Witness Name:	Evelyn Hoy
Statement No:	1
Exhibits:	EH/1 – EH/17
Dated:	28 May 2025

UK COVID-19 INQUIRY

WITNESS STATEMENT OF EVELYN HOY

I, Evelyn Hoy, Chief Executive to the Commissioner for Older People for Northern Ireland, whose office is at Equality House, 7-9 Shaftsbury Square, Belfast, BT2 7DP, Northern Ireland, will say as follows: -

INTRODUCTION

1. The Commissioner for Older People for Northern Ireland's office received correspondence dated 4 February 2025 on behalf of Baroness Heather Hallett, the Chair of the UK Covid-19 Inquiry ("Inquiry") seeking a witness statement ("Statement") and the disclosure of documents for Module 7 pursuant to Rule 9 of the Inquiry Rules 2006 ("Rule 9 Request").

2. This correspondence was addressed to Eddie Lynch, the former Commissioner for Older People for Northern Ireland, who has provided statements and documents to the Inquiry in Modules 2C, 3 and 6, pursuant to a Rule 9 Request. On 12 December 2024 Eddie Lynch stepped down from his successful eight years in post. He was only the second Commissioner for Older People for Northern Ireland since the office was established in 2012. A new Commissioner for Older People for Northern Ireland has just been announced by the Northern Ireland Executive Office as Siobhan Casey, who is a former director of the charity Age NI. She will take up her post as Commissioner on 7 April 2025.

3. In these circumstances, I believe I am the individual best placed to provide this Statement to the Inquiry. I was appointed Chief Executive to the Commissioner for Older People for Northern Ireland in September 2013, after joining the office in June 2012 as Head of Operations. My role involves the task of developing and managing programmes and projects to achieve the Commissioner's objectives. Throughout the period of 1 January 2020 to 28 June 2022 ('Relevant Period') I was the key advisor to the Commissioner in all pandemic-related matters and personally attended many of the important meetings with officials.

4. The Inquiry was established on 28 June 2022 to examine the UK's response to, and impact of, the Covid-19 pandemic, and to learn lessons for the future. It is being conducted in modules and it is my understanding, from the Inquiry's 'Provisional Outline of Scope for Module 7', that Module 7 will examine the approach to testing, tracing and isolation adopted during the pandemic in England, Wales, Scotland and Northern Ireland. Test, Trace and Isolate ('TTI') is a neutral term coined by the Inquiry for the purposes of Module 7 which encompasses Test, Trace, Protect (Northern Ireland), Test and Protect (Scotland), Test and Trace (England) and Test, Trace, Protect (Wales).

5. This Statement, including the documents exhibited to it, relates solely to the work being undertaken in Module 7. It constitutes my response to the matters to be addressed as set out at Annex A of the Rule 9 Request. The Commissioner for Older People previously provided a statement and documents pursuant to a Rule 9 Request for both Modules 2C, 3 and 6. However, I have not assumed that the Inquiry team working on Module 7 has seen or considered either those statements or their associated documents, so I have incorporated some material from them statements insofar as it is relevant to the issues in Module 7.

6. This Statement is provided under three core chapter headings:

   I. Overview of the Commissioner for Older People
   II. The TTI System – Our Contributions and Concerns
   III. Lessons Learned

I. OVERVIEW OF THE COMMISSIONER FOR OLDER PEOPLE

7. The Commissioner for Older People is a statutory role and is at arms-length of government. The office is set up as a non-departmental public body sponsored by the Department for Communities but, critically for the work conducted, is operationally independent. It was established in accordance with the Commissioner for Older People Act (Northern Ireland) 2011 ("the Act") with the principal aim, as enshrined in section 2 (1) of the Act, of safeguarding and promoting the interests of older people in Northern Ireland. The Act affords the Commissioner promotional, advisory, educational and general investigatory duties and powers.

8. The necessity of such a position was campaigned for, for some time by age sector organisations such as Age NI and Age Sector Platform. The Northern Ireland Executive committed in their 2007 Programme for Government to providing a 'strong independent voice' for older people. In December 2007 the First Minister and Deputy First Minister announced their intention to establish a Commissioner for Older People.

9. Under section 25 of the Act, subject to subsections (2) to (4), the term 'older person' is defined as a person aged 60 or over. As of March 2021, Northern Ireland had an over 60s population of approximately 439,600. In some exceptional circumstances and where it is considered appropriate to do so, the Commissioner would be entitled to direct that 'older person' means a person aged 50 or over and to apply their powers under the Act accordingly. Such decisions would be highly fact specific, and no such scenario arose during the Relevant Period.

10. The statutory obligations and duties associated with the role of the Commissioner could not be properly discharged without the support of a much wider team. The key office holders in the team are the office of Commissioner and that of the office of the Chief Executive. There is also a management team. Following a restructuring in August 2021, that management team comprises: Head of Legal and Advocacy Services; Head of Research and Policy Advice: Head of Corporate Services; and Head of Communications and Engagement. The total team

comprises of nineteen staff members who are all highly motivated, hugely experienced and absolutely dedicated to the welfare of older people.

11. The mandatory duties of the Commissioner are outlined in section 3 of the Act:

"(1) The Commissioner must promote an awareness of matters relating to the interests of older persons and of the need to safeguard those interests.

(2) The Commissioner must keep under review the adequacy and effectiveness of law and practice relating to the interests of older persons.

(3) The Commissioner must keep under review the adequacy and effectiveness of services provided for older persons by relevant authorities.

(4) The Commissioner must promote the provision of opportunities for, and the elimination of discrimination against, older persons.

(5) The Commissioner must encourage best practice in the treatment of older persons.

(6) The Commissioner must promote positive attitudes towards older persons and encourage participation by older persons in public life.

(7) The Commissioner must advise the Secretary of State, the Executive Committee of the Assembly and a relevant authority on matters concerning the interests of older persons—

(a) as soon as reasonably practicable after receipt of a request for advice; and

(b) on such other occasions as the Commissioner thinks appropriate.

(8) The Commissioner must take reasonable steps to ensure that—

(a) older persons are made aware of—

(i) the functions of the Commissioner.

(ii) the location of the Commissioner's office; and

(iii) the ways in which they may communicate with the Commissioner.

(b) older persons are encouraged to communicate with the Commissioner.

(c) the views of older persons are sought concerning the exercise by the Commissioner of the Commissioner's functions.

(d) the services of the Commissioner are, so far as practicable, made available to older persons in the locality in which they live."

12. Almost all those statutory duties were engaged by the Commissioner during the Relevant Period and are relevant to the Rule 9 Request for Module 7. Of particular significance is the mandatory duty under section 3 (7) to *"advise the Secretary of State, the Executive Committee of the Assembly and a relevant authority on matters concerning the interests of older persons"* as the Commissioner considers appropriate. Some examples of this which relate to the development of the TTI system adopted in Northern Ireland are discussed subsequently in this Statement.

13. The general powers of the Commissioner are outlined in section 4 of the Act:

> *"(1) The Commissioner may undertake, commission or provide financial or other assistance for research or educational activities concerning the interests of older persons or the exercise of the Commissioner's functions.*
> *(2) The Commissioner may, after consultation with such bodies or persons as the Commissioner thinks appropriate, issue guidance on best practice in relation to any matter concerning the interests of older persons.*
> *(3) The Commissioner may, for the purposes of any of the Commissioner's functions, conduct such investigations as the Commissioner considers necessary or expedient.*
> *(4) If the Commissioner so determines, Schedule 2 is to apply in relation to an investigation conducted by the Commissioner for the purposes of the Commissioner's functions under section 3(2) or (3).*
> *(5) The Commissioner may—*
> *(a) compile information concerning the interests of older persons;*
> *(b) provide advice or information on any matter concerning the interests of older persons;*
> *(c) publish any matter concerning the interests of older persons, including—*
> *(i) the outcome of any research or activities mentioned in subsection (1);*
> *(ii) the outcome of any investigations conducted under subsection (3);*
> *(iii) any advice provided by the Commissioner.*
> *(6) The Commissioner may make representations or recommendations to anybody or person about any matter concerning the interests of older persons."*

14. The Commissioner's general powers to publish and make representations under section 4 (5) (c) and (6), were also particularly important during the Relevant Period and they were resorted to repeatedly. Some examples of this in respect of the development of the TTI system adopted in Northern Ireland are discussed subsequently in the Statement at paragraphs forty-one and forty-two.

15. The Commissioner represents the interests of potentially over 600,000 older people and their families in Northern Ireland. This encompasses a broad spectrum of personal circumstances. The Commissioner deals with and represents individuals living in their own homes, those living at home but reliant on domiciliary care, those living in supported living or in residential care homes as well as those in hospitals and hospices and those constituents confined to prison establishments. To properly represent those interests and carry out the role effectively, the office of the Commissioner has established trusted lines of communication with Health and Social Care Trusts; senior personnel in the Department of Health; the Chief Social Work Officer; and the Director of Mental Health, Disability and Older People. Our office regularly submits responses to government consultations in respect of proposed policy and legislative reform.

16. In addition, and most importantly, the office engages on an almost daily basis with older people and their families. During the pandemic this increased dramatically as people struggled to understand the information on Covid-19 and the government's response to the escalating transmission rate. They were also desperate to have their concerns about what was happening to them taken to the government to bring about change. Over the Relevant Period, our office received complaints and requests for assistance from over 400 individuals and families about pandemic related issues.

II. THE TTI SYSTEM – OUR CONTRIBUTIONS AND CONCERNS

a. Government Interaction

17. The Commissioner's duties are to promote and safeguard the rights of older people in Northern Ireland and to do this by keeping under review the adequacy and

effectiveness of law, practice and services relating to older people. This very much remained the former Commissioner's focus during the pandemic. From the outset, the attention was centered on not only protecting older people as much as possible from contracting the virus but also working with many authorities to support and keep safe the thousands of older people who had to immediately shield.

18. Throughout the pandemic there was direct engagement on Covid-19 issues either personally through the Commissioner or key members in our team including myself, with the Minister of Health, the Chief Medical Officer, Department of Health officials, The Office of the First and Deputy First Minister, Department for Communities, Regulation and Quality Improvement Authority, Public Health Authority and the Patient and Client Council. I have exhibited at **[EH/1, INQ000507378]** a chronological list of meetings with Ministers, politicians and civil servants in which I have highlighted those of relevance to the development of the TTI system adopted in Northern Ireland.

19. The purpose of that engagement was to enable us to use the information we had from older people, their families and those working on issues concerning older people, together with our own knowledge and experience of the weaknesses in the health and social care sector, to contribute to improving the response of decision makers to the pandemic.

20. Meetings with Ministers and politicians were often carried out over the telephone or remotely by platforms such as 'Zoom' in reaction to issues that were happening 'on the ground.' The reactive and ad hoc nature of these meetings and interactions meant that no agenda was set, and no minute was taken. This will undoubtedly be a matter of learning for the future, as such unstructured and ad hoc communications are not an ideal method of policy development or decision making. The subject of discussion invariably centered around the most prominent issues on that day. Meetings were not recorded nor was any dissent or disagreement between participants. That it not to say they were not noted by other participants, but if that was the case then they were not circulated to our team.

21. I have been asked by the Inquiry to identify how the work of the Commissioner for Older People of Northern Ireland contributed to the information available to

decision makers, which may then have informed the development of the TTI system adopted Northern Ireland.

22. At the outset of this section and for ease of the Inquiry, I have exhibited at **[EH/2, INQ000587547]** the Department of Health's formal '*Covid-19 Test, Trace and Protect Strategy*' dated 27 May 2020. It confirms that contact tracing for all cases of Covid-19 stopped on 12 March 2020 as efforts shifted from individual contact tracing to wider containment measures.

23. It further outlines the four key elements of Northern Ireland's 'Test, Trace and Protect' as encompassing:

    (I) Early identification and isolation of possible cases, clusters and outbreaks
    (II) Rapid testing of possible cases
    (III) Tracing of close contacts of cases
    (IV) Early effective and supported isolation of close contacts to prevent onward transmission of infection

24. The above elements of most concern to the office of the Commissioner for Older People of Northern Ireland were (I) and (II). This is because lockdown, which was introduced on 23 March 2020, necessarily created a closed environment for older people in care homes as well as those in their own homes. The virus required a high-level of control over who entered care homes to prevent the almost free circulation of Covid-19 amongst such a vulnerable population. This was also the case with older people living in their own homes, particularly those who were shielding for health reasons.

25. For that reason, TTI elements (III) and (IV) above, were of much less relevance to our constituents who were disproportionately represented in those categories that experienced prolonged periods of isolation as opposed to ordinary members of the public who may have had the infrequent direct experience with the system of close contact tracing followed by a subsequent short isolation period. Accordingly, there are certain elements of the TTI system adopted in Northern Ireland that are of interest to the Inquiry in Module 7 but which the office of the Commissioner for Older People is not best placed to provide a detailed view. This

includes predominantly the safety, infrastructure and modelling of TTI systems, the use of apps and technology for TTI and enforcement strategies.

26. In my view, the most prominent contributions of our office to the information available to decision makers that may have then informed TTI, were our calls in the early stages of the pandemic on the following two issues:

    (I) Regular testing of residents and care workers, especially agency and domiciliary care workers who were also operating in the community or working in other care homes.

    (II) Testing of those discharged from hospital back to their care homes and the testing of those who were being newly admitted to care homes when they could no longer manage in their own homes, often for Covid-19 related reasons.

27. I was invited by senior officials at the Department for Health to attend a meeting on 16 March 2020 to discuss forthcoming guidance for care homes. By that time our team had already been conducting informal discussions to obtain the views of key stakeholders (older people) and other organisations like AgeNI, the leading charity for older people and the Independent Health and Care Providers ("IHCP") which represents about 50 per cent of the care home providers. As a result, we were clear about the issues that any guidance should cover and where assistance was likely to be required.

28. One of the contributions we intended to make at that meeting, which was TTI related, was the call for testing of care home residents and all staff who encountered care home residents. For myself personally, this desire was partially borne out of the fact that high numbers of elderly people in Italy were contracting and dying of Covid-19 in residential facilities. All of us in the office of the Commissioner were extremely keen to avoid any such development in Northern Ireland.

29. I attended that meeting as the Commissioner was involved in other meetings at Stormont. In addition to myself, the Chief Executive of AgeNI and IHCP group were

also present. A draft of the guidance was provided on the day of the meeting **[EH/3, INQ000250245].** In my view there was insufficient time to consider this guidance properly and so much of the meeting was taken up with its content being explained.

30. The 'Covid-19: Guidance for Nursing and Residential Care Homes in Northern Ireland' ("Guidance") was published the following day on 17 March 2020 and states: *"It has been developed in consultation with a number of representative bodies."* In my view that did not accurately capture the reality of the situation. I have exhibited the Guidance at **[EH/4, INQ000553517].** At the meeting I, and colleagues from AgeNI and IHCP, asked a series of questions about matters that were not included in the guidance. My focus was on what actions providers could take to keep infection out of care homes. No answers were given to my questions at that meeting. The position adopted by the senior officials in attendance from the Department of Health was that the guidance was to be published imminently and there was no time to amend it.

31. My impression was that the deadline for the issue of the guidance was given more importance than the content of the guidance itself. I appreciate that Module 7 is not concerned with the granular detail of the content of this guidance, however, I raise this issue to illustrate how it was a missed early opportunity to put TTI measures in place and identify and isolate possible cases, clusters and outbreaks of Covid-19, especially in the care home setting.

32. Later that week I attended another meeting, together with the Commissioner and our Head of Communications and Engagement. This meeting was convened by the Chief Medical Officer, the Chief Scientific Advisor, the Chief Social Worker, the Director of Mental Health, Disability and Older People and officials from Public Health Agency. This meeting was a briefing at which information was provided in respect of hospital surge plans and what was happening generally in Northern Ireland.

33. Despite my drawing attention, at that meeting, to the high numbers of elderly in Italy who were contracting and dying of Covid-19 in residential facilities, there was an air of unreality about the possibility of that happening in Northern Ireland. The

view expressed by the Chief Medical Officer and Chief Social Worker seemed to be 'that won't happen here, they have a completely different system over there.'

34. The former Commissioner and I were very worried about that meeting and what it indicated for the future. We had expected the Department of Health would wish to make use of our acknowledged expertise and experience and we had attended that meeting informed and ready to assist. We had expected a consultation but that is not what happened. We were told, rather than engaged with, and not given the opportunity to make much, if any, difference.

35. The guidance that was published contained little on testing for Covid-19, which the Commissioner and I considered to be an essential aspect of an overall strategy to keep older people safe. However, it did state at paragraph 21 that: *"The Public Health Agency will ensure that a dedicated team engages with the home, in the event of one or more residents testing positive for COVID-19, to help you to ensure that isolation arrangements are put in place to minimise the risk of the infection spreading."* This of course presupposes that testing has been made available. It did not address the situation when members of staff note that residents are displaying the symptoms of Covid-19. Rather than this being the case, we were soon hearing from care home managers that they were being asked to admit residents direct from hospital without them being tested or receiving the results of tests for COVID 19 infection.

36. It was clear at the outset of the pandemic that the government did not feel a track and test type approach was suitable for care home residents. The Chief Medical Officer gave evidence before the Northern Ireland Assembly on 23 April 2020 confirming the government's stance that testing would not happen in Northern Ireland in a care home setting. My instinct, and knowledge of how care homes operate, was that a properly established testing programme would be an essential tool in the fight to control Covid-19.

37. At the same time the families engaging with the office of the Commissioner were bringing their own experiences and urging us to press for the testing of those in care homes. We were also receiving calls from providers who wanted their staff, and the residents tested. In all the circumstances, we found it difficult to see how

the extent of the problem could be gauged, and any realistic planning developed, without an effective means of tracking those infected with Covid-19 and testing them.

38. On 31 March 2020, our office emailed the Department of Health seeking information such as, *"How are Covid tests in resid/care home setting being administered, recorded and tracked?"* More queries were emailed on 8 April 2020, including: *"Given the recent ramp up in testing sites, what plans are there for prioritising testing of care home workers and domiciliary care workers?"* These emails are exhibited at **[EH/5, INQ000532624].** The Commissioner also used the media to press for such a regimen, including an interview he gave the following day on 9 April 2020. By this time, the Commissioner had secured support from Colm Gildernew MLA, the Chair of the Northern Ireland Assembly Health Committee. Then on 24 April 2020 the Commissioner wrote to the Minister of Health concerning the ongoing situation with testing for Covid-19 in care homes and his call for universal testing in care homes. I have exhibited this letter at **[EH/6, INQ000237827].**

39. This work undoubtedly contributed to the development of the TTI system adopted in Northern Ireland. The government effectively performed a 'U-turn' on their initial testing policy, as reflected in a letter from the Minister of Health dated 26 May 2020 exhibited at **[EH/7,INQ000417085].** It acknowledged that the *"pandemic has drawn particular attention to the frailty of the care home sector"* and notified an expansion of testing to all care home residents and staff and the work being done to roll out a programme of testing for all care home staff.

40. Whilst this response was helpful and we remain grateful to the access the Commissioner was given to the Office of the First Minister and Deputy First Minister and the Minister for Health, our concern was that what was ultimately accepted was something that we had raised very early on. It required sustained efforts to achieve it but with all the resources at the disposal of the Department of Health it should, in my view, have been capable of being addressed far sooner. The 'frailty of the care home sector' was well known before the arrival of Covid-19.

41. In that same respect the development of the TTI system adopted in Northern Ireland did not need to take as long as it did. Whilst I do not of course claim that we had all the answers, I do believe that we were asking the right questions early on, and I think it would have been beneficial to have had a proper opportunity to engage with the Department of Health in a proactive way during those early stages of the pandemic as we may have seen elements of the TTI system adopted much earlier than they ultimately were.

42. By June 2020 the requirements for lockdown had been eased and the Department of Health's '*Covid-19 Test, Trace and Protect Strategy'* had been published (dated 27 May 2020 and previously exhibited at paragraph 22 of this Statement). The figures from Northern Ireland Statistics and Research Agency showed that by 29 May 2020, there were 328 deaths in care home settings, accounting for almost half the total number of deaths at that time. The former Commissioner and I thought it was time for the government to have an urgent inquiry into its response to the pandemic in relation to care homes, so that lessons could be learned for the further wave of infection that many believed was likely to follow the resumption of face-to-face interaction. Unfortunately, that did not happen. Instead, there was a more limited investigation by the Health Committee into the impact of Covid-19 in care homes, which the Commissioner welcomed but made clear at that time that he did not believe this should be seen as a substitute for a broader inquiry.

43. As part of the Commissioner's call for an investigation, he provided a briefing to the Health Committee on 4 June 2020 on the handling of key Covid-19 issues and his concerns going forward, which I have exhibited at **[EH/8, INQ000237828].**

44. I accompanied the Commissioner at that briefing along with the Head of Legal and Advocacy Services. The Commissioner's principal focus during that briefing was two-fold: (i) to obtain a roll out of a proper testing program, and (ii) to draw attention to the potential impact on older people as society emerged from lockdown and measures were eased. Other issues aired at that briefing included concerns over discharge from hospital without testing (which I will address in further detail subsequently in this Statement) and concerns among constituents over 70 years of age who were in good health, away from a care home, that no longer wanted to

be in lockdown. This demonstrates the breadth of issues our office was dealing with in respect of older people during the Relevant Period.

45. Based on all the evidence it received, the Health Committee decided to conduct an inquiry on the 'Impact of Covid-19 in Care Homes' that would produce recommendations to the Assembly on its findings. The terms of reference, which I have exhibited at **[EH/9, INQ000239431]** were issued in early September 2020 and indicated that the Health Committee would:

    (I) Identify the key issues impacting care homes as a result of the Covid-19 pandemic

    (II) Identify domestic and international examples of best practice in arrangements to protect and care for residents of care homes during the pandemic

    (III) Report to the Assembly on its findings and recommendations by 13 November 2020

46. Whilst this was not a public inquiry, the Commissioner did consider the terms of reference as providing an early and important opportunity to assess what had happened and learn lessons. The Commissioner gave evidence to the Health Committee on 13 October 2020, which I have exhibited at **[EH/10, INQ000237830].** I accompanied the Commissioner on this occasion with our Head of Legal and Advocacy Services. The Commissioner's oral submissions were essentially a follow up to issues he shared at the briefing on 4 June 2020. He emphasised how there were currently some 14,000 older people in care homes in Northern Ireland and the government had a duty to protect their human rights.

47. Of most relevance to Module 7, the advice given by the Commissioner to the Health Committee relating to TTI policies was that testing in general was still a big issue. It was either not happening or it was taking too long between tests being performed to function as a useful tool to manage the spread of infection. The Commissioner informed the Health Committee that we were receiving reports that it was taking 4 – 8 days for some test results to be returned. Many care homes were not physically configured to easily provide adequate isolation and certainly not with a stretched workforce. He further made the point that financing in general

for care home and care providers needed to be addressed as their costs of responding to the pandemic and implementing the government's guidance had increased markedly. The Commissioner provided written submissions on 19 October 2020, which I have exhibited at **[EH/11, INQ000237831],** to highlight in a point format the issues raised during the oral submissions.

b. Discharge Policy

48. A key concern of the former Commissioner pertaining to the TTI system and policies as they related to older people, was the policy on discharge from hospital to care homes without testing prior to discharge.

49. In the earlier phase of the pandemic there was a real fear that hospitals would become overwhelmed and Health and Social Care Trusts were under pressure to discharge patients as quickly as possible and speed up placements to care homes who would then be responsible for their health and social care. That pressure is illustrated by the 'surge plans' developed by the Department of Health in particular the following two documents that are exhibited at **[EH/12, INQ000417091].** For example the *Health and Social Care (NI) Summary Covid-19 Plan for the period mid-March to Mid-April 2020* states: *"In the weeks ahead it will be more important than ever for Trusts to implement effective discharge arrangements for patients as soon as they are well enough to leave hospital in order to release beds for newly admitted patients…Trusts will work to maximise and utilize all spare capacity in residential, nursing and domiciliary home care."*

50. The surge plans did not explicitly take account of the predictable outcome of discharging patients who had not been tested for Covid-19 into enclosed and locked down care homes.

51. In those circumstances some care home providers felt that the position they were put in by the Health and Social Care Trusts meant that they had to take in new residents discharged from hospital despite their concerns about the impact of doing so or risk a loss of future business. Considering around 98 per cent of care in Northern Ireland is delivered by the private sector, for some care home providers these placements from the Health and Social Care Trusts constituted their primary source of occupants and income. They feared that refusing patients being

discharged from hospitals could lead to repercussions from the Health and Social Care Trusts in terms of their future occupancy rates. Their business model is reliant on the homes being at or close to full capacity. These fears came to my attention in conversations with Pauline Shepherd Chief Executive of IHCP. Additionally, three care home owners raised with me directly, in verbal conversation, their concerns about this coercive attitude and the risks they felt it held for the safety of their residents, in the sense that new admissions from hospital without adequate prior testing comprised their ability to minimise the risk of outbreaks and control the spread of infection within their homes.

52. It is incomprehensible that the early recognition of the particular risk to older people did not translate into stringent TTI policies to ensure that residents of care homes were protected. The inherent weaknesses in the health and social care system and the need for reform, was not a new phenomenon as it had been an ongoing discussion for 30 or 40 years and was the subject of detailed reports such as the 2016 Bengoa Report *Systems not Structures: Changing Health and Social Care* and the 2017 Kelly & Kennedy report *Power to People: Proposals to Reboot Adult Care & Support in NI*. I have exhibited these reports at **[EH/13, INQ000551838 & EH/14, INQ000553530].** When the transmission rate of Covid-19 started to rise markedly and a government response was required, the sector's ability to respond to the pandemic should have been appreciated and factored into all policy and planning related to TTI to avoid potentially disastrous outcomes for older people and unfortunately this was not the case.

53. In mine and the former Commissioner's view, what was required, as the Commissioner stated in an article he published jointly with the Chief Commissioner of the Northern Ireland Human Rights Commission on 6 May 2020, was to create *"a ring of steel to protect care homes from the virus with effective PPE and priority testing."* For ease of the Inquiry, I have exhibited this article at **[EH/15, INQ000191277].** Within days of that being published the Secretary of State for Health, Matt Hancock, during a Downing Street press conference said that: *"Right from the start, it's been clear that this horrible virus affects older people most. So right from the start, we've tried to throw a protective ring around our care homes."* He was correct, it was clear, but a 'protective ring' was not thrown around the

Northern Ireland care homes. Sufficient protection was not given to older people even though they were foreseeably most likely to be vulnerable to Covid-19.

54. Rather, a false narrative of lockdown in care homes was allowed to perpetuate giving a misleading impression of the safety of those within the care homes or shielding elsewhere. Families were isolated from residents, some of whom were vital their mental health and overall well-being, on the pretext that such isolation was essential to keeping the older people as safe as possible. In reality, care home staff and domiciliary care staff were unvaccinated, not tested for Covid-19 and yet able to come and go as they pleased into care homes and older peoples' homes. Furthermore, there appeared to be a premature discharge process to unblock hospital beds before older people were sufficiently recovered to be safely discharged and therefore, they were at continuing risk and few good options; go back to their care homes that often did not have the expertise to care for them in the current condition; go to other facilities that they did not know and where they were unfamiliar.

c. Variation in TTI across the UK

55. The Inquiry has further asked me to address the variation of TTI rules across the United Kingdom.

56. On 15 April 2020, the Secretary of State for Health Matt Hancock made the announcement that the government would roll out Covid-19 testing to all symptomatic adult social care staff, their family members and care home residents, following mounting concerns about the impact of the virus on the sector. By contrast the guidance for Northern Ireland that was subsequently published on 26 April 2020, provided only that symptomatic care home staff will be tested unless there is an 'outbreak'. This more restricted approach to testing meant that suspected cases of Covid-19 in care homes were not always subjected to confirmatory testing.

57. Moreover, the Commissioner brought to the attention of the Minister of Health in a letter dated 8 October 2020 the variation in testing between Northern Ireland and Scotland at that time. I have exhibited the letter in full at **[EH/16, INQ000514708]** but the most relevant extract for Module 7 is the following:

"Your officials have advised that the programme of testing (fortnightly for care home staff and monthly for residents) is adequate and has been effective in terms of identifying positive cases as early as possible. I was previously advised (in July) that should the levels of community transmission rise, then the testing regime would respond accordingly. Given the increase in community transmission, coupled with recent meetings I have held with virologists, I believe that we need to follow the regularity of testing that is currently in place in Scotland, where care home staff are tested weekly."

58. Relatedly, given there was so much urgency to assess the impact of measures and make proposals that would protect older people, which was the Commissioner's primary concern, he was not content to rely on his local network but reached out to bodies and organisations in the rest of the UK. This was initially to understand what they were doing but it quickly became a means of generating greater influence.

59. The Commissioner participated in weekly 'Four Nations meetings' that were established by the Older People's Commissioner for Wales. They took place every Friday and in addition to Commissioners, they involved the Chief Executives of: Age UK; Independent Age; Chief Executive Age Cymru; Chief Executive Care Scotland; and Chief Executive Age Scotland. The purpose of these meetings was to allow the sharing of information from individual nations on issues such as vaccination programmes, testing, lockdown experiences and learn how the devolved administrations were responding to the pandemic in comparison to the Westminster government. There was no agenda for these meetings and no formal minutes were taken as open debate was encouraged.

60. As a group they released signed joint statements on key areas where they had a shared concern and on which they were seeking progress in their own jurisdictions. This not only gave greater prominence to an issue of concern but was also a means of increasing individual leverage. These joint statements include the following, which are exhibited as **[EH/17, INQ000417337]:**

(I) The rights of older people in the UK to treatment during this pandemic

(II) Protecting the rights of older people: Commissioner's joint statement on older people being pressurised to sign Do Not Attempt CPR forms; and

(III) Relentless focus on protecting older people's rights needed as we deal with the next phase of the pandemic.

d. Supported Isolation

61. The Department of Health's *'Covid-19 Test, Trace and Protect Strategy'* published on 27 May 2020 (previously exhibited) acknowledged that testing and contact tracing will only have an impact on reducing transmission in the community if self-isolation is carried out when required. Reference is made in that publication to work being underway to develop plans for providing the support that is needed to enable people to isolate effectively, by delivering practical support with food and medicine, whilst ensuring their physical and mental health needs are met.

62. This notion of supported isolation was directly linked with the need for compliance with the TTI system. However, in my view older people were the most compliant with government guidance on isolation. As I have previously stated, they were likely to be disproportionately represented in the 'shielding category' and in the category of recipients of domiciliary care. Therefore, they were still not leaving the house and encountering mass members of the public even when the formal TTI system was adopted in Northern Ireland in and around April and May 2020. This is reflective in the fact that throughout the Relevant Period our office did not receive any complaints or concerns from older people pertaining to the TTI system.

63. In any event it is worth nothing that the support for the individuals that our organisation represents came initially from local volunteer groups and neighbours and then progressed to commercial entitles, for example supermarkets who dedicated specific shopping times for those people who were required to shield.

64. Moreover, a key concern of the former Commissioner was that lot of domiciliary care packages ceased during the Relevant Period as family members who had been furloughed were willing and considered capable of picking up the caring role.

However, when that furlough came to an end, a lot of people then struggled to get their care packages reinstated.

65. In discussing the prolonged periods of isolation that many older people were subject to during the Relevant Period it would be inappropriate to omit comment on the loneliness and isolation many of these people felt. To try and mitigate this this the office of the Commissioner for Older People for Northern Ireland conducted meetings with AgeNI, to develop the 'Check in and Chat' telephone service free of charge for the over 60's to offer reassuring calls and help for those feeling lonely or anxious. Specifically, we engaged with government on the provision of funding for the service and became involved with taking 'Check in and Chat' calls. This helpline was active throughout the first year of the pandemic.

66. The above initiative mitigated against a further concern of our office, that much of the communication from the government was by periodic announcements on the TV and more importantly, through the internet. At times the former Commissioner believed that there was an assumption that everyone would have access to the internet to get the most up-to-date and accurate information on pandemic related rules and regulations, which of course is not the case for many in the older population. Along similar lines, and directly related to TTI, the Department for Health explored digital options which were attractive to only some parts of the population. For example, a web-platform to alert users when they have been in close contacts with someone identified as a case, enable people to report and track their symptoms, order a test and input the details of their contacts themselves were all initiatives which much of the older people could not easily access as they did not feel able to navigate their way through such a platform.

III. LESSONS LEARNED

67. A key thing that I think should have been done differently, in relation to TTI, was that the Department of Health should have found a way to enable a wider network, to contribute to its work before a policy became determined and the guidance published. Put another way, the Department of Health were not immediately accepting of the advice the former Commissioner offered in relation to information

that would then go on to inform the subsequent TTI system. The result of this was a delay in the introduction of what we seen to be crucial initiatives right from the start. For example, the unacceptable delays in the implementation of appropriate personal protective equipment and tracking and testing within the care sector space.

68. Given that it was known that older people were uniquely vulnerable to Covid-19 and that significant numbers of them lived in nursing and residential care homes, in hospices or alone in their own homes with domiciliary support, an appropriate starting point before any TTI policies or systems were formulated, should have been a rapid assessment of any structural weaknesses in the sector likely to be most relevant, together with the numbers of readily available staff and the nature of the facilities. This basic information was available, but it was likely to be held across several government departments particularly the Department of Health and Department for Communities, as well as other public bodies such as Health and Social Care Boards, Public Health Agency, Health and Social Care Trusts and the Regulation and Quality Improvement Authority. In my view, the Northern Irish government was not sufficiently on top of this most basic first step, and it would have significantly assisted the timing and approach to its response to the pandemic in relation to TTI issues.

69. An important lesson is how the Northern Irish government can ensure this process is more speedily and accurately carried out. In addition to its own resources, it had a range of external sources with proven experience and capability to draw on, some of whom, like our office, not only had a statutory duty to assist but had provided reports and briefing papers commenting on inter-linked issues. There is a lesson to be learnt about how best to make use of that resource so that the implementation of all necessary measures, such as the adoption of the system of TTI, is not delayed.

70. If the government had been aware of when best to consult and about what, the former Commissioner would not have felt it necessary to come out strongly in the media to make clear that he felt that the government needed to increase the pace of decision making to introduce testing of older people in cohorted and quarantined

settings before they were discharged from hospital, as a means of restricting the transmission of Covid-19. The number of lives of older people that were being put at risk due to the lack of testing, was the most dangerous thing, where staff (including those domiciliary staff working in the community) and residents (including those discharged from hospital) were able to freely move about care homes without determining their Covid-19 status.

71. Some of the problematic TTI issues only really emerged in operation, for instance; managing hospital discharges to make best use of scare National Health Service resources and developing a programme for the tracking and testing of Covid-19 to protect vulnerable sections of the population. When the former Commissioner had reliable evidence of issues arising, he sought to draw it to the attention of the relevant authorities, usually personnel in the Department of Health. I am aware that others did so too. However, no effective mechanism was established for this, and the Commissioner was left to largely escalate concerns up to Ministers and take to the media. This is neither efficient nor ideal. It is not conducive to the trust and confidence in government that is particularly required during a pandemic for serious criticism to have to be made so publicly of the government's policies and guidance and to see resultant 'U-turns' and changes.

72. I understand the former Commissioner would have preferred to have been able to use his interactions with the media in a more supportive way and for his engagement with older people and their families to have been used more as a means of reassuring, translating, explaining and reinforcing the government's policies and guidance on TTI rather than questioning them publicly as was considered vital in the early stages of the pandemic.

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

STATEMENT OF TRUTH

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

Signed: Personal Data

Dated: ____28 May 2025_____