agency staff as well so
16 that it reduced the amount of footfall, I think, to
17 bring legislation in that would have prevented people to
18 do that.

19 I'm not sure how you would start into regards --
20 into employment law and the crossover, into some of
21 those areas as well, with -- in regards to that, but
22 I do think we took steps in regards to supporting
23 financially those providers, the likes of the -- also
24 additional sick pay as well, so that people weren't
25 encouraged to either go to work when they were feeling
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1 providers, and the sector as well, that those were --
2 they were nuanced, they were put into where we were
3 being told the financial need actually was or had grown,
4 or how we could actually make payments to address some
5 of the challenges or concerns, the ability to block book
6 staff being one of them.

7 **Q.** All right. In due course I think 11.7 million was given
8 in June and then 27 million in October of 2020.

9 Given the increasing size of the funding made
10 available, is it implicit the initial one-off payments
11 of 10,000-20,000 were not in fact sufficient to help
12 care homes?

13 **A.** Well, it was about getting an initial payment out as
14 quickly as possible without -- well, as -- with as
15 little bureaucracy as possible, and still recognising
16 that it was public monies that at some stage somebody
17 will challenge the expenditure of.

18 It was also how the department received additional
19 monies throughout the period over of the pandemic as
20 well that allowed us to make additional payments. It
21 wasn't, I don't think, ever envisaged that that initial
22 payment was going to be a one-off payment that would
23 suffice through the pandemic. It was always about how,
24 as we got more money, we could actually make those
25 additional payments and support become realistic.
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1 Q. Whichever tranche of funding we're looking at, was any
2 of it ring-fenced for either supporting the enhancements
3 to Statutory Sick Pay or ring-fence for PPE or was it
4 just "Here's the money, you spend it how you see fit"?
5 A. No, it was -- there never was a tight ring-fence put on
6 it, but there was allocations and guidance given as to
7 what pots could be drawn down in regards to different
8 areas.
9 Q. Can I ask you about PPE. We have heard that, of course,
10 the trusts were to help independent care providers who
11 couldn't source their own PPE. What were the funding
12 arrangements in place if a care home provider had to
13 seek PPE from a trust? Was it given to them?
14 A. Once we were able to get those systems up and running
15 that was given to them free of charge, my Lady, I think
16 from -- the Northern Ireland Audit Office actually did
17 a review into that and I think the price that they put
18 on it was in regards -- £54 million worth of PPE was
19 distributed over the pandemic through care homes and
20 domiciliary care. So it was not an insignificant
21 investment but it was a necessary investment at that
22 time.
23 Q. You say in your statement that as early as
24 13 March 2020, concerns were being raised about the
25 ability of PPE with you. And indeed, there's emails
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1 or BSO PaLS actually being the central point of contact
2 I think as well, or even purchasing, should care homes
3 or domiciliary care providers be able or willing to go
4 through them as a purchase agent so there could be
5 I suppose cost savings in the bulk buying of that. It's
6 something that hasn't been done in the past in regards
7 to that but something I believe could be looked at in
8 the future.
9 Q. I think you said in a ministerial statement on 27 April
10 that you were ensuring care homes have sufficient
11 supplies as an absolute priority, to use your words, and
12 you wanted to work with care homes to ensure each home
13 had a buffer stock of PPE.
14 But you go on to say that you learnt through the
15 IHCP that the trusts were only making limited supplies
16 available to care homes, there was inconsistency across
17 the region, hence why you then requested the buffer
18 stock was made available.
19 Can you just help us with what you were being told
20 and what you envisaged the buffer stock -- how long it
21 would last, what was the arrangements?
22 A. I think the initial arrangement was that on -- on what
23 they had been using or what they had been drawing down,
24 there would be a two-week buffer stop provided in
25 regards to that. Each care home needs a domiciliary
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1 you've seen where it's been raised.
2 Can you help with what steps you took to try to
3 ensure that both care homes and indeed the domiciliary
4 care sector had equal access to PPE?
5 A. It was -- we stepped in at that stage and trusts were
6 instructed that PPE was to be provided by -- again, by
7 the domiciliary care providers and the care homes that
8 they had the contracts with.
9 The arrangement was that each trust was to provide
10 a single point of contact in regards to how they could
11 access, where they can access, and the deliveries would
12 be made via BSO, Business Services Organisation, to
13 trusts, and then trusts -- now it was something -- it
14 was a new system that was created. It was -- it wasn't
15 as seamless as it should have been at the start, and
16 again, one of my recommendations is that we should look
17 now to make sure that if there is a future pandemic in
18 regards to that, that those systems can be quickly
19 activated in regards to -- as to how we do that, because
20 again, the contracts between care home providers,
21 domiciliary care providers with the trust, they're
22 responsible for providing their own PPE. But as we saw
23 at that point, you know, those supply lines quickly
24 dried up.
25 There is a possibility, as well, in regards to BSO
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1 care provider so that, should there be a difficulty in
2 supply within the trust, either the trust supply chain
3 or BSO supply chain, at least they had something to be
4 able to keep them going until whatever concerns or
5 problems could -- could be rectified.
6 Q. Just thinking about PPE in relation to unpaid carers,
7 I think you said trusts had to continue to supply PPE
8 where they already did so to unpaid carers and to ensure
9 that anyone in receipt of a direct payment or had
10 a named worker receive PPE. But you go on in your
11 statement to recommend a central registry of unpaid
12 carers or at least a register to be maintained at trust
13 level.
14 Why do you think that a central registry of unpaid
15 carers would help?
16 A. Because I think -- well, I know, my Lady, that during
17 the pandemic that the identification of unpaid carers
18 was extremely difficult from us from a central point of
19 view, in regards to those who needed not just PPE but
20 also, at later stages, when it came to access to
21 vaccines as well, in regards to that as well.
22 So we didn't have, and still don't have, that
23 central registry of unpaid carers. People can come
24 forward and identify themselves as unpaid carers to
25 trusts, individual trusts, and they go on a register
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there where they receive updates in regards to what's happening or what other supports are there, but I believe that if we had a central register where unpaid carers could be encouraged to apply to it but also identifying through healthcare providers in regards to the additional -- additionality that they're supplying as a care provision to a loved one or a family member, that they could also be identified as well.

Because during the pandemic, when we wrote out to actually indicate what support was available to unpaid carers, we actually had to send a leaflet to every household in Northern Ireland, because we didn't have that central register. So a central register would allow the dissemination of information of support a lot easier in regards to that.

And again, my Lady, going back to the size of Northern Ireland and our ability to do something like this, I don't think it's beyond our capability now.

Q. And a central register held by the Department of Health?

A. By the Department of Health, yes. Or if there was a single adult social care trust across Northern Ireland, my Lady.

Q. Do you think though, there may be challenges to defining who is an unpaid carer, and indeed a fluidity to who may be an unpaid carer? They may only be an unpaid carer

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A. I don't think it's fair but I do know, again, the passion that the commissioner did bring in regards to the representation of older people in Northern Ireland, in regards to that.

We were testing on a frequency that, again, was recommended through the Expert Advisory Group on Testing in regards to how often and who we were actually doing in regards to that, because there was also that concern raised about the personal -- the personal testing of people. At that stage it was still PCRs, my Lady, so it was swabs up nose -- noses and swabs down the back of throats in regards to being able to do that for older people on the continual basis. There was a discomfort in regards to that. And the frequency had to be balanced with, I suppose, the positive results that it were given in regards to the usefulness of that frequency as well.

Q. He went on to say from his perspective there didn't seem to be "a huge appetite for testing, particularly in care home settings". Do you have any observations on that, Mr Swann?

A. I would, my Lady, I was very passionate in regards to testing and PPE and support and vaccination in regards to care homes, and I think the department and those who've -- who have presented (unclear) will know that

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for a set amount of time whilst their relative is recovering?

A. There would be a fluidity as well, but also, you know, working through the Department for Communities in regards to that, there are indeed some of the organisations that Carers NI were able -- we were able to support during the pandemic as well. It wouldn't be beyond the ability to do that as well.

And especially in regards to that fluidity, somebody who is an unpaid carer for a very short -- or a shorter space of time shouldn't be neglected by the system, either in regards to being able to access that additional information or support.

Q. I've asked Professor McBride about testing in detail so I won't ask you, but can I just ask you this: I think you've seen in your bundle a letter from COPNI in October of 2020 where the commissioner was urging you to test staff weekly rather than fortnightly as was the regime in place at that time. And he told us that he was calling for the weekly testing to try to prevent the spread, which rose then as the autumn progressed.

And he said generally overall, though, he thought that you were playing catch-up with testing at the time. Do you think that's a fair observation made by the commissioner?

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that was something I was keen to progress at all opportunities.

Q. Aside from the policy, I'd like to ask you, please, about some evidence the Inquiry has received from a manager of a Northern Irish care home.

Could I have on screen, please, INQ000587747_5.

And can we see there at paragraph 9 the care home manager provides a lengthy answer about the practicalities that were happening. At that stage, testing was weekly for staff and every 28 days for residents and then other *ad hoc* testing.

They said:

"In relation to testing, staff required to be trained to ensure adequate technique and errors did occur due to ineligible writing or incorrect personal details."

The Public Health Agency put out a video to try to facilitate this.

But they say:

"The testing ... was time consuming for residents, many of whom who could not cooperate or had difficulty tolerating ... the swabbing [you've just spoken about]. Extra staffing was therefore required and this had great implication on resources that were already overstretched."

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1 There needed to be an allocated testing area to
2 manage the sheer volume of testing to reduce the risk of
3 cross infection.

4 And even under that, problems then set out there
5 with the courier collection service and results being
6 slow to return.

7 Were you made aware of on-the-ground problems and,
8 indeed, things that needed to be overcome by care home
9 managers, and if so, what did you do to try and
10 alleviate those problems?

11 **A.** In regards to the issues raised are not something new in
12 regards to that and that's why some of the funding pots
13 that we actually spoke of earlier on in regards to that
14 was actually to allow additional time and space and even
15 facilities for staff members to be able to carry out
16 those tests and the administration connected to that, as
17 well. So it was part of some of those funding packages
18 that were actually given to care homes.

19 **Q.** You say -- you acknowledge in your statement that
20 domiciliary care testing and, indeed, asymptomatic
21 domiciliary care staff had to wait until the capacity
22 was in a position so you could roll out testing for them
23 and, indeed, we heard from the CMO this morning that
24 that was the position.

25 But you say in your statement that you would

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1 So, I think, taking the opportunity now to look at
2 how people could be prioritised depending on the nature
3 of the pandemic, could be a useful use of time.

4 **LADY HALLETT:** Do you think -- I'm sorry, I didn't mean to
5 interrupt.

6 Would you need to know the characteristics of the
7 disease to do detailed prioritisation planning?

8 **A.** But there could be multiple prioritisations in regards
9 to if it was a respiratory disease most likely to affect
10 older people, or if it was a viral disease. My Lady,
11 I'm not a virologist nor do I claim to be but I think
12 there could be --

13 **LADY HALLETT:** So you would have a set of
14 plans -- (overspeaking) --

15 **A.** It would be a set of -- and it's one of those -- sorry,
16 my Lady, I didn't mean to interrupt.

17 **LADY HALLETT:** No.

18 **A.** In regards to that I think one of the challenges we had,
19 and it's often the line that's used, was we didn't have
20 a guide or a rule book to lift off the shelf in regards
21 to this. So it wouldn't take -- well, sorry, it
22 wouldn't take an awful lot of heads, I think, to come up
23 with a number of scenarios in regards to that. I think
24 one of the biggest regrets, and I think one of the
25 challenges in regards to that, is those mass testing

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1 recommend that the Inquiry should include a direction as
2 to how to prioritise tests in any future pandemic. What
3 did you have in mind and how would that help the
4 position in Northern Ireland?

5 **A.** Well, I don't think it's just in regards to Northern
6 Ireland. I think in any future pandemic, I think the
7 pressures that we saw, and again, this Inquiry has
8 looked at, is about how you prioritise and when you
9 prioritise, what can be a new set of tests or a new
10 testing regime. What we were doing was doing that under
11 pressure as testing, I suppose, expanded or changed from
12 PCRs to LFDs.

13 On reflection, if that work had been done earlier,
14 in peacetime rather than wartime, in regards to who
15 could be prioritised, when they could be prioritised,
16 and as ability scaled up, that people could be
17 identified, so there is a clear understanding. While
18 I'm here talking about the pressures that we were
19 getting on testing from within our own sector, within
20 all sectors, I was also receiving pressures from the
21 economy minister who wanted to ensure that all
22 powerstation workers were tested regularly, from the
23 justice minister who wanted to ensure that all prison
24 officers were tested regularly and all prison inmates
25 were, as well.

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1 facilities that were created across the United Kingdom
2 that we were able to use, I think I've seen a lot of
3 them now stood down in regards to that because of, I
4 suppose, the economic decisions in regards to keeping
5 those almost, you know, in standby in case they were
6 needed, as well. So there's work to be done there.

7 **LADY HALLETT:** Sorry to interrupt.

8 **MS CAREY:** Not at all.

9 You say it wouldn't take that many heads. Whose
10 heads? Which department? Who should lead this work?

11 **A.** Well, in regards to who could lead that, you know, SAGE,
12 there's a number of bodies out there who could -- chief
13 scientific advisers from across the jurisdictions in
14 regards to that, or academics in regards to university
15 input too.

16 **Q.** Can I move on to visiting as a topic, and two discrete
17 topics here. One is in relation to end-of-life visits.
18 And in your paragraph 287a you make reference to the
19 principles of end-of-life care that were included in the
20 UK Government's updated principle.

21 I'll just wait for you to get there. It's at your
22 page 93, Mr Swann.

23 **A.** Okay.

24 **Q.** 11 May 2020, there was guidance put out which meant
25 that, essentially, end-of-life visiting was deemed

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1 essential, but that was not replicated in Northern Irish
 2 guidelines, and I wanted to try to understand with you
 3 why end-of-life visiting was permitted in the UK but
 4 that wasn't repeated in the Northern Irish guidance.
 5 **A.** I think in regards to visiting, the Chief Nursing
 6 Officer was very clear in regards to facilitating
 7 end-of-life visiting in all areas where we could, where
 8 it could be safely done, as well.
 9 **Q.** We know that your statement sets out a number of
 10 concerns about the visiting policy from both the
 11 perspective of the resident and the impact it had on
 12 them and their loved ones and, indeed, the impact it had
 13 on the care homes who were trying to reduce the ingress
 14 of transmission.

15 You said, I think, in your statement as an overall
 16 reflection that you considered the decisions taken in
 17 respect of visiting were not a hundred per cent right.
 18 In what ways, Mr Swann, were they not right?

19 **A.** In regards to, I suppose, the restrictive nature of
 20 them, and just how restrictive they were at the
 21 beginning, as well, in regards to that, and I think
 22 that's where our development in regards to Care Partners
 23 has allowed to ease that restrictive nature, as well, in
 24 regards to just how quickly, you know, that initial
 25 lockdown actually shut down visiting as well, because it

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1 Did you think that there should have been more
 2 guidance put out about the role that testing could play
 3 as a reassurance for care homes that infection wasn't
 4 coming into the home?

5 **A.** I think it was -- now, I don't have the document in
 6 front of me but from recall I think in regards to the
 7 leaflet, it was clear to Care Partners that they may be
 8 expected to take Covid tests in regards to that, should
 9 that be a requirement of, you know, that they were added
 10 along with the staff testing regime at a later date when
 11 that capacity became available, as well, but I think,
 12 just to strengthen in regards to where I saw Care
 13 Partners or where we saw Care Partners, it was about
 14 relationships between the Care Partner and the -- not
 15 just the person they were supporting but also the
 16 relationship with the care home and the care home
 17 management themselves, because I think we can look,
 18 I suppose, too quickly or too easily that that
 19 relationship was only between the resident and the Care
 20 Partner, whereas in many homes the relationship between
 21 the management, the nursing staff, the support workers
 22 with somebody who may deem themselves a Care Partner is
 23 actually maybe as strong or as important in regards to
 24 the additional support that can be given to those
 25 residents.

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1 was, I know it's been said elsewhere, but it was, and
 2 still is my belief that, you know, care homes are
 3 residents' homes as well as being those health
 4 facilities, as well, in regards to that.
 5 **Q.** I think the Commissioner for Older People was a powerful
 6 advocate in terms of trying to increase the number of
 7 visitors in care homes, and -- but there was potentially
 8 problems, was there not, Mr Swann, with the
 9 implementation of the Care Partner model? From your
 10 perspective, what were the impediments for rolling out
 11 this model across the care homes in Northern Ireland?
 12 **A.** I think there was a concern from some homes and some of
 13 the management in some homes as to what it actually
 14 meant in regards to increased footfall and the, I
 15 suppose, the chance of increased positivity in regards
 16 to testing in regards to that, as well. It was
 17 a reluctance that I found challenging in regards to that
 18 as in regards to what we wanted to do in regards to the
 19 implementation and the delivery of Care Partners.
 20 **Q.** Clearly, though, the counterargument is: we don't want
 21 more people our homes, it might bring in more infection.
 22 The CMO told us this morning that there wasn't testing
 23 written into the Care Partner guidance because, at that
 24 stage there probably wasn't capacity given the increase
 25 in the numbers of Covid infections.

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1 **Q.** I think you have seen a number of letters from the IHCP
 2 expressing their concerns about the Care Partner scheme,
 3 particularly in November and December 2020 -- I won't go
 4 through them all, Mr Swann, but can I summarise them in
 5 this way: they were worried about the greater the
 6 footfall, the likelihood of a rise in transmission, they
 7 were concerned about the definition of a Care Partner
 8 and they were also concerned that whilst,
 9 understandably, the family's views had been listened to,
 10 the care home providers' views about the feasibility of
 11 Care Partners hadn't been listened to.

12 Do you acknowledge the concerns of the IHCP and do
 13 you have any observations to make about their concerns?

14 **A.** The IHCP did raise those concerns as well, but to
 15 counter that, as well, we announced the Care Partner
 16 initiative in early September, I think it was, or sorry,
 17 in September. And I think within days of that being
 18 announced we were contacting -- the home, I remember, it
 19 was (unclear) Care Home, which is a small village in
 20 County Down, which had a care home who were in contact
 21 to see how they could do this, they really wanted to do
 22 it, they wanted to be part of it. So when it came to
 23 that engagement over that six-week period before
 24 implementation, there were a number of homes, a number
 25 of, I suppose, stakeholders in regards to that, that we

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1 worked along with in regards to making sure it worked as
 2 efficiently and as easily as possible for those homes
 3 and those individuals who wanted to make it work.
 4 **Q.** We know from Mr Holland that there were varying numbers
 5 that rose throughout the pandemic of care homes that did
 6 roll out the Care Partner model and when I asked
 7 Mr Holland about whether there should be legislation
 8 perhaps to try to make it mandatory, he said in fact he
 9 thought that the contracts that existed between
 10 providers and the trusts might be the lever, and thought
 11 that there had been a reluctance on the part of trusts
 12 to use the contract with the care home to influence Care
 13 Partner practice.

14 From your perspective, would you take any action to
 15 enforce the contractual obligations between care home
 16 provider and, indeed, the trust to bring in the Care
 17 Partner guidance?

18 **A.** Well, again, it wouldn't have been within my remit as
 19 the contracting authority -- (overspeaking) --

20 **Q.** I follow that, and maybe I've phrased it badly, but did
 21 you try and encourage the trusts to take action --

22 **A.** -- (overspeaking) --

23 **Q.** -- to enforce the contracts?

24 **A.** Through RQIA there was, I think, an encouragement in
 25 regards to supporting homes in regards to that. There

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1 **Q.** Can you help us outside of care homes as to a summary of
 2 support provided to domiciliary care, and I think I'm at
 3 your paragraph 357, if it helps you, Mr Swann.

4 Forgive me, the support provided financially to
 5 domiciliary care, would you be able to help us with what
 6 you put in place?

7 **A.** Well, again, coming from that paragraph, alongside the
 8 provision which was worth -- in regards to -- the figure
 9 that's there, the 41 million, it was, again, about
 10 support to independent domiciliary providers under that
 11 arrangement where the providers had their income
 12 supplemented, actually to be a hundred per cent. So if
 13 there were care packages actually cancelled, which we
 14 did see during the pandemic, that, you know, their
 15 income was still supplemented to that to make sure,
 16 again, that that provision was still there, and that
 17 domiciliary care providers, when they saw packages being
 18 cancelled or handed back because people were staying at
 19 home, working from home, and cancelling packages that we
 20 didn't actually lost (sic) the workforce either.

21 There was also the 80% payment towards domiciliary
 22 workers should they have indicated that they'd either
 23 tested positive or had Covid symptoms, so that they
 24 didn't feel that they were going to be financially
 25 penalised for not coming into work, as well. So that

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1 was also additional monies put into supporting care
 2 homes, as well, I think in the package of 27 million
 3 that we provided round the October time, also the
 4 support of Care Partners was there, as well.

5 Building on using that contractual (unclear) is one
 6 of the recommendations that I put forward again to the
 7 Inquiry was actually putting that Care Partner's
 8 relationship or opportunity, actually, in legislation --

9 **Q.** Yes.

10 **A.** -- in regards to that because, again, I think rather
 11 than having to rely on contracts or interpretation,
 12 a facility like that, I think, has a benefit in regards
 13 to being actually in legislation.

14 **Q.** You've referred earlier in your evidence to some of the
 15 funding that was granted to care homes and indeed,
 16 I think to be eligible for some of the funding, the care
 17 home had to confirm they were implementing the Care
 18 Partner guidance. Can I ask you, though, if, for
 19 legitimate reasons, any care home wasn't able to
 20 implement the Care Partner guidance, did that mean that
 21 they didn't get the October tranche of funding given to
 22 them?

23 **A.** No, it only meant they got the -- they weren't eligible
 24 to the allocation that was for the support of the Care
 25 Partner scheme.

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1 additionality was there, too, which was replicated
 2 across the care home sector, too.

3 **Q.** In your statement in relation to unpaid carers you say
 4 that, I think, on 19 April, there was funding of
 5 4.4 million to support unpaid carers which was to last
 6 until March 2024. Can you help with why specific funds
 7 to unpaid carers were not put in place until April 2021?

8 **A.** My Lady, the financial opportunity, again, because we
 9 were unable to identify unpaid carers, so the ability to
 10 actually give them the £500 bonus that we were able to
 11 give, not just all healthcare workers, but also care
 12 home workers and domiciliary care workers, I wanted to
 13 explore another opportunity as to how we could support
 14 them. So it actually came through a tranche of monies
 15 that the department was able to bring down that we put
 16 into a very specific pot to support unpaid carers
 17 through an unpaid carers support fund. There was a pot
 18 of 4.4 million that was allocated to Community
 19 Foundation Northern Ireland that organisations were able
 20 to apply for to support them. Carers NI and a number of
 21 other voluntary and community organisations were able to
 22 do that.

23 I did that through ministerial direction, my Lady,
 24 at that stage, because the permanent secretary wasn't
 25 able to prove value for money through governance

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1 arrangements, as elsewhere in the -- it wasn't that he
2 was opposed to it; it was that it was necessary for me
3 to direct him to do that, to make sure that money got
4 out in some way to be able to support our financial
5 carers.

6 So because it was, I suppose, Covid monies, it was
7 for a three-year project and that's why it was
8 specifically for that timeframe, as well. There has
9 been extensive representations made, I know, to the
10 current minister, as well, in regards to being able to
11 find funding to extend some of those projects because of
12 the value, but I am not sure he's going to be able to do
13 that.

14 **Q.** One of the contributors to Every Story Matters, who was
15 an unpaid carer living with a person they cared for in
16 Northern Ireland, said this:

17 "At one point I was probably only getting about
18 4 hours sleep a day for months and it just became the
19 norm. I thought I was all right, but I was absolutely
20 exhausted."

21 And can I ask, please, that we call up on screen
22 INQ000176237.

23 This is from a Carers Northern Ireland report called
24 Caring Behind Closed Doors. It came out in April 2020,
25 and if one looks to the column on the right-hand side,

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1 to that, and that's why I do think we need, again, that
2 central register, so that we can get those -- guidance
3 and support, actually, into place as quickly as
4 possible.

5 **Q.** You mentioned in an answer a moment ago reference to the
6 £500 Special Recognition Payment to health and social
7 care staff, which I think was announced in
8 January of 2021.

9 Can I have up on screen, please, INQ000597566_1.

10 This is an email dated October 2021 to you, and it
11 includes a number of pieces of information, but if we go
12 down to the section stated "£500 bonus payment", this is
13 a homecare provider who sets out their difficulties and
14 she says:

15 "The £500 bonus payment is still outstanding. She
16 advises that Health Trusts have not been engaging with
17 providers. (she suggests Trusts set criteria, [that]
18 providers can establish from their payroll ... who would
19 qualify ... Could payback clauses be built in? Why not
20 adopt such a system."

21 And if we just go down:

22 "I would ask that the overdue £500 bonus payment for
23 carers is urgently addressed and that with the new
24 National Insurance contributions towards health and
25 care, that as a society we ... should value the vital

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1 they conducted a survey of over 420 carers in
2 Northern Ireland, and:

3 "The majority (64%) of carers agreed/strongly agreed
4 with the statement -- 'I feel overwhelmed and I am
5 worried that I'm going to burn out in the coming weeks'.

6 "[Their] biggest concern was what would happen if
7 they themselves became ill. The overwhelming majority,
8 87%, of carers agreed/strongly agreed with the statement
9 'I am worried about what will happen to the people
10 I care for if I have to self-isolate or become ill'."

11 Aside from the funding that came into being in
12 April 2021, what steps did you take to try to mitigate,
13 insofar as you were able, these pressures on unpaid
14 carers in Northern Ireland?

15 **A.** My Lady, in regards to, I suppose, the comments that are
16 seen there, that was replicated extensively across
17 society in Northern Ireland, especially in regards to
18 our unpaid carers, the funding allocation was what was
19 available in 2021. Prior to that, again, I was working
20 through voluntary and community organisations through
21 their core funding in being able to see how we could
22 support those unpaid carers. Again, going back to --
23 and not meaning to repeat myself, my Lady, it was the
24 identification of individuals and those families proved
25 actually difficult and challenging sometimes in regards

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1 role that carers carry out."

2 Were you aware that there was such significant
3 delays now, of eight months or so, in that Special
4 Recognition Payment being made to the people it was
5 intended for?

6 **A.** Yes. And I did ask for a regular updates in regards to
7 that, because again, of that contract, the nature of the
8 workers working in domiciliary and care homes, as well,
9 it was -- the providers had to put in -- payroll put in
10 claims, and then it was put back out as well.

11 But in regards to the point of the National
12 Insurance, that was actually (unclear) as well, so it
13 was a £730-whatever as well, because what we actually
14 put into a pay packets for those eligible was to ensure
15 that they got £500 on their bottom line and not that
16 they lost National Insurance or tax out of it. And that
17 was supported through executive colleagues and the
18 Finance Minister as well.

19 **Q.** Do you know whether the £500 payment did speed up and
20 get to those on the ground?

21 **A.** There was -- I know there was challenges for it. You
22 know, the number of options that I was given at that
23 time when I decided to follow this route, there was,
24 I suppose, those simpler automatic -- a simplified
25 system that would have been easier, but the £500 was one

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1 that was eligible across all individuals in regards to
2 that. So I know there was a small team worked very
3 diligent in regards to making sure they could get as
4 many payments out as possible for people who weren't on
5 trusts' payrolls. So in regards to this, this was
6 under -- where we had to identify through third-party
7 providers who was eligible so they could receive it as
8 well.

9 **Q.** Perhaps one other topic if I may before the afternoon
10 break. Thank you, my Lady.

11 And may I ask you, Mr Swann, about DNACPRs.

12 In your statement you said you were aware, following
13 articles in the media, about the concerns raised in
14 relation to DNACPRs. And I think in March 2021 you were
15 asked formally how many local audits had been undertaken
16 since the start of the pandemic to monitor adherence to
17 policies and guidance in relation to do not resuscitate
18 orders, and the response was that two health and social
19 care trusts are currently progressing audits.

20 Did you request the audits to see what the audit
21 found?

22 **A.** They weren't requested specifically by me but I do know
23 they were on -- on the back of -- I think it was
24 a written question from Willy Humphrey, who was one of
25 the MLAs in regards to that, that was the answer that

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1 **A.** I think in regards to the feedback that we had, and
2 again, the information pack that I referred to was
3 actually on -- and I've been able to get it since --
4 since that session -- on the information pack that was
5 actually behind that written question in regards to what
6 was being done. So in regards to the Belfast trusts,
7 their morbidity and mortality review that they did every
8 month looked at all DNACPRs, as well, so they were doing
9 that as well, as well as work being done by the Western
10 Trust, as well. I know it was an issue that COPNI, the
11 Commissioner for Older People, also raised. But in his
12 statement, I believe, where he has raised some concerns,
13 he said the concerns that were brought to him were,
14 again, in only single figures in regards to that.

15 **Q.** In your Module 3 evidence you also observed that you
16 thought there was now an opportunity to retrospectively
17 conduct an evaluation and make recommendations in that
18 regard. Do you know, and I appreciate you're no longer
19 in the Northern Irish government, whether anything has
20 been done to conduct such a systematic evaluation?

21 **A.** I'm not aware, apart from what I've heard from
22 Professor McBride's evidence this morning, my Lady.

23 **MS CAREY:** My Lady, that may be a --

24 **LADY HALLETT:** Certainly; I shall return at 3.15.

25 **MS CAREY:** Thank you.

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1 come back. With regards to the blanket imposition of
2 DNACPRs, I was very clear in regards to answers as well
3 that I thought any sort of blanket obligation would be
4 discriminatory and unethical in regards to -- to where
5 I stood.

6 **Q.** You I think gave similar evidence to relation in
7 Module 3, where you said that orders based on age or
8 disability were discriminatory and unethical, and you
9 said:

10 "In terms of the policy in Northern Ireland media
11 reports were ill-founded."

12 And you said you'd been given insurances based on an
13 information pack that had been provided to you.

14 The Inquiry instructed some end-of-life care
15 experts, Professors Sleeman and Barclay, and they've
16 stated in their report that they were unable to identify
17 any systematic evaluation of DNACPR form usage in
18 Northern Ireland, and indeed, the learning disabilities
19 experts could not find any Northern Irish material
20 relating to DNACPRs and people with learning
21 disabilities during the pandemic.

22 So can I ask you then, given that there were the
23 concerns that we've heard about, on what basis do you
24 say, absent an evaluation, that media reports were ill
25 founded?

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1 (3.01 pm)

2 (A short break)

3 (3.15 pm)

4 **MS CAREY:** Thank you, my Lady.

5 **LADY HALLETT:** Ms Carey.

6 **MS CAREY:** Mr Swann, the Inquiry is familiar with the
7 changes made to the regulatory inspection regime in
8 Northern Ireland and I think you say upon reflection you
9 consider it was appropriate to direct the RQIA to reduce
10 its statutory inspection activity and, indeed, to
11 suspend its non-statutory inspection activity.

12 But given the suspension and, indeed, reduction in
13 that activity, what assurances did you receive that the
14 residents of care homes would be safeguarded in Northern
15 Ireland?

16 **A.** Well, I think in regards to, even in regards to this
17 response that I gave to the joint letter from COPNI and
18 the Northern Ireland Human Rights Commission in regards
19 to the RQIA statutory inspections actually weren't
20 suspended, they were still being carried out in regards
21 to, my Lady, I'm actually aware, you know, there was one
22 home where RQIA was actually stepping in in regards to
23 such a concern that they had over residents that we were
24 (unclear) not just putting on impositions in regards to
25 the home but actually moving people out of that home, so

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1 such was the extent and the concern as well, so it was
2 about a reduction of statutory inspections rather than
3 the complete suspension.

4 **Q.** Yes, a reduction of statutory but a cessation, as I
5 understand it, or suspension, of non-statutory
6 inspection activity -- I'm sorry if I didn't make that
7 clear, but that's what you set out at your paragraph 439
8 in your statement.

9 But whichever it was, whether it was a reduction or
10 indeed a suspension, what I'm trying to get at is: what
11 steps were you happy with that were put in place to
12 ensure quality of care insofar as it was possible in the
13 pandemic and, indeed, that the residents were
14 safeguarded?

15 **A.** Well, there was, in regards to that, the reporting from
16 the care homes to RQIA through the establishment of the
17 app, but also in regards to the supports through trust
18 workers actually being put into supplement care homes
19 where they didn't have enough staff to do that, as well,
20 so there was that footfall, as well, as in regards to
21 that, but I think looking on, the repurposing of that
22 staff and the RQIA to the service support team, I also
23 think gave that bit of extra to care home and care home
24 staff and management, as well.

25 **Q.** That was a supportive, primarily, though, system that
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1 I think has been cited by other representatives to the
2 Inquiry, actually, from England, I think it was
3 Ms Townsend (sic) in regards to their feedback from
4 their care home suppliers, that the feedback they got
5 that SST in Northern Ireland provided a service over and
6 above what CQC was actually giving in regards to that
7 and was seen as a positive as well.

8 So I do say in my recommendation that such a team
9 should be stood up as where, you know, critical response
10 units and centres across other departments, and even
11 including -- even including the Department of Health,
12 that such a facility staffed by professionals outside
13 one of the main bodies, where people could go ask for
14 assistance, clarification and guidance, would be useful
15 as well. And I'm clear as well that such a body doesn't
16 necessarily have to come in the future from RQIA.

17 **Q.** May I ask you about two discrete areas of data, and in
18 particular data in relation to dementia patients.

19 Professor Banerjee, who gave evidence, expert
20 evidence to the Inquiry, said that despite dementia
21 being very common, it did not explicitly get mentioned
22 in key policy documents for the first nine months of the
23 pandemic, even notwithstanding the fact that there were
24 a disproportionate number of deaths of people with
25 dementia.

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1 was set up. Given that there was a reduction in the
2 number of visitors and loved ones that we've heard of,
3 indeed potentially some reduction in professionals going
4 into care homes to look after the residents, were you
5 satisfied that the service support team, or SST as we've
6 been calling it, was capable of being the eyes and ears
7 as well as providing the support that we know the team
8 did?

9 **A.** Well, I think because of the professional qualifications
10 and the professionals that they were, as well, because
11 care homes and care home staff were actually contacting
12 them about concerns, as well, they had. In my opinion,
13 they had the ability that would have been able to flag
14 concerns in regards to the questions that they were
15 being asked in regards to what certain care homes or
16 what certain care staff were asking in regards to those
17 concerns, as well.

18 **Q.** You say in your statement that you thought that the
19 support established in fact was of such importance that
20 you should -- it should be considered as to whether to
21 set it down in statute. Why do you think the SST, or an
22 equivalent scheme, should be put into legislation?

23 **A.** I think in regards to the ability that they were able to
24 provide care home providers -- sorry, specifically in
25 Northern Ireland during that time, actually has been --
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1 Does his observation that dementia did not get
2 a mention in key policy documents in 2020 hold true for
3 Northern Ireland, do you think?

4 **A.** As far as I'm aware, that would be an adequate
5 reflection, and it's regrettable as well.

6 **Q.** Did you call for any data in relation to the proportion
7 of Covid deaths in people with dementia?

8 **A.** Not that I can recall specifically at this point.

9 **Q.** A second aspect of data is in your statement. You said
10 there should be a core data set for domiciliary care
11 during the pandemic agreed across the trusts and
12 regional agencies. And I wanted to ask you why you
13 thought there should be such a core data set, what it
14 should include as the core data, and who should collate
15 it?

16 **A.** Well, again, at this point RQIA could be an option as
17 facilitating that, but, not to be repeating, if there
18 was a single trust, single adult social care trust in
19 Northern Ireland, across Northern Ireland, there would
20 be such a set that they could hold as well in regards to
21 that. In regards to, I suppose, the physical and mental
22 conditions of the people who the domiciliary care
23 providers were going into to actually -- what conditions
24 they were supporting people with.

25 **Q.** And what data is it that you think would be of
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1 assistance in a pandemic?

2 **A.** Well, it goes back to that point, I suppose, going back
3 even to M1 and M2C in regards to the lack of accessible
4 data that Northern Ireland actually had at that point,
5 as to one collection point.

6 Now, the introduction of encompass will move some
7 way in doing that to have that central allocation, but
8 it's something that wasn't there at that point so,
9 again, it goes back to if -- and I hope there isn't
10 another pandemic -- it goes back to my Lady's point, if
11 there's a different condition, a different virus,
12 working in different ways, affecting different cohorts
13 in different ways, that they can be easily identifiable
14 so that support and assistance can be given.

15 **Q.** All right, so clearly, obviously, you need, effectively,
16 to know who is acting as a domiciliary care worker, and,
17 I dare say, which region or trust within which they're
18 working, but is there anything else that you
19 particularly think the core data set should include?

20 **A.** Well, it could include -- it could actually all
21 section 75 criteria that applies to Northern Ireland in
22 regards to ethnicity, gender, age profile, because not
23 all -- not everyone receiving domiciliary care is aged
24 in regards to that. So there are, you know, a number of
25 young people in regards to even young adults who receive

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1 domiciliary care."

2 Do you consider that there was a failure by the
3 Northern Irish government to grapple with the policies
4 in relation to both care homes and indeed the
5 domiciliary care sector?

6 **A.** I think expanding on COPNI's statement in regards to
7 that, I did have to read it a couple of times, because
8 the first time I read it, I thought he was implying that
9 we shouldn't have locked down or went into lockdown
10 until there was adequate staff and adequate testing in
11 regards to those sections as well, which I think would
12 have been actually detrimental to our older people in
13 Northern Ireland and the care home sector as well.

14 But reflecting on what he meant in regards to the
15 challenges that were faced by domiciliary care and our
16 care home sector, as our opening comments have --
17 I was -- you know, I remain concerned in regards to the
18 support that has been in place over the past number of
19 years, and continues to do that even though the steps
20 that have been made in regards to even the reviews that
21 have been completed since in regards to that sense of
22 still a Cinderella service, who people look to when they
23 need to, but often are forgotten about in regards to
24 terms, conditions, and support as well. And that's why,
25 out of the reform of adult social care,

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1 those packages too.

2 **Q.** One of the overarching observations you make was that,
3 in addition to saying that decisions in respect of
4 visiting perhaps were not a hundred per cent right, you
5 said decisions in respect of PPE were not a hundred per
6 cent right.

7 In what ways, Mr Swann, were they not right?

8 **A.** I think in regards to the speed and the distribution
9 lines that we actually had when we moved to, you know,
10 ensuring that a centrally held BSO trust, PPE was
11 accessible to all sections of people delivering care in
12 regards to that. You know, the people that you talked
13 about earlier on, those unpaid carers, people in receipt
14 of direct payment as well, so that a central register
15 can actually identify them as well.

16 **Q.** Just finally before I finish, two things, please.

17 COPNI, in their statement, the commissioner said this:

18 "In my view the government's failure to properly
19 grapple in its policy and guidance with the lack of PPE,
20 the imposition of lock down without ensuring that there
21 were adequate staffing levels, and the need to provide
22 Covid-19 testing of older people and those working with
23 them, created a perfect and fatal storm in care homes.
24 There was similar concern for older people locked down
25 or isolating in their own homes and reliant on

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1 that I instigated the -- the collaborative -- the Social
2 Care Collaborative Forum, which brings together
3 suppliers and contractors, trusts, RQIA, PHA, all those
4 organisations, and actually gives a sound footing in
5 regards to how we can ensure that any future directions,
6 guidances, and all that -- that we don't face that storm
7 or those challenges again.

8 **Q.** Aside from your enthusiastic support for a social care
9 trust and, indeed, your comments just made there in
10 relation to a social collaborative forum, do you have
11 any other recommendation that you would urge upon her
12 Ladyship that would benefit the adult social care sector
13 in Northern Ireland in a pandemic?

14 **A.** I think in regards to that social care forum that I've
15 suggested was created as well that actually could be the
16 (unclear) reform to a single trust, my Lady, in regards
17 to otherwise is, actually -- I think it's that detailed
18 support plan for the care sector with clear
19 responsibilities across all who is responsible for doing
20 different parts, different sections. Should it be
21 testing, should it be PPE as well?

22 Again, going back to that point we discussed
23 earlier, my Lady, in regards to taking the time,
24 actually, to do it now and to look at the various
25 options. Part of the challenge and part of the language

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used at the start of, I suppose, this Inquiry was from some that we had prepared for the wrong pandemic. It's about using the time now to look at -- and, I suppose, future scan in regards to what could be out there, what could potentially be the next challenge that health and social care or, indeed, society faces as well.

Questions from THE CHAIR

LADY HALLETT: Can I just ask you, in relation to the separate trust for adult social care, you'll know, as former minister and in times of limited resources, anybody who wants to suggest a reform will -- change in some kind of structure has to be careful of, you know, what would it cost? Sorry to be so basic. Have you thought about what the resource implications of a separate trust would be?

A. My Lady, this is taking a service that already exists across five current trusts, and bringing it into the one body. So with directors of adult social care, we've five directors of adult social care looking after a single geographical area in a population, whereas I think if you start to streamline that into a single trust area based on the same form and structure as our ambulance service is in Northern Ireland, so a trust, a chief executive, it wouldn't be over and above the costs that are already there, but there also could that then

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services across Northern Ireland in regards, it was Professor Ray Jones, again working with Professor Sean Holland and we looked at about how we could actually, again, pull all the children's services from different trusts, and also actually coming from different other departments.

Now, again, because of the politics of Northern Ireland, when the Executive collapsed in October 2020, that work went on the shelf, and I know Professor Ray Jones has been keen in getting it re-instigated again.

So it is about the ability to, I suppose, civil servants and politicians, to be able to step back and actually look outside the silos of safety and security and see how a service can actually be progressed and made better in regards to the delivery of the people that they're looking after, in regards to that.

So there will be -- there will be opposition, my Lady. There's always opposition to change, but if we don't take the opportunity to change for the better, I think, you know, we could lose the benefit of this Inquiry, my Lady, in regards to what -- how those status quo and those silos can be challenged.

LADY HALLETT: My last question on this before Ms Campbell asks her questions -- sorry to keep you waiting, Ms Campbell -- last question on this.

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in regards to the costs saving in regards to you've one organisation dealing with BSO for the procurement of PPE, you've one organisation that then can look to HR in regards to the staff that they directly employ, but you've also then the ability for one organisation to be contracting with all the domiciliary care or homecare providers, so you're not looking at different contract negotiations for different rates at different times across the entirety of a sector.

We have instances in some towns and villages where there could be two domiciliary care providers providing packages for two neighbours, where I suppose a more streamlined and more acute and more alert management system introduced by that could see the same domiciliary care provider providing the same care for the two neighbours rather than two different groups of individuals, coming in as well. So there could be a level of cost. It's not something that I've done that detail of work on, my Lady, but I definitely think it's something there is an option to pursue.

LADY HALLETT: Could I ask you to play devil's advocate for a minute and think had you proposed this when you were in office, what would the arguments against have been?

A. My Lady, I did actually -- you know, where some of this comes from, I started a review in regards to children's

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Just supposing I were persuaded to make recommendations, and supposing the recommendation didn't find favour for the reasons that you've said, is there any way one could ensure that social care doesn't end up as a (unclear) -- as you say, the low-lying fruit for the budget? Is there any way you could ring-fence budgets or protect social care within the current trust system?

A. Well, and I think that should be part of the key remit of the Social Care Collaborative Forum that is now in place, and now working as well, part of that, there's a Fair Work Forum within that in regards to making sure that those staff are properly remunerated as well, and I know the current minister is actually in favour of that, as well, so that we go to those domiciliary and care providers move to the real living wage, so that there becomes a surety in regards to that.

But I think it is about that challenge again, about breaking down silos and areas of responsibility, I still believe that Northern Ireland is of a size that we're small enough to be able to do it but we're large enough to get it right as well if it's done.

LADY HALLETT: Ms Campbell -- over there.

Questions from MS CAMPBELL KC

MS CAMPBELL: Thank you.

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Mr Swann, good afternoon. You know that I ask questions on behalf of the Northern Ireland Covid Bereaved Families for Justice, and although her Ladyship has granted us permission on a number of topics, we are indebted to Ms Carey King's Counsel who, as ever, is alert to many of the issues of concern to the bereaved and has addressed some of the topics in her questions already, leaving me to revisit briefly, if I may, the issue of discharge from hospitals into care homes and then coming on, in a moment, to deal with visiting and care partner guidance.

On the topic of discharge, and going right back to 17 March 2020, we know that the guidance for nursing and residential care homes in Northern Ireland that was issued that day gave notice to care homes of the need for them to, firstly, work closely with trusts -- and I'm taking this, really, from the guidance itself -- to work closely with trusts to facilitate discharges from hospital, to ensure the effective flow of patients from hospitals, to communicate vacant placements quickly, and to facilitate the filling of places within care home providers.

Can you understand why on receipt of this guidance on 17 March 2020, and her Ladyship has heard how hungry the sector was for guidance at this point in time, can

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that point to protect the care homes. And your answer was that it was the ability of the care home to say no when asked to accept a resident back into their facility or a patient back into their facility.

Do you think that the March 2020 guidance made that protective measure clear?

A. Well, I think the March guidance was -- I think even as Professor McBride indicated earlier on, was a repetition of guidance that had already been in place. It wasn't new in regards to that. So when it came to winter pressures, it was a similar guidance that was based on that point as well.

And as I said to Ms Carey in regards to that, I think, and I believe, that the relationship between those care homes and the trusts is mature enough, that the contact is there, that if they were concerned about receipt or receiving patients, that they could say no, because also the additional provision that was in there as well, that if it wasn't that case that those patients were to remain in the trust's care until they could find a suitable placement for them.

Q. So we're of course in very uncharted territories. We've got a pandemic looming, we've got a vulnerable section of society, and we've got guidance telling care homes to work closely with trusts to fill up places from

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you understand why many care home managers may well have felt it was their obligation to free up beds in the hospital sector by filling vacant beds in their own facilities at that time?

A. And I think, on reflection in regards to that, it still goes back to that point: it should have been done on clinical decisions in regards to the suitability and -- the suitability but also the condition of those people being discharged, as well.

Q. Yes, but my question is slightly different. Can you understand why care home managers, fearful for the residents in whatever facility they were managing, felt, nonetheless, an obligation to accept discharges from hospital on receipt of that guidance in mid-March?

A. In regards to receiving their own, I suppose, their own residents back again who had had a spell in hospital due to whatever reason, there were many of them, I would assume, who would also want to have those residents back in somewhere where they could provide that care for them but also in regards to, as I said earlier, in regards to an earlier question that the hospital, and sometimes in some instances isn't the best place for some of those patients to actually be.

Q. Yes. You were asked by Ms Carey King's Counsel in relation to this discharge policy what was in place at

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hospitals into care homes. Was there ever a time, you think, that you made adequately clear to care homes that they had the option to protect their care homes by saying no?

A. I don't think it was a message that I ever felt I had to give in regards to that, because the relationship was long established before I come into post at that stage, in regards to that communication and that ability. The communication that went to the care homes came from the trusts who were the contract holder at that stage.

MS CAMPBELL: Well, if you might then touch briefly on the Herity report from a slightly different angle, but really picking up on your evidence, you quoted at the outset of your evidence Dr Herity's findings in relation to the percentages of people being discharged in quarter 1 of 2019 and quarter 2 of 2020.

My Lady, it's a slightly different question than that which I have been permitted, but if I may just expand on that evidence a little bit?

LADY HALLETT: You may.

MS CAMPBELL: Thank you.

The figure you gave I think was about 6% or thereabouts in those respective quarters as a comparison which pushes back on the idea that the care sector was being flooded, as you say, by patients being discharged

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1 from hospital. Behind that 6% figure, if we look at the
2 actual figures in quarter 1 of 2020, 2,868 patients were
3 discharged following an unscheduled hospital admission
4 into care homes, an increase of 200 or so from the
5 equivalent quarter the year before. The numbers
6 approach 3,000 if elective patients are added to the
7 mix.

8 Firstly, those figures raise the prospect of
9 hundreds of untested patients being discharged to the
10 care sector on a weekly basis in early 2020, isn't that
11 right?

12 **A.** And that was quarter 1. That was before, I think, the
13 date on the permanent secretary's letter as 26 March.

14 **Q.** Yes.

15 **A.** So it was actually at the end of quarter 1.

16 The figures themselves I think indicate that first
17 quarter was actually an increase of 179 for unscheduled
18 care. The second quarter then actually sees, from 19 --
19 sorry, from 2019, was 2,660, which dropped to 1,750. So
20 the following quarter there was actually a drop of
21 nearly a thousand.

22 **Q.** Yes, and --

23 **A.** -- (overspeaking) --

24 **Q.** -- I don't actually want to -- there may well be good
25 reasons for that in terms of the numbers of patients

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1 available, and the quantity of testing became available,
2 is somewhere we looked at.

3 **Q.** Again, Ms Carey has asked you and you've referenced the
4 emails from Martina Ferguson, which we know were on
5 30 March 2020 at a very early stage, and you accepted
6 fairly in your evidence that you were aware of those
7 concerns from elsewhere as well, but do you agree that
8 given the obvious vulnerabilities of people in care
9 homes and the known or even, at that the stage, the
10 unknown transmissibility of the virus, and the risks of
11 contracting Covid in hospital, that the dangers of
12 discharging untested patients from hospitals to care
13 homes should have been more obvious from the outset, as
14 indeed they were to Martina Ferguson?

15 **A.** Well, it's not that they weren't obvious in regards to
16 that. It was how we were able to manage them and
17 actually support those patients in regards to being in
18 the hospital where a patient hadn't -- or a resident
19 actually hadn't Covid or contracted Covid, the ability
20 to discharge them into a care home then, you know, back
21 to their own home, the place of safety, was something
22 that wasn't unusual in regards to that discharge policy
23 through, you know, other winter pressures as well,
24 because it was -- it wasn't a new policy. It was,
25 I think, a rearticulation by the permanent secretary in

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1 going into hospital, and we've heard about that in
2 Module 3, but really the question is this: if the
3 numbers of patients discharged from hospital to care
4 homes in the pandemic, that period including March 2020,
5 remained the same or even increased slightly in
6 quarter 1 of 2020, does that not suggest that care homes
7 did not or didn't feel able to protect themselves by
8 saying no?

9 **A.** If they had a concern in regards to those patients being
10 transferred at that point, which I don't think was ever
11 indicated, again, as I said earlier, in regards to those
12 patients at that point in time.

13 **Q.** Do you understand, and I know you've heard the concerns
14 of the bereaved that at least until the time that
15 testing was made a prerequisite, which we know I think
16 was by the 19th -- in guidance, on or by 19 April 2020,
17 that our integrated health and social care system was,
18 as a matter of fact, prioritising the risks to the
19 health service over the risks to those within the care
20 sector?

21 **A.** I'm not sure I accept that -- that premise. I do --
22 relating to the concerns that were there, as were
23 articulated by Ms Ferguson's e-mail earlier on were --
24 were well articulated in regards to those concerns that
25 were there, and that's why, when testing became

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1 regards to processes that were already there.

2 **Q.** Well, can you say why many of the bereaved might well
3 think that there ought to have been greater protections
4 for the care sector than the ability of individual care
5 homes to say no?

6 **A.** Yes, but I think the ultimate protection or the ability
7 there -- and again, as I've said in evidence to
8 Ms Carey, is that ability to say no should be
9 reinforced, and that, again, I'm more than happy to make
10 it through evidence to this session that if this did --
11 if there was a pandemic in the future, that ability to
12 say no should be writ large in regards to any guidance.

13 **Q.** I want to move on then to visiting and the Care Partner
14 guidance, because you know and we know that the Care
15 Partner scheme guidance that was issued on
16 23 September 2020 represented a very long-awaited and
17 much needed opportunity for loved ones to visit their
18 families in care homes, and you accept that?

19 **A.** Yeah.

20 **Q.** And it came with an expectation that care homes would
21 work towards full implementation by a date in early
22 November 2020. You recall that?

23 **A.** Yes.

24 **Q.** How soon after it was issued did you become aware of
25 problems with its implementation and concerns on the

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1 part of family members that they were still being denied
 2 access to their loved ones in care homes?
 3 **A.** Again, pretty early on, because it was a frustration.
 4 I've said that in my statement, that I would have liked
 5 to have seen it implemented. But that's why we gave
 6 that six-week lead-in time. It's also why we gave
 7 financial support to care homes as well, and why the
 8 recommendation that I've made to my Lady and this
 9 Inquiry that I believe it should be put on a statutory
 10 footing, and that the learnings that we took from that
 11 initial period of those six weeks is actually
 12 underpinned so that everyone understands what the
 13 requirements are.
 14 My Lady, in regards to the Care Partner arrangement,
 15 I think ... well, I think some of the challenge that
 16 came was that it was a Northern Ireland initiative. It
 17 wasn't -- been tried or trialled or even suggested
 18 anywhere else. It was something that had come from
 19 I think the Rapid Learning Initiative from the Chief
 20 Nursing Officer, but I do know now that it's actually
 21 being looked at in Scotland by way of a Private Members'
 22 Bill, under Anne's Law. It has been discussed in -- in
 23 the Oireachtas, in the government of the Republic of
 24 Ireland.
 25 So the ability to deliver it and what we intended to

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1 **A.** There was and there was always engagement between
 2 families who engaged with the Department in regards to
 3 that because we -- you know, not only did it contact
 4 COPNI, COPNI made me aware, and then the Chief Nursing
 5 Officer Group who led in this work was able to engage
 6 with the homes to allay those.
 7 **Q.** Okay. Well, I want to look at some of that engagement
 8 through a series of correspondence issued by the IHCP,
 9 of whom we have heard within this Inquiry.
 10 On 18 November 2020, so this is of course after the
 11 date by which implementation was expected to have been
 12 fully delivered, the chief executive of that agency
 13 wrote to you about rapid testing in care homes, and she
 14 observed in that letter:
 15 [As read] "My recent letters have outlined concerns
 16 in relation to the misalignment of departmental visiting
 17 policy with the readiness of care homes to increase
 18 footfall and relax visiting."
 19 So that's on 18 November.
 20 On 1 December, so two weeks later, she observed in
 21 another letter that the 18 November letter had not been
 22 responded to, and she pleaded with you to:
 23 [As read] "Please fully engage with all parties on
 24 this issue and in particular to move forward with rapid
 25 testing to enable meaningful visiting."

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1 do is, I still think, crucial -- crucial in regards to
 2 what -- what I wanted it to be.
 3 **Q.** We're not going to disagree on that, Mr Swann, but if
 4 I might just ask you to keep your answers shorter and
 5 more focused on the question because we do have limited
 6 time.
 7 Back to how soon you became aware of the problems,
 8 on 8 October 2020, Mr Lynch from COPNI wrote -- or the
 9 commissioner wrote to you, and he said:
 10 "My office has spent the last four weeks dealing
 11 with calls from families in distress and then angry,
 12 when care providers could not deliver the access to
 13 their loved one which they believe the new guidance
 14 entitled them to.
 15 "Home providers [on the other hand] are stating that
 16 they are not able to safely facilitate the visiting
 17 arrangements outlined in the [more] recent Guidance."
 18 So here we are, by 8 October 2020, just a matter of
 19 weeks, and you're aware that the guidance that ought to
 20 have been providing comfort and access between residents
 21 and families was leading to distress and conflict on the
 22 doorsteps of care homes.
 23 Do you agree that by 8 October, there was a reason
 24 for immediate action to be taken to facilitate, or to
 25 address any impasses?

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1 And two weeks thereafter, again, she wrote to you on
 2 15 December, expressing her extreme disappointment that
 3 in the absence, the continuing absence of a response
 4 from you or your department, on 11 December you had
 5 instead issued a public statement pointing to "the
 6 reluctance of care homes to introduce the Care Partner
 7 guidance", in circumstances where she said the IHCP's
 8 efforts to engage with you to find resolution had not
 9 received any response, and she requested an urgent
 10 meeting.
 11 Given the importance to families of finding an
 12 urgent way through this impasse at the doorsteps of care
 13 homes, why didn't the IHCP's letters and requests to
 14 engage receive a direct response from you?
 15 **A.** I'm not sure at that point if they were brought to my
 16 attention in regards to those letters coming in to the
 17 department, but I do know there was continual
 18 engagement, through the Chief Nursing Officer's group,
 19 with IHCP in regards to Care Partners, through the
 20 Patient and Client Council, in regards to groups, as
 21 well.
 22 **Q.** But Mr Swann, if I just interrupt you there, given how
 23 important this was, this was months into this guidance
 24 being issued and expected to be implemented. Should it
 25 not have been brought to your attention that the

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1 representative of 50% of the independent care sector was
 2 repeatedly writing asking for engagement and receiving
 3 no response?
 4 **A.** But there was engagement in regards to those homes, we
 5 were working with other care providers as well, whether
 6 the direct engagement was with Ms Shepherd in regards to
 7 as being the chief executive of IHCP, I don't know at
 8 this point in time, but I do know there was continual
 9 engagement in regards to that. And I know in preparing
 10 for this evidence, as well, I'm also aware of a letter
 11 from IHCP, as well, which -- on the -- I think it's
 12 18 November one you referenced as well, where she
 13 actually said that adding Care Partners to the current
 14 system will therefore have unintended consequences of
 15 actually closing homes to all visits, as well.
 16 The issue of the statement of 11 December was one in
 17 regards to frustration from me that -- I don't believe
 18 there was a deliberate delay or stalling in regards to
 19 the implementation of Care Partners, but it wasn't as,
 20 I suppose, as fluid and as quick as I wanted it to be.
 21 **Q.** Thank you. I'm going to move on as quickly as I can
 22 because I'm conscious of the time but in doing so, in
 23 response to your observation just now, I should make it
 24 clear that those I, many of those whom I represent have
 25 concerns about that resistance that they too felt was
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1 with -- and I'll stand corrected on that figure in
 2 regards to that engagement with departmental officials
 3 with IHCP or their representatives, or indeed,
 4 individual care homes in regards to that.
 5 The fact those letters weren't answered, I can't
 6 speak to in regards to this. They weren't letters that
 7 came, as you understand, through a private office. They
 8 didn't come directly.
 9 **Q.** Well, finally just on that note, on 21 January, so
 10 again, two weeks later, faced with another non-response,
 11 Ms Shepherd emailed your special adviser, seeking his
 12 help in generating a response or engagement from you
 13 directly, observing that she felt she had "exhausted all
 14 avenues to try to engage with the Department on the
 15 issue of visiting in care homes."
 16 And so the question really is repeated: is there any
 17 possible justification for the department's apparent
 18 refusal to engage with representatives of the
 19 independent care sector on behalf of families, and it's
 20 important that I stress, because families were bearing
 21 the brunt of this, to seek a resolution to the issues
 22 around Care Partner guidance?
 23 **A.** In regards to, I suppose, the avenues of communication
 24 it was one that I made sure was open to Ms Shepherd in
 25 regards to that either contacting my special adviser or
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1 coming from the care sector, and that more could and
 2 should have been done by providers to make it work.
 3 But again, following up on the correspondence from
 4 Ms Shepherd, on 7 January she writes again, this time
 5 under a heading "Request for engagement", and she
 6 observes that:
 7 [As read] "Over the last number of months I have
 8 issued a number of letters and communications to the
 9 Department of Health outlining the issues that the care
 10 providers are concerned about. Regrettably I have not
 11 received a response to any of my recent communications."
 12 And she goes on to list issues that she had
 13 previously raised, including testing, lateral flow
 14 testing, and the role of the Care Partner.
 15 Given where we now are in January 2020, and we know
 16 that problems were continuing and many of our clients
 17 were facing those problems, is there any possible
 18 justification for the department's apparent withdrawal
 19 or refusal to communicate with representatives from the
 20 independent care sector who, at least on the face of it,
 21 were saying that they wanted to seek a resolution?
 22 **A.** No, and I don't think by not responding to those
 23 letters, I don't think that the department wasn't
 24 engaging with IHCP. I think, my Lady, from what I've
 25 been made aware of, I think there was the 27 meetings
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1 me directly, should she have those concerns
 2 around -- (overspeaking) --
 3 **Q.** It was open, but is it fair to observe it was one way?
 4 **A.** But, no, not in regards to the connection in regards to
 5 raising the issue with my special adviser because after
 6 that I assume action was taken, I don't have the
 7 response here with me in regards to that, but that's,
 8 that's how the system was operated. But there was --
 9 I say there was that continual engagement between
 10 departmental officials at different levels on different
 11 issues, in regards to those issues that Ms Shepherd had
 12 raised.
 13 **Q.** Thank you. Well, finally then, in terms of lessons
 14 learned, and we'll address those with the Inquiry in
 15 other means, as well, but do you accept that one of the
 16 key lessons learned for your department, as it was,
 17 during the pandemic, is that it is essential to take
 18 a communicative and consultative approach to the
 19 development of guidance including working in partnership
 20 with service users and providers, and that when it comes
 21 to pandemic planning, that must start now?
 22 **A.** I agree fully and you've heard my -- the answers and
 23 comments I've made to my Lady in regards to the Social
 24 Care Collaborative Forum, which I instigated, which was
 25 set up and run and now meets regularly, those bodies are
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part of it, in regards for preparing for a pandemic, a pandemic, sorry, I don't think they should start now, I think they should have already started. They should have started at the end of the last the pandemic where lessons learned should have been reinforced, put in legislation, put in concrete, but I wouldn't want to pre-empt any of my Lady's recommendations.

MS CAMPBELL: Thank you, my Lady.

LADY HALLETT: Thank you, Ms Campbell.
Ms Beattie. Ms Beattie is that way.

Questions from MS BEATTIE

MS BEATTIE: Mr Swann, I ask questions on behalf of Disabled People's Organisations, and in particular in Northern Ireland, Disability Action, and my questions are about testing for domiciliary care workers.
Given domiciliary care involved close physical contact and personal care multiple times a day and workers visiting many different people in different homes in the one day, did you agree with Eddie Lynch, Commissioner for Older People, who wrote to you on 8 October 2020 that these workers were in a different position from members of the public and that it was not reasonable to expect such workers to go and arrange tests for themselves in the same way as members of the public did?

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issue of domiciliary care worker testing was directly affecting older people who were in need and receipt of care packages as demand had been affected. So did that lack of testing for domiciliary care workers in effect leave disabled people in the invidious position of having to choose between untested workers coming into their home regularly and performing those personal care tasks, or going without domiciliary care and assistance that might be fundamental to activities of daily living, their dignity, health and wellbeing?

A. The testing was supplementary to the PPE that was being provided in that guidance as well, that was given to domiciliary care providers through those training videos, through -- from the Chief Nursing Officer, to make sure that they were donning and doffing appropriately, the supply of PPE as well. So the testing wasn't the final arbiter as well in regards to people going into domiciliary care homes, the support -- or people's homes, the support that we put in place in regards to making sure that they had the appropriate PPE the appropriate training, and that -- in regards to how they provided their service as well.

Q. And for future planning, given what Professor McBride has told us this morning is a growing population of domiciliary care recipients, some with complex needs,

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A. I think in the nature of them not working from a single base or a single point of source and often, actually, working from their own homes, I think that's where that perception may have been, but in regards to the additionality of testing for domiciliary care workers, the SMART NI programme, which was actually launched, which I think has been covered in earlier modules, as well, to add asymptomatic testing for employees of companies that had more than ten employees. So the domiciliary care providers who again, are private companies, often subcontracted to individual trusts, could have availed as employers and as companies through that route, as well.

Q. Okay. I think that came in later than 8 October when Mr Lynch was writing to you; is that right?

A. That's correct. But again, it was in regards to the ability and volume of testing, as well, at that point in time, you know, we're still talking PCR tests, when Mr Lynch was writing to me, whereas now, in regards to what we often -- when people start to talk about testing, we often talk -- or think back to the lateral flow devices that we had at the end which was the ease of the device, the availability, and the quantity as well.

Q. And Mr Lynch in that letter also told you that this

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who are receiving medical and social care support outside residential care at home, does the need for that cohort -- of that cohort for testing, and indeed for PPE, as you've just mentioned, need to be recognised and prioritised?

A. And again, in -- one of my recommendations in my statement is actually that plan to prioritise limited testing, should the next pandemic -- or should there be another pandemic, and how that -- how the tests develop, how quickly they test now, how available they are as well. So, my Lady, in my view that plan to prioritise that limited testing should take into care -- into domiciliary care workers and health workers and all other aspects as well in regards to what could be brought forward.

Q. And going back to your comment before about it, it wouldn't take an awful lot of heads to come up with these scenarios. For this issue, would you agree that those heads, whoever they are, really need to understand the lives and the realities of disabled people and how care at home is received, and, in fact, would really best be the disabled people and DPO themselves?

A. Certainly. You know, I think anything that -- of that level, that once those heads come together, the idea of a co-production or co-design, which was always important

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1 to me as minister, is something that should be
 2 considered and involved as well, to make sure that those
 3 who are going to be affected by it are actually part of
 4 it. And, you know, nothing with -- "nothing about us
 5 without us" I think was a phrase that was used and
 6 something that I definitely would have been supportive
 7 of.

8 **MS BEATTIE:** Thank you, my Lady.

9 **LADY HALLETT:** Thank you, Ms Beattie.

10 That completes the questions we have for you,
 11 Mr Swann. I think you'll probably be quite pleased to
 12 learn that's the last time, I think, that we shall be
 13 calling upon you.

14 **THE WITNESS:** Thank you.

15 **LADY HALLETT:** I do appreciate that it's difficult,
 16 especially when you have other demanding roles to
 17 perform. So thank you very much for all the help that
 18 you've given to the Inquiry.

19 **THE WITNESS:** Thank you.

20 **LADY HALLETT:** I shall sit again at 10.15 on 28 July.

21 Thank you.

22 **(4.59 pm)**

23 **(The hearing adjourned until 10.15 am on Monday,**
 24 **28 July 2025)**

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