OPUS2

Scottish Covid-19 Inquiry

Day 34

April 17, 2024

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1 Wednesday, 17 April 2024
2 (9.45 am)
3 THE CHAIR: Good morning, Mr Caskie, can you hear me?
4 MR CASKIE: Good morning, my Lord.
5 THE CHAIR: Good morning. And good morning, Mr Smith and
6 Ms McLaren.
7 MR BRYAN SMITH and MS CATHERINE MCLAREN (called)
8 MS MCLAREN: Good morning.
9 MR SMITH: Good morning, my Lord.
10 THE CHAIR: We're all ready to start when you're ready,
11 Mr Caskie.
12 MR CASKIE: Thank you, my Lord.
13 Questions by MR CASKIE
14 MR CASKIE: I'll ask you firstly to introduce themselves.
15 Can I ask the person on the left, my left, to provide
16 the Inquiry with their name?
17 MR SMITH: My name is Bryan Smith and I'm the chief
18 executive officer of Transform Community Development in
19 Dundee.
20 MR CASKIE: And the person on my right?
21 MS MCLAREN: I'm Catherine McLaren and I'm the support
22 services manager for Transform Community Development in
23 Dundee.
24 MR CASKIE: Okay. Can you provide us with information
25 regarding your personal background within and prior to

1 working for the organisation?
2 MR SMITH: Yes. I qualified as an RMN, a registered mental
3 nurse, in 1992 and worked in various roles in Oxford and
4 in London before moving to New Zealand and working in
5 mental health services in New Zealand for several years,
6 returning to the UK in 2000. And since that I have
7 worked for Transform Community Development, formerly
8 Dundee Cyrenians, in various roles, culminating in me
9 becoming chief executive about two years ago.
10 MR CASKIE: What was your role prior to that?
11 MR SMITH: I was a project manager at one of our registered
12 accommodation roles and I was a service manager within
13 the organisation, within the senior management team,
14 running the registered services for the organisation.
15 MR CASKIE: And Ms McLaren?
16 MS MCLAREN: So I started within childcare when I left
17 school. My background isn't as extensive as Bryan's.
18 MR CASKIE: Well, you're a lot younger!
19 MS MCLAREN: Well, yes. Then I completed an HNC within
20 college and my placement was within Transform Community
21 Development. I then started as a support worker and
22 then became a senior support worker within our hostel
23 accommodations and then I became registered manager for
24 our registered services two years ago.
25 MR CASKIE: You may be aware that yesterday we heard

1 evidence from SAMH, Penumbra and Cyrenians Edinburgh and
2 therefore there is a degree of overlap between what it's
3 likely you're going to be telling us and in particular
4 what the Cyrenians were telling us yesterday.
5 MR SMITH: Yes.
6 MR CASKIE: That makes life a bit easier for all of us, but
7 can you just give us an outline of the organisation, how
8 it works, its charitable status and so on?
9 MR SMITH: Yeah. We're a charity, a registered charity,
10 with OSCR in Scotland. we are a company limited by
11 guarantee. We have three main parts of the
12 organisation. We do housing support services, which
13 combine a Housing First service based at Alasdair
14 Macqueen House in Dundee, which provides a Housing First
15 service to -- contracted by Dundee Health and Social
16 Care Partnership in Dundee, which supports around 80
17 individuals presently. So that's the main part of the
18 organisation.
19 We also have a temporary accommodation unit,
20 Brewery Lane in Dundee, which offers temporary
21 accommodation to 22 individuals within kind of -- and --
22 these are referred by Dundee Housing Department.
23 We also run the FareShare franchise within Dundee,
24 which is providing food and surplus food from the food
25 industry to charities and other third sector

1 organisations and non-profits within Tayside, Fife and
2 Clackmannanshire. And finally we have a furniture reuse
3 project, which -- we collect furniture and use that to
4 furnish people who require furniture, setting up homes,
5 as well as a shop within Dundee. So it's quite an
6 extensive operation. I believe we're the largest
7 independent charity in Dundee and we had a turnover of
8 about £2 million last year.
9 MR CASKIE: Okay, I'll ask you a little bit more about that.
10 Within the organisation, Ms McLaren, what's your role in
11 terms of where do you fit into that overall structure?
12 MS MCLAREN: So I'm the registered manager for our
13 registered services with the SSSC, which is our housing
14 services, so that's Brewery Lane, our accommodation and
15 also the Housing First project.
16 MR CASKIE: We heard evidence yesterday about what Housing
17 First is and if I can summarise that rather than have
18 you re-explain it. You can just correct me if I'm
19 wrong.
20 MR SMITH: Okay.
21 MR CASKIE: Previously the idea of dealing with homelessness
22 was that individuals would have various services
23 provided to them with a view to hoping that they would
24 be able to maintain tenancies ultimately, but Housing
25 First provides people with accommodation first and then

1 bolts on those services. Is that the pattern?
2 MR SMITH: That's broadly correct. The difference -- the
3 only thing is that that support is intensive and the
4 staff to service user ratio is much less than kind of
5 normal. It's normally -- it could be one to 40 for
6 a support worker, but we're one to five, one to seven,
7 so it gives the intensity that's required for people to
8 maintain that -- their tenancies.
9 MR CASKIE: I will ask you a bit more about the level of
10 intensity of support provided later. In terms of the
11 food support and the furniture support that you provide,
12 that was described to us yesterday as being a concern
13 for charities such as Cyrenians because those issues are
14 effectively upstream of actual homelessness. They're
15 matters which are of concern because, if you can cut
16 those off, it will impact on the levels of homelessness.
17 Is that also the approach taken by your organisation?
18 MR SMITH: Yes. I mean, we -- I think -- I mean, those are
19 there to kind of just support the local community,
20 whether those are homeless people or people who are
21 vulnerable and have other vulnerabilities. But,
22 broadly, yes, I would agree with that.
23 MR CASKIE: At paragraph 10 in your witness statement there
24 is reference to the size of the organisation and you've
25 already provided evidence as to the level of your

5

1 budget, around £2 million.
2 MR SMITH: Yes.
3 MR CASKIE: Tell me about your staffing levels.
4 MR SMITH: Staffing level, we have 38 -- I think we're --
5 when I said that, we were at 39. There's one current
6 vacancy. But we've got 38 at the moment and one
7 part-time. The majority of those are housing support
8 workers and work within the housing support services
9 within Transform Community Development. We've also got
10 admin and business support staff within that and, with
11 regards to FareShare and the furniture project, we have
12 core staff and that's supplemented by volunteers. The
13 volunteers come from a variety of channels, including
14 individuals who are staying in our hostel accommodation
15 or receiving support and looking for volunteering
16 opportunities to get them back into employability or
17 some sort of meaningful activity kind of going forward.
18 MR CASKIE: Can you give us an idea of the number of
19 volunteers that you typically had prior to the pandemic?
20 MR SMITH: We typically had kind of similar to where we are,
21 probably around 20 -- 20 to 25. It fluctuated.
22 Sometimes that goes up. It's more about volunteer
23 sessions. We have, say, 30 volunteer sessions,
24 a session being a morning or an afternoon per week, and
25 sometimes there's people who will do the whole week and

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1 other times people will do an afternoon a week. But
2 typically we're around the 20 to 25 mark of volunteers.
3 MR CASKIE: I also understand that another source of
4 volunteers is prisoners who are on day release.
5 MR SMITH: Whether they're volunteers is potentially
6 debatable, but, yeah, programmes from Castle Huntly
7 generally, which is obviously near Dundee, and the new
8 Bella Centre, which is the women's unit based in Dundee.
9 We've also had placement through youth services, such as
10 Helm, which is a youth training programme in Dundee. So
11 there's been a variety of organisations which use the
12 placements that we can offer.
13 MR CASKIE: Now, I will ask you about the role of volunteers
14 or the roles of volunteers later, but at this stage I'm
15 just looking at numbers. What happened to the number of
16 volunteers during the pandemic, during lockdowns?
17 MR SMITH: They jumped up significantly. They jumped up
18 significantly for two reasons. There was a degree of
19 people looking for stuff to do and kind of to try and
20 help out within the pandemic. There was also an
21 increase of food, so we required more individuals to be
22 on hand to help distribute the food that was coming
23 through, whether that was bought food in the sense that
24 the Scottish Government and other kind of agencies were
25 providing money to buy food or whether that was donated

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1 food from the food industry.
2 MR CASKIE: Again I'll ask you about that aspect of the
3 organisation in a few moments. You told us about your
4 budget and you've given us an idea of the scale of
5 staffing and the volunteering. Where do you get your
6 money?
7 MR SMITH: There are three different -- well, four different
8 elements for the organisation. Within the housing
9 support we are contracted by Dundee Health and Social
10 Care Partnership and get money to provide the support
11 through a contractual arrangement with them. Within
12 Brewery Lane, there's also -- we charge rent and that's
13 generally paid through housing benefit.
14 Within FareShare, we generate most of that money
15 ourselves through a charging fee. So basically there's
16 different models within the FareShare family, if you
17 want to call it that, and we basically charge £2.50 for
18 a tray of food, which would typically be about £30 to
19 £35 worth of produce, and that covers kind of storage
20 and delivery, et cetera. Other organisations do
21 a membership fee for that. We also get some money from
22 the Scottish Government for kind of central roles within
23 that. We also do occasional fundraising for FareShare
24 as well.
25 Within furniture, furniture is a purely commercial

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1 operation. We collect furniture and we have a contract
2 with Dundee City Council regarding the referral of
3 furniture on to people who require it. But that depends
4 on need. So the other thing we do is we sell the
5 furniture to the general public and -- whether that's
6 through our shop or we find interesting items that we
7 might sell on an Etsy website kind of -- yeah.
8 MR CASKIE: The valuable stuff?
9 MR SMITH: The more valuable stuff, yes.
10 MR CASKIE: At paragraph 19 you give us an idea of the
11 sources of your funding.
12 MR SMITH: Yes.
13 MR CASKIE: That indicates mostly from HSCP. Is that grant
14 funding?
15 MR SMITH: It's a contract. So we have to -- every year
16 that's renewed on the basis of us meeting KPIs specified
17 within the contractual arrangement.
18 MR CASKIE: And you also receive money by way of housing
19 benefit?
20 MR SMITH: For Brewery Lane, yes.
21 MR CASKIE: For Brewery Lane.
22 MR SMITH: Just to clarify, because the people in
23 Housing First, it's their own tenancy so they make their
24 own applications and payments for their housing benefit.
25 MR CASKIE: We know what Housing First is. Can I ask you,

1 Ms McLaren, to have a look at your witness statement, if
2 those behind me are able to jump to that, and can I take
3 you to the section at paragraph 18, where you, as
4 effectively a front-line worker, provide us with a bit
5 more detail. Some of this may have been superseded
6 since you gave the statement so we'll get that
7 information from you just now.
8 "At the beginning of COVID we were running three
9 hostels ... "
10 So tell me about the three hostels.
11 MS MCLAREN: So we had a direct access hostel,
12 Soapwork Lane, which was 33 rooms, four self-contained
13 flats, with communal toilets. There was already a plan
14 in place that Soapwork Lane would be decommissioned and
15 the monies -- the contract money that we received for
16 Soapwork Lane would be redirected so we could carry out
17 the Housing First project rather than have the money
18 spent within a hostel accommodation. That was through
19 the rapid rehousing transition plan for Dundee City
20 Council. So that was already closing, so we
21 decommissioned that right at the beginning of COVID --
22 right at the beginning of lockdown actually -- and then
23 we had the Seagate Project, which was 15 self-contained
24 flats. We just decommissioned the Seagate two years --
25 MR SMITH: We decommissioned that on 31 March 2023.

1 MS MCLAREN: 2023. That was for -- that was people's own
2 tenancies and for people with long and enduring mental
3 health issues, but there was staff in there to support
4 24/7. Then we also have and still have Brewery Lane,
5 which Bryan has already discussed there. It was 22
6 self-contained flats.
7 MR CASKIE: And the closure of Soapwork Lane and the
8 Seagate Project, were those decisions taken
9 independently of COVID?
10 MS MCLAREN: Yes. I think there was discussions --
11 Soapwork Lane was always closing because the
12 Scottish Government and Dundee City Council were in
13 agreement that hostel accommodation is not appropriate
14 anymore for somebody to be living like that when they're
15 homeless, especially for the periods of time that we
16 were seeing people living within our accommodation --
17 shared bathrooms, et cetera, shared kitchen areas, it
18 just wasn't appropriate anymore. It's no way for
19 somebody to be able to graduate on to be able to sustain
20 tenancy. So that was always the plan to close
21 Soapwork Lane. There was discussions to keep
22 Soapwork Lane open or extend because of the pandemic and
23 because of lockdown, however we didn't agree that it
24 would be appropriate to keep people who are having to
25 isolate or having to stay within a small bedroom and

1 have shared bathrooms in the middle of a pandemic, so we
2 carried on with the closure of Soapwork Lane.
3 MR CASKIE: You talk about the closure in paragraph 20 of
4 your witness statement.
5 MS MCLAREN: Yeah.
6 MR CASKIE: Again, can you just tell us about that and the
7 timing in particular?
8 MS MCLAREN: Yeah, so it was an amazing time to be closing
9 one service and starting a new service. It was right at
10 the start of the first lockdown and so, when we closed
11 Soapwork Lane, people were redistributed to other
12 accommodation or into their own network flats. So staff
13 there were predominantly -- once the building started
14 becoming quieter and quieter, because we had the same
15 staff number, the same staff team -- staff there were
16 predominantly supporting people in moving out and
17 getting them settled within their new accommodations.
18 And then we were then recommissioned to carry out
19 a Housing First base service, which actually was really
20 beneficial. Because we didn't have a caseload as such,
21 we weren't exactly sure what we should have been doing
22 from our contractors because everything was kind of up
23 in the air because of the pandemic. We were then able
24 to really target those who had kind of been forgotten,
25 I suppose, so it was our beggars within our city.

1 That's where our team really focused our time. So we
2 just went into town and communicated with our beggars,
3 made sure that they were aware of what was happening,
4 made sure they were getting access to what they needed
5 to get access to. And we also then started supporting
6 chemists because at that time there was no plan in place
7 for some of our participants who maybe are on an opiate
8 substitute treatment for their addiction -- there was no
9 plan in place for them to be able to pick up their
10 prescriptions daily, so the chemists very quickly came
11 up with a time that people had to come --
12 MR CASKIE: An appointment system?
13 MS MCLAREN: Yes, an appointment system, which wasn't the
14 best because the people we support don't have -- they
15 don't keep appointments. They've got other more
16 important things to be doing. So that was staff really
17 supporting with that. Staff then started taxiing
18 prescriptions --
19 MR CASKIE: Explain the taxi.
20 MS MCLAREN: Yes, so staff -- to support the chemists and to
21 support our service users from I suppose being at the
22 chemist and shouting and all of the arguments that
23 started to happen within the chemists with our
24 service users and members of the general public --
25 because there was two separate queues, so it made our

1 service users stand out like a sore thumb -- staff then
2 started to support -- to actually go to the pharmacy and
3 pick up the prescription and take it to the participant
4 rather than the participant going to the pharmacy.
5 MR CASKIE: I think the description given of that in your
6 witness statement by Mr Smith is that they acted as
7 bouncers at the chemist.
8 MS MCLAREN: We were -- staff were, absolutely. Because the
9 pharmacists insisted on having two individual queues --
10 so there was a queue for the general public who were
11 maybe there to pick up, I don't know, their own type of
12 prescription and then there was a completely separate
13 queue for people who were there to pick up methadone, so
14 it caused issues. Members of the public were unhappy if
15 somebody who was picking up methadone was getting in
16 because why should they get in before them and our guys
17 felt like they were treated like second-class citizens.
18 So, yeah, it wasn't nice.
19 MR CASKIE: Did that remain the situation until the end of
20 the pandemic?
21 MS MCLAREN: Pretty -- in some pharmacies yeah, yeah.
22 MR CASKIE: And in others were you able to negotiate
23 a single queue?
24 MS MCLAREN: No. No, there was no negotiating on the single
25 queues. If it was a queue system, it was two separate

1 queues. But other pharmacies changed to the appointment
2 times, which I suppose made it a little bit easier for
3 those who were able to keep the appointments.
4 MR CASKIE: At paragraph 24, Mr Smith, you provide some
5 information about the background to Housing First, which
6 is quite interesting, about the Helsinki experience.
7 Tell me about the Helsinki experience.
8 MR SMITH: Well, Finland and Scotland to some extent have
9 been at the forefront of kind of developing kind of much
10 more empathetic housing support services and, whilst
11 Housing First was developed initially in the US, the
12 Finns took it on on a slightly different basis and had
13 congregate housing, where there was a group of housing
14 all in the same area where people were kind of in
15 housing first, but the idea was roughly that you're
16 giving people their own accommodation very, very
17 quickly.
18 What they'd done in Helsinki was they looked at all
19 the hostels, et cetera, they had and basically diverted
20 resources -- not all of them, there are still some of
21 them -- but they rediverted that into Housing First and,
22 with that, it meant people were able to get access to
23 kind of a house quicker and not be in hostel
24 accommodation. So what it meant, that hostel
25 accommodation was only really ever used for real

1 emergencies. So if someone's partner kind of threw them
2 out at 2.00 in the morning, then they could go somewhere
3 because you wouldn't be getting a new house at that
4 point, but it was very short term and kind of a very,
5 very limited number. I think I said 14 or 15.
6 MR CASKIE: You said there were 14 in Helsinki.
7 MR SMITH: 14 or 15, yeah, in Helsinki, for the whole
8 metropolitan of Helsinki at one point, yes.
9 MR CASKIE: In terms of mirroring or learning from the
10 Helsinki experience, how many emergency beds do you
11 have?
12 MR SMITH: Well, as an organisation, we are trying to get
13 rid of beds and kind of -- and try and move to this
14 Housing First model. There are still some beds in
15 Dundee and, off the top of my head, I'm thinking
16 approximately 40/45/50.
17 MS MCLAREN: About 70.
18 MR SMITH: Is it 70? Okay.
19 MS MCLAREN: Including number 22.
20 MR SMITH: Okay. But the plan is to move them, and that was
21 the plan of the RRTP --
22 MR CASKIE: RRTP?
23 MR SMITH: -- which is the Rapid Rehousing -- Dundee City
24 Council's Rapid Rehousing Transition Plan, and the plan
25 was always to move to as few hostel beds as possible and

1 having people living -- whether that was in a Finnish
2 model, ie a block of flats with support on site but it
3 was their own tenancy, or whether that was dispersed
4 more like the American model.
5 Q. At the moment, what are Dundee doing? Do they have
6 blocks of flats that people move to or is it a more
7 dispersed --
8 MR SMITH: It's more a dispersed model. We're in discussion
9 with them about using our Brewery Lane accommodation as
10 that, but there's some legal issues that we need to kind
11 of get over regarding the ownership of the building.
12 But, I mean, I think there is a will to do that, but
13 it's complicated by the fact of who owns the building
14 and the site, et cetera.
15 MR CASKIE: Is there a strategy -- obviously coming together
16 right at the start of the pandemic with the closure of
17 one of the hostels, is there a strategy to bring the
18 number of emergency beds down?
19 MR SMITH: Well, where we are at the moment -- so the RRTP,
20 the Rapid Rehousing Transition Plan, started and we
21 got -- at the start of that we got -- we received
22 funding from Social Bite, the Corra Foundation and the
23 Scottish Government to do the pathfinder for
24 Housing First. So that in a sense was a catalyst to
25 bring Housing First forward in the transition plan

1 which, had initially been in about year 3 or 4, but
2 suddenly using that money was brought forward.
3 With that, the idea at the end of the five years,
4 there would be very limited beds. Exact numbers were
5 a bit kind of woolly, but the idea was to kind of look
6 at transferring temporary accommodation into
7 accommodation which people could then -- be their own
8 accommodation. Obviously the pandemic came around at
9 the end of year 2 of the transition plan, so in year 3
10 the plan was to shut Jessie Devlin Close or
11 Soapwork Lane and we did.
12 I mean, the pandemic obviously had played havoc with
13 the strategy and the strategy went out the window
14 a little bit and in essence the strategy should have
15 ended and a new one been in place from 1 April this
16 year. Because of the disruption of COVID and the
17 effects it's had, et cetera, the plan has been given an
18 extra year and a new plan will be published, as with all
19 local authorities --
20 MR CASKIE: In due course?
21 MR SMITH: Not in due course. For the end of -- well, it
22 may be in due course, but it should be by the end of
23 this financial -- the current financial year. So from
24 1 April 2025 the successor to the RRTP should be in
25 place and should be taking -- moving on from the

1 position that we ended up at RRTP. But the direction of
2 travel is very much that Housing First is a remedy for
3 people who have traditionally been in the revolving door
4 of homelessness and have been excluded kind of from
5 mainstream accommodation and kind of have been kind
6 of -- the public have maybe been a bit wary of -- "Well,
7 where are you going to put these people who are using
8 drugs and are homeless? Where are you going to put them
9 in the community?". The answer is it's about enriching
10 that community further, and we've got statistics and
11 figures that show that Housing First is a better option
12 in mainstream accommodation; for example, sustainability
13 levels of Housing First are beyond normal accommodation.
14 MR CASKIE: I think in your statement you provide that
15 information about the increased level of sustainability.
16 MR SMITH: Yes. Yeah, and it's a marked increase. We work
17 with individuals who have had 12, 13, 14 homeless
18 presentations over the years and have now been in
19 accommodation, the same accommodation, for
20 18 months/two years without any great issue. So it's
21 about kind of giving people responsibility and letting
22 them become active members of their community rather
23 than kind of a different -- this homeless drug-using
24 community and the other.
25 MR CASKIE: I will come back to the housing services and

1 I'll ask more questions of you, Ms McLaren, but I want
2 to move on to the other aspect of the work that you do
3 and I would draw your attention to paragraph 27 in
4 Mr Smith's statement. So this is FareShare. That's
5 about 20% of the work that you do?
6 MR SMITH: In budgetary terms, yes.
7 MR CASKIE: And at paragraph 28 you provide information
8 about the geographic area over which your organisation
9 deals with FareShare --
10 MR SMITH: Yeah.
11 MR CASKIE: -- or does FareShare. Tell us about that
12 geographic range.
13 MR SMITH: So the geographic range is kind of the old local
14 regional authority area of Tayside, which is Perth and
15 Kinross, the City of Dundee, Angus. We also deliver to
16 the whole of Fife and Clackmannanshire. So we've got
17 five local authority areas and, although we're kind of
18 in the middle, there is kind of large areas of
19 hinterland, the majority of our food goes in kind of the
20 main urban areas there, being Dundee, Perth and the
21 south of Fife, so Dunfermline, Kirkcaldy, that area.
22 But we do go up to Montrose. We have people up in
23 Pitlochry, Blair Atholl, so it does go quite a way.
24 MR CASKIE: You tell us how that's organised, as it were, in
25 staffing terms at paragraph 29. Can you tell us about

1 that?
2 MR SMITH: Yeah. So basically we have a core group of staff
3 who run the warehouse, and running the warehouse means
4 getting the -- organising the deliveries of the surplus
5 food in, supporting the volunteers to sort that surplus
6 food, doing waste, kind of sorting out what waste is
7 there, what we can use, setting up orders. So we phone
8 all the -- what they're called, community food members
9 or CFMs -- we phone them the day prior to their delivery
10 and say, "This is what we've got. What would you
11 like?". So kind of we give people the choice of what
12 we've got, and it's primarily food, but we are kind
13 of -- we have done -- we do get kind of pet food at the
14 moment and sometimes we take whatever comes in. So
15 sometimes there's stuff that isn't technically food but
16 is stuff that people may want. And it's generally --
17 the volunteers generally do the driving and they go out
18 with two or three volunteers within a van. We've got
19 12 routes planned throughout the week and those routes
20 kind of go through kind of the different areas,
21 delivering food to the 154, currently we have, community
22 food members right across the region we've talked about.
23 MR CASKIE: So those community food members, they're what
24 you might call local hubs rather than individuals?
25 MR SMITH: They're not individuals. You call them local

1 hubs, you can call them -- it can be a pantry, a food
2 pantry, it can be -- not so much now -- food banks, it
3 can be an after-school club, it can be a nursery club,
4 church groups.
5 MR CASKIE: Hubs?
6 MR SMITH: Hubs, yeah.
7 MR CASKIE: Tell us about the availability of food resources
8 during the pandemic.
9 MR SMITH: Food resources that we were able to deliver went
10 up. There was a real push from the food industry and
11 from kind of Government to increase the level of food
12 and to kind of prevent -- make sure that people were
13 nourished, et cetera, so we'd seen a vast increase in
14 the amount of food delivered to us. And because there
15 was an established network through FareShare, the
16 Scottish Government and other organisations, Dundee City
17 Council, et cetera, used that network to distribute food
18 to kind of the communities around the city and the wider
19 region.
20 MR CASKIE: You've got a lot more food coming in during the
21 pandemic. How are you able to get it out?
22 MR SMITH: We needed a lot more people, so we put out a call
23 for volunteers and volunteers came. We also --
24 furniture, because there was no new tenancies coming
25 online because there was -- we couldn't open our shop

1 during the pandemic -- I mean, we turned the resources
2 we had within furniture over to food as well. So we
3 were able to kind of increase the amount of food we were
4 getting -- we were processing really.
5 MR CASKIE: At paragraph 33 you make, in the last sentence,
6 a comment about the role of your work in infection
7 control. Can you just read the last sentence?
8 MR SMITH: "I would like to think that it minimised
9 infection rates because it meant that people were not
10 having to go out as much and people were able to access
11 food in a timely manner."
12 MR CASKIE: Then, at paragraph 35, you talk about using the
13 food resource as a hook. Tell us about that.
14 MR SMITH: Yeah, well, there was a lot of people out there
15 struggling with loneliness or with kind of inactivity or
16 kind of other issues, whether that was drug addiction,
17 mental health issues, and using the food was -- and
18 a lot of people weren't able or didn't know what service
19 to access. So by using the food, individuals were able
20 to say, "Well, you're also -- FareShare are also
21 Transform Community Development", and we were able to
22 get in and maybe talk to people about other issues that
23 were happening in their life, and it was the food that
24 made that initial contact with people.
25 MR CASKIE: Now, I've said that we've heard a lot about

1 Housing First and other things. We haven't heard,
2 I don't think, very much about what you talk about at
3 paragraph 36, which is cash first. Tell us about cash
4 first.
5 MR SMITH: Well, the idea of cash first is the idea of not
6 just giving people food. It's about kind of dignity, so
7 it's about saying, "Well, the first option if people are
8 requiring food is that there should be some element of
9 a transaction with that", and so we're -- because the
10 idea is if you give people -- if you just give people
11 food, it lacks choice, there's kind of less dignity,
12 et cetera, so the move is that we're moving to a more
13 cash first model.
14 Now, what that cash looks like doesn't necessarily
15 mean it's the same price, but it's about kind of saying
16 to people, "The food you're getting isn't just somebody
17 is giving you it out of the goodness of their heart or
18 out of charity, it's actually food that you've bought
19 and you can say you've bought", so that's kind of the
20 model that the Scottish Government are keen to promote,
21 that it's not just giving people meals; it's about
22 sustaining that and getting people back into buying
23 food.
24 MR CASKIE: At 37 and 38 you move on to consider the part of
25 your work relating to furniture. Could you summarise

1 that for us, please?
2 MR SMITH: Well, at the moment what we do is we collect
3 furniture in the Dundee area, generally furniture that
4 can be sold or put on referral without very much work --
5 maybe a clean, kind of small repairs. So the referral
6 system is anybody who requires furniture for moving into
7 new accommodation. A certain amount of referrals can
8 put in referrals and say that they need a bed, this,
9 that, and we make up that pack for them and deliver it
10 to them. The other part is that we kind of just sell it
11 to the general public in a shop and, as I say, we've got
12 more high-end stuff that we can sell online if that
13 comes on. The idea of that is -- I mean, the first bit
14 is about supporting people into their own tenancies and
15 making the house they are given into a home and the
16 other bit is kind of making more resourceful the
17 organisation so we can kind of develop other services.
18 MR CASKIE: How was that service impacted by the pandemic?
19 MR SMITH: As I said -- I mentioned it quickly before --
20 basically that ended. We weren't able to go into
21 people's houses to collect furniture. People weren't
22 buying furniture because they couldn't get out to shops.
23 People didn't have any furniture to go away because they
24 couldn't buy new furniture, so basically that ended.
25 MR CASKIE: I understand that one of the ways that you would

1 normally work is to provide furniture to people who are
2 allocated housing from a housing association or the
3 local authority and that basically was effectively a big
4 starter pack.
5 MR SMITH: Yes.
6 MR CASKIE: Is that right?
7 MR SMITH: Yeah, and that stopped also because, obviously,
8 when the pandemic hit, there was no real allocation of
9 housing, so there was nobody moving into houses to
10 need -- require furniture. People were stuck in hostel
11 accommodation, temporary accommodation.
12 MR CASKIE: I'll come back to that. We'll get to that.
13 I think the phrase that you use is "gummed up".
14 MR SMITH: Yes.
15 MR CASKIE: We'll get to how it became gummed up.
16 You take an overview of the impact of COVID-19 on
17 the organisation starting at paragraph 39 and you say
18 there, amongst other things, that you think that the
19 organisation had a good pandemic.
20 MR SMITH: I think we were very -- if you look at it
21 financially we had a very positive experience. We've
22 seen more people being supported, more people being
23 helped. We were very, very lucky in the sense that we
24 had very little direct impact from the actual
25 infection -- I mean staff. We had the odd member of

1 staff going off and isolating, et cetera, for the odd
2 period, but we had nobody who was really ill.
3 We were really concerned at the start of the
4 pandemic that -- we were working with a group of people
5 whose lifestyles may not be the most healthy and may be
6 kind of disproportionately impacted by kind of a virus
7 going round and we were very, very lucky in that way.
8 But if you looked at it in the sense of the money that
9 was -- and the resource and the responsibility that was
10 given to the organisation by the local authority and
11 Scottish Government, I think we had a very positive
12 pandemic. Not that I would want another one.
13 MR CASKIE: I'll come back to that.
14 MR SMITH: Yeah.
15 MR CASKIE: At 42 you say that nobody furloughed.
16 MR SMITH: Yes.
17 MR CASKIE: That was across the whole organisation?
18 MR SMITH: Yeah, as I say, we reallocated -- as I mentioned
19 previously, we had reallocated individuals who were
20 working in furniture into FareShare, and that kind of --
21 that's how --
22 MR CASKIE: I think you mentioned that there was one person
23 who was furloughed for a week.
24 MR SMITH: Yeah, that was the shop manager and she came back
25 and helped with the organisation of the orders,

1 et cetera, doing some admin work there.
2 MR CASKIE: In terms of food or in terms of --
3 MR SMITH: In terms of food, yeah. Everybody, basically --
4 we just -- not quite, but we just shut the door on the
5 furniture for the period and kind of -- and it slowly
6 came out of hibernation as houses became available
7 again, and then we were able to kind of take bits and
8 pieces out the warehouse and kind of furnish people's
9 homes.
10 MR CASKIE: At paragraph 43 you talk about the different way
11 in which you were working and that you were no longer
12 going into people's houses. Tell us about that.
13 MR SMITH: Well, the staff were very inventive on how they
14 were dealing with people. We still had housing -- kind
15 of housing support going on in the community and in the
16 buildings, but it was much more hybrid, so we were maybe
17 meeting people outside in gardens, in kind of -- there
18 was cases of through windows that people were meeting --
19 were meeting people. We were doing drops of food, of
20 electricity cards, SIM cards -- what do you call it? --
21 top-ups, et cetera, for phones. We had one person we
22 did have to go into their house, just because of their
23 situation, but we were looking at different ways to meet
24 people. And people were genuinely receptive to it
25 because they were appreciative of the support and

1 required that support because it was about -- one of the
2 biggest issues we had was people being socially isolated
3 at that point and it was kind of -- it was a way that
4 people could have a social interaction, especially if
5 they couldn't do things like they would normally do,
6 like, as Ms McLaren said, go to the chemist, which could
7 be at times a social hub for people kind of coming --
8 meeting others at certain times of day, et cetera. So
9 those things were taken away.
10 Things like DDARS, which is the Dundee Drugs and
11 Alcohol Recovery Service, their building was shut, so
12 places where people would -- our client group would
13 generally kind of congregate and meet, they were all
14 shut, so this was sometimes the only social contact that
15 people had. So different things for different people,
16 but there was a whole host of things. We were also able
17 to give --
18 MR CASKIE: I think you skipped over there that these were
19 the only kind of social contacts that people had. So
20 during the pandemic, did your staff fill that gap?
21 MR SMITH: For some people, yes, they did. Yes, they did.
22 It was -- a lot of the individuals we work with have
23 little to no family contacts, so their social group are
24 individuals and some were (inaudible) to them. It can
25 be -- they can be quite fractious, some of those groups,

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1 and they kind of fall apart and come back, so keeping
2 people out of contact with others was causing people
3 kind of real social isolation.
4 MR CASKIE: And at 45 you talk about going to chemists and
5 your staff acting as bouncers --
6 MR SMITH: Yeah.
7 MR CASKIE: -- at the chemists, and I think you've already
8 explained that pretty fully --
9 MR SMITH: Hmm-hmm.
10 MR CASKIE: -- but just to get the cross-reference in to
11 your statement. At 46 you talk about delivering
12 medication to people who couldn't go.
13 MR SMITH: Yeah, I would say -- I'm reading slightly ahead
14 to 47 and that would be something that would
15 obviously -- in a non-pandemic time might be, "Well, you
16 can't be taking methadone, sticking it in your car and
17 taking it up to someone's house". But there was that
18 can-do attitude at the time and kind of how do we make
19 sure that people -- the vulnerable people in our
20 society -- how do we make sure that they're supported
21 and what can we do to do it. There was a real attitude,
22 "Well, not let's throw the rules out the window but
23 let's see where we can work within the bounds of
24 legality to make sure that people are safe, people are
25 supported and people are secure".

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1 MR CASKIE: And I think, Ms McLaren, you describe two
2 occasions upon which there was police contact as
3 a result of users of your service coming into contact
4 with the police about drugs. Tell me about that.
5 MS MCLAREN: So thankfully we have a really good
6 relationship with our local police officers and they
7 will give staff a call from time to time to say that
8 they have seen Joe Bloggs in the city centre, he
9 shouldn't be in the city centre, et cetera. So this
10 happened on a couple of occasions during the pandemic,
11 and normally our guys would be in the city centre to buy
12 substance to make themselves feel better, I suppose,
13 because they have obviously a physical addiction. But
14 the police thankfully took a soft approach to that
15 during the pandemic and they would call the key worker
16 to say, "Joe Bloggs is in the city centre. They know
17 they shouldn't be here. We've just had a word with
18 them, but would you like to come down?". So staff were
19 able to sort of minimise the impact of that very
20 quickly.
21 MR CASKIE: You refer to that at paragraph 54 of your
22 statement and I think there's also reference in
23 Mr Smith's witness statement at paragraph 107. The
24 document -- the people who are producing the documents
25 are earning their wages today. You, Mr Smith, at

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1 paragraph 107 of your statement, talk about a great
2 relationship with the police.
3 MR SMITH: We had a great relationship with both the officer
4 on kind of -- on the street as well as kind of higher up
5 at inspector level -- I think that's what her role is --
6 inspector level. So there was that kind of more
7 strategic view that they weren't looking at this as
8 crime, they were looking at this as how can they support
9 these individuals. Whilst it was really highlighted
10 through COVID -- and I would say generally that
11 relationship was there prior to COVID and remains --
12 kind of remains now, but it was really kind of brought
13 into sharp focus during COVID.
14 MR CASKIE: From reading the witness statement from each of
15 you, I make notes as to things to say to you and one of
16 the things that I've noted down is, "Was it
17 a metaphorical clip round the ear?".
18 MR SMITH: Yeah, yeah, and that also happened on several
19 occasions. They would come up especially to
20 Brewery Lane and say, "Look, we've seen so-and-so doing
21 this and doing that. Could you just tell them not to
22 because next time we might have to do something". But
23 there was never any point, as far as I can recall, where
24 anybody was ever arrested or kind of any formal action
25 was taken against any of our service users because we

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1 all -- right at the start of the pandemic we didn't
2 think that they might be the most compliant of our
3 citizens.
4 MR CASKIE: And what was your experience?
5 MR SMITH: Much -- pleasantly shocked, I think.
6 MR CASKIE: Not just surprised, shocked?
7 MR SMITH: For some people -- some people, shocked, yes.
8 Yes, we had occasions where staff had to kind of have
9 words about people going into other's rooms and that,
10 but some individuals who have led very chaotic
11 lifestyles continued to live -- we'd say, "You have to
12 isolate for ten days", and they would isolate for ten
13 days, not a problem. And we said to them, "We're
14 shocked". But, yeah, it was all very positive and
15 I think they took it -- they kind of bought into the
16 Public Health narrative, that kind of, yes, this was
17 dangerous. Whether it was out of kind of concern -- you
18 know, they've got concern for each other and concern for
19 the staff group, so I think they --
20 MR CASKIE: One of the things that we heard yesterday,
21 I think from the Cyrenians, was that people were
22 surprised at the level of buying-in by the user groups
23 but also that people were surprised by users
24 demonstrating abilities that they were not known to
25 have, for example, people going to the shop on their own

1 when previously they required support. Is that
2 something you're able to speak about?
3 MR SMITH: We did see -- I think our service user group have
4 a remarkable degree of skills and abilities that are
5 often kind of masked because of their drug use or kind
6 of ongoing mental health issues, and I think there was
7 situations where people -- I think it was more
8 a self-realisation that they didn't need the support
9 that they thought they needed. So, yes, we did see
10 people kind of blossoming during the pandemic in the
11 sense that we did see people doing things that they
12 didn't feel that they were maybe able to do pre-pandemic
13 and, because of circumstances, had to do.
14 MR CASKIE: There was a concern expressed yesterday by the
15 person who gave us that evidence that that might impact
16 on funding, in the sense that if someone is able to go
17 to the shop or the chemist on their own, then they don't
18 need you to help them do that.
19 MR SMITH: I would -- whilst I get that, I think that --
20 I suppose there's -- unfortunately, there is some --
21 there's generally referrals in the system and I would
22 like -- as an organisation, I'd dearly like to see us
23 shut down because there's no need for our service
24 because everybody is kind of -- there's no homelessness,
25 there's no drug issues. So if one person moves on,

1 that's a success for the organisation, that's a success
2 for the person, that's a success for the staff group,
3 and then -- but unfortunately there's someone generally
4 coming up behind. And the way -- we generally work
5 with -- we're doing housing support, so it's generally
6 more transient than maybe some care roles, where kind of
7 I could see that being a concern.
8 MR CASKIE: At 48 and 49 in your witness statement,
9 Mr Smith, you provide two other examples of how it might
10 be described that you had a good pandemic. Tell us
11 about that.
12 MR SMITH: Well, as we said, there was a greater number of
13 groups requiring food. Both the local government and
14 the Scottish Government were putting money forward to
15 buy, purchase, food. So some of the things that you
16 don't always -- one thing about FareShare, you can't
17 predict what's coming in because it's surplus from the
18 food industry, and so it can't be 25-litre tins of
19 Bovril and it can't be things that you can't get out.
20 So the Government and local authority bought food. So
21 that -- so at the minute we generally don't buy food and
22 we didn't buy food prior to the pandemic. So, with
23 that, it just increased the amount of food, the physical
24 amount of food, that was coming through the warehouse.
25 Now, obviously, the same charges kind of --

1 different charges apply, but some of those same charges
2 applied, so therefore income to the organisation went up
3 to deliver this food, and at times there was nowhere --
4 we were putting some of the ambient food in kind of
5 clearing areas in the other warehouse we have, which was
6 predominantly furniture, to kind of put ambient food in,
7 so we had enough room to do it --
8 MR CASKIE: So it wouldn't go off?
9 MR SMITH: So it wouldn't good off. Some local authorities
10 hired warehouses. They hired the warehouse in Perth and
11 Kinross, for example, that we shared with Perth and
12 Kinross Council as another hub that we could deliver
13 food from. So there was -- just the amount of food that
14 was around was kind of -- it went up -- I can't give
15 exact numbers, but it went up by kind of over 100%.
16 MR CASKIE: Okay. I want to move on to paragraph 52 in your
17 statement, Mr Smith, where you talk about visiting.
18 MR SMITH: Yeah.
19 MR CASKIE: You talk about:
20 "During the pandemic we were only going out to visit
21 and check on people who were known to us as an
22 organisation ..."
23 So you weren't effectively taking on new clients,
24 although there were exceptions to that?
25 MR SMITH: Yeah.

1 MR CASKIE: Can you tell us about the exceptions?
2 MR SMITH: The exceptions would be that people would --
3 I suppose -- you know, the way Housing First works is
4 that Housing First predominantly is about getting people
5 a new house, but obviously there wasn't kind of
6 tenancies being offered during the pandemic so we were
7 working with people -- we were occasionally working with
8 people who were in housing crisis but currently within
9 a tenancy, so those would be discussed with Dundee
10 City Council Housing Department, that people were
11 potentially at risk of -- I know people weren't
12 affected, but their behaviour was such, it was causing
13 alarm to neighbours, et cetera. So it was about kind of
14 people who were in some sort of crisis during that
15 period but in their own flat. So part of the
16 Housing First, ie getting people a tenancy, wasn't there
17 but the ongoing support was there.
18 MR CASKIE: Okay, that was useful, but the reason I asked
19 you about visits was to ask: did they continue during
20 the pandemic? Were you still knocking on people's
21 doors?
22 MR SMITH: Yes.
23 MR CASKIE: I see at paragraph 52 you talk about the
24 connection with the Social Work Department. Tell us
25 about that in the context of knocking on doors.

1 MR SMITH: Well, we were one of the -- especially at the
2 very start, we were one of the few services who were
3 still going out to see people and a lot of things were
4 done over phone calls, done over kind of Teams, Skype,
5 whatever -- so we were one of the few people going out.
6 So sometimes Social Work were saying, "Could you
7 have a look in on this person? Are they there?
8 Are they ..." -- so there was some joint work with --
9 MR CASKIE: Would that normally be something that
10 Social Work would do themselves --
11 MR SMITH: Yes.
12 MR CASKIE: -- outside the pandemic?
13 MR SMITH: Yes. We would look at -- in a sense we would
14 support our clients and Social Work would support their
15 clients, but during the pandemic we done some -- as
16 I said there, eyes and ears. We weren't doing full
17 assessments, but we were just going in and saying,
18 "Yeah, we've seen them. They're fine. They're
19 managing. They need this, they need that". But
20 Social Work weren't going out at the start of the
21 pandemic.
22 MR CASKIE: One of the things we heard yesterday from
23 I think two of the people who provided evidence was that
24 the statutory authorities pulled back and left you or
25 those organisations to fill that gap. Was that your

1 experience in Dundee?
2 MR SMITH: Yeah, that was certainly our experience. And
3 there was a lot of, "Well, you can do that, you can do
4 that, you can do that", and whilst that can-do attitude
5 was great, sometimes we were the ones kind of jogging on
6 the spot, so to speak.
7 MR CASKIE: Ms McLaren, can I ask you to look at 27 in your
8 witness statement? I think you say something about
9 a similar area there. Could you say some more about
10 what's in 27, please?
11 MS MCLAREN: Yeah, so that's discussing about the wait times
12 for -- if someone presents to DDARS, Dundee Drug and
13 Alcohol Recovery Service, for OST, so the opioid
14 substitute treatment --
15 MR CASKIE: Methadone?
16 MS MCLAREN: Yes, so methadone or Subutex or something along
17 those lines. Pre-pandemic you would be given an
18 appointment, you would then be given things called --
19 it's called a "drug diary", where you would have to list
20 everything that you'd -- all substances that you'd used
21 in that day and at what times and your thoughts and
22 feelings before and after use, and there would be pages
23 of this. So you would have to do this for sometimes up
24 to three months, where you would at times see another
25 worker from DDARS during this period of time. However,

1 during the pandemic, one of the real benefits, that
2 completely stopped because there was no staff within
3 DDAR, the building was closed. Nobody was seeing
4 anyone, so the really good thing was staff were able to
5 call and say, "This person, Joe Bloggs, needs
6 a prescription. This is how they're presenting.
7 They're in withdrawals. This is how much they're using
8 per day", and very quickly Joe Bloggs was given
9 a prescription at a chemist, sometimes within 24 hours.
10 MR CASKIE: I imagine from what we've heard, that for people
11 with particularly drug problems, keeping a diary for
12 three months is not going to happen.
13 MS MCLAREN: No, and it didn't. It never happened. It was
14 a massive barrier for people. Also the people we work
15 with when --
16 MR CASKIE: Sorry, you said it never happened?
17 MS MCLAREN: I have never known anybody to complete the
18 three months' diaries, never.
19 MR CASKIE: Was that the mechanism by which people were able
20 to access methadone?
21 MS MCLAREN: Yes. So there was just -- there was always
22 a step back, it was always a step back and it was
23 always -- it was a fight. It was a fight to get people
24 to be able to gain prescription pre-pandemic.
25 MR CASKIE: But during the pandemic that changed?

1 MS MCLAREN: Absolutely, it turned completely on its head
2 and thankfully -- we are starting to creep back up to
3 a small waiting time now, however that has stayed.
4 There is no drug diaries being re-established within
5 Dundee, within DDARS.
6 MR CASKIE: At paragraph 40 you talk about barriers to
7 a different source of support. Can you tell us about
8 that?
9 MS MCLAREN: GPs. GPs, obviously they closed their doors
10 and you could only call. A lot of the people we work
11 with don't have a phone. If they do have a phone, it's
12 what we would call a "burner phone" so there's no access
13 to wifi, there's no internet. I think they do have
14 a camera but I don't think they send camera photos or
15 anything like that. Certainly no WhatsApp abilities.
16 The GPs -- so you had to call and, if the person had an
17 ailment -- so a lot of our guys, they will have sores,
18 et cetera, or abscesses, ulcers, you would have to send
19 a picture -- well, the people we work with predominantly
20 just would not be able to do that.
21 MR CASKIE: Because they don't have camera phones?
22 MS MCLAREN: Because they don't have the facilities. They
23 don't have the facilities to be able to do so. So staff
24 would try to call the GP and ask the GP for a call-back
25 time so that the staff member could be with the person

1 at the time. With some GPs that was a massive barrier.
2 They wouldn't even take the call from staff. The staff
3 member had to be with the person, which meant the staff
4 member would have to expose themselves by leaving their
5 homes to be with the person just to make the call at
6 8 o'clock in the morning, which sometimes you can't get
7 our people up at 8 o'clock in the morning. And then the
8 staff member would have to go away, wait for the GP to
9 call back and get back to the person's house very, very
10 quickly because there was no times given. And then
11 staff would have to sometimes take the pictures, which
12 obviously wasn't great for the people's dignity or for
13 staff, but that's what we done -- that's what staff
14 done.
15 MR CASKIE: Okay, we've heard evidence already from other
16 sources about Connecting Scotland and you, Mr Smith,
17 refer to that at paragraph 55 in your witness statement.
18 MR SMITH: So Connecting Scotland, it was prior to -- both
19 prior to and during the pandemic, we had
20 Connecting Scotland funding, and that gave service users
21 the opportunity to get -- what do you call them? --
22 a Chromebook or at that point it was an actual iPad.
23 Subsequently we said, "They don't need to be iPads, they
24 can be anything". So we were able to give out those.
25 But I think, as important as the laptops or whatever

1 were the data packages, the dongles that came with them,
2 because they were the ones -- it was that that gave
3 people the access to the internet and being able to do
4 things. And whether that was about doing things via
5 Skype or Zoom or what have you or whether that was about
6 kind of watching football on YouTube, it just gave
7 people a connection into that wider digital world,
8 whereas kind of traditionally this group of individuals
9 had been excluded from.
10 We were somewhat sceptical prior to the handing-out
11 of these that they would all -- we'd find them all in
12 Cash Converters the next day. It was -- once people
13 valued them, it was amazing. The vast majority were
14 kept and used and valued and people looked at, "Well,
15 how can we continue that support?". That came in in
16 several tranches.
17 MR CASKIE: Well, Ms McLaren, you talk about the same area
18 at paragraphs 29 and 30 of your witness statement. So
19 if you give the magicians behind me a second -- there we
20 are -- can you talk about what's in 29 and 30?
21 MS MCLAREN: Yeah, so we -- as Bryan has already stated, we
22 were able to get the data packs and the mobile phones,
23 and particularly it was very, very handy, as I said
24 before, especially with things like the GP and for
25 benefits, et cetera, but not only -- for the news.

1 People we support were so disconnected, the only time
2 they were getting any advice was from staff --
3 MR CASKIE: When you say "advice", do you mean news?
4 MS MCLAREN: Yeah, news, news. So the Scottish Government
5 advice, the Public Health advice, for during the
6 pandemic, it was all from staff because they weren't
7 watching the news. Some of them didn't have
8 televisions. They didn't have access, like I say, to
9 wifi or any data. Some didn't have a phone at all. So
10 being able to get them the devices and the ability to be
11 able to listen to the news, make contact with family --
12 because they couldn't get out to see family, those that
13 we support that are still in touch with family -- just
14 seeing a massive difference. It was such a benefit to
15 the people that we supported --
16 MR CASKIE: You talk about that again at paragraphs 42 and
17 43 of your witness statement. Tell us about what's
18 there.
19 MS MCLAREN: Yeah, so this was more about the informal use
20 of the data and the phones, but being able to FaceTime
21 family and WhatsApp to be able to keep in touch so that
22 it wasn't costing any money for their minutes or their
23 messages. And to keep them in and to have something to
24 do within their accommodation -- whether that was within
25 our Brewery Lane accommodation or within their own

1 tenancies because I couldn't imagine being in the middle
2 of a pandemic and staring at four walls for 24/7. So
3 having something to do was amazing.
4 And then the guy who was able to access recovery
5 meetings but within America -- so he was really
6 struggling with his recovery, but through the night, so
7 being able to access those meetings outwith the UK was
8 invaluable to him, and that was because of the
9 Connecting Scotland and being able to get the phone and
10 the data pack.
11 MR CASKIE: And has any of that continued post pandemic?
12 MS MCLAREN: So we did -- post pandemic we had another
13 tranche of data packs and phones. The funding has
14 unfortunately stopped. However, they are bidding to get
15 some more funding to be able to do that again and
16 I think this time they're going to call it
17 "Connecting 200", I believe. So, yes, fingers crossed
18 for that because that would be really good for the
19 people that we support.
20 MR CASKIE: Did it make a significant difference --
21 MS MCLAREN: Oh, absolutely.
22 MR CASKIE: -- during the pandemic last time?
23 MS MCLAREN: Yeah, absolutely, yeah. And like what Bryan
24 was saying, our guys, our participants, have really seen
25 the value in that and most of them now who have a tablet

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1 or some other form of device, like a laptop, who are in
2 their own tenancies, they now pay for their own wifi so
3 they can still use those devices which is -- it
4 surprises me still.
5 MR CASKIE: It surprises you that they've not turned up in
6 Cash Converters?
7 MS MCLAREN: Yeah, and I think -- I was trying to recollect
8 whilst Bryan was talking, but I'm sure from the start
9 there's only two people that I know of that no longer
10 have their device and we had --
11 MR SMITH: And one was genuinely lost.
12 MS MCLAREN: Yes.
13 MR SMITH: One was genuinely -- it fell somewhere and was
14 lost.
15 MS MCLAREN: And I think we had -- we had over 100 devices
16 from Connecting Scotland, and Connect 500 was the other
17 one.
18 MR CASKIE: I'm going back to you, Mr Smith. At 56 and 57,
19 you talk there about the burners phones.
20 MR SMITH: Yeah, we were able -- we found -- it's not a big
21 secret but we found a supplier, ie Tescos, who were able
22 to supply a phone and a SIM card with £10 credit for £12
23 during the pandemic. So we were buying quite a few of
24 them and had kind of drawers full of those, and we were
25 giving those to people who didn't have any way of

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1 contacting the service. So at least, if nothing else,
2 we could phone and keep in contact with them. And we
3 got the money for that just through our own resources.
4 Also if people had phones that they were kind of
5 getting rid of, upgrading et cetera, we would take them
6 and kind of give them to people but, yeah, we found
7 Tescos were able to kind of be able -- would supply
8 phones at that price and we'd give them the £10 phone
9 with the £10 credit and it made a huge difference,
10 especially because mostly we were phoning them. So it
11 really wasn't kind of -- it really wasn't impacting on
12 their cost but it did really impact on the level of
13 support we could give.
14 And even kind of very simple things like they would
15 phone and say, "I'm not feeling well today, don't come
16 up" whereas kind of -- so we could check that they were
17 going up to see someone and they would be there, or we
18 could check that they were well or -- there was all
19 sorts of just that kind of very low-level support but
20 just to make sure people were safe.
21 MR CASKIE: As you know, we're going to have a break at
22 11 o'clock, we're not quite there yet, I have one more
23 thing to ask you about and that's paragraph 59 in your
24 witness statement. This is going back to FareShare food
25 and you talk there about the increase in the number of

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1 volunteers meaning that people were able to go out and
2 deliver food. But you also talk about taxis.
3 MR SMITH: Yeah.
4 MR CASKIE: Tell me about the taxi organisation.
5 MR SMITH: Well, again, that was -- there was a company in
6 Dundee that was -- I can't remember -- I think Zippy
7 Delivery, who were a kind of taxi/food delivery company
8 and, during the pandemic, themselves and kind of
9 traditional taxi companies as well were, "If there's
10 food to go out and you don't have the resource to do it,
11 we will help", and that was all funnelled through
12 Dundee City Council.
13 With us being on the gold response team or group --
14 I can't remember what the exact name was -- we were
15 able -- they were able to co-ordinate people coming in
16 and offering help, whether that be local businesses or
17 individuals, and saying, "Well, I'd like to do something
18 during the pandemic". So they would put volunteers and
19 organisations our way which could help in the delivery
20 of that food, so some of that being taxis. So if we had
21 vans going out but there was still lots of other food to
22 go out, there was an organisation, one was -- there was
23 taxi companies, there was also Alexander Community
24 Development, which was basically a painter and
25 decorators who would use their vans to kind of deliver

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1 food in suitable hygienic casing in that and take that
2 food out to the people who needed it. So it was just
3 about kind of using the resources and the gold group
4 kind of helped kind of bring that all together.
5 MR CASKIE: My Lord, that's an appropriate point to have
6 a break.
7 THE CHAIR: Very good. Thank you. I notice from the
8 timetable you might not want the normal 15 minutes, you
9 want longer. Is that right?
10 MR CASKIE: No, my Lord, 15 minutes is ample.
11 THE CHAIR: 15 minutes is fine.
12 MR CASKIE: I don't think we'll be going till 1 o'clock.
13 THE CHAIR: Okay, super. Thank you.
14 (11.00 am)
15 (A short break)
16 (11.16 am)
17 MR CASKIE: We're ready to begin, my Lord.
18 THE CHAIR: Yes, can you hear me?
19 MR CASKIE: Yes.
20 THE CHAIR: Very good. Proceed, Mr Caskie.
21 MR CASKIE: Thank you. I was just about to move on to
22 paragraph 60 of Mr Smith's witness statement. I'll wait
23 for that. That talks about -- in terms of the
24 accommodation you're able to source for people, who are
25 the landlords generally?

1 MR SMITH: The landlords are generally Dundee City Council
2 or RSLs, which are housing associations. Primarily that
3 would be Hillcrest Housing or the Home Group, but there
4 is potential -- there are other smaller housing
5 associations within Dundee. There has on occasions been
6 private rented landlords --
7 MR CASKIE: I'll ask you about that in a second.
8 MR SMITH: -- but not as popular.
9 MR CASKIE: You tell me that, amongst your users, there's
10 a distinction between Dundee City Council accommodation
11 and housing association accommodation. You talk about
12 that at paragraph 61.
13 MR SMITH: Yeah, Dundee City Council are -- housing tends to
14 be in the outskirts of Dundee -- the schemes kind of on
15 the periphery, the other side of the Kingsway in
16 Dundee -- not exclusively but kind of generally,
17 whereas, especially in the last couple of years, housing
18 associations are building properties in kind of gap
19 sites and smaller and maybe in areas where people would
20 want them more, near the town centre.
21 MR CASKIE: And at 62 you refer, just as you did a moment
22 ago, to private accommodation and indicate that that's
23 not something that's generally used.
24 MR SMITH: We don't exclude it but it can be more difficult
25 with regards to things like repairs and the

1 understanding of private landlords. If there is damage
2 or that, maybe housing associations and the local
3 authority are slightly more understanding than private
4 landlords.
5 The only time we've had people using private
6 landlords is generally -- there's several areas in
7 Dundee where there's very, very little social housing
8 and, if people's support mechanisms or kind of
9 preferences are there, then we would look at private
10 landlords. But currently we have no one in private
11 accommodation.
12 MR CASKIE: I think you say later in your statement that,
13 simply because of the size of Dundee, getting people
14 into their home area, if I can put it that way, isn't
15 such a major issue.
16 MR SMITH: That's right. Dundee is geographically quite
17 hemmed in so -- and public transport, whilst not kind of
18 five star, it's is certainly kind of relatively
19 effective. So it's not such a big deal than, say,
20 a rural area where you can put somebody in a different
21 town. So kind of putting people -- moving people in
22 areas they're not necessarily mad keen on isn't such
23 a big deal as it can be in other local authority areas.
24 MR CASKIE: Because people can get back relatively easily to
25 the connections that they had in their, quotes, "home

1 area"?
2 MR SMITH: Yes. The other thing is there is somewhat
3 a difference -- the east part of the town, generally the
4 houses are slightly bigger, so the one-bedroom flats,
5 which our participants are looking for, tend to be in
6 the west end of the town.
7 MR CASKIE: Okay. You say that during the pandemic there
8 was a particular problem with your 22-bedroom. I take
9 it that's Brewery Lane?
10 MR SMITH: Yes. Yeah, the particular problem there was
11 as -- it was almost frozen in time. The pandemic
12 lockdown came and there was no -- there was no way for
13 people then to move on to other accommodation because --
14 MR CASKIE: There was no allocation, as you said earlier.
15 MR SMITH: There was no allocation. Yeah, so there was no
16 allocation. So people who were in Brewery Lane on the
17 day of the lockdown, almost that was them there. That
18 point -- and that had the -- that basically backed up
19 right through the system so there was no temporary
20 accommodation -- there was a lack of temporary
21 accommodation for people to move into, and so I think
22 they were --
23 MR CASKIE: And typically, pre-pandemic, what's the turnover
24 at Brewery Lane?
25 MR SMITH: I would say on average about five to six people

1 per month would move in and out of Brewery Lane.
2 Generally --
3 MR CASKIE: So what you have is you have 22 beds and you
4 have five to six people a month moving into their own
5 accommodation --
6 MR SMITH: Yeah.
7 MR CASKIE: -- but their own accommodation is no longer
8 available to move to --
9 MR SMITH: Yeah.
10 MR CASKIE: -- and therefore they're fixed in that
11 accommodation?
12 MR SMITH: That's exactly it, yeah.
13 MR CASKIE: I think you describe that as the system being
14 "gummed up".
15 MR SMITH: That's exactly what happened. So any time anyone
16 presented as homeless with Dundee City Council, their
17 normal reserve of temporary accommodation was full
18 because -- if I remember correctly, we were full or --
19 I'm talking Dundee-wide -- full or almost full at the
20 time of the lockdown so there was very little wriggle
21 room. There was some people who kind of got in under
22 the wire and there was a couple kind of just before the
23 lockdown and created a little bit of capacity, but that
24 was very quickly gobbled up. So, in that sense, we had
25 to kind of -- they had to look at different ways of

1 giving people temporary accommodation under the Act,
2 which they're kind of compelled to do, and that was
3 generally hotels and bed and breakfasts.
4 MR CASKIE: I'll ask about the hotels in a moment. But you
5 provide some interesting information at 66 in relation
6 to rough sleepers and you tend to indicate that rough
7 sleeping isn't a problem in Dundee.
8 MR SMITH: It generally isn't a problem in Dundee. I'm not
9 saying that there isn't some rough sleeping in Dundee
10 but our numbers -- our anecdotal evidence shows that
11 people are rough sleeping out of ignorance of the
12 services that are available, and once people are aware
13 of what services are available, then people will access
14 generally services. So people are rough sleeping
15 because, for example, they've been thrown out of their
16 accommodation at an hour -- or arrive in the city at an
17 hour which kind of they don't know what to do. So it's
18 generally very short term. It's intermittent.
19 I think there's a disconnect -- and it's proving
20 a negative so it can be very difficult to prove -- but
21 you do get people saying on their housing application --
22 their homelessness application that they slept rough the
23 night before. We can find no evidence of that, but they
24 feel that it's beneficial to them to -- their
25 application by saying, "I'm sleeping rough", but, under

1 investigation it's maybe not as clear-cut as that.
2 MR CASKIE: Okay. Ms McLaren, at paragraphs 36 and 37 of
3 your witness statement, you talk about the extent to
4 which lockdown impacted upon the ability to provide
5 talking services, both in Brewery Lane and also for
6 people who had moved on from there. Can you tell us
7 a bit more about that?
8 MS MCLAREN: Yes. So, as we've already touched on, one of
9 the biggest impacts for the people we support is the
10 self-isolation. That was already a need before the
11 pandemic. During the pandemic that was obviously
12 heightened massively. When we, as a service and
13 following guidance, were saying, "You cannot enter
14 people's homes, you can't spend the same support
15 sessions with people, it has to be very quick sessions
16 just to see how they are", whether that was through
17 a window, in their closie or seeing them in the garden,
18 we'd seen that people's mental health drastically
19 dropped. They were very depressed, very lonely, just
20 couldn't see a way out, had nobody to talk to. That's
21 why the phones again were a massive thing because they
22 were able at least to communicate with family or staff.
23 But we then took advice from our staff, who were saying,
24 "That's not enough. What you're telling us that we are
25 providing for the people that we're supporting is not

1 enough" --
2 MR CASKIE: Not enough for them?
3 MS MCLAREN: For our people.
4 MR CASKIE: For your clients?
5 MS MCLAREN: For the people that we support, absolutely. So
6 we then looked at our risk assessments as a whole, as
7 a service, and said, "Well, what can we provide then
8 safely for our staff and for our participants and for
9 the wider public but be able to minimise the
10 self-isolation as much as possible?". So there was an
11 agreement that, if somebody was extremely struggling and
12 seen as in crisis from self-isolation, staff, as long as
13 they were full PPE'd, could spend longer with that
14 person, and that was taking advice from our staff. Our
15 staff reported that to us.
16 MR CASKIE: Going back to you, Mr Smith, in your statement
17 at 68 you mentioned in passing earlier the use of
18 hotels. Can you tell us a bit about that?
19 MR SMITH: Yeah. I mean, obviously, there was a real
20 drop-off of travel and tourism during the pandemic and
21 therefore -- but with people kind of still presenting as
22 homeless during the pandemic, it was -- there was almost
23 I suppose a quid pro quo in the sense that the hotels
24 were looking at ways that they could continue to
25 operate, Dundee City Council were looking for

1 accommodation and the two came together. So to stop
2 that kind of gummed-upness, people were able to go into
3 kind of hotel accommodation. There were several hotels
4 in Dundee who really kind of took it on.
5 Some higher-end hotels were actually -- some of the
6 better hotels and their staff were amazing and kind of
7 amazingly supportive of our staff -- of our client
8 group, but it was just about kind of making sure that
9 nobody was sleeping rough, that people's rights, ie kind
10 of the 28-day assessment of being homeless, was still
11 being seen to and it was giving people accommodation.
12 So the hotels were kind of scattered around Dundee.
13 They weren't necessarily in areas where traditionally
14 homeless people would congregate, but, despite that --
15 I mean, as I say, the local community and the staff
16 within the -- there was one hotel in particular where --
17 in kind of Broughty Ferry, Monifieth area, which is kind
18 of a considerable distance from the centre of Dundee,
19 and kind of services like chemists and what have you
20 were using our housing support team, supported the staff
21 as well as the service users within their hotel.
22 MR CASKIE: Because there isn't a lot of methadone use in
23 Broughty Ferry?
24 MR SMITH: I would probably think that's the case, yeah.
25 MR CASKIE: Okay. You then move on to talk about the impact

1 on your own staff and you talk about the difficulty of
2 staff going online. At 71 you talk about the absence of
3 a debrief.
4 MR SMITH: Yeah. I'm not saying debriefs didn't happen, but
5 there was that informal debrief where, as the day goes
6 on, people come in and out of the office and say, "Well,
7 that was terrible" or "That was great" and kind of
8 getting feedback. So it could be very difficult and
9 people -- in pinning staff down and kind of saying, "How
10 are things?", because a lot of that informal kind of
11 support that is there in kind of a normal office
12 situation had disappeared. So to debrief or to kind of
13 feed back to staff, there had to be -- you'll be on one
14 side of the phone, I'll be on the other side, and we can
15 speak about it. That kind of standing around and having
16 a cup of coffee or whatever had gone and that was
17 difficult. And staff were fantastic but they're also
18 quite stoic in, "Och, it will be fine", and go on to the
19 next thing, and kind of assessing how they really were
20 could be very difficult.
21 MR CASKIE: At the end of paragraph 73, the final line, you
22 talk about, amongst your staff, an increased level of
23 weariness among staff regarding transmission of COVID.
24 How did that manifest itself?
25 MR SMITH: Just because numbers were going up and we were

1 doing more work in a sense. Now, whether that was more
2 work, ie kind of people within the warehouse kind of
3 getting food out, meeting -- interacting with drivers,
4 et cetera, whether that was about staff going out and
5 kind of seeing other individuals, whether that was about
6 staff then doing all this and going home -- and so there
7 was -- and I think, especially near the start, there was
8 a lot of unknowns and I think people were worried,
9 "Well, am I -- is what I'm doing safe? Are the risks
10 we're taking -- are they risks that are acceptable or
11 should we be doing more, should we be doing less?".
12 Like all organisations, we had some people who felt it
13 was some sort of hoax and they didn't need any
14 protection and you had some people who were kind of
15 almost terrified of the consequences of ...
16 MR CASKIE: You also talk about, in particular in the food
17 end of the service, increasing levels of stress because
18 of the increased workload.
19 MR SMITH: Yeah.
20 MR CASKIE: Did you get additional staff -- I don't mean
21 volunteers. You said you got extra volunteers --
22 did you get additional staff or funding for additional
23 staff?
24 MR SMITH: No, we didn't get any additional staff as such.
25 There was additional staff by the redeployment of staff

1 from furniture into ... and there was often kind of --
2 we asked for kind of others within the organisation to
3 help out. So I went down a couple of times and helped,
4 I know Catherine did, I know the whole chief executive
5 at that point kind of went in and helped. So we all
6 kind of mucked in a bit to do what was required because,
7 although the housing support workload remained, there
8 was elements of their work that they weren't able to do
9 because of the pandemic, so there was maybe some slack
10 at some times where we could relieve some staff members
11 to kind of support the wider operations of the
12 organisation.
13 MR CASKIE: If I could summarise paragraph 77, you talk
14 about staff morale kind of going up and down, varying
15 over time. But you also say:
16 "... I [want to] credit the staff because they did
17 not let that impact on their morale [impact in] their
18 jobs [essentially]."
19 MR SMITH: Yes, I would say the staff were amazing
20 throughout. I mean, they supported the service users,
21 the organisation and each other in a way that I'll never
22 be able to thank them enough for.
23 MR CASKIE: You're not the first chief executive we've heard
24 that from.
25 On paragraph 79, you talk about absences, staff

1 absences.
2 MR SMITH: Yeah.
3 MR CASKIE: That didn't increase?
4 MR SMITH: It didn't increase because of live COVID
5 infections, as far as I remember. There was an increase
6 due to self-isolation and the rule -- do you know what
7 I mean? -- people's partners or children or what have
8 you having COVID and therefore having to self-isolate.
9 But we didn't see a marked increase that caused problems
10 with staffing. It was above normal levels, but our
11 normal levels are relatively low, so it was above normal
12 levels but still within a manageable level and we were
13 able to work around it.
14 MR CASKIE: At 47 and 48 of your statement, Ms McLaren, you
15 talk about some confusion among staff. Can you tell us
16 about that from your position as not chief executive, if
17 I can put it that way?
18 MS MCLAREN: Yes, so I'd like to think we've got a very good
19 relationship with our staff, where they are able to say
20 how they feel and what they're thinking at the time,
21 sometimes very loudly, and during the pandemic this was
22 a massive concern for staff. They were very confused
23 around the guidance. It probably didn't help that we
24 were -- myself and Mr Smith, who were giving the
25 guidance, were also confused by the guidance, so we were

1 trying to make grab-it sheets for our staff and for our
2 participants which broke down the guidance as simply as
3 possible. However, just one example I've given is about
4 the masks. The masks had to be worn when you were up
5 and walking but you were fine to sit at your desk with
6 no mask on with somebody sitting at their desk with no
7 mask on, so staff were just very confused.
8 It also didn't help when the guidance -- there was
9 no clear guidance for hostel accommodation. So we were
10 following guidance from Public Health for day-care
11 services because we're not a care home. We do not do
12 any personal care within our services. So when the time
13 came that we were able to relieve staff of wearing masks
14 predominantly, et cetera, and some of the rules were
15 lapsed within our accommodation, we followed that for
16 day care. We then were given an inspection from our
17 Care Inspectorate and she was very clear that we are
18 a registered care service so we should be following care
19 home guidance, which was very different to day-care
20 services.
21 MR CASKIE: I'll come on to that. I'll get some more. But
22 if I can go back to your statement, Mr Smith, and
23 paragraphs 82 and 83, where you talk about precisely
24 that.
25 MR SMITH: Yeah.

1 MR CASKIE: Tell us about that.
2 MR SMITH: Yeah, so we were -- I mean, we obviously have
3 contact and information that was coming through our
4 contractor, the Health and Social Care Partnership, and
5 that was coming through public -- NHS Tayside
6 Public Health. We were also getting advice from
7 FareShare UK, who are the national kind of charity that
8 governs FareShare, and kind of we were looking at all
9 this information kind of coming down. So with regards
10 to -- so we followed public -- we were contacting
11 Public Health and we had to do notifications, et cetera,
12 and kind of -- and feeding back through our contractual
13 mechanisms and monitoring mechanisms to the Health and
14 Social Care Partnership, and that was -- and they were
15 aware of what we were following, what we weren't
16 following. We were taking -- if we had any queries, we
17 were phoning up the Tayside Public Health team and they
18 were saying, "You do this and you do that" or "You don't
19 do this and that", et cetera, and that was all going
20 well and we felt it was appropriate, given the kind of
21 support we were giving to individuals.
22 And, yeah, we increased things like cleaning. We
23 had -- I mean, for example, we got hand-wash dispensers
24 from Marks & Spencer which were dotted all around and
25 there were big industrial ones, which means that there

1 was always opportunities for people to kind of keep
2 their hands going. We had posters up. We had kind of
3 2-metre markings, et cetera.
4 MR CASKIE: In your statement at paragraph 84, you refer to
5 the matter that Ms McLaren just referred to.
6 MR SMITH: Yes.
7 MR CASKIE: Could you just read paragraph 84 for us?
8 MR SMITH: Yes.
9 "We received our annual inspection from the
10 Care Inspectorate -- as the pandemic -- we were coming
11 out the other side of the pandemic. The inspectorate
12 dates were 11 August and then followed up on the 25th.
13 At the beginning of the inspection I was asked why I was
14 not wearing a mask, to which I replied that we were not
15 required to wear masks in line with the Public Health
16 guidance. However, she informed me that we were
17 classified as a care home and should be following care
18 home guidance even though Public Health had told us we
19 shouldn't. As a result of this, our marks for
20 inspection were put down to a 2 on a scale that goes up
21 to 6, so we were classed as inadequate, and despite
22 appealing this mark, it was argued that, because we were
23 following Public Health advice, we were told we should
24 have been following Care Inspectorate advice [as read]."
25 MR CASKIE: At paragraph 89 you say there that that was

1 frustrating .
2 MR SMITH: Yes.
3 MR CASKIE: Tell us about that.
4 MR SMITH: It was frustrating because the amount of work
5 that the staff had done during the pandemic and the care
6 they had taken to follow ultimately the wrong guidance
7 had been shown in a —— whilst I appreciate, when a care
8 inspector report comes out, one should read it and look
9 at the context and everything —— but ultimately it all
10 boils down to a number, and that number is —— was 2, and
11 the staff had seen that and felt kind of devalued and
12 demoralised, that kind of all the hard work they had put
13 in —— that they had been kind of told they were doing
14 the wrong thing. And I think it was —— as a management
15 team and as a chief executive, for us it was kind of ——
16 I felt , well, "Why were we then left in this position
17 where we weren't sure what guidance to follow at that
18 point?".
19 MR CASKIE: Can you tell us about paragraph 89 in your
20 witness statement, please?
21 MR SMITH: Yeah, it was —— we didn't —— there was guidance
22 coming out kind of regularly from Public Health and
23 there was guidance coming out from the Health and Social
24 Care Partnership, there was guidance coming out from the
25 Care Inspectorate but we've always found with lots of

1 things that housing support and homeless housing support
2 always kind of falls between two stools, and at no point
3 were we told, "You're a care home" and at no point were
4 we —— do you know what I mean? So we looked at what was
5 most appropriate for us and Public Health agreed. So
6 there was —— no specific guidance came out for hostel
7 accommodation that we ——
8 MR CASKIE: And 85?
9 MR SMITH: Yes, it was near the end. If I remember, it was
10 about the eighth or ninth reiteration of the guidance
11 that homeless accommodation was finally in the guidance
12 as almost a footnote. Whether it was because of our
13 protestations or because of others' protestations , it
14 was —— up to that point we were kind of looking at what
15 we were doing in line with what the regulations were
16 saying and kind of pitching ourselves in the kind of
17 support we were given ——
18 MR CASKIE: You said this was the eighth or ninth
19 iteration ——
20 MR SMITH: Yes.
21 MR CASKIE: —— of the guidance that had been provided.
22 Presumably you and your colleagues and your management
23 team had to go through the previous seven or eight?
24 MR SMITH: Yes.
25 MR CASKIE: But there was nothing in there directly for you

1 at all?
2 MR SMITH: No, that we could see. And taking advice from
3 kind of colleagues and kind of others in the sector ——
4 MR CASKIE: How about 87? Can you say something about that?
5 MR SMITH: Yeah, sometimes it was potentially too much
6 information and contradictory. I think the example I've
7 given of the different view from Public Health and the
8 Care Inspectorate —— I mean, the information was
9 basically the same but there was no one who could say,
10 "Well, that's the information that's required for you".
11 I think it should be said —— we talk about lack of
12 clarity . If I remember correctly, on the 11th —— the
13 first day the inspector came and said, "This is where
14 we —— this is the situation and you should be wearing
15 masks", I then phoned Public Health later that day and
16 he says, "No, no, we think you're right". It wasn't
17 until about three days later that the Care Inspectorate,
18 following kind of lots of discussions, came back and
19 says, "Well, we've agreed that you're wrong".
20 MR CASKIE: With whom?
21 MR SMITH: The Care Inspectorate.
22 MR CASKIE: Have agreed with whom?
23 MR SMITH: Have agreed with others in the Care Inspectorate.
24 MR CASKIE: You've mentioned earlier your good working
25 relationship with Dundee City Council ——

1 MR SMITH: Yes.
2 MR CASKIE: —— and also the police.
3 MR SMITH: Yes.
4 MR CASKIE: You haven't mentioned your working relationship
5 with other third sector organisations very much, but you
6 do say something about that at paragraph 88.
7 MR SMITH: Yes. So basically I think we were ——
8 MS MCLAREN: The first.
9 MR SMITH: —— somewhat unlucky. We were one of the first
10 organisations inspected post pandemic. So after we'd
11 been given these lower scores, we basically got the word
12 out to other organisations in our local area and said,
13 "If they're coming to inspect you, be aware they're
14 looking to hold you to these standards, not the
15 standards ..." —— because we know for a fact that they
16 were following the same ——
17 MR CASKIE: Processes?
18 MR SMITH: —— processes that we were. They subsequently
19 beefed up their standards and were given higher scores
20 accordingly.
21 MR CASKIE: One of the things that you also refer to is that
22 that scoring mechanism can impact on future funding.
23 MR SMITH: Yes.
24 MR CASKIE: Tell us about that and tell us about your
25 relationship with the health partnership and the

1 council.
2 MR SMITH: Well, I would say they -- I think in general
3 I would agree that getting a score of inadequate or a 2
4 could potentially -- would lead a contractor --
5 a commissioner to say, "Why are we commissioning
6 a service which is seen as inadequate?". So those
7 discussions weren't had because they were confident that
8 we were following kind of the Public Health advice and
9 took it as a, "Well, that's a disagreement, it's
10 unfortunate but it's one of these things and we know
11 that you were following advice because we were part of
12 supporting you in getting that advice".
13 MR CASKIE: Okay. Could you read paragraph 94 aloud,
14 please?
15 MR SMITH: "There was a disconnect between the
16 Care Inspectorate and [Public Health Scotland or Tayside
17 Health]."
18 I think there was just so much similar but different
19 information coming through at that time.
20 MR CASKIE: And in essence it would appear from paragraph 96
21 that your funders just overlooked the 2 out of 6.
22 MR SMITH: Yeah, and basically said, "We know you. You were
23 following Public Health. We would have expected you to
24 follow that", and yeah.
25 MR CASKIE: So is that another example of practicality

1 kicking in?
2 MR SMITH: Yes. They were aware what we were doing and
3 comfortable with what we were doing. We had a forum
4 that kind of at the start of the pandemic was meeting
5 three times a week, if I remember right, where all the
6 third sector and statutory agencies were getting
7 together and looking at what we were doing, and we were
8 all following the same -- it was about monitoring kind
9 of infection rates and monitoring kind of work,
10 et cetera, what procedures, what access to PPE,
11 et cetera. So that was all going on.
12 So they were well aware of what we were doing right
13 along the pandemic and were happy with it and, where any
14 advice we were seeking from the Health and Social Care
15 Partnership, they would say, "Go and speak to Public
16 Health Scotland or NHS Tayside".
17 MR CASKIE: But not the Care Inspectorate?
18 MR SMITH: Not the Care Inspectorate.
19 MR CASKIE: We haven't heard from the front-line worker on
20 that. Can I go to your statement, Ms McLaren, at
21 paragraph 51? So you're getting guidance in and you're
22 talking about tailoring it to suit your needs. Tell me
23 about that.
24 MS MCLAREN: The guidance was guidance for the amount of
25 time that you were supposed to spend with someone. I'm

1 not sure if the 15 minutes is correct. I can't remember
2 fully. I think sometimes we have to use common sense
3 and, if our staff are saying that the people who we're
4 supporting are in crisis and need longer than
5 15 minutes, sometimes that can be the difference between
6 someone going home and having to call NHS because
7 they're then in crisis with their mental health and
8 either that could escalate to whatever -- who knows? --
9 then I think we need to do that and that is what we
10 done. We took advice from our staff. Our staff were
11 very careful in making sure they had full appropriate
12 PPE on and, if the person was able to, the person would
13 also wear full PPE. I just think we had to use some
14 common sense through the guidance. Also, like I said
15 before, some of the guidance just didn't make sense.
16 With regards to some of the guidance that was in for
17 the care home that we were then instructed that we
18 should have been following, we would never have been
19 able to because some of that included the disposal of
20 PPE and, if somebody was suspected to have COVID, the
21 guidance within the care homes is it gets wrapped into
22 a specific colour of bodily fluid bag -- I'm guessing it
23 would be red -- and that would be put into a yellow bin.
24 We don't have those facilities because we're a homeless
25 hostel, we're not a care home.

1 MR CASKIE: Can I take you to paragraph 69 and just ask you
2 to read that, please?
3 MS MCLAREN: "The guidelines were not written for housing
4 support organisations such as ours. We did not really
5 fit into the guidance being provided. We were following
6 guidance, I can't recall the specific one, but it was
7 not the one for care homes."
8 MR CASKIE: Mr Smith, can you go back to 96 in your
9 statement? I'm not going to ask you to read it aloud,
10 I'm just going to ask you to tell us about it.
11 MR SMITH: Because we were -- we were following the guidance
12 and we were seeing people face to face -- so people were
13 coming down to the office or, if people had issues with
14 their flats, we would have to maybe go up and support
15 them in their flats, but we were doing everything kind
16 of within guidance for the general public. So it was
17 2 metres, it was masks, sanitising, washing hands. If
18 there was concerns, we had masks, we had -- I mean, eye
19 protection, visors, we had access to more PPE if we
20 needed it. And we were doing extra cleaning. We had
21 gloves everywhere, we had aprons everywhere, masks
22 everywhere, we had the sanitiser in every room, and
23 every time somebody interacted, we would wipe down
24 tables. So we were probably doing more than the general
25 public -- we were following that guidance, but we were

1 doing more than anybody -- than the normal general
2 public were doing.
3 MR CASKIE: The next section is relating to PPE.
4 MR SMITH: Yes.
5 MR CASKIE: You indicate something that we've heard from
6 elsewhere, that initially there were problems accessing
7 PPE but, once a local portal was opened up in Dundee,
8 those problems effectively disappeared.
9 MR SMITH: Yes. I mean, it was -- we talk about the
10 problems. We're only talking about kind of probably
11 a couple of weeks until things kind of kicked into
12 place.
13 MR CASKIE: At paragraph 102 you talk about something we
14 haven't heard about elsewhere, which is bombs.
15 MR SMITH: Yes.
16 MR CASKIE: Tell me about your bombs.
17 MR SMITH: Yes, we located them through a cleaning company
18 who came to us. We had a relationship with them, like
19 a chemical supply company, and they had these bombs,
20 similar to bug bombs, where you would place them in the
21 room, they would explode in some way -- because we
22 weren't allowed in the room as they exploded so we're
23 not quite sure what happened -- but they explode and
24 sanitised the room within four hours, and they were kind
25 of -- they were registered or licensed to do that. That

1 allowed us, when people did leave, that we could turn
2 rooms round within the same day. They were quite
3 expensive, but if you're looking at it in a pure
4 financial -- it was much cheaper buying the bombs than
5 having a room sit empty for 72 hours. It also helped
6 kind of getting some movement back into the system.
7 They were kind of -- they were excellent. They were the
8 only company we could ever find who done them.
9 MR CASKIE: Did they discount it for you?
10 MR SMITH: No.
11 MR CASKIE: Discount the price?
12 MR SMITH: No.
13 MR CASKIE: You paid full price?
14 MR SMITH: We paid full price for them, yeah.
15 MR CASKIE: But it covered its own cost?
16 MR SMITH: Yes, and I think -- there was discount just
17 because of the amount we were buying, but not a special
18 discount. We got bulk buying.
19 MR CASKIE: You then move on to legislation and I don't need
20 to ask you anything about that. But you then move on to
21 funding and at 110 you say:
22 "... funding for housing support did not change but
23 the funding for the food did change."
24 I think what we can take from your evidence earlier
25 is that your housing costs, if I can put it that way,

1 didn't change but your food costs did.
2 MR SMITH: Yes.
3 MR CASKIE: So your funding mirrored that?
4 MR SMITH: Yes, so there was more food coming in but there
5 was obviously more food going out, so whilst it was kind
6 of pretty, in that sense, it was all about turnover, so
7 it was just more coming in but there was more outgoings
8 as well on that. So there was no great difference in --
9 kind of in a sense the bottom line, but just the volume
10 was there.
11 MR CASKIE: Paragraph 117, you talk about additional
12 funding.
13 MR SMITH: Yes, there was -- we were given extra funding --
14 there was some extra funding come through FareShare UK
15 and some of that was for logistics. That was the kind
16 of the central element of FareShare UK, kind of looking
17 at how we get food round the country. And there was
18 also stuff from local authorities. As I previously
19 said, Perth and Kinross rented a warehouse kind of at
20 the confluence where the Glasgow and Edinburgh roads
21 meet, which was ideal, which was able to kind of have
22 warehousing there.
23 There was potentially extra money there to -- there
24 was potentially extra money for extra vans, et cetera,
25 if need be, but a lot of the money, especially from the

1 Scottish Government and from kind of the national
2 Government through FareShare UK, was given very much
3 directly for specific things, and so some of those
4 things were directly given -- were directly to us and
5 some things were us having exclusive or part-use of.
6 MR CASKIE: In relation to funding at paragraph 118 you talk
7 about the process by which you could access it.
8 MR SMITH: Yes, there was a -- as I say, I wasn't as
9 directly involved at that point because that's at the
10 point I was just taking over. But, yeah, the chief
11 executive's office in Dundee had an overview of what was
12 happening in the city and they were linking with
13 Scottish and national Government to look at what funds,
14 et cetera, were available both for access to local
15 organisations or the local authority or could access,
16 and therefore kind of support the development of
17 services within Dundee.
18 MR CASKIE: At 119 and 120 you say that things were more
19 proactive and less bureaucratic.
20 MR SMITH: Yes. Yeah, that was very much -- in that
21 paragraph, I talk about funding, but that's often -- we
22 found that in a lot of things. But, yeah, there would
23 be times where we'd get calls from, say, Dundee City
24 Council or from FareShare UK to say, "We've got some
25 money to do this specific piece of work or to get this

1 amount of food out. We'll send the money and we need
2 this form filled in, but get that form done when you can
3 get that done because the important thing is to get the
4 money out there and get it helping people".
5 Some of that stopped the minute the last lockdown or
6 kind of restrictions finished. Some of --
7 MR CASKIE: Has any of that carried on?
8 MR SMITH: In some areas, and Ms McLaren kind of said
9 earlier on about -- I can't remember the exact
10 example -- but there was an example -- it was about the
11 drug diaries. So some of those processes have carried
12 on.
13 MR CASKIE: But funders' supervision of what you're doing
14 with the money --
15 MR SMITH: No, they've gone back --
16 MR CASKIE: Back to square one?
17 MR SMITH: -- to square one generally. I think there's
18 maybe been some changes in how some of the lessons
19 learnt have been -- so some of the monitoring has
20 maybe -- is different -- not necessarily looser but
21 different.
22 MR CASKIE: You next talk about no access to public funds
23 people --
24 MR SMITH: Yes.
25 MR CASKIE: -- and that doesn't really impact on your

1 organisation.
2 MR SMITH: No.
3 MR CASKIE: But you then move on to service users without
4 allocated accommodation. Can I take you to 128? 127
5 talks about the bus that went round town which was
6 a support mechanism for drug users. But you then, at
7 128, say something additional.
8 MR SMITH: Yeah, I think -- I mean, the bus was a great help
9 during that period and I think that has been -- the way
10 the bus has worked has really been a driver for kind of
11 changing those access to statutory services in Dundee,
12 and now we have the Hope Centre in Dundee, which has --
13 basically has derived from the bus, which is now
14 a 24-hour support for people who are in crisis. Our
15 team advocates for the service users and whether -- so
16 we will get people turning up, people's friends,
17 people's family, who are in crisis, and we kind of will
18 advocate for them. As I say, the bus was a great way of
19 doing that.
20 MR CASKIE: That was a start and then it moved on?
21 MR SMITH: It's moved into a dedicated building in Dundee,
22 and I'd say thank God because the bus was probably out
23 of its MOT by now. It wasn't the best bus, but it did
24 do a job. And the great thing, during the pandemic, it
25 was able to go round the city and go to specific places

1 where we knew that people were. So people weren't
2 having to come into the town centres. So we were going
3 into Lochee, to Hilltown, into Whitfield and doing
4 those.
5 MR CASKIE: The part of paragraph 128 that I was seeking to
6 draw your attention to that I don't think you picked up
7 on was there were issues surrounding access to statutory
8 services which was problematic. Then you talk about
9 your advocacy skills. Are there still problems in
10 Dundee accessing statutory services?
11 MR SMITH: Yes. I would say it depends on the team and it
12 depends on what services we're looking to access, but
13 there can be issues accessing people -- I would say
14 particularly mental health services, it can be
15 problematic for people. There has been some real good
16 changes in accessing drug and alcohol services, but
17 mental health services are problematic.
18 MR CASKIE: And were those exacerbated during COVID?
19 MR SMITH: Yes, I would say they certainly were exacerbated
20 through COVID. Mental health services have been
21 a problem in Dundee for quite a while, which is kind of
22 highlighted in other reports, et cetera.
23 MR CASKIE: The next thing you talk about are delays in
24 temporary accommodation. I think we've covered all of
25 that. It's about essentially hotels.

1 Paragraph 136, you talk about something about
2 yourself. Could you read that aloud?
3 MR SMITH: "Because I am the CEO, if I was going into places
4 then infection control measures were well maintained and
5 everybody was doing it. However, in the middle of the
6 night, when people were wandering about it was perhaps
7 not as tight."
8 MR CASKIE: Is that a reflection of the old phrase that "The
9 Queen thinks the world smells of fresh paint"?
10 MR SMITH: Yes, I would agree. I don't -- I think kind of
11 there was a -- I think kind of we can all probably agree
12 that, as the pandemic went on, there was a weariness for
13 it and people would think -- Ms McLaren brought up
14 earlier about people sitting at a table without a mask
15 and then wearing a mask if they're standing up. If
16 somebody's standing up only to go and grab a biscuit or
17 something, "I don't need to put a mask on to do that",
18 and I think that was -- yes, I would agree. And that
19 still exists in any organisation. I'm not -- I know
20 that people might not always be following everything at
21 all times, but you have to be pragmatic about that. But
22 yeah, it was a potential -- I knew that was probably
23 happening.
24 MR CASKIE: At 141 you talk about the different attitude
25 during the pandemic.

1 MR SMITH: Yeah, and I think that was one of the really
2 interesting things about the pandemic in the sense there
3 was almost a Dunkirk spirit to it in the sense that we
4 would have these meetings and everybody was volunteering
5 to do stuff and kind of go out with their contracted
6 services and, "We can do that and we can meet them there
7 and we can ..." -- and there was just a completely
8 different attitude and it was like the reins had come
9 off.
10 As a third sector organisation, what I love about it
11 is, if someone comes to me with an idea, we can say,
12 "Oh, yeah, we'll try that and we can start that on
13 Monday". Sometimes in the statutory services, you know,
14 that can take months. It has to go to committee and
15 come back and it's diluted and what have you. I think
16 there was much more of that, "How do we fix this?", and
17 a kind of much more solution-focused thinking by
18 everyone in the public and third sector.
19 MR CASKIE: 142, please, can you just tell us what you're
20 saying there?
21 MR SMITH: Yeah, I think a lot of that has gone back up.
22 People who were working -- who were working in silos
23 have gone back to their silos. I think a lot of that,
24 "We can fix things, we can do -- we can between us get
25 a solution for this", has gone back up and there is --

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1 kind of a lot of the bureaucracy has fed back in,
2 despite, I would say, the -- during the pandemic, people
3 would say, "This is great. We're getting things done.
4 It's really kind of positive, co-operative", and I think
5 in some areas that's drifted back.
6 MR CASKIE: Ms McLaren, in your statement at paragraph 32
7 you talk about a similar thing. Can you just tell us
8 what's there and what you have to say about it?
9 MS MCLAREN: Just the same as what Mr Smith was saying.
10 I've described it as "the red tape was cut". I think
11 before the pandemic our staff -- and certainly when
12 I was front-line staff -- you felt that the statutory
13 services were superior, you were never given any
14 information. If you requested information from
15 statutory services, even though, as the third sector
16 organisation, you would be the one working with this
17 person the closest, you'd be providing the most support
18 on the ground -- that changed during the pandemic. We
19 were seen as proper key partners alongside our statutory
20 services, sometimes more than that, especially when
21 statutory services weren't leaving their homes. So we
22 were relied on and staff felt really, really valued
23 during that time. As Mr Smith has said, some
24 organisations, that has gone back. I'm very glad to
25 say, though, not all organisations. We still do have

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1 some great working relationships with some of the
2 organisations in the city.
3 MR CASKIE: At 144 in your statement, Mr Smith, there's talk
4 about addiction support. We've heard quite a lot about
5 that today, but you say something quite interesting at
6 146.
7 MR SMITH: Yeah, I think one thing that happened over the
8 pandemic was we did see a real change in the drugs that
9 people were using. It had traditionally been kind of
10 a lot of opiates, a lot of heroin, in Dundee and we've
11 seen kind of a real shift. Now, whether that would have
12 happened in spite of the pandemic, it will be difficult
13 to say, but we have seen kind of a real increase in
14 cocaine, in crack cocaine, in synthetic benzodiazepines
15 and things which are -- really we're not 100% clear what
16 exactly they are and what the outcome -- what the
17 outcomes for individuals could be.
18 I think the difficulty -- and this is kind of --
19 they're still kind of an opiate-based recovery services
20 in Dundee. I know they're trying to change, but, as we
21 spoke earlier, some of the statutory services, it takes
22 them much longer to change than some third sector
23 organisations because we are seeing a marked decrease in
24 Dundee of opiate use and kind of a real increase in
25 stimulant use.

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1 MR CASKIE: At 147 you give the information you have
2 regarding overall drug usage.
3 MR SMITH: Yeah. I mean, treatment -- we said earlier on
4 that we are kind of advocating for service users and it
5 can be difficult accessing because we are the -- we
6 would be advocating for and supporting the service user
7 in accessing drug services, and that wasn't always
8 possible due to restrictions. That was used a lot of
9 times, that, "That can't happen because of the COVID
10 restrictions, that can't happen because of the COVID
11 restrictions", and not being person-centred on -- the
12 pressing issue here is someone's addiction and how can
13 we work with that.
14 MR CASKIE: You say -- the next thing that you address is
15 alcoholism, and that speaks for itself. We don't need
16 to go there.
17 MR SMITH: Okay.
18 MR CASKIE: But in terms of homelessness and addiction
19 support, you say something at 154. Could you just
20 read 154?
21 MR SMITH: Yeah.
22 "Around 80% of the homeless individuals that we
23 support have some kind of addiction need and this has
24 and did remain fairly static throughout the pandemic."
25 I would say that most people who come into our

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1 homeless services are kind of chaotic and have either
2 drug or alcohol or a severe enduring mental health
3 issue. And you could argue all day kind of why and what
4 came first, et cetera, but I think that -- if you are
5 homeless and coming into services and all you need is
6 a new accommodation, that can be -- that's fairly easy
7 to -- not easy to resolve, that's -- "I need a house"
8 and we can support you to get a house, but it's the
9 maintaining the house. It's the other issues that are
10 preventing people from maintaining the house which are
11 an issue, and I would say that number of 80% is still
12 around where we are.
13 MR CASKIE: Okay. You talk about the impact on you as chief
14 executive officer and, again, at 159, you talk about
15 your team being strong and good.
16 MR SMITH: I would say they're a fantastic team and, as
17 I say, what was -- we talked about that can-do attitude
18 and a lot of that came from the teams, saying, "That's
19 something we want to do". We're here to work with kind
20 of some of the most complex people in Dundee and it's
21 important that we do that and give people who need that
22 support the support they need.
23 MR CASKIE: In light of the lessons that your organisation
24 considers it's learned, you say something about
25 developing policy. Can I ask you to read 165?

1 MR SMITH: "We found that a lot of organisations were very
2 keen to engage with developing policy especially within
3 the third sector. For example, the Health and Social
4 Care Partnership were very engaged and there were
5 individuals within that who were super engaged. The
6 Scottish Government were also well engaged but found
7 that the more 'arm's length' organisations, such as the
8 Scottish Social Services Council and the
9 Care Inspectorate were not as helpful as they could have
10 been."
11 MR CASKIE: You then say the lessons to be learned is about
12 communications and consistency.
13 MR SMITH: Yes. Yeah, as I say, I think it is about kind of
14 everybody being aware of what their role is and who is
15 taking those roles. I think there was too much
16 insularity by some organisations, kind of national
17 organisations, who were looking at their own kind of --
18 what they were doing and didn't see what it was like on
19 the ground and how -- and at the heart of what we were
20 doing were service users, and service users who were
21 struggling and requiring support, and it was important
22 that their voice was heard in all of this. And I think
23 kind of that communication from service users -- and
24 maybe we're at fault in that as well -- wasn't getting
25 up to those organisations to kind of tell them what

1 service users were at the heart of it.
2 MR CASKIE: Mr Smith, I've tried to ask you all the
3 questions that I think are relevant. Is there anything
4 useful and necessary that you think you can add at this
5 stage?
6 MR SMITH: No, I'm quite satisfied with what I've said to
7 this point, other than to kind of again thank the
8 organisation and the staff team for the service they
9 provided during the pandemic because it was a remarkable
10 job.
11 MR CASKIE: Ms McLaren, the same question for you: is there
12 anything that you considered you can usefully add that
13 we haven't heard yet?
14 MS MCLAREN: No. No, thank you.
15 MR CASKIE: Can I thank you both for your attendance today
16 and your evidence on behalf of the Inquiry.
17 MR SMITH: Thank you.
18 MS MCLAREN: Thank you.
19 THE CHAIR: Indeed. Thank you both.
20 1.30 for the next session?
21 MR CASKIE: I think that's correct, my Lord.
22 (12.16 pm)
23 (The short adjournment)
24 (1.29 pm)
25 THE CHAIR: Good afternoon, Mr Gale.

1 MR GALE: Good afternoon, my Lord.
2 MR MICHAEL JOHN MCKIRDY (called)
3 THE CHAIR: Good afternoon, Mr McKirdy.
4 A. Good afternoon, my Lord.
5 THE CHAIR: When you're ready, Mr Gale.
6 MR GALE: Thank you, my Lord.
7 Questions by MR GALE
8 MR GALE: Yes, the next witness is Michael John McKirdy.
9 His witness statement reference is SCI-WT0148-000001.
10 Mr McKirdy, I think I've given your full name; is
11 that right?
12 A. Yes, indeed.
13 Q. As with all witnesses, you have provided the Inquiry
14 with a detailed statement of your evidence to us and you
15 are content that that statement is published and also
16 that the evidence that you give to us today in
17 amplification of that statement is recorded and also
18 published; is that correct?
19 A. That's correct, Mr Gale. There are minor typographical
20 errors here and there, for which I take responsibility,
21 but there are two perhaps that we should correct, if
22 I can.
23 Q. Yes, please.
24 A. At paragraph 22, on the fifth line, it reads:
25 "The colleges were working with these associations

1 to do work on the prisonisation ..."
2 That should be "prioritisation".
3 Q. Yes, thank you. I did have to look up what
4 "prisonisation" was. There is such a word.
5 A. But that's not what I meant. And at paragraph 53, our
6 patients in the Clyde catchment area are mainly in the
7 Islands and Argyll, but it would not be usual for us to
8 see patients from the Western Isles. They would tend to
9 go to Inverness. So the Islands and Argyll.
10 Q. Inner islands, yes.
11 A. Yes. Apologies for those.
12 Q. Thank you very much indeed for that.
13 Now, you are president of the Royal College of
14 Physicians and Surgeons of Glasgow?
15 A. Correct.
16 Q. From paragraphs 4 and 5, we can see that you became
17 president in 2021 --
18 A. Yes.
19 Q. -- and I think your tenure of office continues
20 until December of this year, so a three-year tenure?
21 A. That's correct.
22 Q. Prior to that you were president elect from
23 December 2020 and then, prior to that and as from the
24 outset of the pandemic, you were, amongst other things,
25 the director of global health and chairman of the

1 Hope Foundation of the college?
2 A. Correct.
3 Q. Could you just briefly indicate what the role of
4 director of global health involved?
5 A. So that's a good question, Mr Gale. After the pandemic
6 began, "global health" began to assume all sorts of
7 different connotations, but, up until that time, for
8 those of us working in NHS Scotland, it usually meant
9 involvement in the Global Citizenship programme, by
10 which we volunteer for projects in low and middle income
11 countries. The projects that we were involved in in the
12 college mainly were centred around Malawi and support
13 for medical services in that country. So as director of
14 global health, I was responsible for those programmes of
15 activity within the college and I also had a role from
16 2018 onwards as part of the Global Citizenship programme
17 for NHS Scotland.
18 Q. The Hope Foundation of the college, is that something
19 different?
20 A. It is slightly different. It's a charitable part of the
21 college which does raise money for our work in Malawi
22 but it also raises money for projects closer to home,
23 usually in our medical charitable sector.
24 Q. I think we get a flavour of obviously the work of the
25 college in the particular overview of the college's

1 activities that you've given in your statement and
2 I think we can obviously take from that some of the
3 roles that you would have in those activities, so
4 I think we'll leave that as is said. Can I just
5 indicate at this stage that, because of time
6 constraints -- and there is a good deal of substance
7 that we want to go through in your statement -- there
8 will be parts of the statement that I won't touch on,
9 but please be assured that the Inquiry will be taking
10 into account everything that's said in your statement
11 and will be utilising it as we progress further.
12 Your own area of specialty, I think, as you say, is
13 that from 2017 you've dealt only with breast cancer
14 surgery.
15 A. Yes. I've always specialised in breast cancer but,
16 between appointment in 1997 as a consultant and 2017,
17 I also had responsibilities, my Lord, in general surgery
18 and general surgical emergency work. But from 2017
19 onwards, my clinical practice was exclusively in the
20 field of breast surgery.
21 Q. I think many of the comments that you make as we
22 progress through your statement are either directly
23 informed by your experience in the treatment of women
24 with breast cancer during the pandemic or are
25 observations based on that experience that you can apply

1 to other areas of surgery.
2 A. Yes.
3 Q. I think that would be correct in saying.
4 A. Yes.
5 Q. Now, you have a section at paragraphs 16 to 20 in your
6 statement in which you deal with the college's role as
7 an educational and assessment institute. We can again
8 obviously read that section. That section has been
9 passed on to my colleagues in the Inquiry who are
10 dealing with the implications of strategic decisions
11 that were taken in respect of education and, on their
12 behalf, there are one or two questions I've been asked
13 to ask you specifically, but they may well come back to
14 you in respect of other matters. But at this stage,
15 just a few matters.
16 At paragraph 8 of your statement, you refer to the
17 work that the college does in relation to CPD and
18 post-graduate work. It's really the post-graduate work
19 that I'm interested in. Is that internal post-graduate
20 work or is it in conjunction with other institutions?
21 A. A bit of both. Our main work would be working in
22 partnership with the other colleges of physicians in the
23 UK. That's the Royal College of Physicians here in
24 Edinburgh and the Royal College of Physicians in London.
25 On the surgical side of the coin, we work with four --

1 three other colleges in a conglomerate of four: the
2 Royal College of Surgeons of Edinburgh, the
3 Royal College of Surgeons of England and the Royal
4 College of Surgeons in Ireland. So post-graduate
5 training, education and assessment in surgery is on a UK
6 and Ireland basis and post-graduate training, education
7 and assessment in the physicianly specialties is done on
8 a UK-wide basis.
9 Q. Thank you. In the period of the pandemic -- I'm sorry,
10 let's go before the pandemic. Pre-pandemic, were these
11 post-graduate courses, if I can call them that -- were
12 they taught in person or were they taught online?
13 A. So mainly our teaching would have been in person prior
14 to the pandemic. Some work would have been delivered
15 online and we had a suite of materials available to
16 trainees which they could then access in their own time
17 by logging in and accessing preparation materials for
18 their learning. But most of our day-to-day
19 post-graduate teaching and training would have been done
20 face to face.
21 Q. Right. And did that cease?
22 A. Yes, obviously, immediately.
23 Q. When that ceased, did it go online?
24 A. Yes. I think we learned how to do that pretty quickly,
25 yeah.

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1 Q. Did that cause problems?
2 A. In terms of teaching in a didactic sense of sharing
3 information, not particularly, because we did have some
4 online experience and it's easy enough to deliver that,
5 so no particular problems with teaching. Clinical
6 skills and clinical training were obviously impacted by
7 the pandemic and the emergency that followed.
8 Q. Yes.
9 A. It would also be, I think, important to note that there
10 were some upsides to that teaching moving online, which
11 was an expansion of our capacity and an expansion of an
12 audience, and we have kept to that now, some years
13 later, and we use much more online teaching in order to
14 reach audiences and save travel and so on.
15 Q. And given that a considerable number of your students
16 will have been overseas students --
17 A. Yes.
18 Q. -- I take it that a lot of the online teaching would
19 have been recorded --
20 A. Yes.
21 Q. -- so that you could avoid the difficulties inherent in
22 live teaching with time differences?
23 A. Yeah, and I think all of that we did -- and we had done
24 some before the pandemic -- that was accelerated during
25 it and then we've been able to continue with the good

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1 parts of that since.
2 Q. The students who, as it were, pivoted over the start of
3 the pandemic, they had started their work with the
4 college prior to the pandemic and then transferred to it
5 being online, did they continue to do so post the
6 pandemic?
7 A. Yes, they will have done. I think everybody -- as we
8 recovered out of the pandemic, I think people were
9 grateful for the opportunity to meet face to face and do
10 more of the face-to-face type teaching and learning that
11 we had been familiar with before the pandemic, but we've
12 continued to deliver much online.
13 Q. Was there any appreciable effect on attainment?
14 A. We've not found any evidence of attainment of knowledge.
15 There has been an issue, which I think I allude to in
16 paragraph 60 of my statement, about attainment of
17 clinical skills. Obviously -- perhaps the most obvious
18 example would be around elective surgery, and during the
19 pandemic it was not possible to conduct major surgery
20 and the Inquiry will be familiar with the impact that
21 that's had on waiting lists in the NHS. In many ways
22 the waiting lists are obviously sadly people waiting for
23 treatment but they're also a waiting list of training
24 opportunities for those who would normally be learning
25 by being involved in that kind of surgery. So, for

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1 example, hip replacements, an orthopaedic trainee hoping
2 to become an orthopaedic surgeon will have to have
3 experience of hip replacement surgery and, because that
4 kind of surgery was completely paused for a large part
5 of 2020 and into 2021, obviously that experience
6 couldn't be gained. So it wasn't necessarily a problem
7 of attainment; rather, one of attainment opportunity.
8 So it wasn't that attainment was itself impacted. The
9 trainees were perfectly able to attain knowledge and
10 experience. It's just that that kind of experience was
11 not available to them at that time.
12 Q. Okay, so qualification delayed?
13 A. Delayed, yes, so training was lengthened for many
14 people. So we have time -- structured time for training
15 and most programmes, they run over a period of years.
16 There's always been a possibility for trainees who
17 needed extra time to be given that, but those trainees
18 in that position obviously increased in number during
19 the pandemic.
20 THE CHAIR: And I suppose, from the individual trainee
21 surgeon's perspective, potential deferment of promotion
22 and therefore deferment of advancement of income
23 opportunity?
24 A. I'm sorry, my Lord, I'm slightly hard of hearing so
25 that's difficult for me to pick up everything you said.

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1 Apologies.
2 THE CHAIR: What I was suggesting was the delays occasioned
3 in training because of the lack of the experience
4 opportunities would probably, I suspect, also mean delay
5 of employment advancement, promotion to consultant rank
6 and therefore, no doubt, over a career, some income
7 diminution for the surgeons involved?
8 A. I think that's a very fair point, my Lord. I'm not
9 aware of anybody quantifying that in any way to date,
10 but there undoubtedly will have been people who will
11 have been delayed in taking up consultant post because
12 they were unable to attain all of their competencies in
13 the time that they would have normally expected to.
14 I think, as trainers, we tried very hard in 2021 to
15 ensure that that was minimised as much as possible, and
16 that did involve some trainees moving their training
17 environment, for example, to take up opportunities. One
18 of the things we've been able to do, the surgical
19 colleges, is, for example, negotiate access to the
20 waiting list recovery activities, some of which took
21 place in the private sector as well as in the public
22 sector, and to negotiate that trainees were able to gain
23 as much competence -- as much experience as possible, as
24 quickly as possible, to try and minimise the impact that
25 you described. But I think what you say is very fair.

1 THE CHAIR: Thank you. Mr Gale.
2 MR GALE: Thank you, my Lord.
3 I don't know again whether this is something that is
4 measurable or has been measured, but has there been,
5 either in the short term or in the medium term, an
6 appreciable deficit in the skills that one would have
7 otherwise expected in surgical work?
8 A. Not that I am aware of in any measurable way, Mr Gale.
9 I think there are always individual cases and anecdotes
10 of somebody who would say, "I don't think I've had
11 enough experience". The NHS is a big busy place and
12 I think the concept that we've had previously of the
13 iconoclastic consultant surgeon who doesn't work as
14 a part of a team is rather outdated. So anybody who
15 perhaps had felt that they hadn't had the opportunity to
16 gain as much experience for a particular procedure at
17 the time of appointment would be functioning as part of
18 a team and would have ongoing mentoring and support. So
19 I'm not aware of that being a major problem in any of
20 the common surgical specialties.
21 Q. Thank you. Can I move to the section of your statement
22 on public affairs, please? Prior to this, you've
23 mentioned in paragraph 9 of your statement that the
24 college plays a role in public policy and, in that
25 connection, it has an ongoing interaction with the

1 UK Government and also with the devolved administrations
2 as well as other campaigning groups --
3 A. Yes.
4 Q. -- and influencing groups. I think one of the areas
5 you've mentioned is the area of climate change. You've
6 also mentioned the area of minimum pricing --
7 A. Yes.
8 Q. -- which I think is an issue that's come up today,
9 I notice in the news.
10 In this regard and having regard to the pandemic,
11 you mention at paragraph 21 that before surgical
12 colleges worked with what you call the "Specialty
13 Associations in Surgery" to do work with the
14 prioritisation of surgery.
15 A. Yes.
16 Q. Can you just explain what that involved?
17 A. So the group that I became involved in was organised by
18 the UK Government Department of Health in London. It
19 was a series of Teams meetings. The specialty
20 associations -- my Lord, there are ten recognised
21 specialties in surgery, from general surgery, mainly
22 abdominal surgery, trauma and orthopaedics,
23 neurosurgery, ENT and so on, and each of these
24 specialties has a specialty association, which would be
25 the recognised body for particular information within

1 that specialty.
2 We worked very closely with them to look across the
3 spectrum of work that would be in their specialty and
4 worked to try and prioritise the things that should be
5 done, no matter the pandemic going on, and other things
6 which could be safely deferred at that time and would be
7 better not done. That was a fluid situation which
8 changed through 2020 and then, in 2021, as the
9 population was vaccinated and so on, that changed. So
10 we worked together and collaboratively with all four
11 surgical colleges represented, with the Government and
12 civil servants to help us with that work and with the
13 specialist input of each of the specialty associations.
14 So, for example, in plastic surgery, there was
15 a very strong view that some of the more complex
16 time-consuming operations which could be safely delayed
17 with no particular outcome to the patient -- other than
18 disappointment about delay, but there was no medical
19 emergency for those surgeries to take place -- would be
20 in a different situation, for example, than the people
21 within plastic surgery doing cancer surgery. So the
22 cancer surgery would be prioritised, but more cosmetic
23 type of procedures -- and I don't mean by that cosmetic
24 surgery. I mean by that procedures which people needed
25 for good health reasons but which could be safely

1 delayed, obviously with patient and to a large extent
2 surgeon disappointment -- but it was safer to delay
3 those and to make the available space and prioritise
4 those patients, for example, with cancer or more urgent
5 conditions.
6 Q. I think, quite fairly on your part, at paragraph 24 of
7 your statement you do acknowledge the demands that were
8 placed on health departments and -- well, governments in
9 general and health departments in particular. But you
10 also recognise the demands that were placed on
11 clinicians and it was in that context that you felt that
12 it was important that policy work continued to inform
13 the decisions that were being taken by Government during
14 the pandemic.
15 A. Yeah.
16 Q. Is that correct?
17 A. Very much so, Mr Gale. And I think -- again, I'd maybe
18 draw the Inquiry's attention to the fact that nobody had
19 been in this situation before. There was no lived
20 experience of dealing with trying to deliver, in the
21 longer term, clinical care with the background of the
22 pandemic. Nobody had any experience of that and
23 therefore people were placed in a difficult situation.
24 Everybody was. The population was.
25 But within the delivery of healthcare, we had to

1 work collaboratively with clinical leadership but also
2 with scientific input, with managerial input and we also
3 had to do our very best to work together with all
4 parties. And while there was a public-facing aspect for
5 governments, there also needed to be a practical aspect
6 of delivery of care and that required clinical input.
7 To some extent, it's very difficult to remember what
8 things were like, wasn't it? But in 2020 our evening
9 news looked like continued professional development for
10 everybody, including the population. So we were all in
11 a situation of new learning on a week-to-week basis, but
12 everybody was aware of those responsibilities in my
13 experience.
14 Q. Right. You mention one particular area and one
15 particular issue in paragraph 25, which is called
16 "Aerosol-generating procedures" or "AGPs".
17 A. Yes.
18 Q. Now, one of the things we have heard a little bit about
19 in the Inquiry is a concern, at least initially , that
20 a view was taken, particularly by Government in
21 Scotland, that the means of transmission of Corona virus
22 COVID 19 was by droplet rather than aerosol
23 transmission. Was that something that was in mind when
24 you became involved in or your college became involved
25 in the aerosol-generating procedures?

1 A. I think -- again, for context, I think it would be
2 really important to say -- and I've worked in operating
3 theatres since I graduated in 1985 -- I don't think I'd
4 ever heard of the term "aerosol-generating procedures"
5 until 2020. So although we were aware that infection
6 could be spread and the aerosol and droplets, I don't
7 think anyone practising in surgery was particularly
8 expert in any of that. We had to become aware of the
9 means of transmission of a new disease, again that was
10 growing information -- I'm alluding back to these early
11 months in 2020 when we knew very little about this
12 virus -- but we were looking at how could we continue
13 clinical care. And at the very beginning, all that we
14 did was emergency work, but then looking to try and find
15 out if we could expand on that and begin to bring in
16 other procedures to our work, urgent work, for example,
17 in endoscopy -- these are procedures to investigate
18 symptoms in the bowel, either from the upper GI tract or
19 the lower GI tract -- we were aware of infection issues
20 around endoscopy previously and people were concerned
21 that would these procedures in some way help the
22 transmission of COVID.
23 So all of that work was, to some extent, to try and
24 establish the facts, what could and could not be safely
25 done. And in the early days we left very long periods

1 of time between operations in the operating theatre in
2 order for the air in the operating theatre to be
3 changed. Remember also in these first few weeks we had
4 no capacity to test anybody. There was no capacity to
5 test the patients nor to test the staff so we didn't
6 know who did and didn't have COVID. And there was --
7 again I think it's pertinent for the Inquiry and for me
8 to remember back to those early few weeks -- there was
9 a sense of anxiety because healthcare staff, as the
10 population did -- people were dying of COVID and getting
11 extremely ill with COVID and nobody really knew that
12 much in those first few weeks and in those first few
13 months about how it might be spread. So I think it's
14 difficult to disentangle hindsight from how we were
15 feeling at that time.
16 Q. Yes. I think one of the things that you've mentioned
17 already was the need to work collaboratively.
18 A. Yes.
19 Q. I think also you mention that there was a responsibility
20 on the college --
21 A. Yeah.
22 Q. -- to share and disseminate the information that it had
23 within its membership --
24 A. Yeah.
25 Q. -- to its fellows and members.

1 A. Yes.
2 Q. So, again, can you give us perhaps some examples in the
3 context of the pandemic that you were doing that?
4 A. So we were able to hold webinars for our fellowship
5 which were open to all of our fellows, many of whom work
6 outside the UK, and these were webinars aimed to educate
7 our fellows and members of what we were learning about
8 COVID. So we were able to hold those webinars. We were
9 also able to input to the webinars that others were
10 holding. So in my own specialty, in breast surgery, we
11 held weekly webinars at the very beginning to look at
12 just how we could deliver the service in breast cancer.
13 At the college these would be more widely based around
14 all medical and surgical treatment at that time and the
15 learning around COVID. So this was to provide very
16 rapid updates, almost in real-time, for our fellowship
17 and to encourage them to take part in these type of
18 events run by their own specialty organisations.
19 Q. I think one of the points you make subsequently in this
20 section in your lessons to be learned is that perhaps
21 one of the benefits, on a positive side, of the pandemic
22 is and has been the increased use of collaborative
23 working.
24 A. Without doubt I think we're all aware that that period
25 of time brought us all together, established

1 relationships and -- it's not that -- I wouldn't want to
2 give the impression that everything in medicine and
3 surgery prior to that was competitive and
4 non-collaborative, but I think it's important to note
5 that one of the positive outcomes of the pandemic has
6 been an appreciation of working together across
7 colleges, across the profession, working with civil
8 servants and governments and so on, to try and improve
9 the outcomes and delivery of care. I sense that that is
10 still the case and indeed, at a meeting here in
11 Edinburgh only yesterday morning, we were expressing
12 that from the four surgical colleges meeting together
13 here, that we feel that there is a stronger
14 establishment of collaboration than there might have
15 been prior to the pandemic.
16 Q. Thank you. I am going to come back to your specialty of
17 cancer treatment and surgery because that is really
18 perhaps the substance of your particular experience, but
19 there are one or two other things I'd like to touch on
20 before I do that. The first is PPE, which you mention
21 at paragraph 61 and following. You do say that in your
22 own specialty you didn't have a specific problem with
23 PPE at any point, but one of the problems I think you --
24 well, a number of problems that you do highlight and one
25 you've already alluded to was the washing-down of rooms

1 and the doffing and donning of PPE in the context of
2 surgery. Can you explain the implications of that?
3 A. So maybe it started in the outpatient department. It
4 would be normal in an outpatient department for doctors
5 to be wearing their own clothes, for no PPE to be used
6 and for the room to be tidied up between patients but
7 not necessarily every surface washed down. What we were
8 then doing is, between patients, we were taking off
9 aprons, masks, changing things. We didn't have
10 a situation where we needed to wear eye protection in
11 the outpatient department. But then every surface would
12 be washed down and then prepared for the next patient
13 coming in, with putting on a new mask, a new pair of
14 gloves, a new apron and so on. So there was
15 a turnaround just delay of not very long in an
16 outpatient department, but significant, and also there
17 was all the social distancing regulations about distance
18 and so on, so our throughput was cut down a bit in an
19 outpatient setting.
20 In an operating theatre session, the PPE was more
21 extensive because there was more exposure to body
22 fluids, aerosol and so on, droplets, as we were
23 discussing earlier, and so the donning and doffing of
24 theatre gowns, masks, eye protection and so on was much
25 more extensive. Not just cleaning the theatre as we

1 would usually do, pre-pandemic, between patients, but
2 also allowing these air changes to happen. So there
3 were necessarily delays between patients which were much
4 longer than would have occurred pre-pandemic.
5 Q. I think also there is perhaps some more nuanced problems
6 as well. In your particular area of specialty, but
7 obviously in many other areas of specialty, being told
8 that you have cancer and particularly in the case of
9 a woman being told that she has breast cancer is
10 a devastating experience. One of the points you make at
11 various points in your statement is the inevitable
12 difficulty of displaying perhaps the necessary degree of
13 empathy and sympathy if you're having to wear a mask.
14 Was that a difficulty that you found in your dealings
15 with patients?
16 A. Yes, I think all communication was made more difficult
17 by the situation we found ourselves in in the pandemic.
18 Our environment had changed, as we were just discussing,
19 and how we used even a familiar environment was very
20 different. The clothes we were wearing were different.
21 Patients were more anxious because they were aware they
22 were coming to a hospital which would have -- in
23 a hospital situation, would have held patients who had
24 COVID. And our hospital in Paisley had temporary fences
25 down the middle of the front hall in order to keep

1 patient flows down one way and out the other, as we were
2 all familiar with in stations and other public places at
3 that time. So there was a slight anxiety of fear. So
4 that's the kind of background. Then if you add to that
5 that people are wearing a mask, it means our
6 communication ability as two human beings is compromised
7 because all we really have to go on is speech and our
8 eyes and you're not really seeing the whole facial
9 expression of somebody.
10 Also we need to remember that in many outpatient
11 settings it was not possible for patients to bring in
12 a supporter and they were often alone, so that would
13 heighten everybody's anxiety. I think in communication
14 we often think -- and we did have to use the telephone,
15 and I allude to that in my statement, to break bad news
16 on occasion, which was not something that would be
17 normal practice pre-pandemic. I, in my clinical
18 practice, would have told two or three women every
19 working week that they have breast cancer, so it's
20 something I'm very familiar with doing over many, many
21 years. You're then trying to do this in a very
22 unfamiliar environment. And, for example, to use the
23 telephone when all we have is our speech and listening,
24 we don't have any sense of how the patient is looking,
25 what their comprehension is of what we're saying to

1 them, the degree not just of comprehension of what we've
2 just said but also their level of fear and anxiety about
3 what we've just said; does something need to be repeated
4 or would it be best to leave a pause or -- you're
5 working rather literally in the dark because you can't
6 see that patient.
7 Q. Also possibly the level of understanding?
8 A. Yes, yes. So all of that was challenging and very
9 challenging for patients and their families during that
10 time. But I think we became very quickly conscious of
11 that, and one of the things we discussed was trying to
12 adapt our communication to the situation we found
13 ourselves in. I've alluded already -- apologies,
14 Lord Brailsford -- my deafness means I wear bilateral
15 hearing aids, and so to have a mask hooked round your
16 hearing aids was also uncomfortable and difficult and
17 not what you were used to and it meant my capacity to do
18 a little bit of informal lip-reading of what patients
19 were saying was compromised because I couldn't see their
20 mouth moving.
21 So there were all sorts of aspects to our normal
22 communication. And communication is a major part of all
23 medical practice, but the breaking of bad news is
24 a particular theme in all of that and that's something
25 which one develops skills and expertise in as years of

1 practice go on, and that was disrupted by the pandemic,
2 so it was challenging for everybody.
3 Q. I think you've also mentioned the requirements of social
4 distancing --
5 A. Yes.
6 Q. -- and perhaps the inability to have a supporter there
7 with the patient.
8 A. Yes.
9 Q. And that was obviously something that would probably
10 have been familiar to you pre-pandemic. In the course
11 of the pandemic, was the position that a patient could
12 not have a supporter with them or was there a little
13 discretion to be allowed?
14 A. There was certainly discretion in that. We obviously
15 kept to the rules in terms of number of people in
16 a room, and that was calculated for each room and the
17 spaces that we used. But we were fortunate to have
18 rooms that were big enough to allow three or sometimes
19 four people to be in a room. But, again, the sense of
20 disruption, I think, particularly in that first acute
21 period, was difficult.
22 We'd learned to manage it, but in a normal
23 consultation, to meet somebody and go over the news
24 about their breast cancer diagnosis, that would be
25 normal for us to encourage somebody to bring somebody

1 with them. So you would usually ask a patient if there
2 was anybody they would like to bring with them and, if
3 they said "No", often you would probe that to say,
4 "Nobody else? Maybe a friend or a neighbour or a family
5 member", just to make sure there was somebody else there
6 to hear what was being said and for them to check out
7 that communication with them after. It would also be
8 normal for us to have a breast care nurse in the room at
9 that time in order to support the patient with a further
10 conversation after the conversation with the surgeon was
11 over.
12 All of that kind of normality to our work, which had
13 come to be part of common practice in cancer work over
14 a period of 20/30/40 years, where we're trying to
15 improve our communication with patients and their
16 families, that was disrupted by the pandemic and a bit
17 difficult. A very simple thing: in my entire career,
18 every outpatient I met, I would offer to shake their
19 hand as an initial human contact at the beginning of
20 a consultation and to shake their hand again at the end
21 of the consultation as an affirmation of my concern and
22 relationship with them. That wasn't possible during
23 COVID. So these kind of things had an impact on, I'm
24 certain, patients but they also had an impact on staff,
25 of being disruptive of normal work.

1 THE CHAIR: Might I, at the terrible risk of resorting to
2 anecdote and also possibly at the risk of giving
3 evidence, which I shouldn't do, add my little bit there?
4 And that is, from the patient's perspective, which
5 I have some recent experience of, it is very important,
6 I would suggest, that the patient is comfortable and has
7 confidence in the treating clinician, particularly
8 a consultant, and therefore exactly the touches you've
9 just been talking about, shaking hands with the patient,
10 is extremely important and I would imagine, if that were
11 absent, it doesn't make what is a difficult task any
12 easier.
13 A. Thank you. I think that's well observed, my Lord, yes.
14 MR GALE: Thank you, my Lord.
15 You've touched on staff and I wonder if I can move
16 on to the support of staff. I think you're talking here
17 about your clinical staff rather than the college
18 staff --
19 A. Yes, indeed.
20 Q. -- and I'm sure my colleagues in one of the other
21 portfolios may be in touch with you about the
22 furloughing of staff and matters such as that within the
23 college. But can we deal with the supporting of staff?
24 This is at -- you have this at, amongst other places,
25 paragraphs 67 and following. One of the things you talk

1 about are staff well-being hubs and that these were
2 staffed by people who were not being utilised by the
3 airlines.
4 A. Yes.
5 Q. I assume that they were being utilised within
6 Glasgow Airport?
7 A. Well, no, the staff from Glasgow Airport -- I think it
8 was from a number of different airlines -- but they made
9 themselves available and came to the hospital, and we
10 used a vacant piece of space within the RAH to have
11 a well-being hub, a kind of cafe-type area, and it was
12 staffed by people who were otherwise not working and
13 presumably furloughed by their employers at that time.
14 Q. What did they actually provide?
15 A. Oh, I think tea and coffee, a space where people could
16 socially-distanced be together, as it were, so you could
17 still see that your colleagues were there. That was all
18 I ever used it for. I think in different circumstances
19 round the NHS, there was the provision of food. That
20 was sometimes supplied by outside caterers, who wished
21 to do something for the NHS. There were a variety of
22 people volunteering to help with the general well-being
23 materials of somebody to talk to, well-being materials
24 to remind people of how to look after themselves well
25 during that time and so on. My main connection with

1 them was getting a cup of tea or a cup of coffee,
2 I would have to say, rather than anything else.
3 Q. One point you make in paragraph 69 is that there was
4 a concern obviously about junior members of staff --
5 A. Yeah.
6 Q. -- and also trainees.
7 A. Yeah.
8 Q. I think you've mentioned the impact on trainees as well.
9 The particular concern is for the case of trainees who
10 were from overseas --
11 A. Yes.
12 Q. -- because they didn't have the luxury, if I can put it
13 that way, of returning to their home?
14 A. Yes, I think we were very conscious -- and this was
15 something the college had a particular insight on -- one
16 of our key themes during all of this period of time, put
17 in place by my predecessor as president, was about the
18 well-being of staff and also of inclusivity. Many of
19 our staff are international medical graduates who have
20 come to train in the UK. They would not then have the
21 normal family network necessarily at home. Some of them
22 will have been married and with children here in the UK,
23 but many more were likely to be living alone and also in
24 a situation where they were worried about family members
25 back home. And we were very conscious of that; for

1 example, when you saw on the news reports of the impact
2 of COVID in India or -- which I can remember watching on
3 the television how things were there -- in Hong Kong, in
4 China, in other parts of the world, in Africa, we were
5 very aware that that was a real concern for those people
6 whose families were living in those countries. So
7 I think they did need some extra support, even if that
8 was simply a support of conversation to say, "How are
9 things for you and your family?", and so on. But also
10 aware of those who were alone, and that's not
11 necessarily only our international medical graduates but
12 anybody who was living alone because we couldn't visit
13 families, we couldn't go to our parents' homes, we
14 couldn't go to other people's homes at that time. So we
15 were very conscious that anybody who was living alone --
16 maybe their only other contact with anybody was coming
17 to work, so that should be a supportive environment and
18 we should be aware of their challenge and difficulties
19 and be supportive to them.
20 Q. Yes. I'll come on in a little to the mental health
21 impacts both on patients and staff, but just keeping on
22 the matter of staff, at paragraph 70 you say:
23 "Overall, by the end of the pandemic, most of the
24 staff that we lost were those who were coming up to
25 retirement anyway ..."

1 So, if I can put it this way, the elderly, in terms
2 of the working population, cohort of nurses and other
3 staff who did not come back after the pandemic, and you
4 say they felt like they had had enough.
5 A. Yes.
6 Q. Was that something that you were coming across as an
7 expression?
8 A. Yes, and I think, as ever, these things are
9 multi-factorial, aren't they?
10 Q. Yes.
11 A. It was a very traumatic time for people. Often, as
12 people come to the end of their career, there will be
13 a discussion of should they stay on for a bit -- they've
14 reached a stage in life where they perhaps could retire
15 but they're a little fearful of retirement, what that
16 might mean -- should they stay on and work a little bit
17 longer. I think COVID made people's minds up a bit more
18 sharply across many of our staff groups. And for
19 nursing staff, who often -- nursing staff of my
20 generation would often have the capacity to retire in
21 their late 50s because they'd started work in the NHS
22 often on leaving school at the age of 16 or 17, so, as
23 they came into their late 50s/early 60s, many of them
24 would have had the financial capacity to retire.
25 Two/three challenging years of being redeployed

1 across the hospital, of a lot of change in working
2 environment and also perhaps for all of us a sense of
3 our own mortality that we had been given by the pandemic
4 because many people lost loved ones during the
5 pandemic -- so all of that would have added up to,
6 I think, more people coming out of the workforce. And
7 I think that's borne out by the statistics of the number
8 of people who are economically not active but are in
9 working age, and that's particularly for those people in
10 their late 50s/early 60s.
11 Q. I'm brought on to the topic of mental health, as I think
12 I indicated. In paragraphs 81 to 83 of your statement
13 you talk about that. You begin with a general
14 observation, which I think we probably heard from
15 a number of witnesses. I'm interested to understand it
16 from your perspective. You say:
17 "Overall it can be seen that the mental health of
18 the nation was impacted by the pandemic."
19 Can you explain -- it may be something that's quite
20 obvious, but if you can just explain your perspective on
21 that, please.
22 A. So if on any one day you survey a large enough
23 population of adults, you will find that somewhere
24 between 15% and 20%, without necessarily knowing there's
25 any disruption of their mental health, will be

1 exhibiting traits of anxiety or depression, sometimes
2 called "common mental health disorder", so not
3 necessarily a mental health issue which needs serious
4 psychiatric treatment, but these days commonly known as
5 "mental health" and often addressed in that way.
6 That figure of 15% to 20% of people who may be
7 exhibiting traits, showing their anxiety and depression,
8 if surveyed -- more surveys as we came out of the
9 pandemic showed that that figure had doubled to
10 something around 35% to 40%. So there's very clear
11 statistical evidence from surveys that the background
12 level of anxiety and depression amongst the population
13 had doubled at that time.
14 Similar surveys of staff in the NHS confirmed that,
15 and again that that rate had increased, and there are
16 deeper-level studies looking into people exhibiting
17 slightly more concerning behaviours. Something that
18 might be termed as "post-traumatic stress" or abuse of
19 alcohol or drugs, those figures had increased during
20 that time also. And those surveys have been carried out
21 in the general population and also on NHS staff.
22 Q. Again given your specialty, you do say in paragraph 82
23 that one particular group that was impacted was women
24 and, in particular, young women, and you go on to say
25 you'd run a clinic for many years or a number of years

1 for young women under the age of 30 with breast cancer
2 symptoms. Can you explain that and why you ran that
3 clinic and what reflection you have on that post the
4 pandemic?
5 A. So maybe to start it by explaining why we set up that
6 clinic. In our service we have very, very short waiting
7 times for our clinical service, and that's been the case
8 for very many years and has continued through the
9 pandemic and still is the case today, I'm pleased to
10 say.
11 One of the ways we've achieved these short waiting
12 times is by being innovative in our practice. So we'd
13 identified that there was a large increase in the number
14 of young women being referred to our service with
15 symptoms, but in fact breast cancer is a very unusual
16 diagnosis in a woman under the age of 30. Only 1%,
17 possibly up to 2%, in any one year of all of our
18 patients diagnosed with breast cancer will be in that
19 age group and yet they'll make up 20% to 25% of all the
20 women referred. The reason is that young women have
21 access, as we all have, I suppose -- but are much more
22 likely to look at social media and be familiar with
23 symptoms and be health-aware, and so more and more of
24 these young women were being referred to us.
25 In investigation of their symptoms, they will very,

1 very rarely ever require a mammogram, a breast x-ray,
2 and breast x-rays are a rate-limiting step for us in the
3 delivery of outpatient services. So, because of that,
4 we could bring these women to a single clinic where we
5 needn't have access to mammography but had access only
6 to breast ultrasound, and these patients could be seen
7 by, as it happened, me, somebody senior, and trained
8 personnel working with me, and in the vast majority
9 reassured quickly that they did not have breast cancer
10 and that they had nothing to worry about. So that was
11 the purpose in setting up that clinic and it's worked
12 very successfully over the years.
13 During COVID and subsequently, in the initial phase
14 of COVID, for many of these women, we didn't see them at
15 clinics because we simply telephoned them and told them
16 that they didn't have anything to worry about by reading
17 their file letter from their GP. Some of the symptoms
18 which they were worried about, they could be reassured
19 were not symptoms of cancer in somebody in that age
20 group, and so we deferred some of those people during
21 that initial phase of COVID.
22 Subsequent to that, though, I'm very conscious --
23 because that's a sub-group of all the people I see and
24 obviously, as a breast cancer specialist, most of my
25 work is with women -- I'm really conscious of the level

1 of anxiety -- and this is without me quantifying it in
2 any way, in a scientific way -- but just in day-to-day
3 interaction with these young women, they are much more
4 anxious than they were previously, and that's borne out
5 by these population surveys that I referred to earlier.
6 Q. Thank you. Obviously for a woman who has been diagnosed
7 with breast cancer, during the pandemic, if there was
8 a delay in treatment, whether that be surgical or
9 otherwise, that would increase that person's mental
10 anxiety over the progression of the disease and the
11 progression of treatment.
12 A. We did not have a major problem with that, Mr Gale. We
13 quickly put into place alternative means of practice
14 which made sure that we did diagnose those women
15 referred to us promptly and that we were able to put in
16 place treatment for them promptly. There are some --
17 and I've alluded to that in my statement -- there were
18 some areas where we had to change practice, but to make
19 sure that it was effective and timely was at all times
20 our priority, and so we did do that.
21 Perhaps one group that's worth mentioning, although
22 it was a very small group at the very beginning, was
23 women who were in the shielding group who were referred
24 with symptoms and for whom it was safer -- and I think
25 I allude to one conversation I had with a woman who was

1 in one of the islands who was very concerned that she
2 needed to come to the clinic and we explained that she
3 was better to stay where she was and have treatment with
4 a tablet, which, if she did have breast cancer, as her
5 GP believed that she did have, would be good and safe
6 and effective treatment for somebody in her age group,
7 and that's because many clinical trials over the years
8 have shown that what's called "primary endocrine
9 therapy", taking a tablet to treat breast cancer, is an
10 extremely safe and effective treatment in a woman over
11 the age of 70. So we already had those trials, as it
12 were, from a historical basis and we knew that was an
13 effective treatment and often, even in ideal practice,
14 is the best treatment for an elderly person who has
15 other comorbidities, making surgery unsafe for them.
16 So it was safer in those first few months, was our
17 national feeling and national guidance, to treat
18 patients with a tablet without knowing for definite that
19 they had cancer. And then, as we were able to bring
20 them to the clinic a few months later, undertake their
21 biopsies, prove they had cancer or not -- for a handful
22 they did not have a cancer and they had taken a few
23 months of a tablet to no great harm to them, no harm at
24 all -- but that was the safest thing to do. And so that
25 was a national guidance at the beginning of the pandemic

1 in 2020 and is a good example of a safe, effective means
2 of dealing with the pandemic's restrictions on normal
3 clinical practice to make sure that timely and effective
4 care was put in place. Sorry, I'll ...
5 Q. No, that's really helpful. Thank you.
6 Right. Can we go to the impact on your own
7 specialty now in a little more detail? If I can
8 contextualise this, we note from paragraph 27 that you
9 and your team of -- pre-pandemic -- four consultant
10 surgeons delivered a breast cancer service to around, on
11 average, 375 women in an average year.
12 A. Yes, that's newly diagnosed patients in a year. We
13 would normally be referred about 5,000 women to find
14 these 375 women who had breast cancer, so we normally
15 have about 100 referrals every week and we would
16 diagnose 375 or so women each year.
17 Q. Now, the pandemic had an effect on the number of
18 surgeons who were available within your team.
19 A. Yes.
20 Q. I think you were halved --
21 A. Yes.
22 Q. -- in simple terms. One was because of a surgeon being
23 reallocated to general surgery --
24 A. Yeah.
25 Q. -- another surgeon who was over 70 being shielded --

1 A. Yes.
2 Q. -- and it became the situation, as I understand it, that
3 you were operating from one place and your colleague,
4 she was operating from -- initially from the
5 Nuffield Hospital in Glasgow, where there were surgical
6 facilities.
7 A. Yes. The situation there was -- as I think I've
8 explained there and hopefully clearly -- that our normal
9 outpatient facilities in each of the hospitals from
10 which we run our service, at the Vale of Leven in
11 Alexandria, Inverclyde Royal Hospital in Greenock and
12 the Royal Alexandria in Paisley -- each of our
13 outpatient departments is actually very close to the A&E
14 or acute part of the hospital, and these areas were
15 repurposed during the pandemic in order to keep the flow
16 of patients who might have COVID separate from the
17 patients who did not have COVID or that did not have
18 COVID symptoms so that we could try and limit the spread
19 of infection within the hospital as much as possible, so
20 therefore our normal outpatients weren't available to
21 us -- outpatient facilities.
22 However, handily, luckily, breast screening was also
23 paused at that time -- that is the invitation of women
24 aged between 50 and 70 to come and have mammograms on
25 a three-yearly basis -- and the facility by which that

1 organisation in the west of Scotland happens for the
2 breast-screening service happens to be in Mandela Place
3 in the centre of town. So with the great help of
4 colleagues working in Mandela Place, I was able to
5 relocate our outpatient service to the centre of
6 Glasgow, meaning that the patients coming from outside
7 Glasgow, in the Clyde area, did have to travel into
8 Glasgow to come and meet us in an outpatient setting.
9 We were able to repurpose the rooms there because the
10 equipment we required, mammogram equipment and
11 ultrasound and so on, was already there, so the
12 diagnostic part of our practice moved to Mandela Place.
13 Similarly, for surgery, all of our acute hospital
14 surgical space was taken up by those people who did have
15 priority one urgent surgery, emergency surgery and that
16 was complex to deliver. We went from having one
17 intensive care unit in Paisley to having two all the
18 time and a third one on standby, which was only open
19 a couple of times. But we had to repurpose all of the
20 staff at that time.
21 So NHS Scotland in effect purchased from the private
22 sector -- in different parts of Scotland but certainly
23 in West and Central Scotland they purchased operating
24 time from the Nuffield Hospital, which had its own work
25 temporarily stopped anyway because of the pandemic, but

1 the theatre facilities were there, and so we worked
2 cooperatively with -- again with people who we were not
3 familiar with working with, but my colleague based
4 herself there and did the operating and I saw everybody
5 in the outpatient clinic and we kept in touch by phone
6 and Teams and we carried on.
7 I didn't allude to it in my statement, but I think
8 it's worth noting, if I may, my Lord, we would normally
9 have had a weekly meeting in which everybody involved in
10 the care of breast cancer patients in our area would
11 meet together, sometimes called a "multi-disciplinary
12 team meeting". And so the specialist surgeons would
13 meet with the specialist radiologists, pathologists and
14 nurses, oncology colleagues, and we would discuss the
15 management of a patient at a weekly team meeting. That
16 would have normally happened in a room like this, but
17 within the first week or two we moved it all to a Teams
18 meeting, technology which we were very unfamiliar with
19 at the beginning, but we were able to continue that
20 multi-disciplinary team management of all patients
21 diagnosed with breast cancer from essentially the very
22 beginning of the pandemic.
23 Q. Obviously the journey from screening through diagnosis
24 to treatment is a difficult and a long one.
25 A. Sure.

1 Q. Just because you've given us within your statement a lot
2 of detail about that journey for women either with or
3 leading up to the diagnosis of breast cancer, what, in
4 your view, as somebody who is at the very sharp end of
5 this, was the effect of the pandemic and the
6 restrictions in the early days? So if we take it up to,
7 say, September 2020, what was the effect on the
8 treatment that you were able to offer?
9 A. So I think, Mr Gale, I've given a couple of concrete
10 examples. So we had to change what we normally would
11 have done. So we changed the protocols by which we
12 would normally have delivered care. Good examples of
13 that are with chemotherapy. Chemotherapy is very
14 effective in particular situations in breast cancer and
15 for a normal cohort of women coming newly diagnosed,
16 perhaps 15% or 20% would be best treated by upfront or
17 sometimes called "neoadjuvant chemotherapy", where their
18 first treatment would not be surgery but would be
19 chemotherapy. And the purpose of that chemotherapy
20 would be to stop the growth of their tumour, shrink the
21 tumour and sometimes, in a number of cases, make the
22 tumour completely disappear, be killed completely and
23 then have a more minimal surgical procedure.
24 The problem at the very beginning of the pandemic --
25 and it was a journey through those first six months, as

1 you describe -- was we were extremely concerned about
2 giving anybody chemotherapy because chemotherapy in
3 a percentage of patients will make them
4 immunocompromised in such a way that, if they had been
5 infected with COVID, they would have very likely died.
6 So we didn't use neoadjuvant or upfront chemotherapy in
7 those first few months. We were still identifying those
8 patients who in normal circumstances would have had that
9 treatment as their optimum first treatment but we were
10 able to say to them, "What we're going to do is not
11 start with that treatment, but we're going to start with
12 surgery which is still effective and safe treatment. We
13 will remove your tumour, we will get some further
14 information about your tumour by removing some
15 lymph glands to find out if it's spread and so on" --
16 and we worked out new ways of doing all of that -- "and
17 then we will decide if you would benefit from
18 chemotherapy", and in fact, relatively quickly through
19 the first three/four months, by the time somebody has
20 had surgery and recovered from surgery. There were
21 perhaps small delays in people who would have had
22 chemotherapy after their surgery rather than before, but
23 we changed how we did the treatment.
24 So it was still effective treatment but it wasn't
25 the position we'd got to pre-pandemic of what we would

1 have considered to be optimum treatment. So that would
2 be one example around chemotherapy use.
3 The other would be around the extent of surgery. So
4 it would have been -- absolutely part of my clinical
5 practice since appointment would be that, if any woman
6 needed a mastectomy operation, we would try to offer her
7 reconstruction surgery to mitigate the physical loss of
8 her breast. It was not possible to do that type of
9 surgery again in that early part of the pandemic because
10 of the length of the procedure and the perception that
11 there would be an increased risk to that patient in
12 their post-operative recovery if they were to catch
13 COVID at that time. So we had to say to many of these
14 women, "This is something we'll come back to. It's not
15 something we can offer you at this time". Our best
16 advice is that mastectomy is still what we would have
17 been doing, these patients would have had a mastectomy
18 anyway, but it's just that the, if you like, mitigating
19 extra surgery of having reconstruction or -- sometimes
20 called "oncoplastic surgery". There are some other
21 options around -- mastectomy reconstruction around
22 what's called "oncoplastic surgery", reshaping the
23 breast, doing breast reduction procedures, more complex
24 surgery to the breast tissue, it was not possible to do
25 that in those early months. And some of those women, it

1 is important to say to the Inquiry, will still be
2 waiting for those delayed procedures because we've not
3 had the capacity to get to all of them as yet, as we've
4 come out of the pandemic.
5 Q. So far as screening was concerned, what was the impact
6 of the pandemic, again in the early days --
7 A. The early days was --
8 Q. -- on screening and in particular --
9 A. Apologies.
10 Q. Not at all -- and in particular, given the geographic
11 area that you cover, patients from perhaps some of the
12 more remote locations that might either require
13 screening or further diagnostic treatment?
14 A. So screening is -- breast cancer screening is quite
15 a difficult skill to explain in terms of -- I've tried
16 to give it in the Inquiry [sic] there -- in order to
17 find seven or eight women with breast cancer, you have
18 to invite 1,000 women to leave their home, so that's
19 a big number in a time when we were in lockdown. So the
20 decision was made that the safest thing to do was to
21 delay screening.
22 The purpose of screening is to find tiny cancers
23 which are not yet palpable; that is they can't be felt.
24 So the vast majority of cancers that are found through
25 the screening programme are at the earliest possible

1 stage, before anybody could be aware of their symptoms.
2 That's what's meant by "screening". It's sometimes
3 a term that's used rather loosely about all breast
4 surgery.
5 Q. Yes. I fear I probably used it loosely.
6 A. So the breast cancer screen programme is just population
7 screening, women between the age of 50 and 70 being
8 invited to come for a mammogram. If you invite 1,000,
9 roughly speaking 700 will turn up. Of those 700,
10 35 will need to come back for further assessment and, of
11 those 35, seven or eight will be found to have a cancer.
12 It is done on a population area by area basis and it
13 restarted end of August/beginning of September 2020, and
14 so it was simply a pause of six months in finding these
15 very early cancers. And it simply went back to its
16 pre-programmed -- in our area of Clyde, the screening
17 invitations go round our entire geographical area in
18 a three-year cycle. So whether you're in an island or
19 a remote place would have made no difference. It simply
20 was a six-month pause, so whether you were in the centre
21 of Paisley or in Islay, screening got to you but, in the
22 beginning, six months behind schedule. My understanding
23 is that that schedule has entirely been caught up now in
24 the first cycle.
25 Q. Right. That's interesting. Thank you. Perhaps in the

1 discussion we've had so far, we've focused on the
2 period -- perhaps the initial period of the pandemic.
3 A. Yes.
4 Q. After that initial period, did things improve or --
5 A. Yes, they --
6 Q. Appreciably and in what way?
7 A. Yes, they did. We were able to go back to doing most
8 things as normal. We returned to our own outpatient
9 departments in Inverclyde and the RAH in September of
10 2020 and we are still there. A slight sadness that we
11 have not been able to start our diagnostic clinic at the
12 Vale of Leven again, and that's due to a complex of
13 different reasons around staffing and so on. It's not
14 entirely attributable to the pandemic. But it's always
15 difficult to restart something rather than keep it
16 going. So our outpatient service isn't back to normal
17 entirely.
18 Our surgery is back to normal entirely and our
19 treatment protocols are back to normal, and that began
20 to happen through 2021. I think the main reasons for
21 that were the end of lockdown-type restrictions, the
22 vaccination of the population, widespread testing, which
23 it was then easier to manage, and we got better at
24 managing the flow of patients who were diagnosed because
25 we were able to return -- we were able to return to

1 giving chemotherapy as normal once people were
2 vaccinated, for example.
3 Once testing and once the -- even the treatment of
4 COVID had all improved during that time -- not my area
5 of expertise, but all the trials and so on were done at
6 that time -- our treatment of COVID had all improved.
7 So by and large, by the time we came to a year on from
8 the restoration of services in September 2020 -- by the
9 time we got to September 2021, almost everything was
10 back to normal. We need to acknowledge that there are
11 some women who are still waiting for the treatment they
12 might have had, but, in fact, for newly diagnosed women
13 there was no appreciable difference from then on in
14 terms of their diagnostic or treatment journey.
15 Q. I'm mindful of time, Mr McKirdy, and I'd like to go to
16 some of your observations because I think they're very
17 relevant and, if I may say, quite pithy. If we go to
18 "Lessons to be learned", which is at paragraph 84 of
19 your statement, you do identify a number of positives
20 that emerged out of the pandemic and I think we've
21 probably touched on some of these and we can read what
22 you say, the first being in relation to communication
23 and then the use of online facilities --
24 A. Yes.
25 Q. -- which -- you gave a specific example of the use of

1 online facilities which hadn't been previously used but
2 is now used in your specialty.
3 A. Yes.
4 Q. You also talk about the collaborative efforts of your
5 colleagues. But you do give an obvious negative impact
6 in paragraph 87 and I wonder if I could just ask you to
7 read that paragraph so that we do get the full impact of
8 it from you.
9 A. Sure. Paragraph 87 is:
10 "I think there has been an obvious negative impact
11 on the health service in that there was the decision
12 taken to delay work that had to be done and to diminish
13 our capacity to deliver [that kind] of work. This has
14 left us now in a situation where it feels like, for some
15 people, that this has left us [with] a problem which
16 feels too big to solve. I think this is contributed to
17 by a political gap where people do not feel that the UK
18 or devolved governments actually have a capacity to
19 deliver the restoration of the NHS which we used to talk
20 about in 2021 and 2022 when there was talk of rebuilding
21 and restoring the NHS. I did many interviews with the
22 media in 2021 and 2022 around the restoring of the NHS
23 and I worry now that I was perhaps too optimistic
24 because I fear now that people feel that this is too big
25 a hill to climb. I think that we need to recover some

1 of that spirit that was felt in 2020 that we had an
2 issue but if we put our minds to it this is something we
3 can deal with. I think this is particularly noticeable
4 in numbers on waiting lists for the NHS. The impact of
5 COVID on the ability for the NHS to deliver planned care
6 has had a negative societal impact and I fear that there
7 is now, after the pandemic ... a loss of faith in the
8 NHS to deliver services."
9 Q. Would that loss of faith, in your opinion, have occurred
10 without the effects of the pandemic?
11 A. That's a good question, Mr Gale, and an unanswerable
12 one. I think it's reasonable to say that, on a UK-wide
13 basis, waiting lists for treatment had steadily
14 increased from 2010 through to 2020 and the NHS's
15 capacity to deliver planned care across all four
16 countries in the UK had led to increasing waiting time
17 for planned or elective surgery, increasing waiting time
18 for outpatient appointments and for investigations, and
19 it was measured in the acute service by the four-hour
20 wait in A&E. During that period of time from 2020 to
21 2020 [sic], invariably, in different parts of the UK,
22 one could see that the overall performance of the NHS
23 was not improving.
24 I think that's also been recently commented on, that
25 public confidence and public happiness with the NHS was

1 at the highest ever recorded in 2010 -- ever recorded in
2 2010 -- but gradually diminished during that period of
3 time through to 2020. So the question you're asking me,
4 "If there had been no pandemic, in 2024 would people be
5 unhappy with the NHS?", I suspect they would have been
6 less happy than they had been in 2010 but I don't think
7 things would have been as bad as they have been, as they
8 are now, because we had a complete loss of capacity to
9 deliver planned care for those without urgent -- or
10 cancer, for example, as their diagnosis -- for a period
11 of six/twelve/nearly 18 months. So to take that out of
12 a system which is usually working as close to capacity
13 as is possible, it's not possible to restore that
14 quickly.
15 I feel a certain sense of responsibility,
16 particularly in my position as president of the college,
17 to try and encourage everyone, including our fellows and
18 members who are delivering care, and in my public
19 communication, to say that I do think it is possible for
20 us to restore that model. We know that it can be
21 restored. It just will take a lot of effort and it will
22 take some time. But the way of restoring the NHS, the
23 position it was in prior to the pandemic, is to increase
24 the capacity of our service to deliver for the patients
25 who are waiting. And that will take capacity and money

1 and resource, but it will also take leadership and
2 willingness and, to some extent, sadly patients'
3 patience.
4 Q. Is that leadership both within your profession and also
5 political?
6 A. Yes, it is and for all of us. And for a public
7 understanding of the impact, it's very difficult and
8 when people are anxious and they know that they
9 themselves or a family member are waiting for something
10 to be delivered by the NHS and that waiting number is
11 coming down but it's not coming down as quickly as any
12 of us would like to see, everybody is anxious in that
13 time, but it's about capacity.
14 If the service normally runs at close to full
15 capacity, you have to create extra resource to deliver
16 a catch-up. There is no space to deliver six to
17 18 months worth of work in a normal working week in
18 a way that that 18 months' backlog can be caught up on
19 quickly. That's just demand management and it's
20 impossible for that to happen.
21 That's difficult for people to accept and my
22 concern, which I'm happy to express to the Inquiry, is
23 that I think I would encourage people, as I encourage
24 our fellows and members, not to lose faith in the
25 capacity for that to happen. It's not necessarily that

1 the model of delivery is wrong or the funding model is
2 wrong or any of the other things we sometimes hear
3 commentators suggest; it may be that simply this is
4 a system which doesn't yet have the capacity to deliver
5 that catch-up.
6 Q. One of the other observations you make, if I can take
7 you back to paragraph 71 and also paragraph 74 -- I'm
8 sorry, 75 of your statement, you mention the question of
9 the gradient of healthcare inequality.
10 A. Yes.
11 Q. And, again, you say that this was heightened during
12 COVID. Could you just explain that, please?
13 A. So health inequality is a subject dear to my heart,
14 Mr Gale, but if you were to -- and the Inquiry may be
15 already familiar with this from other witnesses, but
16 Scotland has the greatest healthcare inequalities in the
17 UK, as measured by life expectancy between the richest
18 and the poorest. So if we look at the richest end of
19 society, they will in Scotland live for about an
20 extra -- it depends which area you look at but several
21 years, perhaps up to 15/16/17 years longer in healthy
22 life expectancy than the people in the poorest parts of
23 society.
24 COVID hit the poor and vulnerable harder than it did
25 the wealthier parts of society. That's the case for

1 almost all health situations and has been known to be
2 the case for the last 40 or 50 years. So we know that
3 there is a gradient of health inequality from the
4 richest to poorest in society.
5 That's sometimes not helped by behaviours and
6 there's a gradient of behaviours, so vaccine uptake was
7 poorest in the poorest parts of society, despite the
8 NHS's best efforts to get to hard-reached communities,
9 to provide vaccination centre as close to people's
10 homes. But, and not to be unduly trite about it,
11 my Lord, but if you live in a wealthier part of my home
12 city of Glasgow and you have a car, to drive anywhere to
13 be vaccinated is fairly straightforward. If you live in
14 one of our poorer peripheral housing estates and to get
15 to a vaccination centre is a long journey by bus in the
16 rain, you may be less likely to go.
17 Q. Thank you. The final point, Mr McKirdy, from me, is to
18 take you to your hopes for the Inquiry. In
19 paragraph 88, you make a very pointed observation about
20 your watching of the UKI and its concentration on what
21 you call "inconsequential interactions" between
22 Government ministers, advisers and the like. I think
23 you recognise that that may be a political interest and
24 I'm sure that our colleagues in the UKI will be looking
25 at the impacts in due course. But at the moment,

1 am I correct in thinking that you subscribe to the view
2 that looking at the impacts of the COVID pandemic is
3 a useful, at least, way forward in looking to the steps
4 that may be taken in addressing a future pandemic?
5 A. Yes, it is. I think we need to recognise none of us
6 will know when another pandemic might occur. It was
7 over a hundred years since the previous one and so none
8 of us might live to see another pandemic. But I think
9 if lessons can be learned, they will perhaps be helpful
10 in other situations which are not a pandemic. So around
11 collaborative working, use of IT, how we can better
12 prepare for an emergency and have facilities and teams
13 ready to deal with an emergency should it come along, as
14 we have tried to do in planning for a pandemic. But we
15 need to learn lessons from this one about how that could
16 be done better and I would hope for our Inquiry here in
17 Scotland that we achieve that.
18 Q. Thank you. Finally, the other lesson to be learned is
19 I think you emphasise that there should be recognition
20 of the huge impact that the pandemic had on the elderly.
21 A. Yes, and my understanding -- I'm not an epidemiologist
22 or a virologist, but my understanding is that most
23 infectious disease in any community happens in the young
24 rather than in the old because the young tend to be
25 exposed to more social interaction, that your immune

1 systems have not yet developed, and we need to remember
2 that in any future pandemic it may not model like the
3 last one. So it may be -- and we need to recognise the
4 huge impact there was on the elderly and those with
5 comorbidities. So many of the people who died were not
6 in an elderly age group, but were people who were unwell
7 for other reasons in midlife -- and we need to recognise
8 that the next pandemic may not be like that, but
9 therefore the generality of lessons we can learn may be
10 as valid as the specifics of COVID-19.
11 Q. Thank you very much.
12 Mr McKirdy, those are all the matters that I would
13 like to discuss with you. As with all witnesses, we
14 offer the opportunity -- if there is something that you
15 feel we haven't touched on, that you would like to
16 mention, this is an opportunity for you to do so.
17 A. No, thank you very much, Mr Gale. I'm content.
18 Apologies for the typographical errors in my statement
19 but I'm content that otherwise it's an account I'm happy
20 to --
21 Q. I'm sure we can forgive those, Mr McKirdy, and I've at
22 least learnt the meaning of I think three new words that
23 I hadn't previously come across. So thank you very
24 much, Mr McKirdy. Thank you, my Lord.
25 A. Thank you, Mr Gale. Thank you, my Lord.

1 THE CHAIR: My thanks to you, Mr McKirdy. I'm very grateful
2 for your very interesting and informative evidence.
3 A. Thank you.
4 MR GALE: Thank you, my Lord.
5 THE CHAIR: Shall we say 3.05 for the next session?
6 MR GALE: Thank you, my Lord, yes.
7 (2.49 pm)
8 (A short break)
9 (3.05 pm)
10 THE CHAIR: Right, when you're ready, Ms Bahrami, please
11 proceed.
12 MS BAHRAMI: Thank you, my Lord.
13 MR ADAM STACHURA (called)
14 MS BAHRAMI: Starting off for the record, Mr Stachura's
15 witness statement is referenced SCI-WT0214-000001.
16 Questions by MS BAHRAMI
17 MS BAHRAMI: Mr Stachura, could you please start by telling
18 us a bit about your own background?
19 A. Yes, sure. So I'm currently the associate director for
20 policy, communications and external affairs. At the
21 time that this Inquiry is looking at, I was the head of
22 policy and communications, a senior member of the
23 Age Scotland team and had a broad overview of all the
24 work the charity was doing, understanding the insights
25 from older people, as they were calling our national

1 helpline, and through a myriad of other routes, and to
2 deal with stakeholders and deal with, constructively, of
3 course, stakeholders such as the Scottish Government,
4 the media, partner organisations and indeed making sure
5 that colleagues across the charity were well informed
6 about what we were doing and how we were trying to
7 impact the lives positively of older people.
8 Now Age Scotland has been Age Scotland since 2019.
9 It is the formation of -- Age Concern and Help the Aged
10 back then became Age Scotland. We're an independent
11 charity but we're a brand partner of Age UK, who you
12 will be aware of, and partners with Age Cymru and
13 Age Northern Ireland as part of a UK-wide Age network,
14 looking at improving the lives of older people, and by
15 that we mean over the age of 50.
16 Q. Thank you. Now, Age Scotland was contacted by the
17 Scottish Government prior to the first lockdown and they
18 asked you to help disseminate information among the
19 older population, and that included upscaling your
20 national helpline to handle more calls, and for that the
21 First Minister announced funding of £80,000 to assist
22 with that, describing it as "the fourth emergency
23 service". How important was that early recognition, the
24 request for assistance and the funding that was
25 provided?

1 A. I mean, it was incredibly important for us in terms of
2 how we thought we could support older people, but going
3 back a couple of steps, it was really interesting to
4 have that phone call from the Government early March, as
5 I recall, trying to scope out if the Scottish Government
6 were -- needed to provide an information service,
7 particularly for older people, how could we do that,
8 what were our sort of routes, how could we potentially
9 scale up the work they do. They have been a funder of
10 our national helpline or a part-funder of that for many
11 years so they knew of its existence and what it did, but
12 what it really helped us do was I think meet as much of
13 the demand from the public as possible before sort of
14 the first lockdown, let's say. We possibly deal in the
15 helpline with an average of 80 calls a day, for
16 instance, but as we got into that we were, you know,
17 towards 1,000 a day. 800 in the early kind of weeks was
18 a sort of average -- an average day.
19 So our work with the Scottish Government was to
20 design a service which could scale up massively from
21 what it had been doing to take up to 1,500 phone calls
22 from people a day. I think what we realised over time
23 was that our peak ability to handle calls, which is
24 different to just answering the phone -- it's to have
25 a conversation, to deal with complex enquiries -- 800 or

1 so is probably at our peak. Colleagues who were drafted
2 in from across the charity to support this, my goodness,
3 they were inundated with this and incredibly difficult
4 work for them as well.
5 Q. Did they work from home? Did you set up a virtual call
6 centre or did you have people come into your office?
7 A. So on the -- before the lockdown -- yeah, we had to work
8 from home, but the helpline -- once we were aware of the
9 Scottish Government looking to support us financially,
10 colleagues -- very talented colleagues were able to look
11 at how we could change the nature of our helpline, which
12 was fundamentally in an office, hard-wired phones,
13 computers, through a kind of online database -- in
14 a sense that part already existed -- to try and move
15 that and create a virtual call centre, so colleagues
16 could work from home or wherever they needed to be to
17 answer calls, to be able to use the database, to be able
18 to communicate with colleagues too.
19 We'd been in a slightly lucky position that probably
20 at the end of 2019 we had been working towards
21 a flexible approach in our organisation. The
22 introduction of certain platforms such as
23 Microsoft Teams and other things were starting to be
24 introduced, so we already had a tiny bit of a head start
25 on how you might use these things, how video calls might

1 be used or not and how they could be properly effective
2 in terms of internal communications.
3 We were able to, in a matter of a week or so, move
4 our operation from being sort of hard-wired in a room
5 to -- wherever you might be, you had a VoIP connection
6 for the phone call, that the 0800 phone number would go
7 to you -- it would be sent to whoever was available --
8 and folks were able to handle those calls and
9 communicate back with our database and with other
10 colleagues.
11 Q. Thank you. What sort of calls was the helpline
12 initially receiving?
13 A. At the start of the lockdown?
14 Q. Yes.
15 A. Panic calls is probably how I would describe the first
16 wave; people not knowing what to do. They'd been asked
17 to stay at home, but actually they didn't have any food,
18 they were running low on medication, they may have
19 needed to see and deal with the Health Service, that
20 they were completely isolated and lonely, that their
21 mental health was suffering as a result. I think they
22 were sort of panic calls in those early days and weeks
23 and trying to identify where they could go to get the
24 support. For instance, cupboards were bare but -- you
25 know, "I've been asked to shield. I'm not allowed to

1 really go out anywhere"; "I'm digitally disconnected.
2 I don't have the internet at home"; "I don't have any
3 device. I don't have a mobile phone". They were using
4 landlines to call us and trying to find out who they
5 speak to because the usual routes, council offices, the
6 Health Service -- the usual phone numbers didn't work
7 anymore. So I think those really were panic calls,
8 "What do I do and actually how do I eat? What can
9 I do?".
10 Q. Thank you. So they didn't have access to internet and
11 things, so they also then, I presume, called the
12 helpline to get updates on the restrictions and what
13 they should be doing or shouldn't be doing.
14 Other than the Age Scotland helpline, I understand
15 from your statement that the main avenue for them
16 keeping abreast of developments were the live television
17 broadcasts each day. Those were extremely valuable for
18 that demographic. But at one point the BBC considered
19 moving that broadcast online and your organisation wrote
20 to them, asking them not to do that. What would have
21 been the consequence if those broadcasts had been moved
22 online?
23 A. I mean, we knew from people who were calling us that
24 they were important. Again, there was about -- at that
25 time about half a million over-60s in Scotland weren't

1 online. It's -- more people now are online at that age
2 group than were before, but half a million -- so that's
3 about 40% or so of that age group weren't connected
4 online. And if you consider that 350,000 people of that
5 age group were living alone as well with no one else to
6 kind of turn to to do this, the televised briefings, the
7 sort of lunchtime regular briefings, we know from that
8 feedback were incredibly important. It gave them that
9 simple, up-to-date and regular information, the top-line
10 information, about what the Government or the
11 Health Service was asking people to do.
12 I think they were also important for a long period
13 of time, not just because they were disconnected but
14 they became -- once you're at home for a number of weeks
15 or months, there's a routine in this, there's a sense
16 of -- we heard from people there's a sense of comfort in
17 knowing that this is where they'll find out what's going
18 on. And as we'd find from our helpline, immediately
19 after those briefings had ended or towards the end of
20 them, we would be getting an influx of phone calls with
21 extra questions, "What did this mean? What does this
22 mean? How can I access X or Y?", whatever the new
23 initiative was, "Can I do this? "The First Minister has
24 just said -- whatever it is -- I can travel to help care
25 for a relative but actually what does that mean?". So it

1 was looking for extra clarity beyond the messages that
2 were delivered from the Government and the Health
3 Service.
4 Q. You say one of the points that people were uncertain of
5 was whether they should follow Scottish Government or
6 UK Government guidance and directions. Why do you think
7 that uncertainty existed? Do you think there was a lack
8 of clarity around the messaging from both governments?
9 A. At the beginning it was the same, if you recall almost
10 four years ago, that the messages of "Stay home, protect
11 the NHS" was fundamental. It was the same thing. The
12 date upon which there was a deviation, I can't remember,
13 I don't recall, but I think it all depended on what
14 people were watching. So, for instance, what was the
15 first briefing that came out? Was it a Prime Minister's
16 briefing for the evening news, for instance, that they
17 caught the next day -- I suppose depending on what that
18 person's preference was -- and actually trying to work
19 out as well, does the Scottish guidance override, when
20 it changed, a UK guidance or advice. While they might
21 have been broadly similar, they might have been talked
22 about in a slightly different way as well, and even the
23 language around, at times, as I recall -- like "social
24 distancing" became "physical distancing" at one point.
25 There might have been questions -- there were questions

1 about, "Is that different?". No, it wasn't, but
2 actually it was a very legitimate question, "What does
3 that mean? Is it still 2 metres and what do I have to
4 do here?".
5 So I think there could have been confusion from
6 people, depending on their source of news and what they
7 were just regularly watching, what their preference was.
8 While it might still have been on the BBC, for instance,
9 it might have been the UK news rather than the Scottish
10 news that they'd have watched.
11 Q. Thank you. Now, despite being asked by the
12 Scottish Government to help disseminate information,
13 even after you asked, they refused to share details of
14 updates with you ahead of the televised briefings. You
15 say that this made things quite challenging for you and
16 colleagues and you had to use your policy team to create
17 briefings for the helpline team because there was no way
18 the helpline team would have had time. What was the
19 impact of this on service users and on your staff?
20 A. I mean, "refused" might be slightly overstating it.
21 I think more it was the case that the folks they were
22 speaking with just weren't in a position to share this.
23 I believe from them it was quite a closed group of
24 people who, for instance, had sight of the
25 First Minister's statement or further detail that's

1 being announced or as it's being announced it might be
2 being worked on. So it was more of an inability to
3 share than a kind of refusal. It just wasn't in their
4 gift to do.
5 The difficulty then was, as I said earlier on, when
6 people are calling you at 20 past 12 or whatever time it
7 might have been because the First Minister just
8 announced, for instance, a programme to expand the use
9 of digital devices, to almost offer through a
10 Connecting Scotland programme, which was looking at
11 digital devices, digital connections, people phoning up
12 immediately, saying, "How do I get my free computer?".
13 We knew nothing more. That's one example. There were
14 lots of things, but whatever the announcement was, the
15 calls immediately came for further clarity.
16 And what we'd be having to do -- our policy team,
17 who were excellent, they'd be watching the briefing,
18 taking notes and actually trying to translate that into
19 something that call handlers could use because call
20 handlers are dealing with calls all the time anyway.
21 They couldn't stop what they were doing to watch the
22 broadcast themselves because we would still be having
23 calls even -- different to the substance of the
24 televised briefings. So making sure that people within
25 a short period of time had a document they could refer

1 to, saying, "The First Minister said this. This is what
2 we understand it means".
3 The challenge, however, was that the
4 Scottish Government's own website would often take hours
5 and hours after often the end of the working day to have
6 either a transcript of the briefing or indeed any
7 further information available online, so we'd be able to
8 kind of update for the next day's briefing, further
9 clarity, but it took an awful long time to get the
10 answers that people needed. And if you consider the
11 number of calls that we were receiving, our ability to
12 maybe call people back on that as you are receiving an
13 absolute deluge of incoming calls, inbound calls, to
14 give them extra clarity was pretty tricky if not
15 impossible.
16 So the thing that I think we often needed and felt
17 we needed was, "Just tell us what this information is
18 because people are asking immediately", and I think that
19 demonstrated the value of having sort of offline routes
20 for people to have a conversation because kind of the
21 written communications might not have made as much sense
22 on their own even if they are online. They might have
23 gone to NHS, a form or Scottish website, and called us
24 to ask us, "What does it mean? How does this impact my
25 life or the decisions I'm going to make today or

1 tomorrow?". So I think that's why it was quite
2 important to get the information as soon as possible.
3 Q. You did try to ask for it to be made available sooner
4 after the televised briefings?
5 A. Yeah.
6 Q. What was the response and, you know, were you satisfied
7 with that response?
8 A. No.
9 Q. Did anyone offer to get permission from higher-ups to
10 share the information sooner?
11 A. No, we asked a few times and it was the same kind of
12 response at that moment. I can't remember when we
13 stopped asking. It wasn't a regular thing, "We must
14 have this". We would often go to officials to seek
15 clarity on whatever item it was that people had been
16 calling about in volume and then they would have to go
17 off and find out what that was, but making the point
18 that, "Look, someone must know what this is. Could you
19 just share this quickly or even having it on the website
20 that we can find ourselves".
21 We found ourselves at times actually following the
22 Twitter feed of the SNP's press office, who were almost
23 live-tweeting the words, the transcript, which made it
24 much easier almost to catch up and remember what was
25 said here. I didn't really understand why the

1 Scottish Government, for instance, couldn't do exactly
2 the same thing.
3 Q. Thank you. Now, you've just mentioned that back in 2020
4 more than half a million over the age of 60 didn't have
5 access to the internet and you say in your statement
6 about 600,000 didn't use smartphones and there were also
7 some who may have had devices or access to the internet
8 but found websites and apps too difficult to use so were
9 digitally excluded because of that. They were
10 essentially left behind when there was a sudden shift to
11 online consumption and services use, interactions. You
12 say in your statement that politicians and civil
13 servants seemed surprised by this, by the scale of it
14 and the fact of it. Could you tell us a bit more about
15 that?
16 A. Yes. I'm trying to recall particular instances, but the
17 figures that I've used in this were from the
18 Scottish Household Survey, the Scottish Government's own
19 analysis of digital use across the country, so it was
20 Scottish Government's own figures that we would be
21 quoting back to them. But I suppose, if you consider
22 that, you know, what is 500,000 people in a population
23 of 5 million, if 90% of people or most people, for
24 instance, in this room are online and that's your
25 universe, you think it's -- you're kind of native and

1 why aren't people online. If you haven't been living
2 and breathing that, then you might not have considered
3 that to that degree.
4 Also, beyond the 500,000 people that didn't have
5 access to the internet, even if you did, it didn't mean
6 that you were particularly au fait with how to use it.
7 Your limitations might be quite simply using it for
8 social media, browsing news websites, but actually
9 trying to navigate kind of public sector websites,
10 I think we all might find them quite a challenge at
11 time, councils in particular. We found GPs' practice
12 websites really tricky. The platforms they were using
13 and the design of them were very difficult if you had
14 sight loss to some degree. But even just trying to work
15 out what to click and where to click, information not
16 being updated quickly, I think that -- in the instance
17 we would be talking to the Scottish Government,
18 I remember -- it must have been May 2020 in a Scottish
19 Parliament Inquiry. Forgive me, I can't remember which
20 committee it was -- mentioning this and actually seeing
21 politicians, you know, almost calling out, "Goodness,
22 half a million people aren't online", and that would be
23 equivalent to the population of Edinburgh, for instance,
24 so it's not a small number of people.
25 Again, those with smartphones, there's a different

1 degree of what that smartphone can do, so, you know,
2 "Download this app" or "Scan this QR code", you're
3 asking people to do things which most of us who do this
4 on a regular basis would be quite comfortable with, but
5 you've sort of missed a beat in trying to explain what
6 a QR code is, how you access that, what it's going to
7 do, and actually people are a bit nervous about where
8 they're going on the internet, where is this thing and
9 trusting the data, trusting the information that's being
10 passed around. I think they're legitimate concerns that
11 people have about using the internet or using digital
12 devices, but I think the vast scale of those that just
13 didn't have it was -- yeah, on every occasion you almost
14 had to remind officials or politicians that the scale of
15 digital exclusion in Scotland, just for older people --
16 there's more beyond that. If you're lower income, if
17 you're disabled -- lots of different types of people
18 didn't have access. So that was just looking at people
19 over the age of 60 and if we're looking at 50 there
20 would be even more.
21 So I think that's something that took people back,
22 that the only option we had apparently was a digital
23 route and therefore, if it worked for the majority, then
24 that would just have to be what it is. I don't think
25 that really landed particularly well with those who were

1 probably more likely to need support in services but had
2 no way of accessing it.
3 Q. So nobody, as a result of that being highlighted to
4 them, thought, "Let's take things a step back and make
5 telephone access a possibility again"? They just said
6 that that was -- that there was nothing that could be
7 done?
8 A. To the credit of the Scottish Government, they quite
9 quickly set up -- I referred to it earlier on --
10 Connecting Scotland, which was about kind of
11 proliferation of digital devices -- tablets, I believe,
12 or laptops -- and the first phase of this, I think from
13 May until June, was looking at older people and using
14 intermediary organisations to almost identify who might
15 be needing them and how to kind of access that.
16 It was quite a low number of people in the end who
17 would get something compared to kind of the need, but
18 I think in terms of public services, maybe why the
19 Scottish Government had asked us to expand our freephone
20 helpline -- you call up, you're not dialling 1 to get
21 through to person X or 2 for person Y. It was straight
22 through, someone would triage and move on. But you
23 would be calling up local authorities and it would go
24 nowhere because actually there was no one to answer the
25 phone. There wasn't a system in place. And calling the

1 health services, even a GP practice, you would be
2 referred on an answering machine to consult NHS Inform,
3 so you'd be phoning up and actually asked to go and find
4 out more about your condition or your concern on
5 a website.
6 You can understand to a degree if that was the only
7 option in an emergency, but I think the challenge for
8 public services that people rely on is that over time
9 there didn't seem to be any impetus to revert back to
10 the things that people clearly needed or that, "This is
11 working fine as we are". I think now we look at
12 ourselves in 2024, that services are predominantly
13 there, we're moving to a digital-only everything and it
14 works for lots of people but we've completely forgotten
15 those who just aren't able to. And it's not just about
16 older age.
17 But I think this is why, looking across the period
18 that the Inquiry is interested in, we never saw any
19 return to telephones, to face to face, to paper copies
20 of things that people needed. That just wasn't
21 possible, and the longer it went on, it just became the
22 norm and it kind of institutionalised this remote access
23 to the public.
24 Q. You mentioned Connecting Scotland there and you also
25 mention that in your statement, that as well as devices,

1 they provided data packages to older people, so that
2 helps improve digital exclusion for those that simply
3 didn't have the facilities. Did they take any steps to
4 help those that were digitally excluded by virtue of
5 a lack of sufficient technical knowledge or ability?
6 A. As I understand, yes. I believe the package of support
7 for individuals wasn't just you'd be shipped off
8 a device or a kind of data SIM card, for instance, if it
9 was an iPad or whatever, but there was a connection made
10 with someone who could support you. Now, a lot of this
11 obviously would have to be remote. You couldn't go and
12 see somebody face to face or have someone sit in your
13 living room with you. I can't recall the exact detail
14 of how that worked for everybody, but I think the aim in
15 the early stages was to use intermediary charities, for
16 instance, who had their own networks to -- how they
17 would support people and kind of left to them to best do
18 that. I might be mistaken on all of the detail, but, as
19 I recall at the time, it was setting up something for
20 nothing. But I think the way that people feel more
21 comfortable with it would be -- for instance, saying to
22 somebody, "Okay, now you've got this, go to YouTube and
23 find out more"; "Okay, what's YouTube?". It's about
24 that kind of retranslation.
25 So I think there is a broader piece here as well

1 about how the reliance on people just to know what
2 you're talking about is sort of a bit of a fool's errand
3 at times. But, yeah, I'm sure the system worked better
4 than I recall for those that were accessing it, but
5 I think the gulf between -- I think the funding pot was
6 around about £30 million -- it potentially helped 30,000
7 people across Scotland to do this. So while that's
8 a big project, it was, I think, a drop in the ocean in
9 terms of what the need was.
10 Q. So the lack of resources made it less effective than it
11 maybe would have been otherwise if --
12 A. I think there's probably a lot of resource. I mean
13 £30 million is a lot of money. How you actually manage
14 to do that I think was very, very challenging, so
15 there's no real criticism of that. I just think that
16 there were different phases, for instance. So for
17 looking at older people, the first phase was for older
18 people. It moved on, I think in that summer, to
19 families with children and maybe looking at those who
20 were out of school and how to connect them, and maybe
21 a year later I think older people were back in as
22 a phase. So I think the first phase probably had the
23 lowest impact.
24 I recall trying to find figures of the number of
25 people who had been supported and it was really

1 difficult to find how many older people actually got
2 a device and had been supported, particularly against
3 everyone who was supported. But there was definitely
4 recognition that older people were more likely to be
5 digitally disconnected, to require support, so they were
6 the first phase, but it's quite hard to demonstrate, in
7 terms of my own eyes, the impact that's had for the
8 whole population who are disconnected.
9 Q. Thank you. Now, you've mentioned and you say in your
10 statement that it was impossible for many older people
11 to order groceries and other necessities online because
12 they were digitally excluded and this led to food
13 insecurity for many, but you say that Morrisons, the
14 supermarket, accepted telephone orders and payments and
15 then subsequently you and other third sector
16 organisations wrote to the Government and to major
17 retailers asking them to step in and work together. How
18 did that go? What was the response?
19 A. The origin of this was a phone call or a message I had
20 from Which, the consumer organisation charity -- forgive
21 me for maybe getting their definition wrong -- who --
22 somebody there that I knew and know who wanted to
23 highlight that they were seeing some significant
24 challenges across the folks that they were hearing from
25 about access to food and had we heard similar things,

1 and of course we had from day one, particularly for
2 those that weren't online that couldn't -- the only
3 route to order online groceries was online and there
4 were very few delivery slots available as well.
5 So if you were shielding, for instance, that was
6 a route and Morrisons -- yes, I think they did a good
7 job. I can't remember the criteria, but there was an
8 option to call up to give them your order, to pay over
9 the phone and it would be delivered to you. So the
10 conversation which turned into us looking at, "Okay, who
11 else has an issue here?" -- and there was a range of
12 organisations and charities that, from their constituent
13 groups, were having problems to do with accessing
14 supermarkets. You know, even your sight loss charities,
15 as you can imagine, with social distancing or physical
16 distancing, made it very, very difficult to be in
17 a supermarket.
18 So we ended up getting together, thinking about who
19 is it in the Scottish Government that we could speak to
20 to identify -- like, "Here is a problem from this
21 constituent group of people who are really struggling to
22 access food, who are reliant on neighbours, who are
23 reliant on, you know, other local action groups or
24 community organisations to do this". But for those who
25 are completely isolated themselves, whether they just --

1 they might be in a street of 100 other houses but
2 completely isolated from everyone else around them, how
3 can they, if they're not online, get access?
4 So I remember writing to the Scottish Government to
5 just make the case for more action to expand the -- it
6 was Government and supermarkets, the major kind of food
7 retailers -- to expand availability of deliveries, of
8 having some kind of priority system for those that we
9 felt were kind of most excluded or otherwise couldn't
10 get to shops themselves by virtue of shielding or their
11 own mobility or their location. So, for instance, if
12 you're in rural parts of Scotland, there might not have
13 been a supermarket network available to you, so I think
14 life looked very different depending on where you were.
15 But, as part of this, we were desperately trying to
16 find out who in the Scottish Government was in charge of
17 this, and I think the intelligence from Which? was that
18 DEFRA, the UK Department for Environment and Food, they
19 were co-ordinating UK-wide things. We're not really
20 sure if there was a separate Scottish action on this.
21 So I think what I'm really trying to say is it's
22 quite hard to work out who to go to, and even asking
23 people, the Government officials weren't entirely sure
24 at the time. So it wasn't just that we were trying to
25 find out ourselves. We genuinely asked, "Who do we

1 speak to?", trying to get some action to improve the
2 situation as quickly as you possibly could. There was
3 certainly an appetite from the retailers to do this and
4 I think they were really trying to find out how they
5 scale up their operations. When a lockdown moves from
6 two weeks to two months or whatever, you know, they've
7 realised, "We must do more. How do you get more vans?
8 How do you increase your kind of packing of food and
9 getting it out?" So, yeah, that was a tricky time.
10 I don't think we've ever got a particularly
11 satisfactory answer from the Government. Whether or not
12 we were, you know, a necessary kind of vehicle for that,
13 for them, we wanted to make sure at the very least they
14 had information about who was being left behind here,
15 the impact on their lives and, "My goodness, can you
16 think about how to improve this and pretty quickly?".
17 But that was the origin story and kind of the reason
18 for doing this, but it was certainly something that came
19 through different surveys that we all did with our
20 constituent groups, feedback we had from our helpline on
21 a regular basis, but it really demonstrated an
22 incredibly pressing need to fix this because, you know,
23 people will get very ill or die without any food and
24 there was a lot of people really struggling with where
25 to go.

1 Q. Thank you. People who contacted your helpline were also
2 helped by Age Scotland to get in contact with local
3 organisations who might be able to help them; is that
4 correct?
5 A. Yeah, we had colleagues who were sort of tasked with
6 working out what was happening across the country,
7 almost building a list of community groups, resilience
8 groups, local organisations and charities, who were
9 essentially doing food deliveries themselves, they were
10 doing shopping orders. So if somebody called us up, we
11 could sort of refer them in or signpost them to somebody
12 else local to them who can help. What we weren't really
13 geared up to do ourselves was to do that, but we did
14 have colleagues at times who -- there was no other
15 option and I understand some people at times just got in
16 their cars and took food to some people. I think that
17 was -- it wasn't the norm, but -- because often there
18 were really great local answers. But kind of collating
19 that information in a hurry and in those early days and
20 weeks was I think a big challenge for colleagues, but
21 I think they did a really good job. I think helpline
22 advisers and call handlers had a good list across the
23 country of who you could call.
24 What we didn't have any real sight of was how
25 effective that was for them, but I think we were quite

1 reassured by the conversation we had with these groups
2 that they were able to meet those needs. I think what
3 we found from the pandemic was individuals, wherever
4 they lived, just wanted to do something. You're asked
5 to be at home and actually trying to organise yourself
6 to something that's effective rather than just being at
7 home, watching the TV and hearing dreadful news every
8 single day -- people wanted to take action. So that
9 kind of self-organisation across the country was
10 incredibly effective and I think really filled an
11 incredible gap before local authority resilience
12 committee work happened, which were to deliver food
13 parcels or to support people in the shielding list
14 because that might have taken a number of weeks to
15 happen. But local organisations jumped in and were able
16 to identify who they were in most places across the
17 country.
18 Q. The local authority food packages that you mention
19 there, there was an issue with them not catering to
20 dietary requirements. Did Age Scotland raise that issue
21 with local authorities?
22 A. I'm trying to remember exactly how we did, but we
23 certainly will have through whatever routes we had at
24 the time. As I mentioned before, it was often quite
25 difficult to get in contact with anyone at local

1 authorities and our main route into the Government was
2 through a team of officials in the Equalities Department
3 who were really very responsive and helped kind of share
4 information that we had through Government, as we
5 understood. I'm fairly sure that we made that clear in
6 a different piece of correspondence with the
7 Scottish Government or ministers on how people were
8 coping with the kind of lack of suitable food.
9 I think it was particularly important for people
10 from ethnic minority communities, who would be
11 vegetarian but there were items in food parcels that
12 would contain meat, and obviously the number of items in
13 the parcel were quite restricted. You know, if you
14 didn't eat that, you didn't have anything else. Also
15 a real kind of consideration for dietary requirements,
16 so whether someone doesn't, as a diet, eat pasta, for
17 instance, but actually maybe lentils or other things are
18 really, really important. I don't think that was
19 a luxury, but I do know that there were organisations
20 who were able to get funding from the
21 Scottish Government to kind of work on their own
22 initiatives to get kind of -- sort of more sort of
23 sensitive food stuffs to the people that they knew in
24 their own networks. I think that was incredibly
25 effective, but I think that the early stages of sort of

1 packing boxes of a variety of things might not always
2 have been the -- it didn't work for everybody all the
3 time.
4 And I think, once food parcels arrived, they were
5 necessarily finding that a number of items just
6 weren't suitable and you're doing a bit more
7 self-rationing, which are already quite limited
8 supplies, of what you could eat. I don't think there
9 was really an effective way of trying to get
10 replacements. That's my recollection of -- yes, at this
11 point it would have been four years ago.
12 Q. Thank you. Now, another consequence of the lockdown
13 restrictions was that almost all social care packages
14 ended. What were the consequences of that and did
15 Age Scotland try to raise the issue with the
16 Scottish Government?
17 A. This was really quite harrowing. There were phone calls
18 in mid to late March 2020 from people in different local
19 authorities. As I recall, particular challenges from
20 Glasgow, Falkirk and there's another one -- I don't want
21 to name them in case it's wrong -- where the social care
22 package at home, in their own home, they were told by
23 those delivering the care package -- Glasgow, for
24 instance, I think social care was outsourced to
25 a company called "Cordia", and by virtue of lockdown

1 restrictions or social distancing or people being kind
2 of vulnerable themselves, they wouldn't have had enough
3 social care staff to do this, but people were told with
4 a day's notice, up to four days' notice, that, "Your
5 care package will completely stop, we could no longer do
6 this".
7 And there would be people who were reliant on carers
8 for medication, for showering, for food -- all the types
9 of things which are absolutely essential for someone to
10 live independently in their own home were turned off
11 overnight. And I think for a lot of people it would
12 have taken months for that to return and, even once
13 things returned, the care packages that were delivered
14 were sort of to a lesser degree than they would have had
15 initially assessed for. The challenges for people here
16 was that they were sort of told that, "Well, you have
17 family who live nearby" -- it was quite subjective,
18 within I think 30 miles some places said -- "they have
19 to do this, they have to do this". But actually what we
20 were getting from the families was, "Actually we can't
21 because we've been asked to shield. We'd love to, but
22 I'm actually clinically vulnerable myself" or "There's
23 somebody in the household who has COVID 19 so I can't
24 leave. I certainly don't want to give this to my loved
25 one in their own home because this will be catastrophic

1 for them". So I think there were very legitimate, fair
2 and strong reasons why -- the alternative just seemed to
3 be rustled up that, "Okay, you've got someone who lives
4 close to you and will do this", but actually the reality
5 was very different.
6 So people will have gone without and I think the
7 impact on people's lives there, without that social care
8 package, even for a few days, never mind weeks, would
9 have been very severe on their health and undoubtedly
10 resulted in needing medical attention, medical care, as
11 opposed to social care, to kind of sustain their quality
12 of life. And actually I'm very sure sadly that will
13 have resulted in some of the excess deaths that we
14 experienced in that first year beyond kind of just
15 COVID-related issues too. So very severe consequences,
16 but this was a common theme across the country of
17 packages just turned off, very little notice and not
18 really anywhere to go.
19 I think the phone numbers that were available to
20 call local authorities to almost appeal them would go to
21 the same people who have decided that the package has to
22 stop, so there wasn't really any appeal process or any
23 obvious way upon which a resolution can be found. I
24 remember we did make the Scottish Government aware of
25 this immediately but never really heard of an answer

1 because, actually, at that point, it just started to
2 proliferate in terms of who was experiencing this and
3 where they were experiencing this, so it might be
4 something that they couldn't possibly do anything about.
5 Q. And following on from that -- because you mentioned they
6 would then need medical treatment and more people
7 potentially died that wouldn't have otherwise -- another
8 big impact on older people was the suspension of routine
9 screenings and the subsequent backlog when the services
10 re-opened also meant there were delays. What was the
11 consequence of that in terms of health and life
12 expectancy as well?
13 A. Some of that will be speculation on my part in terms of
14 the consequences, of course, but I think -- going back
15 to some facts on this, I remember insight from
16 a helpline about people who were calling who were over
17 the age of 70 about breast cancer screening. Now,
18 before then I think you could self-refer. The previous
19 witness here was talking about people between the age of
20 50 and 70 are invited to go on a three-year cycle for
21 breast cancer screening, for instance, but we were
22 particularly concerned about people who were no longer
23 able to self-refer, even those who felt they might be at
24 risk of this or had survived cancer in the past and sort
25 of exploring what happens here, when will this re-open,

1 when will this -- there was a -- it was impossible to
2 find out.
3 And actually, speaking to some cancer charities at
4 the time, just trying to find out from them -- they'll
5 be experts in this, we weren't -- but hearing from
6 people real concerns about their own lives or the kind
7 of the access to health that they felt they were
8 entitled to or wanted because there wasn't really a date
9 for resuming this -- it just was at some point in the
10 future, but that was so vague, people were really
11 concerned.
12 There was concerns from some of the cancer charities
13 about this as well, sort of from them to us, "Well,
14 actually, the older you get, you might be more at risk
15 from cancer", and they were concerned through us and
16 wanting us to almost kind of push on a little bit with
17 the Government about trying to agitate for kind of
18 a solution. It would be one of many things, of course,
19 and I think with the emergency situation we were in --
20 but this was -- this would have been late 2020, so it
21 wasn't just within the first few weeks. It was, as
22 people started to realise what they couldn't do anymore,
23 what they couldn't get access to, we would get phone
24 calls about this at different times. This particular
25 instance wouldn't have been on any kind of wave but just

1 you would have instances that you just felt were wrong
2 or that people weren't getting -- I don't know --
3 satisfactory answers or feeling reassured that their
4 health concerns would be met at any point.
5 I think that's where -- the kind of screening is an
6 example of this, but that's really stuck in my mind from
7 that time, and actually even from a personal experience
8 of family members who had been in this position and
9 thinking about them if they needed this. I think that
10 kind of is a theme for lots of families, I'm very sure,
11 about impact of kind of health conditions and actually
12 how they couldn't get sort of even, you know, early
13 diagnosis. And there will have been -- and I know of
14 people -- who have died of cancers diagnosed incredibly
15 late and had a very, very short time after diagnosis and
16 people who themselves knew that they weren't well. They
17 had been nurses in the past, they knew that something
18 was wrong but they couldn't get a diagnosis, couldn't
19 get any kind of treatment and have really desperately
20 sadly died well before their time.
21 I think that's something which -- in terms of our
22 evidence and issues I wanted to raise, these are things
23 that struck colleagues across the charity about insight
24 from older people and access to healthcare.
25 Q. Thank you. I'd like to move on to the issue of DNACPR

1 decisions. From the end of March 2020 through April you
2 say that Age Scotland received many calls from people
3 who said they'd been contacted out of the blue by their
4 GP and even in some cases by the surgery receptionist to
5 see if they would agree to a DNACPR decision being put
6 on their medical records. Were all of these people in
7 poor health and people for whom a DNACPR decision, as
8 far as you know, would have been clinically appropriate?
9 A. A lot of the conversations our helpline had with people,
10 it was because they were absolutely taken aback about
11 why on earth are they being phoned about something now
12 and it's never been mentioned by their GP or in the
13 Health Service before. This, again -- you're looking at
14 early April, probably the height of when we sort of saw
15 a trend. Before that, I don't think our helpline had
16 ever received an enquiry about a DNACPR decision or
17 looking for information or advice about that.
18 On a regular basis people would be quite forthcoming
19 about their own health and say, "Actually, I'm in good
20 health. I might have something like COPD but it's mild
21 but all of a sudden I've been asked to agree ..." --
22 initially it was "agree to a DNACPR decision", of which
23 they would say, "Well, no because what does this mean?
24 You've told me nothing else". And at times it wasn't
25 even a clinician, as you said, would call up. It would

1 be the receptionist or admin staff at a GP practice who
2 were making these calls. There might have been some
3 kind of introductory conversation about, "How are you
4 feeling?", and then on some occasions it would move
5 into, "How would your husband cope if you weren't
6 here?", and then moving on to, "Have you considered
7 DNACPR?". Now that -- or "do not resuscitate decision".
8 Now that out, of the blue, with no context -- actually
9 the calls we were getting were asking, "What on earth is
10 a DNACPR or a DNR or a DNAR?", depending on how it was
11 being described.
12 I think this is -- one of the most chilling parts of
13 that early part of the pandemic for us was the scale of
14 calls. I can't quantify it because actually at the
15 beginning we weren't logging them as such, we didn't
16 necessarily have a particular code for that and, you
17 know, there were huge numbers of calls and we were
18 trying to kind of handle as opposed to logging every
19 case very prescriptively. But it was the common -- it
20 was a common issue from all of our helpline call
21 handlers, and there were particular moments probably --
22 yeah, beginning of April, those calls started happening
23 and would continue -- we would receive calls throughout
24 that month into May, for sure, in terms of volume of
25 calls. But it was just -- it just felt from people's

1 experiences that they've been written off. It's their
2 words, their words. Incredibly anxious, "What does this
3 actually mean? Why are they calling me?". There was
4 one example -- of many, I'm sure -- of a woman who had
5 been called about this and asked to agree to such
6 a thing who had said "No" to it. She'd noted that she
7 was on the shielding list herself, had received a letter
8 about that two weeks earlier, and asked, "Well, do they
9 need to speak to her husband as well, but he's not on
10 the shielding list?", and they said, "No, we don't need
11 to speak to him". Similar age; similar kind of health
12 conditions.
13 I remember there was a particular example of a woman
14 in her late 50s who was a runner and I think her only
15 health condition was hearing loss but was asked about
16 it, and there's a range of issues and a range of
17 conditions which you feel would not preclude you from
18 having your heart restarted or your breathing restarted
19 if they stopped. I think that was the part of it and --
20 I could go on for weeks about the type of calls that we
21 had, but I remember being contacted by a woman who -- it
22 must have been her grandad, who was a 101-year-old
23 veteran, living in Glasgow, who one day got a knock on
24 the door from a paramedic and was handed a bit of paper
25 and they told him, "Just keep this by your bed", and he

1 said, "Yes, of course". She'd gone round to visit --
2 this was later in the year -- and found it was a do not
3 attempt resuscitation form and under the reason for, it
4 just said "communication difficulties". That's because
5 he had hearing loss. I think that in itself -- there
6 was no logic to this or why you had to keep this by your
7 bed, so if a paramedic arrived and saw this, to what
8 degree would this mean that you maybe didn't get the
9 necessary treatment, never mind kind of resuscitation?
10 So, again, really chilling examples of how this
11 applied to people in quite a cavalier way at times. And
12 there would be examples in care homes where a whole care
13 home would be -- sort of every single resident would
14 have been issued or a DNAR decision made in their name
15 as a blanket decision but with no real individual
16 clinical assessment of folks.
17 Q. You touched on it there. Did you find that a lot of
18 people thought that the existence of such a decision on
19 their file would impact medical treatment beyond CPR?
20 A. That was what people said and that they felt. Whether
21 or not that -- on a strictly practical basis, a DNACPR
22 decision is just about resuscitating you if your heart
23 stopped or your breathing stopped. But the instances on
24 which we would hear from people about the treatment, the
25 medical treatment, they were receiving or didn't receive

1 at the same time as being asked repeatedly to agree to
2 a DNACPR and them saying "No" and then finding such
3 a thing in place and maybe not having access to the
4 treatment they required was quite difficult to hear.
5 So while I do understand the importance of a DNACPR
6 in anticipatory care planning -- I know it's an
7 important piece so people can make decisions. As much
8 as a clinician, you have the right to decide how you
9 want to be treated, but again clinicians can make this
10 decision unilaterally. But there will be occasions
11 where people would find forms in discharge papers from
12 hospital and the box would be ticked which said
13 "Conversation had with patient" or the equivalent thing
14 and that never happened or a name written in where
15 someone -- just kind of a sign. And I don't think
16 that's standard practice for a form, but I've seen
17 examples of this and those conversations never happened.
18 Q. If somebody were to suggest that clinicians were having
19 these conversations but through the stress and trauma at
20 the time people were forgetting, do you think that could
21 be the case?
22 A. I really don't know. I think there would be occasions,
23 as we find from our own insights, that people who are
24 maybe in hospital, for instance, who are suffering from
25 delirium, who a conversation was had with them -- and it

1 would have been inappropriate, I think, in any measure
2 for them to have had a reasonable answer about agreeing
3 such a thing, obviously with the caveat that they don't
4 need to agree -- but part of the whole DNACPR process is
5 to have a good conversation with somebody -- for
6 clinicians to have a good, well-informed respectful
7 decision about kind of end-of-life decisions. And
8 I think there are far too many occasions that we heard
9 of and a range of other charities and organisations that
10 might -- have groups or people potentially more
11 vulnerable to different kind of health conditions -- who
12 have been in this position, that it was sort of forced
13 upon them out of the blue -- and I've used that again --
14 and the anxiety that people had about what -- "What does
15 this mean to my access to health and care if I needed
16 it?".
17 There are examples of -- you know, I've been sort of
18 quoted, whether it's in news stories or on television
19 news, pieces of people -- real-life examples of this,
20 whether or not -- a case in Edinburgh where an older
21 woman had been asked repeatedly about signing up or
22 agreeing to DNACPR and she died the next morning because
23 the oxygen hadn't been connected. There was ongoing
24 issues there and there were particular medical kind of
25 complaints with her treatment. But this wasn't on its

1 own and I think, when you spoke to other organisations
2 about this, they were getting exactly the same concerns
3 from people but also anxieties about a lack of medical
4 treatment that might otherwise have been available to
5 them but, because a DNACPR had been discussed, it felt
6 like all their medical options were shut down.
7 And even in discussions we had with clinicians
8 through Healthcare Improvement Scotland in 2021, as
9 I recall, they recognise that they haven't been
10 particularly good at having these discussions, so your
11 point about -- you know, under the stress of dealing
12 with all this, I'm sure, you know, that's a particular
13 challenge of trying to work out how to deal with so many
14 patients or how to manage a crisis in the
15 Health Service, but I think there's a recognition from
16 clinicians that they just hadn't been particularly good
17 at having good conversations and that the practice
18 around decisions being made was -- fell short of what
19 they would expect to happen, irrespective of a crisis in
20 the Health Service.
21 Q. Thank you. In your statement you say it was a scandal
22 that people were being written off and you used the
23 phrase "written off" in your evidence today as well.
24 You say that you contacted the Scottish Government about
25 this and they denied asking GPs to start doing this and,

1 at a broader meeting with the Scottish Government, you
2 raised the issue of misuse of DNACPR decisions and
3 a policy officer vigorously denied the issue because
4 they said nobody was contacting the Government about it
5 and they couldn't seem to grasp the reality of the
6 situation.
7 Firstly, on the issue of people contacting the
8 Government, in your experience of speaking to
9 service users, do you think they could have easily
10 contacted someone in the Government to raise this issue?
11 A. At that particular meeting I had no idea the routes upon
12 which they expected people were contacting the
13 Government. Was it through an online form, by email or
14 otherwise and to what degree could they collate all of
15 this? It really wasn't clear at that moment what those
16 routes were.
17 That particular meeting is clear in my mind, a video
18 call that we'd had. It was just a flat denial that
19 there was a problem. There was a flat denial that
20 anybody was getting phone calls from GPs about trying to
21 agree to a DNACPR, and the answer was, "Well, clinicians
22 can do this anyway". But the whole -- despite the
23 evidence, the volume of phone calls, we couldn't fathom
24 that this was actually happening -- not about anything
25 behind the DNACPR, but that people were getting these

1 phone calls in the volumes that they were. It was
2 a source of huge frustration and actually meant we
3 couldn't go forward with this.
4 So we'd written to I think Jeane Freeman at one
5 point, we'd gone through different Government ministers,
6 we'd written to the health committee in the Scottish
7 Parliament at the end of that year, asking for an
8 investigation into this. We eventually concluded that
9 Healthcare Improvement Scotland might have been the best
10 place to go to look for an investigation, but actually
11 it was completely -- it just -- it didn't seem to figure
12 in people's minds that this was happening on the scale
13 it was happening or indeed trying to kind of comprehend
14 the impact that's having on people and how that
15 potentially was affecting their kind of access to health
16 treatment.
17 There was another example towards the end of --
18 I think it was 2022 we had a national conference --
19 international conference and Jason Leitch then -- or
20 he's still -- clinical director was the guest speaker at
21 this Q&A with older people, but it was an online forum,
22 it was filmed live-streamed. And the question came in
23 from the chair about DNACPR and he had said -- and it's
24 available publicly still -- that there wasn't -- it's
25 something that wasn't an issue, people hadn't been kind

1 of asked to call people about it either, and the kind of
2 chat function just set alight with people saying, "This
3 happened to me, this happened to me". I think he was
4 slightly taken aback by that as well in terms of his own
5 understanding of what was maybe going on. I don't mean
6 to say that he didn't know what was going on, of course,
7 but -- I was in the room at the time -- I remember just
8 sort of seeing the impact of that, that people who we
9 hadn't been in contact before about this were saying the
10 scale of this was greater potentially than we had
11 thought. But I think it was just this absolute lack of
12 recognition that this was, I think --
13 Q. Did anyone in the Scottish Government at any point ever
14 take ownership of the issue and try to make -- even if
15 they say the instructions didn't come from them -- take
16 ownership and attempt to contact GPs or their
17 representative bodies to tell them to stop the practice?
18 A. So actually, in April -- towards the end of April --
19 middle to end of April -- I understand that those --
20 after these conversations with Scottish Government in
21 different fora, Jeane Freeman, the Health Secretary at
22 the time, and Gregor Smith, as Deputy Chief Medical
23 Officer, had I think written to GPs to make clear that
24 there is absolutely no need to pre-emptively phone
25 people or contact people about a DNAR decision. The

1 Government had denied that there had been any
2 communication about this to GPs or in a medical setting
3 before that moment, which we absolutely take at its face
4 value, but, yeah, there was an action taken in April to
5 GPs and other (inaudible) to either "Stop doing this" or
6 "There is no need to do this".
7 But after that it was really hard -- because I think
8 what we wanted to find out was the scale of this, how it
9 had changed in the year before the pandemic, you know,
10 what -- the origin of these calls, these highly
11 distressing phone calls, and just what could people do
12 to find out if there was such a thing in their name
13 which might have an impact on their healthcare in the
14 future. So, for instance, if there was, in your medical
15 records, a DNACPR and you wished to have resuscitation
16 attempts but there was a slip essentially in your
17 records, then that wouldn't be attempted because it
18 might have been believed that was your choice, but in
19 a clinical setting you might actually survive. So
20 I think there's some worrying practice in terms of what
21 exists in people's records.
22 Q. Yes.
23 THE CHAIR: Ms Bahrami, you have just over 15 minutes to go.
24 MS BAHRAMI: Thank you, my Lord.
25 Now, you tried to get information about this from

1 the health boards as well through freedom of information
2 requests, but you were told that they don't have the
3 figures because there's no central database; it's just
4 bits of paper on files. Did Age Scotland consider that
5 an acceptable position? Does Age Scotland believe there
6 should be centrally stored numbers?
7 A. As part of our own scoping exercise -- because we've
8 been asking people to investigate this -- one wonders
9 what information was out there. If no one else was
10 willing, Government or Parliament or anyone else, the
11 Health Service, to investigate the scale of this, what
12 could we find ourselves? I think there was one health
13 board -- it might have been Forth Valley -- that had
14 a response, and it was a very low figure -- because one
15 of the questions was not just the number of DNACPRs in
16 a certain time period but how did that compare to the
17 same time period the year before. I think we might be
18 looking at March to June 2020 compared to March
19 to June 2019 and the figures looked very similar, which
20 didn't seem to compute compared to the calls we were
21 getting or the type of thing. But every other health
22 board either responded saying they didn't have this
23 information or it wasn't possible to obtain.
24 And I believe from speaking to one or two of the
25 health boards it was because, you know, these are bits

1 of paper, they weren't necessarily logged anywhere else,
2 but then you sort of find out that there are other
3 routes that these are logged, whether it's through
4 something called "SIPs", some kind of like patient
5 information system that the paramedics have and
6 ambulances have, which presumably, if you arrive at
7 someone's home, then you'll know a little bit more about
8 them -- but it was really difficult to find -- I don't
9 think it was an acceptable position to not know the
10 scale of this. I think the health boards should have
11 been pretty interested in clinical decisions made and
12 how that changes over time and the reasons why. But it
13 feels quite antiquated in terms of -- in this instance,
14 in terms of how patients, individuals, citizens, human
15 beings, have any kind of decision-making or control over
16 the information that's about them.
17 So I think that was a worry in terms of what do
18 health boards know about what's going on and -- it's
19 probably speculation -- but it's never been in any
20 volume before at that point. But it's clear from all
21 the discussions we were having that no one was really
22 wanting to take ownership of finding out any more.
23 Positive discussions with Healthcare Improvement
24 Scotland were about the future, how to reform the
25 system, to make education better both for clinicians and

1 for patients, to improve conversations, to make people
2 more aware of advance care planning essentially. And
3 that was a positive step for the future, but there was
4 no, I think, ability for anybody to look back, which is
5 why we're incredibly keen that this Inquiry -- and we've
6 been calling for it since early 2021, and discussions
7 with John Swinney at the time was that DNACPR was in
8 your terms of reference because it was such an important
9 issue at the time, not just for us and for older people
10 contacting us, but across a range of different citizens
11 in Scotland.
12 Q. Yes, thank you. You say in your statement that
13 Healthcare Improvement Scotland said they lack the power
14 to investigate and they had a round table discussion
15 with you instead, and you've described the outcome of
16 that, but you'd also asked the Scottish Parliament's
17 Health and Sports Committee at the end of 2020 to
18 conduct an investigation, but they told you that they
19 didn't have time within that parliamentary year to do so
20 and they didn't seem able to carry out an investigation
21 in a future year; is that correct?
22 A. No, that's absolutely correct and I think that's
23 probably, on reflection, a reasonable response from the
24 health and support committee at the time because it
25 was November, I believe, 2020. Election would have

1 been -- or sort of Parliament would have stopped
2 operating sort of mid- to end of March. They'll have
3 a schedule. I'm pretty sure we wrote to the equivalent
4 committee after the election as well about this but I'd
5 been in at least one parliamentary inquiry between May
6 and November 2020 and we're talking about DNA CPR and
7 making a case that what had been happening, what we'd
8 been hearing from people, and it was unacceptable, an
9 unacceptable practice and felt quite angry about how
10 people felt they'd been treated, and that there was not
11 really any information or any kind of recourse to
12 information or understanding about what has happened or
13 why it's happened. So that kind of call for
14 investigation into it was a regular occurrence but
15 nobody was able to -- either felt they were capable of
16 doing it or had the time to do it.
17 I think that's a great disappointment because we'll
18 have moved on so far and I think actually getting that
19 information will be a difficult task to do. I don't
20 envy your job here.
21 Q. Thank you. I want to move on briefly to ask you
22 a couple of questions about care homes. Now, we've
23 heard a lot about the issues faced by families and other
24 organisations, so I am just limiting it to a couple of
25 points. But you raised the issue of essentially

1 remaining alive versus actually living. Am I correct in
2 understanding that Age Scotland's position is that more
3 value should have been placed on quality of life and
4 making the final weeks, months, days of people's lives
5 enjoyable rather than potentially extending the duration
6 of life at the expense of quality and quality time with
7 loved ones?
8 A. Absolutely. At the beginning of the pandemic, it was an
9 interesting split in terms of calls from concerned
10 family members about care homes locking their doors.
11 Some people, particularly for a short period of time,
12 believing that, "Okay, I understand this, it will keep
13 my loved one safe"; but as time went on, you know,
14 week 3, 4, 5, month 2, 3, 4, 5, and the doors weren't
15 still open, that visiting was so restricted that it was
16 clear -- it was so obvious that the quality of life for
17 residents had diminished to a great extent, that people
18 had -- their conditions had got worse, that they weren't
19 the same person they were just a number of weeks
20 beforehand. There was a rapid decline in their health.
21 And, for us, on a regular basis, we made that point
22 to Scottish Government, behind the scenes and behind
23 doors, in media statements, that we need to make sure
24 that care homes had everything they possibly need to
25 support visiting and it can't just be a phone call or

1 a video call or something through a window or in
2 a garden.
3 I think the distress that you'd hear from residents
4 and their families about their quality of life, that in
5 itself was harrowing and that -- I think a lot of people
6 have died a lot sooner than they otherwise would have or
7 became a lot more elderly than they would have because
8 of that absolute isolation. And there were examples
9 where people didn't have their personal belongings in
10 rooms and lots of things around this I think were wholly
11 wrong.
12 And it just has taken us far too long, as a country
13 or as any kind of institution, to properly support that.
14 I think there was evidence out there how to do it well
15 but it was very disjointed. I just don't think that
16 care homes or social care got anywhere near the support
17 that they needed from health or from Government to treat
18 this as a priority. And it's still going on today of
19 course, that care homes won't be open for different
20 reasons, for infection control reasons. But my
21 goodness, we -- we might not have been as vocal all the
22 time as we could have but I think the defence at that
23 time was there were lots of different issues that were
24 going on, but on a regular occurrence to the Government
25 or in media statements we were very keen for care home

1 visiting to be supported, yeah.
2 Q. The other point I wanted to touch on was in relation to
3 that. You state that care staff and other contractors
4 have been acknowledged as being the carriers of COVID
5 into care homes and on that basis you think, on balance,
6 that it would have been more beneficial to support care
7 homes to have adequate PPE and testing in place so that
8 families could assist with their loved ones' care.
9 Did you raise that with relevant authorities and what
10 was the response that you got?
11 A. This was -- I think the context behind the sort of
12 carriers of COVID were that you have people just coming
13 into a care home, wherever they're from, necessary
14 critical staff coming in but they weren't in isolation
15 so potentially could be carrying a virus, you know,
16 asymptomatically or otherwise. But why couldn't other
17 key people, whether it was a designated visitor, a key
18 family member, do the same and actually be under
19 probably stricter conditions, potentially, with testing
20 before they went in, having really appropriate PPE? So
21 these conversations were had very early, certainly
22 in April, about first of all the lack of PPE
23 availability for care homes in general, and then real
24 anger about this. You know, there was a -- this is
25 certainly early April conversations and sort of hearing

1 from the care sector about they just didn't have
2 anything. People were going on eBay to find anything
3 they possibly could but it never got to the point where
4 they had enough.
5 But with regard to visitors, I think there was an
6 appetite from family members to do everything necessary,
7 everything in the safest possible way to make sure that
8 the loved one, as best you could and on balance, not
9 contract COVID-19 or some other illness from you. So
10 going in with -- you know, properly kind of sanitised,
11 having maybe a rapid test before you went in, you know,
12 making sure you've had some kind of isolation model for
13 a period of time before you went in. I know from people
14 there was an appetite to do that but it just wasn't ever
15 supported, and there was really good I think
16 internationally recognised standards for infection
17 protection and control that could be utilised that just
18 weren't ever consistently or at all implemented by
19 Public Health. And that kind of -- the landscape of
20 hundreds and hundreds of care homes, they all look very
21 different in how they kind of function and how they --
22 the buildings themselves, you'd probably have quite
23 a unique job reaching them but I don't think that would
24 be impossible to do. I just don't think there was
25 enough effort there and the longer it went on, it just

1 seemed to drift and no one was taking responsibility for
2 how do we make care home visiting possible as opposed
3 to, "It's a risk, we can't do it". I think there should
4 be a differently framed question with someone tasked
5 with making it possible to happen because people at the
6 end of their life will have been poor and I don't think
7 that is something that any of us would want for
8 ourselves or for loved ones.
9 Q. Is there anything we haven't touched on today that you
10 would like to add at this point?
11 A. I don't think there's anything beyond the statement or
12 the other written documents that have come in.
13 MS BAHRAMI: Thank you very much.
14 THE CHAIR: Yes, indeed. Thank you, Mr Stachura. That's
15 all for the day.
16 Now, we're, for a variety of reasons, not sitting
17 until, believe it or not, 3 o'clock tomorrow afternoon,
18 so 3 o'clock tomorrow afternoon. Thank you all.
19 (4.15 pm)
20 (The hearing adjourned until
21 Thursday, 18 April 2024 at 3.00 pm)
22
23
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