Witness Names: Richard Pengelly
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UK COVID-19 INQUIRY

WITNESS STATEMENT OF RICHARD PENGELLY

I, Richard Pengelly, make this statement in response to a request from the UK Covid-19 Inquiry seeking provision of a witness statement in relation to specified matters relating to Module 6.

1. I have written this statement to the best of my recollection of events as they occurred. Given the rapidly evolving situation during the pandemic, and the passage of time, it is inevitable that some of my recollections may be incomplete. I have sought input from colleagues within the Department to help prompt my recall of events.

2. On 1 July 2014, I took up post as Permanent Secretary in the then Department of Health, Social Services and Public Safety - renamed in 2016 as the Department of Health (both iterations of which I will refer to as "the Department". I remained in this post until 4 April 2022, when I moved to the post of Permanent Secretary in the Department of Justice. In April 2024 I moved, on secondment, to become the Chief Executive of the Education Authority. Prior to July 2014, since January 2013 I had been Permanent Secretary in the Department for Regional Development (now the Department for Infrastructure), and before that I held a number of roles in the Department of Finance. I had joined the Northern Ireland Civil Service in 1998, prior to which I worked in the Northern Ireland Audit Office and in private accounting practice. I am a Chartered Accountant.

3. As Permanent Secretary of the Department of Health and the Chief Executive of Health and Social Care (hereafter referred to as "the HSC") my main responsibilities, both before and after the collapse of the power sharing Executive in January 2017, involved providing leadership and direction to the Department and the HSC system to ensure that

the Department's statutory responsibilities under the Health and Social Care (Reform) Act (Northern Ireland) 2009 and the Health Minister's (hereafter referred to as "the Minister") priorities were effectively discharged. The Act requires the Department to promote an integrated system of health and social care designed to secure improvement in: the physical and mental health of people in Northern Ireland (hereafter referred to as "NI"); the prevention, diagnosis and treatment of illness; and the social wellbeing of people in NI. I was also the Department's Accounting Officer and the Principal Accounting Officer for the HSC accountable to the NI Assembly (which I will refer to as "the Assembly") for the stewardship of the Department's resources including its allocated annual budget of approximately £6 billion. I was also responsible for the corporate governance of the Department, ensuring that effective governance procedures and practice was fully implemented. As Permanent Secretary, I chaired meetings of the senior leadership team in the Department (the Top Management Group, TMG), and the Departmental Board.

4. During the normal operation of the Assembly, when the Department had a Minister in place, I was also the principal policy adviser to the Minister in relation to the discharge of the Department's statutory responsibilities and functions. Prior to the pandemic the principal differences in my responsibilities as Permanent Secretary during the period leading up to the pandemic, when the power sharing arrangements were not in place, were influenced by the constraints placed upon the Department in relation to the exercise of its functions and related decisions which normally would have been taken by the Departmental Minister. During this period, the powers of the Department to exercise its functions were set out in Section 3 of the Northern Ireland (Executive Formation and Exercise of Functions) Act 2018, as exercised in line with guidance published by the UK Government. The Act and supporting guidance established the framework for decision making in NI departments during suspension. There were a range of general consequences for the Department arising from the limitations on powers which could be exercised by the Department and from the fact that there was no Minister in place. The consequences included: the limited ability to take decisions; the policy and financial uncertainty; and constraints on opportunities to act on NI Executive (which I will refer to as "the Executive") cross-cutting issues.

5. The main difference between the role of the Department of Health Permanent Secretary in NI as compared to their counterpart in Westminster is that, while both roles cover the position of Accounting Officer of the respective Department and lead policy advisor to the Minister/Secretary of State, in NI (and, I understand, in Scotland and Wales), the

post holder is also the Chief Executive of the Health and Social Care System (uniquely, NI has an integrated system of Health and Social Care). It is important to note that, unlike in England (where there is a separate post holder for Chief Executive of the NHS), the HSC system has no separate legal or organisational status and is effectively a collection of a number of individual organisations.

6. Uniquely in these islands, Northern Ireland has an integrated health and social care position. Five regional Health and Social Care Trusts (hereafter referred to as "the Trusts") are responsible for provision of health and social care services in areas of operation. Whilst the Department has overall responsibility for health and social care services, in terms of delivery of these services and the day-to-day operations, the Department delegates this duty to the Public Health Authority (the PHA) and a number of other health and social care bodies.

7. Operational decision making within Health and Social Care Trusts is a matter for individual Trusts and/or individual clinicians, within the context of the policies and priorities set by the Minister and Department. The Permanent Secretary is not involved in operational decision making - this is a matter for Trusts.

8. As Permanent Secretary, I chaired the Top Management Group (TMG) which was comprised of the lead professional officers - namely the Chief Social Worker (CSW), the Chief Medical Officer (CMO), the Chief Nursing Officer (CNO), the Chief Digital Information Officer (CDIO) - and the two deputy permanent secretaries. Each of these colleagues had clearly defined roles and responsibilities, with the professional post holders having defined professional responsibilities in relation to certain matters. In the context of the care sector, the policy and professional lead was the Chief Social Worker, who was the senior officer within the Chief Social Worker's Policy Group (SSPG). The Chief Medical Officer's Group (CMOG) provided input in relation to professional medical and scientific technical advice, established the arrangements to facilitate the roll out of testing and the vaccination programme in the social care sector and in care homes. The Chief Nursing Officer Group (CNOG) provided advice on all aspects of policy which impacted upon, or interfaced with, Nursing, Midwifery and the Allied Health Professions.

9. As the Department's understanding of the threat from the virus developed during January and February 2020, my discussions with senior colleagues in the Department and the Minister included exchange of information about managing the response to the outbreak. For example, the TMG minutes of 27 January 2020 referred to discussion

about reporting of contingency arrangements in place around coronavirus [RP6/01 INQ000376790]; the TMG minutes of 3 February 2020 referred to discussion in relation to coronavirus and the impact on service [RP6/02 INQ000376791]; the TMG minutes of 10 February 2020 referred to the CMO updating members in relation to the Health Gold response [RP6/03 INQ000376792] and the TMG minutes of 24 February 2020 referred to discussion in relation to staffing of the Emergency Operations Centre (EOC) along with discussion about the CMO having highlighted to other NICS Departments the need to consider their response to coronavirus [RP6/04 INQ000376794]. I also had discussions with the Chief Executives of the Department's main Arm's Length Bodies which would take a central role in managing the response to the outbreak which included the Health and Social Care Board (hereafter referred to as "HSCB"), PHA and the six Trusts (the 5 HSC Trusts and the NIAS, Northern Ireland Ambulance Service).

Discharge of patients

10. The decision to discharge a patient to a residential and nursing home is a clinical decision, based upon a patient's medical needs. Decisions in relation to the discharge of patients was and is not a decision that involved me or the Department. This position was subsequently confirmed as existing in practice in the report commissioned in September 2020 from Niall Herity [RP6/05 INQ000586687 page 2], which specifically concluded that "*There is no evidence to support a view that Ministerial or Departmental communications changed consultants' discharge decision-making during the first pandemic surge, including decisions to discharge people to care homes. Consultants indicated robustly that they make such decisions independent of any external influence*".

11. On 17 February 2020, the Departments Chief Medical Officer asked the HSCB to draw up a surge plan for social care "Surge plan: social care and children's services" [RP6/06 INQ000137326 and RP6/07 INQ000120731]. I was not directly involved in the development or approval of this plan as it was primarily an operational issue. I was aware of its development and publication as part of my discussions within the Department and with Trust Chief Executives, all of whom had the opportunity to contribute to its development. The aim of the surge plan, dated 13 March 2020, was to ensure that services were targeted at people who were most in need and those who were most vulnerable. It also aimed to assure the safety and quality of care, including care homes.

12. In relation to hospital discharge, the surge plan anticipated escalating pressures in hospitals which would place heavy demands on hospital resources and included consideration of steps to increase hospital capacity. This included a focus on expediting safe discharge of those who were medically fit for discharge, as determined by a clinician. I understand that the 13 March 2020 surge plan did not refer to testing, as the Department was still gaining a full understanding of the testing capacity at that point.

Guidance for Nursing and Residential Care Homes

13. On 14 March 2020, the Department's Director of Mental Health, Disability and Older People circulated draft guidance for nursing and residential care homes to all relevant colleagues within the Health and Social Care (HSC), including to the Chief Medical Officer (CMO), the Chief Nursing Officer (CNO), the Regulation and Quality Improvement Authority (RQIA) and Public Health Agency (PHA), seeking their input to its completion. On 17 March 2020, the Director of Mental Health, Disability and Older People issued guidance to nursing and residential Care Homes in NI [RP6/08 INQ000120717]. This guidance noted that "Nursing and residential homes should work closely with the Trusts to facilitate discharge from hospital. Effective flow through our hospitals will be important to ensure the best treatment for as many individuals as possible. Care homes should work with Trusts to communicate vacant placements quickly and facilitate the filling of places." The guidance set out actions for both HSC Trusts and for care homes, including clearer asks for HSC Trusts to work in partnership with nursing and residential Care Homes. There was also guidance in relation to infection control and use of PPE. The guidance advised that in the event of one or more resident testing positive for Covid-19 the PHA will ensure that a dedicated team engages with the home. Care homes were reminded of the information which had already been shared with them on how to manage an outbreak as part of flu preparations and that should be their first point of reference for advice.

I was not directly involved in the development or approval of this guidance as it was primarily an operational issue; however, I was aware of its development and publication as part of my discussions within the Department and with Trust Chief Executives.

Health and Social Care (NI) Summary Plan

14. During February and March 2020, a Covid-19 Regional Surge Planning Subgroup was chaired by the HSCB's Director of Commissioning and comprised of members from the HSCB, PHA, Trusts, Northern Ireland Blood Transfusion Service (NIBTS), Northern

Ireland Ambulance Service (NIAS) and the Healthcare Policy Group (HPG) within the Department. There followed intensive engagement between the Department, the HSCB, the PHA and the Trusts resulting in the publication, on 19 March 2020, of the Health and Social Care (NI) Summary Covid-19 Plan for the period mid-March to mid-April 2020 [RP6/09 INQ000103714].

15. This plan summarised the key actions to be taken by the HSC system from mid-March to mid-April 2020 to ensure that there was sufficient capacity within the system to meet the expected increase in demand from patients contracting Covid-19 during this period. It also outlined the planning assumptions available to the HSC in a reasonable worst-case scenario and of the actions taken across the HSC system to prepare for the impact of Covid-19. The Surge Plan: Social Care and Children's Services' [RP6/07 INQ000120731] supplemented the summary plan [RP6/09 INQ000103714].

16. The summary plan provided guidance in relation to discharge planning for patients in hospitals emphasising that it was more important than ever for Trusts to implement effective discharge arrangements for patients as soon as they were well enough to leave hospital to release beds for newly admitted patients. It added that staff would be redeployed to support hospital social work teams to facilitate safe discharges and maximise patient flow through the HSC system. The summary plan also included information in relation to testing, advising that HSC laboratory services were capable of processing more than 200 tests per day, with the demand for testing expected to increase in the coming weeks. Reference was also made to the establishment of an expert testing advisory group by the Department to consider options to rapidly up-scale testing.

17. The development of the surge plan was led by the Surge Directorate who sought the views of professionals within the Department, to include the medical professionals. Whilst I was copied into the submission which the Surge Directorate issued to the Minister on the 19 March 2020 [RP6/10 INQ000586688 and RP6/11 INQ000586670], I was not directly involved in the development or approval of this guidance. I was aware of its development and publication as part of my discussions within the Department and with Trust Chief Executives.

18. On 13 March 2020, the Department's Director of Mental Health, Disability and Older People issued a submission to the Minister in relation to flexibilities in the use of care home beds for dementia patients in response to Covid-19 [RP6/12 INQ000371017].

This was copied to me for information. The submission stated that the 'HSCB have flagged the fact that waiting to find a registered bed for patients with dementia can cause significant delays in discharging patients. Delays in discharge have an impact on bed availability and with Covid-19 likely to create significant pressures on acute beds, ensuring good flow will be critical to providing effective care for as many people as possible.' The submission also stated 'individuals would only be placed for the duration of the Covid-19 surge and that consideration must be given to moving individuals as soon as a registered bed for dementia becomes available; that efforts to find a registered dementia bed should continue once a placement is made and be ongoing until a bed is found; that there is ongoing and active case management; the care in the setting the individual is placed in is appropriate to need and that the care provider is involved in the decision-making and content with the approach to managing risk.' The submission recommended that the HSCB was provided with flexibility to allow HSC Trusts to place those with dementia in generalist nursing and residential home beds. The submission did not make any reference in relation to the decision to discharge patients, which is a decision for clinicians to make, nor did it make any reference to testing. On 13 March 2020 Minister Swann approved the recommendation, and the Department wrote to HSCB on the 18 March 2020 communicating this decision. [RP6/13 INQ000585018 and RP6/14 INQ000103689]. On 25 March 2020 the HSCB issued correspondence to the RQIA [RP6/14 INQ000103689] which advised that with immediate effect patients with dementia/delirium could be placed into beds currently registered for other purposes. The correspondence stated that this was a temporary arrangement during the period of surge, and that efforts to place the dementia/delirium patient into a suitable placement should continue. The correspondence did not refer to a clinician's decision to discharge a patient, nor did it refer to testing. The correspondence was copied to the Departments Chief Social Worker and his Deputy; however, it was not copied to me.

Suspension of Annual Care Reviews

19. The Departments Chief Social Worker issued correspondence to Marie Roulston, HSCB on 7 April 2020 [RP6/15 INQ000103690] confirming that as of that date the Department was suspending all requirements under Circular HSC [ECCU] 1/2010 regarding the need to complete routine Annual Care Reviews both in respect of residents in Nursing and Residential Care Homes and of clients who were in receipt of care in their own homes. The purpose of this was to seek to reduce footfall in care homes and thereby minimise the risk of infection. The Chief Social Worker advised that the suspension was for a period of three months initially, when it would then be subject to review. The Chief Social Worker added that Trusts, along with providers, still had a responsibility to ensure and assure the quality of care being provided. The Chief Social Worker also stated that the suspension did not negate the need to undertake such reviews that are necessary, paying due attention to those who are particularly vulnerable. The approval for suspension of Annual Care Reviews was given by the Departments Chief Social Worker as it was within his remit to do so, and the correspondence was not copied to me, nor did I have any involvement in its development or approval.

Correspondence to the Chief Executives of Arm's Length Bodies

20. On 26 March 2020, I wrote [RP6/16 INQ000325159] to the Chief Executives of the Department's Arm's Length Bodies setting out the next phase of emergency planning for the initial surge in demand during the first wave of the pandemic. This correspondence constituted a summary of the extensive planning and investment underway across the HSC system at the time, building on work undertaken for both the summary plan [RP6/09 INQ000103714] and guidance for Care Homes [RP6/08 INQ000120717]. This correspondence was drafted by the Head of the Surge Directorate within the Department. He circulated a draft of the letter, seeking comments from the clinical advisory group (that is Chief Medical Officer, both Deputy Chief Medical Officers, Chief Nursing Officer, Chief Social Worker and Chief Pharmaceutical Officer) on the section on prioritisation of care, advising that he had lifted text from NHS England documents and was inviting clinical views given the sensitivity and the importance of getting it right [RP6/17 INQ000586671, RP6/18 INQ000586672, RP6/19 INQ000586674, RP6/20 INQ000586675, RP6/21 INQ000586677 & RP6/22 INQ000586678]. I have no recollection of having received any other professional advice or input, and indeed there is no record of same in relation to the drafting of this correspondence.

21. While I have no recollection of any specific dialogue around the letter [RP6/16 INQ000325159], this letter did not constitute a new discharge policy, rather the Department was using this letter to re-emphasise the importance of timely discharge following a clinician's decision and the position regarding testing capacity at this time.

22. The guidance for Care Homes [RP6/08 INQ000120717) had been drafted with input from the relevant professionals to include CMO, CNO, RQIA and the PHA. It set out advice in relation to the management of infection, to include a section entitled 'infection control and use of PPE'. This made reference to PHE guidance, setting out the appropriate PPE equipment, along with information in relation to the PHA co-ordination of a dedicated team of infection and prevention control nurses. These nurses were available to provide advice and guidance in the event of an outbreak. It is important to note that discharge was a clinical decision made by a clinician knowing the setting to which a patient would be discharged. The Department's Chief Social Worker also emphasised that no-one should be in hospital any longer than necessary, referring to the decline in mobility seen, particularly in older or more frail patients, in hospital settings and the risk of hospital-acquired infection. Acknowledging concerns early in the pandemic about the risk of acute hospitals being overwhelmed, the Department's Chief Social Worker stated that the guidance issued on discharge made it clear that people should be discharged to care homes only where a care home could adequately manage the care of that patient, including capacity to provide barrier nursing. The decision to discharge a person after a hospital admission is an important clinical judgment taken by senior medical professionals, typically consultants. It is one that they take seriously, balancing the benefits versus the risks of a person remaining in hospital.

23. I was aware that delays in discharge would have an impact on bed availability, and with COVID-19 likely to create significant pressures on acute beds, ensuring patient flow was critical to providing effective care for as many people as possible.

24. Guidance issued on discharge made it clear that people should be discharged to care homes only where a care home could adequately manage the care of that patient.

25. It was of central concern that patients who were medically fit for discharge should not be in hospital, primarily for their own safety. Furthermore, hospitals have a finite capacity, and the space was needed for other acutely ill patients.

Capacity of the care sector

26. Effective discharge of patients in line with their healthcare needs was an important part of NI surge plans from the early stages of the pandemic response. The use of spare capacity in nursing homes represented one of a range of possible discharge arrangements, which also included discharge to the patient's own home with domiciliary care support or to residential or nursing home facilities.

27. The Department worked closely with RQIA and PHA in relation to the collection of data from care homes during the pandemic and this underlying data collection process was a fundamental source of care home data for the Department. Data was collated through RQIA as they maintained contact details for all the Care Homes and had ongoing engagement with the sector. RQIA provided the Department with regular reports which provided intelligence form their Service Support Team. Each day, Monday to Thursday, the RQIA provided a briefing report which highlighted information from independent sector providers (Domiciliary Care Agencies, Nursing Homes and Residential Care Homes) in relation to overarching areas of concern. A single report was produced to cover Friday, Saturday and Sunday. These reports were collated from information /concerns recorded by inspectors through contact with relevant services. The daily RQIA returns, collected through the Status Update App, contained individual care home information to include bed status (occupancy levels) and Covid-19 status (whether in outbreak or not). The data in the RQIA reports allowed the Department to assess a number of matters including the available beds across the region. RQIA routinely shared this data with HSC Trusts and the HSCB to minimise burdens on homes so that only one return was required to be completed by homes to meet the neds of the Department, the HSCB and the Trusts.

28. The Department's published 'Health and Social Care (NI) Summary Covid-19 Plan for the Period Mid-March to Mid-April 2020' [RP6/09 INQ000103714] provided a framework for responding to pressures and maintaining services and was underpinned by plans in each HSC Trust.

29. The summary plan highlighted the importance of implementing effective discharge arrangements for patients as soon as they are well enough to leave hospital and noted proposed staff re-deployment arrangements to facilitate safe discharges and maximise patient flow through the health and social care system. Due consideration was given to

the capacity of the sector to provide for, and to accommodate, those discharged from hospital, and the plan also included the following measures that had been put in place:

- Trusts were activating their emergency discharge plans in line with their respective contingency/ emergency and/or major incident plans.
- Trusts were expediting discharges when patients have been deemed medically fit, through shortening assessment to home care package arrangements. In these circumstances it was acknowledged there may have been increased reliance on families to facilitate discharges.
- Trusts worked to maximise and utilise all spare capacity in residential, nursing and domiciliary home care.
- Trusts, as part of their contingency plan, may have needed to re-distribute domiciliary care hours. This will include prioritising and targeting care hours to those clients who are at risk and those with the greatest clinical and/or care needs.
- Trusts set aside the extant choice protocols which provided patients with a choice of residential or nursing care homes.

30. As outlined above, Trusts applied these measures to address any capacity issues in the care sector. However, it must be noted that keeping medically fit patients in hospital was and is not a viable option to address capacity issues in the care sector.

Concerns regarding Discharge Policy

31. Admission and discharge decisions are matters for clinicians and I do not recall any concerns regarding the discharge policy being raised directly with me. The policy was as it had always been, and keeping medically fit patients in hospital was and is not a viable option. If a patient is fit to leave hospital safely they should do so.

32. The Department's Private Office received email correspondence from Ms Martina Ferguson on 30th March 2020 which raised a query in relation to testing of care home residents who passed away since the lockdown came into place [RP6/23 INQ000256495]. Ms Ferguson contacted the Department's Private Office later the same day asking the Minister to stop new admissions to care homes until visiting restrictions were lifted. An official within the Department's Care Homes Branch handled the

correspondence, which was in line with Departmental procedures for responding to communications to the Private Office. There is no evidence in any departmental records that this issue was raised directly with me, and I was not aware of this correspondence at the time - it has only been brought to my attention in October 2024, during the Covid Inquiry.

33. The NI Assembly Committee for Health decided, in July 2020, based on evidence it had taken in the spring in relation to the particular impact of COVID-19 on care homes, to conduct a short inquiry, in order to produce recommendations to help mitigate and manage the impact of a potential second surge of the virus in care homes. A research briefing was commissioned and Members agreed terms of reference in September 2020. The Committee agreed that due to the timescales within which it wished to complete the inquiry, it would not seek public evidence but, instead, would seek written submissions from a targeted group of key stakeholders on the areas of focus identified through its review. The Committee received 21 submissions from a range of organisations spanning public, private and charitable organisations, professional bodies and trade unions. The Committee also held oral evidence sessions with a number of the key stakeholders as well as oral evidence sessions with senior Department of Health officials including the Chief Nursing Officer and Chief Social Worker. The Committee further agreed that it would take account of existing reports, research papers and international best practice; as well as commissioning further research from the Assembly's Research and Information Service (RaISe) to assist the Committee in its consideration of the discharge of care home residents from hospital and the experience of public versus private care home settings. The Committee was also keen to learn directly from the experience of those most impacted, and considered ways in which it could safely engage with, and garner the views of, the residents of care homes, their families and care home staff. The Committee's engagement with these groups was carried out by holding a virtual informal meeting with family members of care home residents facilitated by the Patient Client Council (PCC), Commissioner for Older People NI (COPNI) and AGE NI; and through an online survey seeking the views of owners/ managers, staff and residents/ family members.

34. The Committee's Inquiry Report [RP6/24 INQ000431849] dated January 2021 on the Impact of Covid-19 in Care Homes at paragraph 95, stated "*The Department of Health's Chief Social Worker (CSW) advised that discharge was a clinical decision made by a clinician knowing the setting to which a patient would be discharged. The CSW also emphasised that no-one should be in hospital any longer than necessary, referring to*

the decline in mobility seen, particularly in older or more frail patients, in hospital settings and the risk of hospital-acquired infection. Acknowledging concerns early in the pandemic about the risk of acute hospitals being overwhelmed, the CSW stated that the guidance issued on discharge made it absolutely clear that people should be discharged to care homes only where a care home could adequately manage the care of that patient, including capacity to provide barrier nursing". The decision to discharge a person after a hospital admission is an important clinical judgment taken by senior medical professionals, typically consultants. It is one that they take seriously, balancing the benefits versus the risks of a person remaining in hospital.

35. Addressing concerns raised by stakeholders and those groups most impacted by this issue, the Health Inquiry report's finding at paragraph 200 noted that *"a palpable sense of pressure to admit patients who may have been COVID positive was conveyed to the Committee by a number of respondents".* The Department's position was clear that, as of 27 April 2020, new residents should not be admitted to a care home where a positive test had been obtained and the care home did not have the facilities to allow for the required period of self-isolation. The Director of Mental Health, Disability and Older People engaged with representatives from the sector informally to ask for specific evidence of homes admitting Covid positive residents where they did not have the necessary isolation facilities, but no evidence was provided to confirm this was happening.

36. Guidance issued on discharge made it clear that people should be discharged to care homes only where a care home could adequately manage the care of that patient. A pre admission Infection Prevention and Control Risk Assessment Pro-Forma was provided to allow nursing and residential care home managers to record relevant information regarding past or current infections [as per Annex B of RP6/25 INQ000585013].

37. The Department did not accept Recommendation 16 of the Committee's report - which was that "*new residents should not be admitted to a care home unless they have tested negative*". The Health Minister's response to the Health Committee in 2021 [RP6/26 INQ000522007] stated that the Department "*would accept that new residents should not be admitted to a care home where a positive test has been obtained and the care home does not have the facilities to allow for the required period of self-isolation*."

38. The response went on to note that "*However we would be concerned that refusing to admit a new resident without a negative test, regardless of the care home's ability to*

facilitate the required self isolation period, would create undue pressures on other parts of the system particularly where the care home has the capacity to facilitate the required period of isolation."

39. Again, as per the Health Minister's response of 23 April 2021 to the NI Assembly Committee for Health's Inquiry Report on the Impact of Covid-19 in Care Homes, in regards to the finding at paragraph 25 that "*many homes struggle to isolate individuals, either for reasons of facilities and adequate staff resources or, equally importantly, residents' wellbeing and issues of understanding amongst the significant numbers of residents with cognitive decline*" it was noted that discharge was an area of policy that the Department continued to keep under active consideration.

40. The Department emphasised that this active consideration was necessary in order to ensure that care homes were protected from any risk of infection and importantly that residents did not remain in hospital for a period longer than they needed to. It was noted that it was not necessary to require a negative COVID-19 test in all circumstances involving the discharge of a resident to a care home setting, however it was necessary to consider and fully understand the individual circumstances of the patient; this would include, for example, the timing of the patient's test result, and the period in which the patient remains infectious.

41. In the then Health Minister's response he outlined that the Department was currently revising existing Departmental policy which required that individuals discharged from a hospital to a care home should be tested for COVID-19, ideally 48 hours before discharge, and subject to 14 days isolation on arrival into the care home.

42. The revision to the policy was in the context of advice issued by the PHA (30 March 2021) in relation to isolation periods [RP6/27 INQ000585017]. The advice from the PHA Guidance Cell confirmed that the Departmental guidance for care homes/ supported living in NI should be reviewed to reflect the updated PHE guidance on the discharge of positive patients/residents from hospital.

43. The updated PHE guidance explained that: '*The total 14-day isolation period can be shared across the hospital and designated setting if infection prevention and control practices are not breached. If the individual has had a new COVID-19 exposure prior to discharge, then the 14-day isolation period should start from the day of the last exposure*.'

44. The PHA IPC Cell agreed that 'from an IPC perspective isolation can be shared across facilities provided all IPC practices and Covid secure behaviours remain in place.' This means that if an individual had spent 10 days of their 14 day isolation period in hospital, in a COVID-19 secure environment, with no IPC or PPE breaches or new COVID-19 exposures, they would only be required to isolate for 4 days on discharge to the care home.

45. Although I was copied into the submission to the Minister, this issue was not raised directly with me, and I had no role in clearing the submission or associated response to the Health Committee.

Revised guidance to nursing and residential homes, 26 April 2020

46. Revised draft guidance in relation to nursing and residential care homes in NI was circulated by the Department's Director of Mental Health, Disability and Older People on 18 April 2020 [RP6/28 INQ000145673 and RP6/29 INQ000137415] which stated that anyone discharged from a hospital setting into a care home, including those who tested negative, should isolate for 14 days, and that all discharges to care homes should be tested for Covid-19. It is my understanding that this guidance was drafted to follow the approach taken by Public Health England - the covering email stated that this was reflective of the approach set out in the Public Health England Social Care Strategy to discharge from hospitals into care homes. The Public Health England strategy stated that all discharges to care homes should be tested for Covid-19. The email sought input from senior officials within the Department, including the Chief Medical Officer and Chief Nursing Officer along with professionals in the Department's Arms Lengths Bodies. Comment was sought specifically from Dr Brid Farrell, Deputy Director of Public Health, on the adoption of the PHE guidance to discharge to care homes along with testing of all patients discharged to care homes. I was not involved in the development of this guidance other than having been copied into this draft guidance for information. From my perspective, it was critical that the policy and professional leads within the Department and in its Arm's Length Bodies, such as the PHA and HSCB, had the opportunity to consider and comment on the revised draft guidance. A submission issued to the Minister on 23 April 2020 [RP6/30 INQ000130366], which was copied to me, seeking the Minister's approval to publish the revised guidance. The Minister raised several queries on the submission and guidance, particularly in relation to testing and additional financial support, [RP6/31 INQ000130357]. The queries were responded to

on 24 April 2020 [RP6/32 INQ000130365] and the Minister approved the guidance by e-mail on the same date [RP6/33 INQ000130378].

47. A letter from the Chief Social Work Officer and the revised guidance issued on 26 April 2020 to Health and Social Care Trusts and the Regulation and Quality Improvement Authority for issue to the sector. The revised guidance was published on the Department's website on 27 April 2020 [RP6/34 INQ000087760].

Interim Protocol for Testing

48. The Interim Protocol for Testing (IPT) was an operational tool which provided information on eligibility for testing and advice on how to access testing. The Protocol was kept under continuous review with priority groups for testing extended regularly in line with emerging scientific evidence and with expansions in testing capacity. On 17 April 2020, the Expert Advisory Group on Testing (EAG-T) recommended that, in line with the Public Health England guidance, all patients being discharged from acute hospital care to a care home had to be tested for Covid-19 48 hours in advance of discharge. I was made aware of the content of a draft Version 3 of the IPT and I was copied in on the draft circulated to the Department on 18 April 2020. The emails which were copied to me were for my awareness only, testing was being taken forward by the Testing Cell and EAG-T, which included medical professionals. Version 3 of the IPT (dated and operational from 19 April 2020) was approved by the CMO [RP6/35 INQ000103724], and circulated to me and all Gold, Silver along with all DoH colleagues.

49. On 25 April 2020 I issued a letter to Chief Executives (Health and Social Care Trusts, Public Health Agency, Health and Social Care Board, NI Ambulance Service, and the Regulation and Quality Improvement Authority) highlighting key changes to testing for Covid-19 [RP6/36 INQ000145670]. My letter stated:

"*That there had been a significant focus on testing for COVID-19 over the last number of weeks. The purpose of this letter is to advise you that the Expert Advisory Group on Testing has recommended a number of additional changes to testing for COVID-19 in care homes and in hospitals*"

50. These key changes included "From 24 April 2020, for all new outbreaks in care homes (nursing and residential), all residents and staff should be tested for COVID-19 as part of the initial risk assessment of each outbreak." The letter also stated 'in advance of

discharge from hospital to a care home each patient must be tested for Covid-19, ideally this test will be undertaken 48 hours prior to the patient's discharge to their identified care home. This testing requirement must not hold up a timely discharge.'

51. I issued this letter following a number of changes to testing for Covid-19 having been recommended by the Expert Advisory Group on testing in relation to testing in care homes and hospitals [RP6/37 INQ000586680] and following a request from Olive MacLeod, Interim Chief Executive of the PHA, as she felt it would be beneficial if I asked the other HSC Chief Executives, particularly in Trusts, to ensure their organisation supported care homes with the expansion of testing [RP6/38 INQ000586681, RP6/39 INQ000586682 & RP6/40 INQ000586684]. Policy leads in the Testing Cell drafted the letter with input from Dr Brid Farrell, Chair of the Department's Expert Advisory Group on Testing.

52. Expert advice was sought from relevant organisations and cells to input into specific pieces of work. When developing the revised guidance for care homes in April 2020 the Director of Mental Health, Disability and Older People sought input from a wide range of stakeholders [RP6/28 INQ000145673]. As detailed below, this included the CMO, Deputy CMO, CNO, the CSWO, the RQIA, the HSCB and public health consultants within the PHA. When seeking input, the Director highlighted that the most significant change to the April 2020 guidance was the adoption of the approach set out in the English social care strategy to discharge from hospitals into care homes which stated that all discharges to care homes should be tested for COVID-19. The request for input sought confirmation from the relevant individuals that they were content with that approach. In addition, the testing cell provided advice on issues related to testing in care homes and on discharge, which was reflected in guidance issued to care homes. On 17 April 2020, the Expert Advisory Group on Testing recommended that, in line with the Public Health England guidance, all patients being discharged from acute hospital care to a care home must be tested for Covid-19 48 hours in advance of discharge. Version 3 of the Interim Protocol for Testing (dated and operational from 19 April 2020) approved by the CMO [RP6/35 INQ000103724], included the following Covid-19 testing requirements:

- all symptomatic residents and staff in care homes to be tested if/when a care home had a possible outbreak or cluster of infections. All positive tests were to be discussed with the Health Protection Duty Room in the PHA; and

- all patients to be discharged from hospital to a care home to be tested for Covid-19 48 hours in advance of discharge. The testing protocol advised that this new testing requirement must not hold up a timely discharge and explained that:

"The information from the test results, with any supporting care information, must be communicated and transferred to the relevant care home. Some care providers will be able to accommodate individuals with a confirmed Covid-19 positive through effective isolation strategies or cohorting policies. If appropriate isolation or cohorted care is not available with a local care provider, the local HSC Trust will provide alternative appropriate accommodation and care for the remainder of the required isolation period. This alternative accommodation should also be used in the exceptional cases of test results not being available at the point of discharge."

53. Revised guidance was re-circulated on 18 April 2020 [RP6/28 INQ000145673 and RP6/29 INQ000137415] which included the updated position recommended by Public Health England that anyone discharged from a hospital setting into a care home, including those who tested negative, should isolate for 14 days. This draft guidance was widely shared around the Department (including CMOG and CNOG) and stakeholders (including the HSCB and PHA) for comments with changes to be supplied by 21 April 2020. A submission went to the Minister on 23 April 2020 [RP6/30 INQ000130366] for approval to publish the revised guidance. The Minister raised a number of queries on the submission and guidance, particularly in relation to testing and additional financial support, [RP6/31 INQ000130357]. The queries were responded to on 24 April 2020 [RP6/32 INQ000130365] and the Minister approved the guidance by e-mail on the same date [RP6/33 INQ000130378]. Formal notification of the approval was received from Private Office on 27 April 2020 [RP6/41 INQ000130372].

54. Guidance that patients discharged from a hospital to a Care Home must be tested for Covid-19 48 hours in advance of discharge was first set out in Version 3 of the Interim Protocol for Testing for Covid-19 dated 19 April 2020 [RP6/35 INQ000103724]. Version 3 of the Interim Protocol was communicated to Health and Social Care Trusts on 19 April 2020.

55. Version 3 of the Interim Protocol was based upon advice from the Expert Advisory Group on Testing (EAG-T). The key purpose of the EAG-T was to expand testing capacity in hospital and community services as quickly as possible, exploring all available options. Membership of EAG-T comprised a range of colleagues from the PHA, including public health consultants; virologists from the Belfast Health and Social Care Trust (BHSCT) Regional Virus Laboratory; representation from HSC Trusts; HSC Laboratories Pathology Network (within SPPG); BSO procurement, and the Department's Director of COVID-19 Response and members of his team. Others from across the HSC system and beyond were co-opted or invited to attend meetings as relevant matters were discussed - for example the South Eastern Health and Social Care Trust (SEHSCT) Prison Healthcare Team attended on a number of occasions to discuss testing in prisons. EAG-T advice was considered by policy leads in the Testing Cell (later the Covid-19 Response Directorate) to inform advice provided to the Chief Medical Officer (CMO) and the Minister, which was subsequently reflected in guidance issued to care homes.

56. Version 3 of the Interim Protocol on Testing explained that: "*Additionally, in advance (48 hours) of hospital discharge to a care home the patient must be tested for COVID-19. This new testing requirement must not hold up a timely discharge. The information from the test results, with any supporting care information, must be communicated and transferred to the relevant care home. Some care providers will be able to accommodate individuals with a confirmed COVID-19 positive through effective isolation strategies or cohorting policies. If appropriate isolation or cohorted care is not available with a local care provider, the local HSC Trust will provide alternative appropriate accommodation and care for the remainder of the required isolation period. This alternative accommodation should also be used in the exceptional cases of test results not being available at the point of discharge*."

57. The guidance outlined that discharge should not take place to the small minority of care homes that could not provide isolation facilities for the resident on arrival. This was a matter for the Trusts to manage by applying the mitigations outlined in the Department's published 'Health and Social Care (NI) Summary Covid-19 Plan for the Period Mid-March to Mid-April 2020' [RP6/09 INQ000103714]:

    a. Trusts will work to maximise and utilise all spare capacity in residential, nursing and domiciliary home care.

b. Trusts as part of their contingency plan may need to re-distribute domiciliary care hours. This will include prioritising and targeting care hours to those clients who are at risk and those with the greatest clinical and/or care needs.

c. Trusts setting aside the current choice protocols which provide patients with a choice of residential or nursing care homes.

58. The Department's position was clear that, as of 27 April 2020, new residents should not be admitted to a care home where a positive test had been obtained and the care home did not have the facilities to allow for the required period of self-isolation. The Director of Mental Health, Disability and Older People engaged with representatives from the sector informally to ask for specific evidence of homes admitting Covid positive residents where they did not have the necessary isolation facilities, but no evidence was provided to confirm this was happening.

Management of the pandemic in the care sector

59. I consider the management of the pandemic in the residential and nursing homes, and separately the management of the pandemic in domiciliary and home care settings, was treated with equal importance as the management of pandemic in healthcare settings.

Email exchange with PHA dated 28 March 2020

60. The context for my email dated 28 March 2020 to the Director of Public Health at the Public Health Agency on the issue of testing in which I stated "*can I suggest that you now take this issue a little more seriously than seems to be the case, and provide a comprehensive written response urgently. These issues have been kicking around for a number of days, and I am astonished that you don't seem to appreciate the frustration it is causing*" [RP6/42 INQ000389810] is as follows.

61. On 27 March 2020 the Department received an email from a member of the public stating that they worked for Factcheck NI and that they were undertaking research into the discrepancy between two sets of figures regarding Covid-19 daily testing in NI [RP6/42 INQ000389810]. The email added that on 24 March 2020 the Minister had informed the Assembly that according to figures updated as of Monday 23 March 2020,

over 600 tests were being carried out per day in the regional virus reference laboratory [RP6/43 INQ000390950]

62. On the same day the Department sought clarification from the PHA, who responded to clarify what their surveillance systems follow and that perhaps the Minister was talking about wider testing, which may include patients who do not meet the case definitions which they shared. The Minister's Special Advisor (SpAd) responded on 28 March 2020 - this is when I became aware of the matter, as the SpAd added me to the email address list. The SpAd stated that there were serious discrepancies in what the Minister was being told and what was actually happening. He added that he had serious concerns about the quality of information being published in the daily PHA surveillance report. He addressed the senior PHA officials, reminding them that he and the Minister had sought clarity the day before, which they did not receive. He referred to a teleconference which had taken place on 17 March 2020 between the Department and the Public Health Agency where it was agreed to expand the categories for priority testing to include healthcare workers and tests requested by a Medical Director or nominated senior person. He expressed his concern of the email from the PHA Press office to the Departments Press office on 16 March 2020 and asked the PHA for clarification if that meant that healthcare workers were not being covered by the surveillance. The email chain within exhibit [RP6/42 INQ000389810] refers.

63. The Minister's SpAd also asked the PHA to provide details of the numbers of health care workers across NI who had been tested to date, referring to having made the request the day before without response. He sought confirmation from the PHA that the expansion for testing which had been agreed on 17 March 2020 was relayed to the Trusts and had been fully implemented. His email finally asked for confirmation that all testing, including those carried out by the Trusts, was being reported through the daily surveillance report, as he was concerned that the Northern Trust had reported a nil increase in testing the day prior. [RP6/42 INQ000389810]

64. Professor Hugo Van Woerden, PHA, responded to the SpAd's email the same day, to acknowledge receipt and suggested that a meeting be setup with the relevant individuals in the coming days, as that would provide opportunity to explore the issues in greater depth. I responded to Professor Van Woerden's email suggesting that he needed to take the issue more seriously than seemed to have been the case and urgently provide a comprehensive written response. I stated that the issues had been circulating for several days, and I was astonished that he did not seem to appreciate the frustration

that it was causing. I referred to a conversation that I had held with him and Valerie Watts, the HSCB Chief Executive, earlier that week, and that it seemed that the points we had discussed did not get the traction that Professor Van Woerden had assured me they would. I advised Professor Van Woerden that a meeting was not required, and instead that firm action by him to resolve the matter was required, seeking a full written report from him by the next day. As can been seen in the email exchange [RP6/42 INQ000389810], my concerns primarily stemmed from the discrepancy in the figures being provided to the Department on the reporting of tests, rather than actual testing. Thus, the issue referenced in this dialogue was centred around public confidence in the Department's information, rather than management of the pandemic. Professor Van Woerden responded to advise that a report would be provided later the same day. [RP6/42 INQ000389810] It is regrettable that Professor Van Woerden did not provide the report by close of play the same day, as he had promised (RP6/44 INQ000586685]. My concerns were in relation to the reporting of tests, rather than the testing itself. The issue was regarding public confidence in our information rather than a concern for the management of the pandemic. Given the passage of time I do not recall specifically how, and the precise extent to which, my concerns in relation to the reporting of tests were addressed, but the absence of further correspondence on the matter indicates that it was done so to at least a satisfactory level.

Deaths related to the infection of Covid-19

65. Deaths in the care sector were monitored through several mechanisms over the course of the pandemic. At the outset of the pandemic, the established system for monitoring and reporting on deaths in NI was through the General Register Office (GRO). Data reporting was based on death certification and by necessity included a lag time in reporting, as following each death, certification had to be completed, the death had to be reported to the GRO, and the data analysed and reported. This system continued to operate throughout the pandemic and remained the definitive source of reporting on deaths occurring in NI.

66. In a rapidly evolving context at the outset of the pandemic the PHA established an additional reporting system to capture information on deaths occurring in HSC settings and was based on the definition of 'deaths occurring within 28 days of a positive Covid-19 test'. This reporting and monitoring system established by the PHA mirrored similar reporting systems established in other UK countries and was operated through a SharePoint system. While this data stream mainly captured deaths occurring in acute

settings (namely hospitals) it included some information on deaths occurring in care homes, either because the care home in which the death occurred was an HSC facility and / or the PHA was advised of the death through their programme of support to care homes with incidents or outbreaks of Covid-19. Throughout the pandemic the PHA provided relevant clinical data, including data on deaths, to contribute to the NI Covid-19 Dashboard, which the CMO commissioned, with the agreement of the Minister. The responsibility for collating clinical data remained with the PHA.

67. At the outset of the pandemic, I was aware that some data was not readily available and that there were challenges accessing data to understand the developing situation. However, I was conscious that NI was no different from other parts of the UK in this regard. From the start of the pandemic there was a need for data on levels of community transmission, data on healthcare pressures, and on disease severity including deaths. These data sets were not readily available, and systems had either not yet been established or if established were not linked. This is considered more fully in the UK CMO Technical report (chapter 4, pages 121-161) [RP6/45 INQ000203933].

68. On 13 April 2020 the Minister issued an email to myself and the Department's Special Advisor which was copied to the Chief Executive of the PHA which stated 'we are now being repeatedly challenged as to why we aren't reporting deaths in care homes and in the community, I understand the technicalities and the protocols involved, but until we are able to articulate a number the insinuation and implication is that we are under reporting either because we don't know or are hiding something' [RP6/46 INQ000436808]. On the same day, the CMO forwarded the Minister's email to the Assistant Director of Information Analysis asking for an indication when the programme run would be completed to extract numbers from NISRA data of certified deaths in community and subset in nursing and residential care homes. On the 14 April 2020 the Minister of Health shared a WhatsApp message with me which stated that 'on a serious point we need to capture care home data – the dashboard carries the number of homes, which I think we should now be releasing & surely between RQIA/NISRA/GRO we could establish a number for deaths in care homes?' [RP6/47 INQ000544897]. I responded on the same date stating '*I agree we need to address – the difficulty is the validity and timing of numbers. Will speak to colleagues'*. Later that day, the CMO wrote to the Chief Executive of NISRA asking that data in relation to deaths registered in nursing and residential homes where Covid-19 was mentioned on the record of death was separately extracted and reported separately and more frequently. NISRA responded to the CMO to advise that they were able to add this additional information in that week's statistics.

[RP6/48 INQ000212415). I was aware of these concerns in relation to the recording and reporting of Covid-19 deaths in the Care Sector, and I was aware that the CMO issued correspondence to NISRA along with the detail of their prompt response.

69. On 14 April 2020, the Minister welcomed the commitment by NISRA to publish statistics on deaths and suspected deaths in Care Homes related to Covid-19 [RP6/49 INQ000103692]. NISRA published this information on a Dashboard from 19 April 2020 onwards, working closely with colleagues in PHA and other NISRA branches as necessary. The additional breakdown of Covid-19 deaths in hospitals, care homes, hospices or other settings was confirmed by NISRA in correspondence dated 23 April 2020 [RP6/50 INQ000212410]. The Dashboard included NI wide summary information about the volume of testing and the number of deaths reported by HSC Trusts that were associated with Covid-19.

70. On 20 April 2020 I chaired a meeting with the HSC Chief Executive Officers (CEOs) and the Department's Principal Statistician to agree how deaths were to be reported for publication on the dashboard [RP6/51 INQ000586686]. This was not specifically in relation to deaths in care homes but rather to ensure that deaths reported to the PHA for onward transmission to the Department were both reliable and consistent across NI. The meeting had been prompted following confusion in relation to the recording and reporting of deaths by the HSC. The aim of the meeting was to put in place a process for recording Covid-19 deaths which would be consistently applied across the HSC Trusts along with provision of assurances, via email to the Department's Principal Statistician within DOH, on a daily basis by 10am each morning. This assisted in providing confidence in the quality of PHA Covid-19 Death information.

Systems for Recording Deaths during the Pandemic

71. How RQIA received the data from care homes changed through the course of the pandemic. The RQIA introduced its App for care homes on 22 April 2020. This became how deaths in care homes were reported to RQIA. However, the principle of care homes advising RQIA of deaths in the care home setting was already established as part of the 'notifiable events' requirements of regulation of the sector which allowed deaths to be monitored.

72. Throughout the pandemic the PHA's Health Protection Team delivered a programme of direct support and assistance to care homes for risk assessment and management of incidents and outbreaks of Covid-10. Through this programme the Health Protection Team in the PHA were advised at points-in-time (e.g. at the time of initial risk assessment) of the numbers of cases and contacts involved in a particular incident or outbreak. The Health Protection Team was also advised if any residents were clinically unwell or had died in the context of the incident. It is important to note that this programme was established to provide operational support to care homes and was not specifically a system to monitor deaths occurring in these settings.

73. This was a highly complex and fast evolving situation, and I believe that, after my intervention on 20 April 2020, PHA worked closely and at pace with public health and policy colleagues across all UK nations to agree definitions and associated systems to capture information on cases, contacts, deaths, hospitalisations etc. I was assured that the approach adopted by PHA was similar to that taken by the other public health bodies/agencies in the UK. As the pandemic continued, I was confident that the PHA continued to work closely with Departmental officials and colleagues across all UK nations to both capture and report public health information relating to progress of the pandemic.

74. The PHA produced a Health Protection Daily Care Home Outbreak report which identified current and recent outbreaks in individual care homes. The report contained no personal identifying information, although it did identify the name of the care home, the town where it was located and organism identified (diarrhoea and vomiting, Covid-19 or other flu like illness). These reports were produced from April 2020, although the content contained within, and the format of the report changed over time. These reports were shared with the Department daily and were used to provide updates to Executive meetings.

75. I did not have any concerns regarding the timeliness of this data, as data provided by PHA on care homes referred to the position at 4pm the previous day (Monday to Friday) whilst data provided by PHA on Covid deaths referred to the position at 10am on the day the information was published. These Covid deaths referred to deaths by individuals who had tested positive for Covid within 28 days of their death, whether Covid was the cause of death or not. This information was published daily on the Covid Dashboard by

setting, of which 'Residential / Care Home' was a category. No information was available on whether these were patients or staff.

76. RQIA provided the Department with a report comprising data on all nursing and residential care homes in NI which reported deaths to the RQIA between 1 March 2020 and 6 May 2020. This report [RP6/52 INQ000561006 and RP6/53 INQ000561008] also provided a comparison to the same period in 2019. Key points of note were:

- 251 care homes with a total of 11,025 approved places had reported the death of 1 or more residents for the relevant period;
- 897 deaths had been reported in care homes;
- This was an increase of 438 deaths (49%) from the same period the previous year;
- 644 (72%) of these deaths were expected deaths;
- 190 (21%) of the total deaths were due to a flu like illness / pneumonia / lower respiratory infection;
- 92 of the 190 (48%) were new deaths reported in the 7 day period 30th April – 6th May 2020 inclusive.
- 97 of the 251 (39%) homes had confirmed or suspected Covid 19 at 04.05.20
- 9 homes had closed their Covid status. An outbreak can be declared over/closed when there are no new cases for 14 days after the symptom onset of the most recent case.

77. This report did not specify Covid-19 deaths. It is also important to note that a death is recorded as unexpected if the patient had not been seen by a doctor within the previous 2 weeks; at the time of the report GPs were not visiting homes and therefore some deaths could be recorded as unexpected which might not be.

78. The Minister also referred to reporting deaths in care homes in his opening statement to the NI Assembly's Ad Hoc Committee on 14 May 2020 [RP6/54 INQ000103679] when he informed members that the RQIA were reporting weekly figures about the numbers of deaths in nursing and residential care homes. The Minister advised that the latest figures, when compared to the same period during both 2018 and 2019, indicated that

the number of deaths was falling across the sector, with spikes reported around 21 and 27 April 2020.

79. During the pandemic, RQIA produced a weekly data stream, which commenced on 14 May 2020, reporting on deaths occurring in care homes, which they shared with partner organisations, including the Department. The data feed was sent from RQIA to Social Services Policy Group (SSPG) in the Department; colleagues in SSPG used the data feed to provide regular updates to the Minister and to inform situational updates and communications briefings/updates. This changed to a fortnightly report from 9 July 2020.

80. The information provided in the RQIA Care Home Death Report was not considered to be wholly reliable and could not be published because:

- Notifications to RQIA were self-reported by registered providers;
- Providers should have notified only those deaths which have occurred within the home setting; RQIA was aware however that some providers may have also reported deaths occurring in hospital;
- Notifications could only be validated for accuracy and correct coding at the point of being reviewed by an RQIA inspector.

81. The information contained did however give a helpful indication of the current situation. It is also important to note that it was agreed regionally that the official source of information in relation to deaths is NISRA.

82. In a further statement [RP6/55 INQ000103711] on 29 May 2020 the Minister commented on the weekly bulletin produced by NISRA, welcoming the fact that NISRA's weekly bulletin now contained a more detailed breakdown of information in relation to deaths of care homes residents. The Minister had corresponded with NISRA prior to this and had specifically requested this additional information to be included in the bulletin, in the interests of greater transparency. The Minister stated that the Department's daily statistical dashboard also included more information in respect of care homes.

83. However, I was aware that HSCB was requested by PHA to facilitate the availability of a summary of the data through an internal Dashboard which was refreshed daily from 24 June 2020 to 4 November 2021. I was conscious that there were known data quality issues with the data, due to it being 'self-reported' in nature, so the Dashboard carried

many caveats. The Dashboard remained in 'Draft' status and was not shared with a wide range of users outside of PHA and HSCB Social Care Directorate.

84. From July 2020 the reports were extended to provide a Care Home Data SitRep report [RP6/56 INQ000561009]. The report included data on the weekly Covid 19 deaths occurring by place of death. However, I was aware that there were some limitations noted in the report, including the fact that the data represented in the analysis was taken from the reports made to the PHA Health Protection duty room by private care homes where there was a suspected or confirmed case of Covid-19. In addition, it was noted that the data used from the report was extracted from a case management system to facilitate analysis. The Health Protection Surveillance team continued to quality assure this information and therefore the data was subject to change.

85. The Department was mindful of the need to provide timely and robust information to the public about the impact of the pandemic in care homes. The reporting of deaths in care homes was provided by the NISRA and in the Department's public dashboard, which also provided a wide range of information concerning the impact of the pandemic on the community across NI. This was supplemented by internal management information which gave a comprehensive, daily overview of capacity and issues facing care homes across NI and was used to identify targeted interventions by Health and Social Care Trusts and RQIA.

86. As summarised above, there were a few systems in place and other systems were developed at pace to capture and record information on deaths occurring during the pandemic – these included systems operated by the GRO, PHA, HSC Trusts and the RQIA/care homes. Some of these systems were established and operating before the pandemic, others were rapidly established in the early stages of the pandemic. In the context of data relating to deaths in NI: because there were several systems operating and being established, and each was based on different reporting requirements, there was potential for confusion in the early stages of the pandemic. It was the Department's experience that all parties worked together to address and resolve any areas in which there was a lack of clarity.

Lessons Learned

87. I consider that there were a number of areas in which the Department's management of the care sector which worked well, which I have set out in the following paragraphs. In

the very early weeks of the pandemic, following the activation of Health Gold on 9 March 2020, policy leads from the Department's SSPG participated in meetings of the Strategic Cell to monitor the impact of Covid-19 on the social care sector responding to issues escalated to Health Gold by Silver and developing new policies or responses designed to mitigate or address the difficult, novel, and complex issues faced by the sector. By 6 May 2020 the Department had established, under the Health Gold Strategic Cell [RP6/57 INQ000145672], a subject specific policy structure for the social care sector, including Domiciliary and Residential Care, and impacts and recovery in relation to psychological impacts and mental health. This structure was chaired by the Department's Chief Social Work Officer and included key senior managers from the Department, HSCB, the Chief Executive of the RQIA and a Health and Social Care Leadership Centre Associate. The purpose of these discussions was to oversee the Covid response across social care and agree, log and track key actions. The meetings took place through the early weeks and months of the Covid-19 response [RP6/58 INQ000103671]. During the first wave, and in particular the initial emergency phase, business was conducted within a fast moving and evolving situation, often requiring rapid decision making, responsive to the needs of the sector.

88. In addition, to avoid duplicating structures, Departmental representatives joined key meetings hosted by the HSCB and the PHA. For instance, the Department's Director of Mental Health, Disability and Older People attended weekly meetings chaired by the HSCB which brought together the Directors for Adult Social Care from the HSC Trusts as well as the PHA and RQIA. This allowed the Department to gather feedback and evidence from frontline organisations to assess impact, share good practice, agree action and inform policy and plan making.

89. These structures were developed and refined, with an Adult Social Care Surge Working Group put in place by early August 2020 to further strengthen coordination and collaboration across the Department and wider system [RP6/59 INQ000103715 and RP6/60 INQ000103716] and to support the HSCB in implementing the regional Care Homes Action Plan [RP6/61 INQ000120732] they had developed.

90. Structures were also in place to engage with other relevant Executive departments, such as a weekly meeting with officials at the Department for Communities, to share information and, where appropriate, align interventions in supported living facilities and Care Homes. Guidance on homelessness was jointly signed off by the two Departments and PHA, for instance. The communications with the care sector were improved during

the pandemic response, noting that the nature of the communications during a pandemic differs to the communication needs in a non-pandemic scenario. It is also of note that the decisions in the care sector were taken as a result of the experts in various sectors working collectively in the interests of the sector.

91. The Department of Health was, and is, one of the smallest Departments in terms of numbers of personnel. This presented particular challenges in the context of the dominant role of the Department responding to an unprecedented pandemic. The Department's personnel, to include its professional officers, worked diligently throughout the period of pandemic response, often working long hours in a fast moving and evolving situation, but an inevitable consequence of consistent and unyielding long hours in such a pressurised environment is the risk a diminution in energy levels and focus. Continual requests for assistance were made to colleagues in other Departments – primarily through my repeated raising of this issue with my Permanent Secretary colleagues at our weekly meetings. Unfortunately, these efforts resulted in only a small number of additional personnel providing assistance. I believe that a key lesson from this is that the Northern Ireland Civil Service should develop more systematic procedures to facilitate the rapid redeployment of staff between Departments, particularly where there are emergency situations such as responding to a pandemic. This would ensure that the staffing pressures experienced by the Department of Health would not occur again during a pandemic.

92. The Department was committed throughout the pandemic to learning lessons from the evolving situation within care homes and used this knowledge to further strengthen its response. There were a number of lessons learned exercises led by professional officers such as the rapid learning initiative.

93. On 2 June 2020 [RP6/62 INQ000103701] the Minister announced that a Rapid Learning Initiative was underway, to identify lessons from Care Home experiences of Covid-19. This initiative was designed to obtain input from the Care Home sector and from across the Health and Social Care system.

94. On 17 June 2020 [RP6/63 INQ000103712] the Minister announced plans for a new framework for nursing, medical and multidisciplinary in-reach into Care Homes. He had asked the CNO to co-design this new framework in partnership with the care home sector for the provision of clinical care. This framework included examining how the Department would expand nursing, medical and multidisciplinary support, clinical

leadership and specialist skills in collaboration with care home staff, building on the important role of GPs in care homes.

95. On 24 June 2020 the Minister announced that a new group had been established to learn from the care home experiences of Covid-19 [RP6/64 INQ000103713]. The group was chaired by the Deputy Chief Nursing Officer and included representation from the independent care home sector, the Health and Social Care system and the Royal College of Nursing. The Group was directed to take forward the Rapid Learning Initiative on Care Home experiences.

96. Care home residents, their loved ones and care home staff were critical partners in this work, providing insight and knowledge over a defined 3-month period to identify recommendations for action. In recognition of the powerful impact of the lived experience of residents, their loved ones, and staff, with support from the PHA Experience Team, a separate supplementary report was issued using 10,000 More Voices methodology [RP6/65 INQ000416806]. The narrative of residents, relatives and staff was collected over the period from 24th June 2020 to 31st August 2020. In total, 744 stories were collected in relation to experiences within care homes. This report informed many of the key recommendations outlined in the RLI report and was used to influence change and improvement moving to the next stage of the pandemic.

97. These stories highlighted the deep and lasting impact that the first wave of the pandemic had on care home staff, residents and families. In the early days of the pandemic many reported that they carried the burden of protecting and caring for residents in the absence of clear guidance and support. It was recognised that acknowledging and learning from the key messages would be crucial to supporting and maintaining the health and wellbeing of staff, families and residents as the pandemic progressed in NI.

98. The resulting report was published on 2nd September 2020 [RP6/66 INQ000276404], and the PHA was charged to work with Trusts, the independent sector, and other relevant stakeholders to co-ordinate the implementation of the recommendations.

99. Recommendations from the Rapid Learning Initiatives for both care homes and domiciliary care were incorporated into subsequent planning documents - the Domiciliary Care Surge Action Plan and the NI COVID-19 Regional Action Plan for the Care Home Sector.

100. In September 2020 the Department commissioned Niall Herity, a Consultant Cardiologist, to undertake an analysis of discharge patterns from HSC hospitals across Northern Ireland during early 2020, and explore any link with COVID-19 outbreaks in care homes [RP6/05 INQ000586687 page 2]. Among the helpful points highlighted was the general assurance as regards the approach taken in NI:

"*Given the diversity of countries, regions and healthcare systems that have been reported, differences in local policies, guidelines or communications seem to be less plausible explanations of care home outbreaks and consequent deaths, than the virulence of the SARS-CoV2 virus, its ability to spread rapidly in indoor settings and the innate clinical vulnerability of care home residents*"

101. This, of course, was based on a relatively small sample size and is not a sweeping assurance that everything was done as well as it could be. Nevertheless, commissioning the report in itself highlights that the pursuit of learning was recognised in the Department as being of importance; and its broad conclusions provided some assurance as regards the quality and effectiveness of the approach which had been taken.

102. I left my post as Permanent Secretary to the Department of Health in April 2022, whilst the response to the pandemic was ongoing, and have moved sectors twice in the period since. Moving from the health sector before the response concluded meant that I did not have time while still in that environment to properly and maturely reflect on the approach and key lessons. The passage of time since then, along with the necessity for me to focus on the new sectors I moved to, has meant that my recollection of events has somewhat diminished, and thus the granularity and value of any reflections I may have. This is unfortunate, but I would emphasise that I have a clear recollection of a culture and desire across HSC to continually learn and improve, with a focus on providing the best service possible to the community we served. In many ways this is at least as important as any specific learning exercises.

STATEMENT OF TRUTH

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

Signed: Personal Data

Date: 23 April 2025