Scottish Covid-19 Inquiry

Day 2

October 25, 2023

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(10.00 am)

THE CHAIR: Good morning, everybody. Welcome to Day 2.

Now, we continue with the opening statements and the first this morning is from Scottish Covid Bereaved, Ms Mitchell KC. Thank you very much indeed, Ms Mitchell.

Opening Statement by MS MITCHELL for Scottish Covid Bereaved

DR MITCHELL: Good morning, my Lord. I'm Claire Mitchell and, along with Kevin McCaffery and Kevin Henry Advocates, we are instructed on behalf of Aamer Anwar & Co in relation to the Scottish Covid Bereaved.

The Scottish Covid Bereaved originally started out as part of a Facebook group, "Covid Bereaved Families for Justice", which formed in 2020. Following a meeting with the First Minister, Nicola Sturgeon, in March 2021, it became clear that the Scottish bereaved, that they required to become an autonomous group within the Covid Bereaved Families for Justice. In the Latter half of 2022, they became a separate and independent group, namely the Scottish Covid Bereaved, in order that their voices could clearly and separately be heard. The Scottish Covid Bereaved are represented by the Inquiry's

team at Aamer Anwar & Co, both in the Scottish Inquiry and the UK Inquiry.

The group are a group of bereaved individuals with a common goal of not wanting their loved one's death to have been in vain and for lessons to be learnt to stop others suffering the way that they have and to ensure the next time a pandemic arrives, which it surely will, we are prepared.

The members come from all over Scotland and from all walks of life. Although the group came about because of bereavement, within the group there are members dealing with other wider consequences of the pandemic, ranging from traumatised healthcare workers, teachers who had to buy their own disinfectant to keep classrooms safe and using their own money to feed pupils, to those dealing with long COVID and those dealing with the financial consequences of the pandemic. The group contains many individuals with expertise in a wide variety of fields including medicine, governance and science. Over the past day and continuing on today, we have been listening carefully to the other core participants who have set out their experiences. Sadly, many of those experiences are shared by this group.

The Inquiry will open to evidence of those affected by the pandemic, to give evidence as to how they and

others were affected. They will raise their voices for those who tragically can no longer speak for themselves. The Scottish Covid Bereaved has already had the opportunity to give evidence at the UK Inquiry and are in the process of giving statements to this Inquiry, many of whom are keen to do so and indeed at the end of this week we will hear from one of our members of Scottish Covid Bereaved.

Each individual story provides a devastating vignette of the horror that they lived through and continued to live through, losing a loved one to a deadly pandemic.

On August 24 2021 the Scottish Government announced that they were going to establish a public inquiry into the handling of COVID-19 pandemic in Scotland. This was followed by Deputy First Minister John Swinney, on establishment of the Inquiry, stating in Parliament that the bereaved would be placed very much at the heart of the Inquiry. The Scottish Covid Bereaved expect that process to continue.

They feel that sharing their experiences, both good and bad, will be of great help to the Inquiry in assisting to establish what really happened during the pandemic and in its aftermath. Ultimately, despite the differing life experiences of the members, the

Scottish Covid Bereaved are clear that what they expect from this Inquiry is answers, accountability and, where sincerely and appropriately made, apologies from those who failed Scotland. The bereaved want the legacy of this Inquiry to be that, when the next pandemic comes, the people of Scotland will not have to suffer in the same way that their members have suffered.

The Scottish Covid Bereaved note the unfortunate history of the Scottish Inquiry, with the previous Chair stepping down. Despite both inquiries being announced in 2021, Baroness Hallett is currently powering ahead with her UK Inquiry. The Chair, Lord Brailsford, said on appointment:

"The public are rightly looking for answers and no more so than the loved ones of the nearly 16,000 people in Scotland who died during this pandemic. I am immensely aware of the enormous responsibility this places on me and the Inquiry. I promise the families that, along with the Inquiry team, I will work independently to establish the facts and ensure the Inquiry thoroughly examines the decisions taken through the pandemic."

The Scottish Covid Bereaved quite rightly expect the promises to them are kept.

The Inquiry is also embarking on a listening project

which the group are taking part in. It is vital for the Chair to hear the voices of those directly impacted. Whilst it is understood that due to pressures of time oral evidence will be limited, we ask and no doubt the Chair will give the most careful consideration to the voices and experiences of those who have shared as part of the listening project.

The UK Inquiry has already concluded the module on pandemic planning, which has left the Scottish Covid Bereaved in no doubt that a decade of austerity has left the NHS mortally wounded, the poor poorer, the sick sicker and the UK in a more unequal place than a decade before.

Brexit had put pandemic planning on hold and, despite important lessons being learned in pandemic planning exercises, the vast majority of the learning was left unimplemented. It is against that background that the Scottish Inquiry opens, to explore the provision of health and social care services, including end of life care and the use of do not attempt CPR notices.

Ministers in England and Wales claim to have thrown a protective ring around vulnerable residents in care homes, but the policy not to isolate the people discharged from hospital to care homes in the first

weeks of the pandemic of 2020 without testing was deemed irrational, but Scotland did exactly the same. By the end of March 2021, there had been 3,774 deaths in Scottish Care homes. It matters not one bit to the bereaved if the care home deaths happened in London, Manchester or Glasgow. The policy of discharge of untested patients was ultimately a death sentence for the elderly.

The Scottish Covid Bereaved expect answers on the provisions of PPE in Scotland. The Scottish Covid Bereaved expect to hear again from Jeane Freeman, Scotland's former Health Minister, whether we failed our front-line workers, who were crying out for PPE. Many front-line workers gave their lives trying to save ours, where their leaders were asking for us to clap those workers on our doorsteps every week.

The group wish to know whether the Scottish Government properly considered the science and made appropriate decisions in light of that information or whether they marched a few steps behind Boris Johnson into the deadly bedlam that he stands accused of his handling of the pandemic.

The Scottish Covid Bereaved note the scope of the Inquiry, an intention as set out in the memorandum of

understanding with the UK Inquiry to minimise duplication between the inquiries. It is the experience of Scottish Covid Bereaved that they and other groups have been front and centre of the UK Inquiry and we very much hope that experience is replicated by the Scottish Inquiry. Of course we note that tomorrow this Inquiry is not sitting due to the fact that there are other hearings going on elsewhere and we're obliged to the Scottish Inquiry in that regard.

If the Scottish Covid Bereaved and similar groups truly are to be front and centre of both inquiries, it is vital that the inquiries consider the timetable of hearings, as they indeed have done this week, to ensure where possible the hearings do not overlap. Certainty around Inquiry dates and timeframes is key to ensuring that families are kept fully informed and it reduces the anxiety about the Inquiry process. The group have already raised this issue with the UK Inquiry at its procedural hearings and the Scottish Covid Bereaved and their representatives note that they would require to give evidence at both inquiries and, where it's necessary for hearings to take place at the same time, the members of the group and the representatives will require to catch up using recordings, and whilst it's great that technology allows this, hearing the evidence

in real time is clearly always preferable.

The Scottish Inquiry will expect that key political individuals and their advisers, chief medical officers and scientific advisers are expected to give evidence in this session of Module 2 at the UK Inquiry. Their evidence is of course critical to Scotland in terms of the decisions they made UK-wide and will very much feed into the interaction between Scotland, the Scottish Inquiry and the UK. There will be crossover evidence and we very much intend for the relevant issues to be raised at the Scottish Inquiry. The group ask that the Scottish Inquiry follows the approach of the UK Inquiry in giving core participants a substantive role in the preparation for Inquiry hearings. Core participants are given copies of draft reports for comment and draft evidence proposals are circulated with core participants, who are asked to suggest lines of questioning and are able to put proposals for questioning and ask questions directly of witnesses, of course where appropriate.

The evidence led thus far at the UK Inquiry already raises serious questions as to the Scottish Government's preparedness for a pandemic; the extent to which the machinery of UK Government during critical early stages of the pandemic allowed for the involvement of the

Scottish Government; whether the available data reflected the four nations of the UK or just England; whether attendance at crucial meetings by Scottish Government ministers, civil servants and scientists was simply a charade and whether or not COBR —— the Cabinet Office Briefing Room —— meetings were actually, as has been described, a "Potemkin village", where the devolved administrations were operating under a false belief that they were playing a key role in the process but real key decisions were actually being taken elsewhere. This of course makes it even more important to understand what decisions were being taken in Scotland, by who and on the basis of what science and what data.

In relation to the evidence, this Inquiry will be aware that we raised the issue of WhatsApp messages with the UK Inquiry following the leaking of Matt Hancock's data to the Daily Telegraph and subsequently the Scottish Inquiry was part of the UK Inquiry Judicial Review in respect of those messages. The release of WhatsApps, social media and diaries and contemporaneous notes is critical in building a picture of the state of preparedness for a pandemic, the impact of those decisions and to assist to examine attitudes and conflicts that existed in liaison with Scotland's

devolved administration. Whilst there has been success in the UK in enquiring and retrieving substantial quantities of material from the UK Government and senior officials, the Scottish Covid Bereaved expect that process to be properly replicated by the Scottish Inquiry for those witnesses relevant to Scotland.

As the Scottish Inquiry turns its intention to health and social care services, the Scottish Covid Bereaved turn their mind to those group members who are unable to be with their loved ones at the end of their lives. The thoughts of loved ones dying alone is something that continues to haunt many members of the Scottish Covid Bereaved. As time has gone by, members of Scottish Covid Bereaved have had more and more questions about how and why this was allowed to happen. A number of members of the group wonder whether the restrictions on visiting their loved ones was as a result of inadequate PPE supply. Many are aggrieved that it appears that guidance relating to visiting and attendance at end of life was not consistently applied, not only across health boards but also within the same areas and even across different wards within the same hospital.

Some members have reported that some of the guidance was simply nonsensical. They were told that they could

not visit their terminally ill relatives in hospital as they were advised that the hospital was not letting anyone who was not a patient, only later to be told by the same hospital that they would require to attend the hospital in person to collect the death certificate.

The provision of end of life care and subsequent bereavement has caused significant trauma to members of the Scottish Covid Bereaved. Many members feel a sense of anger and guilt about the standard of care that their loved one received before death and there are some that feel that their loved one's death could have been prevented. Many feel ongoing guilt and anger that they were unable to advocate for their loved one when they most needed them. Members report having been advised that they were told by hospital staff that they had to choose between being present at their loved one's death or attending their funeral due to clinicians misunderstanding guidance on isolation rules. The use of do not attempt cardio—pulmonary resuscitation notices is a matter of grave concern to the Scottish Covid Bereaved and it's hoped that this Inquiry can shed light on that.

While the group focuses on the bereavement suffered by its members, it is not only end of life care that impacts upon the group. Members have concerns about

clinical management of loved ones with pre—existing chronic conditions or who were awaiting treatment for long—term conditions that are more prevalent among the elderly. Others have concerns about the treatment received by their loved ones before they progressed to end of life care. Answers are sought to questions in relation to nosocomial infections, hospital—acquired infections. There are those with experience of reduced access to formal care services for parents who were not resident in a care home, the treatment of care home residents, the historic underfunding in the provision of social care services and the consequences of this once the pandemic hit.

We have already heard and seen in evidence during Module 2 of the UK Covid Inquiry the insulting terms with which the then Prime Minister, Boris Johnson, described long COVID, with the words, "Bollocks. This is Gulf War syndrome stuff", and several months later in a WhatsApp message, "Do we really believe in Long Covid? Why can't we hedge it more? I bet it is complete Gulf War syndrome stuff". It is essential to uncover what impact the UK Government had on how such issues were handled in Scotland but also whether such dismissive attitudes were replicated at Scottish Government level or by health professionals.

We have already had the experience and the benefit of having world-leading experts appear at the UK Inquiry and it is therefore essential, when experts are called by the Scottish Inquiry, that they are of the similar calibre, experience and excellence.

According to the National Records of Scotland, as of 9 October 2023, there were 17,991 deaths in Scotland where COVID-19 was mentioned on the death certificate. Each of those deaths and also the deaths where COVID was not mentioned not only represents an individual tragedy but has affected the friends, the family, the loved ones of each of those who died. No person, institution, no matter how powerful, whether it be in England, Scotland, Wales or Northern Ireland, can obstruct the search for truth.

The Scottish Covid Bereaved welcome the long-awaited start of the Chair's Scottish Inquiry. We ask that all the witnesses who appear at the Inquiry speak with absolute candour and brutal honesty as, without that honesty, we will never learn the vital lessons to ensure that, when the next pandemic comes, as it inevitably will, we are able to save thousands of lives and avoid the unnecessary suffering endured by so many in the pandemic.

The Scottish Covid Bereaved campaigned for this

Scottish Inquiry to be set up and to run parallel to that of the UK Inquiry. They are entitled to expect a robust and fearless inquiry. The Scottish Covid Bereaved welcome that their voices are being heard at both inquiries and that the bereaved must have trust in the process, which means that the Scottish Inquiry must earn that trust and to recognise the central role, active participants in this Inquiry. Until they find the truth behind their loss, there's little hope of healing and without that trust it would inevitably impact on the Scottish Covid Bereaved's perception of whether justice has been served.

The Scottish Covid Bereaved expect a public inquiry that listens to their voices and those of other core participants who have lost so much. In doing so, it will provide the foundations for an inquiry that delivers real change and accountability. That must be the legacy of the Scottish Inquiry.

I'm very much obliged.

THE CHAIR: Thank you very much, Ms Mitchell.

Now, the Care Inspectorate, Mr Macleod.

Opening statement by MR MACLEOD
for the Care Inspectorate

MR MACLEOD: Good morning, my Lord. Along with Emma Toner Advocate, I represent the Care Inspectorate.

The COVID-19 pandemic and the response to it took a heavy toll on Scotland and its people. In few places or perhaps nowhere was that toll heavier than in one of the sectors regulated by the Care Inspectorate; namely care homes for our older people.

In Scotland, there are approximately 800 care homes for older people, in which 44,500 or so staff are employed to care for around 30,500 people. When we think of care homes for our elderly, we think, of course, of those who reside there, many of whom lost their lives to COVID-19, but our minds also turn to their families, to their loss and their distress and the lost opportunities during the pandemic to see and support their loved ones and to provide and to receive the comfort and support that only family contact brings. The Care Inspectorate wishes at this early stage to offer its sincere condolences to all of those who lost family members or friends to COVID-19, particularly in the care services it regulates and across our society as a whole.

As the regulator of services such as care homes for older people and care at home services, the Care Inspectorate also had an insight into the challenges faced by staff in those services during the pandemic. They had to continue to work in

a professional way throughout COVID-19 outbreaks in their workplaces and to do so despite their concerns for their own health. They had to deal with deaths of many people for whom they had cared and whom they held in great affection. They had to support grieving families. Some sadly lost their own lives. The Care Inspectorate also offers its condolences to their families and friends.

While this Inquiry may hear criticisms of the Scottish Government's response to the pandemic in relation to the care sector and may hear evidence critical of some care services, their managers or individual staff members, and while some of those criticisms may be found to be justified, the Care Inspectorate wishes to take this opportunity to recognise the overall contribution made by those working in the care sector in responding to the pandemic, whose efforts were arguably overlooked in a justifiable public outpouring of support for the NHS.

My Lord, it is the principal role of the Care Inspectorate to regulate and inspect care services to ensure that they meet the required standards and to help or, in some situations, to compel them to improve if necessary. Across all of its work, it provides independent assurance and protection for people who

experience care, their families and carers and the wider public. In addition, the Inspectorate plays a significant role in supporting improvements in the quality of care in Scotland.

The Care Inspectorate recognises the importance of this Inquiry and welcomes very much the opportunity to participate in it. It is committed to assisting the Inquiry in any way that it can and has already provided it with all documents and information requested and will continue to do so.

Aspects of the Care Inspectorate's response to the pandemic which the Inquiry may wish to consider include, firstly, whether it should have sought proactively to influence the thinking of the Scottish Government in relation to the discharge of individuals from hospitals to care homes in the early stages of the pandemic, although it had no role in overseeing or implementing that process; secondly, whether its decisions to pause on-site inspection activity briefly, while aligned with those of equivalent regulators elsewhere in the UK and in Europe, were reasonable, proportionate and justified; and, thirdly, whether its approach to the recommencement of inspections earlier than its counterparts in the rest of the UK, using prioritised and risk-assessed on-site inspection, combined with the use of technology, was

again reasonable, proportionate and justified.

No doubt there will be other areas that the Inquiry will wish to explore, such as the arrangements for care home visiting, where the Care Inspectorate will be able to assist the Inquiry or in respect of which the Inquiry will wish to scrutinise the Care Inspectorate's approaches and responses.

While the Care Inspectorate is hopeful that, upon a close analysis, the Inquiry will find that there was merit in its responses to the pandemic, it is not complacent. It takes this Inquiry as an opportunity to hold a mirror to itself, to benefit from the insight that independent consideration of its actions brings and to learn not only from the Inquiry's formal findings and recommendations but also from the evidence the Inquiry hears as it proceeds and from its own ongoing reflections on its practices in light of that evidence.

Where changes or improvements are necessary, it will make those. Where changes or improvements to the services it regulates are necessary, it will encourage and, if necessary, enforce those. With that in mind, my Lord, the Care Inspectorate hopes that for all parties this Inquiry will bring new insights and recommendations which will leave Scotland as prepared as it can be for the future.

THE CHAIR: Thank you very much, Mr Macleod.

Next we have the Central Scotland Care Homes and I think it might be Mr Gray. Am I correct? Yes, I am. Thank you.

Opening statement by MR GRAY
for Central Scotland Care Homes

MR GRAY: Good morning, my Lord, ladies and gentlemen.

I'd like to start by thanking your Lordship for granting core participant status to our group in this Inquiry, for granting us leave to appear at this block of hearings and for allowing us the opportunity to make this opening statement.

I am Alastair Gray, Solicitor Advocate, and I, along with my colleagues, David Fitzpatrick, Sarah MacArthur and Sarah McNicol of Rradar, represent a group of independent care home operators consisting of Oakminister Healthcare Limited, Thistle Healthcare Limited and Keane Premier Group Limited. They will collectively be referred to during this Inquiry as "Central Scotland Care Homes" or "CSCH".

Together the members of CSCH operate 21 care homes throughout the Scottish central belt, with the majority concentrated in the Greater Glasgow area. They are small- to medium-sized care home operators with the maximum occupancy of their homes ranging from 24 to 106.

They employ varying numbers of staff across their homes, with around 30 to 140 staff members assisting with the care of their residents at the smallest and largest homes respectively.

CSCH's staff care for elderly residents who have a range of needs and care requirements. This opening statement is focused upon the Impact Hearings on the Health and Social Care Portfolio but the members of CSCH wish to outline their ongoing commitment to assisting the Inquiry generally by working with the Inquiry team to provide invaluable evidence of their experiences during the pandemic. Our members were brought together by a common desire to have their voices heard and the fact that, as small- to medium-sized care home operators in the central belt, they operate in the same space and had similar experiences of the pandemic. They have a particular story to tell as they operate in the most densely populated areas in Scotland.

The members of the CSCH wish at the outset of this Inquiry to extend their deepest condolences to the bereaved family members and friends of all of those who lost their lives during the pandemic through COVID or related factors. Every life lost was and is a tragedy.

Their sympathies are also extended to those other individuals who have been significantly impacted by the

effect of conditions associated with the virus, such as long COVID. It is hoped that this Inquiry will serve as an appropriate legacy to their lives or their continued suffering by ensuring that future generations are equipped with the plan and information required to avoid a repeat of the devastating impacts felt by the people of Scotland.

The care which our members provide to vulnerable elderly residents is a service which all of us here today and across Scotland, our children and generations beyond them, may come to rely upon. The people deserve an inquiry which gets to the truth of how and why policy decisions were made by key stakeholders, including these decisions which affected the care sector and, importantly, vulnerable individuals such as care home residents.

It has often been said but is worthwhile repeating that care sector staff were working under significant pressure in a fast-developing global pandemic and attempting to implement rapidly changing Government guidance while caring for vulnerable residents. CSCH's staff, at all levels, worked under extreme strain in exceptional conditions. They had to continue their vitally important day-to-day care providing jobs whilst also dealing with the significant toll of the pandemic,

which meant, given the Government's lockdown rules, taking on new responsibilities, such as being the only channel for communication between family members and vulnerable, sick and tragically dying residents.

The stories of the CSCH members are unique. They can provide insight into what was experienced on the ground in care home settings during the period that this Inquiry has been established to consider. These stories cannot be told by the deceased nor can they be told by families who had very limited access to their loved ones at the height of the pandemic. In essence, our members are able to provide the best evidence of the myriad impacts felt by those in this significantly impacted sector.

In saying that, to be absolutely clear, we are not intending to suggest for one moment that the evidence of the bereaved is unimportant, quite the opposite. The evidence that will be given by the bereaved family members of care home residents will be among the most important, if not the most important, evidence that will be heard in this block of hearings and in this Inquiry generally, but, as a matter of fact, family members of care home residents were not able to have normal access to their loved ones during the pandemic due to the restrictions that were in place and that is where our

members can assist: by providing evidence that fills the gaps for the bereaved and for this Inquiry, by providing evidence of the full range of impacts observed in relation to care home staff members and residents in the times when nobody else was able to observe them. Our members are committed to providing that evidence in order to ensure, insofar as they possibly can, that no family member of a care home residents ever again has to experience the awful spectrum of emotions and impacts experienced by the bereaved during the pandemic and that they continue to feel today.

The members of CSCH report very challenging circumstances presented by the pandemic, not least because of the nature of the virus itself but also due to difficulties with issues such as testing, the effects of hospital discharges, communication of guidance and the expectations around implementing that guidance placed upon them by external agencies. At its conclusion, the Inquiry must be able to report why key guidance and policy decisions were made and set out the lessons to be learned about those decision-making processes.

Turning to guidance and outbreak management. The members of CSCH report a lack of consultation with the sector from decision-makers during the pandemic. The

issued guidance changed frequently and, whilst that was to be expected as knowledge and understanding evolved, the messaging which came through was sometimes contradictory and one member of the group advises changed twice in one day. The timing of guidance was often sub-optimal, being issued late on a Friday or on a Bank Holiday making dissemination of new information to staff more difficult.

There were unrealistic expectations of the pace of implementation of advice and change. There was a rigid expectation that guidance would be implemented and implemented immediately. These attitudes led to a demoralising work environment for staff and service managers. The rapidly changing nature of the advice meant that there was worry amongst staff that they had been doing something wrong when following previous guidance. If there had been a collaborative approach, with greater input from the sector, the CSCH members are confident that it would have led to better outcomes.

Discharges from NHS hospitals to care homes were made at very short notice to help free up beds within the NHS. Many of the residents arrived without prior testing for COVID-19. At the beginning of the pandemic there were issues around the declinature of treatment for care home residents when they became unwell and

needed to go to hospital. Accident and emergency units would refuse to take residents and care home staff were expected to deliver care outwith their regular scope of practice. During this time, staff of all levels within CSCH reported as feeling helpless, knowing that medical care in hospital would not be given even when residents desperately needed it.

Turning to external agencies, the CSCH members report that at the beginning of the pandemic, from March 2020 until around May or June that year, limited external agency visits to their care homes were carried out. This led to feelings of isolation for staff within the sector, who were trying their hardest to navigate through the toughest times. When the media reported cases of COVID in care homes, it prompted a very aggressive response by external agencies where, rather than support care homes, the members received several inspections and visits within a short space of time. These inspections were often unannounced and the expectation was that all work was halted to enable participation in the inspections. There was no recognition of the extra responsibilities taken on by care home staff, such as becoming the only conduit of communication between residents and family members. Very little support or guidance was given and many of

the inspection reports did not highlight any positives and focused only on negative aspects. No context was taken into consideration and little support was offered.

An example of this is where there was an active COVID outbreak in one home and staff were required to isolate for 14 days. At this point in time, as part of a contingency plan, housekeeping colleagues helped to support residents who were unwell during staffing shortages rather than completing deep cleans. This was highlighted in one report as being negative. However, no support or advice was ever given as to how the situation could have been handled differently. When external agencies did visit care homes, it was evident that they were unaware of the practicalities of working within a care home. They had unrealistic expectations of advice implementation and changes. This left the service managers and staff feeling deflated and worthless. This contributed to what felt like a culture of blame and exacerbated the feeling of divide between external agencies and care homes at a time when everyone ought to have been working together.

The members of CSCH were advised that, although it was down to individual services to implement guidance and that it was only guidance, they were expected to follow it. Any inspections or health and social care

partnership visits were judged using this guidance, thus removing the autonomy of services to make their own risk assessments based upon their unique knowledge, experience and judgment.

The members of CSCH faced a significant increase in administrative duties during the pandemic. There was a requirement to report all confirmed and suspected COVID-19 cases to the Care Inspectorate, Public Health Scotland and local authorities. There was a major duplication in this workload. It is not known what the level of communication was between these and other agencies but there appeared to be a lack of cohesion.

In addition to that, all positive staff cases required to be notified to the Health and Safety Executive and, when a resident passed away due to COVID-19, reports and information required to be supplied to Police Scotland as part of Operation Koper. This was extremely time-consuming for staff and service managers, who were trying to navigate COVID recovery plans whilst supporting hands-on care delivery to patients who were ill.

When senior managers shared clinical observations with local GP teams and regulators in an attempt to collaborate and raise awareness of methods that had led to recovery of some residents, their professional

opinions were disregarded. Our members felt that they had to advocate for their patients to be given a chance of survival and push external medical staff to help support this. This state of affairs made them feel utterly helpless, anxious and exasperated and it was contrary to everything they believed in and had been trained to do.

Turning to personal protective equipment, PPE. At the outset of the pandemic, our members felt that there was a lack of clear instruction with regard to PPE, including the use of face masks. Instructing staff, visitors and service users on what PPE to use and how to use it was frustrating and demoralising for staff, who complained of feeling undermined and distressed. One member reported that they had no significant supply issues with PPE, however obtaining top-ups initially at support hubs was difficult.

Turning to hospital discharges to care homes. It is well known that in the early stages of the pandemic decisions were made to discharge patients from NHS hospital settings to free space for acute COVID-19 admissions. Between 1 March 2020 and 20 April 2020 clinical advice was that a COVID-19 test was not required prior to discharge of asymptomatic patients. CSCH feel that many of these decisions led to outbreaks

in their homes and would ask the Chair to carefully analyse the evidence in this regard.

CSCH is aware of research from Public Health Scotland published on 28 October 2020 and similar publications since that date which indicate that hospital discharges to care homes were a factor but not a significant factor in leading to outbreaks. According to the Public Health Scotland report, the most significant factor leading to outbreak was the size of the care home in terms of its number of residents. It ought to be determined, as far as possible, whether the decisions to discharge patients from hospital settings to care homes did in fact lead to greater instance of outbreaks. If it is ultimately concluded that size of care home was the main driver of outbreak instance, CSCH wants to know why that was the case. If indeed that is found by this Inquiry to be correct, it would suggest that the risk-based approach should be taken to management of future pandemics so that resources and support are appropriately concentrated in larger care homes where they would seem to be needed most.

Turning to do not attempt cardio-pulmonary resuscitation (DNACPR) requests. The CSCH group wish to highlight their concerns about the use of DNACPR requests from healthcare professionals where it was not

always apparent that the appropriate consultations had taken place. To be clear, where appropriate, such requests were declined by the members of CSCH. Similarly, some advanced care plans prepared between families and residents setting out the intentions for care towards the end of life were disregarded by hospital consultants. The assumption in the main was that COVID was the likely diagnosis and this limited treatment and intervention. Again, the impacts of those decisions on residents, care home staff and family members were profound and must be examined.

Turning to the human-rights-based approach and in particular the right to life. The Inquiry is required to take a human-rights-based approach to its findings in fact and recommendations. At the preliminary hearing in August of this year, your Lordship reaffirmed your intention to do that from the beginning of proceedings. As part of this approach, the right to life will be in sharp focus during this Inquiry and in that regard our members would simply wish to remind the Inquiry that the right to life is universal, applies equally to all and does not diminish with age.

Turning to co-operation with the Inquiry. As the Inquiry progresses, the members of CSCH intend to cooperate fully with the Inquiry team. It is hoped that

in line with this spirit of co-operation, the Inquiry team will commit to making disclosure and communicating important updates in a timely manner, as expressed previously by your Lordship at the preliminary hearing and in the published protocols for the Inquiry. I do recognise, in saying that, my Lord, that since this statement was lodged on 16 October 2023, there have been several tranches of disclosure made via the online disclosure system which I'm pleased to say is up and running and working well. In that regard, I do wish to express my gratitude and our group members' gratitude to your Lordship and all the members of the Inquiry team for the enormous amount of work that has gone in to getting us to this point.

In conclusion, the members of CSCH look forward to assisting the Inquiry in fulfilling its terms of reference in every way that they can in the hope that recommendations will be made that have a genuine and positive impact on future generations and serve as an appropriate legacy to all those that tragically lost their lives or continue to suffer immensely as a result of the COVID-19 pandemic.

Thank you, my Lord.

THE CHAIR: Thank you very much, Mr Gray.

The next core participant is a group made up of

bereaved relatives, former care home staff and Community Response Team. Ms McCall.

Opening statement by MS MCCALL
for the Bereaved Relatives Group (Skye)

MS MCCALL: Thank you, my Lord. I'm Sheila McCall and with Grant Markie Advocate I represent the Bereaved Relatives Group (Skye). We're instructed by PBW Law solicitors.

The Bereaved Relatives Group (Skye) welcomes the start of this Public Inquiry. This group is made up of people whose relatives died in care homes as well as care workers who bore witness to the conditions in those homes. Their experiences span five different health boards, including Scotland's island communities. The members of this group welcome the Chair's decision to hear first from those directly impacted by the pandemic in the health and social care sector. Their thoughts today are with their loved ones.

While everyone's situation is individual and their grief personal, the evidence in these hearings will reveal a commonality of experience among the bereaved. Care home residents and their families were let down. They were let down by the lack of planning and preparedness at a national and local level for dealing with the pandemic. They were let down by decisions made by Government. They were let down by failures in the

inspection regime. They were let down by private care providers, who prioritised profit and reputation over their responsibilities to care for residents, to protect them and to tell the truth.

As well as revealing the suffering of individuals and their families, we anticipate that the evidence in these hearings will point to a systemic failure of the model for the delivery of care in Scotland, for its regulation and inspection. We recognise that those concerns are for later hearings, but, as you listen to the witnesses describe their experiences, we urge you to be thinking of the questions that you should later put to those who made the decisions and those who implemented them. In due course, this group will be asking you to make recommendations that will ensure that the elderly and vulnerable are properly cared for and that what happened during COVID-19 cannot happen again.

The bereaved want to know how it was and why it was that the virus was able to enter care homes when they were in lockdown ahead of the rest of society and how the virus was then able to spread like wildfire within the homes. The Inquiry will hear evidence that people were transferred into care homes from hospitals without testing. This happened at a national level with no obvious consideration given to local capacity or the

best interests of patients and residents. It was at a time when it appears no Scottish hospital had reached a level of capacity that might have signalled an imminent critical incident necessitating such a step.

The Inquiry will hear evidence of staff travelling between care homes and to different parts of the country, including from England to Skye, with concerns that rules on self-isolation were not then followed. There will be evidence that care homes were entirely unprepared for a pandemic and that, once it began, staff were given little or no guidance and training on what to do.

There were deficiencies in infection control, basic cleaning and hygiene. In one home, the alcohol-based cleaning products were locked in a cupboard to which staff were not permitted access by management. Instead they cleaned using air freshener.

There will be evidence of a lack of PPE or staff not using it consistently and properly. There were lacks or no cross-contamination measures in place to prevent staff spreading the virus among residents. Staff were witnessed attending work while displaying symptoms.

Once there was a COVID-19 outbreak in a care home, bereaved relatives were faced with a total lack of transparency about what was happening. Some learned of

an outbreak from Facebook rather than from care home management or staff. There was no proper testing regime within the care homes. When direct questions were asked about whether someone had tested positive, relatives were lied to.

The situation was only exacerbated by the decision of Government that there should be a blanket ban on face-to-face visits with those in care homes. It is a natural human response to be as close as possible to a loved one in the final phase of their life. This was denied to care home residents and their relatives. While there is a recognition, of course, that measures to mitigate the spread of the virus and the risk of infection had to be implemented, bereaved relatives want to know why staff members were permitted to travel between their home and place of work, use public transport, spend time with their own families, all without taking protective measures, and yet still work closely with the vulnerable and elderly in care homes.

Having listened to the witnesses' accounts, the Inquiry should be prepared to ask the decision-makers why alternatives were not considered or, if they were, why were they not approved. Why could families not nominate one relative to bubble with the resident to allow face-to-face contact to continue? Why did no one

consider the cultural impact of denying the island communities their tradition of collective caring?

The Inquiry will hear that when relatives tried to contact their loved ones by video conference or telephone, their efforts were thwarted. Excuses were given about malfunctioning iPads, problems with the wifi network. The excuses kept changing. In some instances management told staff not to share with the outside world what was going on in a home. Some staff formed the view that management cared more about their reputation in the community and the protection of their business than they did about the residents, their families and the care workers who do the job not for the money but because their heart is in it. Some staff went behind management's back, risking their jobs to keep families informed.

Families' calls went unanswered over days and sometimes weeks. On some occasions, when contact was made, families were treated with disdain, as if they were an inconvenience. Families were told their loved one was fine only to get a sudden hurried phone call that they were dying.

Many families witnessed remotely a significant deterioration of their loved one's physical and mental health in lockdown that was nothing to do with COVID-19.

Some suspected their loved one was suffering from neglect, dehydration and starvation. Questions were asked and relatives were fobbed off.

The blanket ban on visits meant that care plans could not be checked. The Inquiry will hear that when records were requested after a loved one's death, relatives found that the records were missing or incomplete. When relatives did manage to make contact over video with their loved one and witnessed for themselves the deterioration in their condition, there is evidence that at times their wishes about medical treatment were ignored or overridden. The reality for bereaved relatives is that some did not see their loved ones face to face again after the lockdown began. The right to visit during the last moments of life was not always granted and, if it was, it was restricted to one family member. Some residents died alone. Care home staff witnessed many excess deaths. They held people's hands as they died. That trauma will never leave some of them.

After death, some relatives were not given all their loved one's belongings back. They expect they were burned in spite of having been quarantined. After death, some relatives were so concerned about what had occurred that they reported the death to the police.

They want to know how it got to that stage.

The Inquiry has promised to take a human-rights-based approach and hearing first from those impacted by the pandemic is a recognition of that approach in action and that is welcomed, but a meaningful human-rights-based approach goes far beyond that. The Inquiry must investigate whether the right to life under Article 2 was respected and protected. We anticipate the Inquiry will hear that people were pressured to agree to do not resuscitate notices, that people were not resuscitated even though no such notice was in place, that residents may have been neglected and left to starve, that families are not sure they were told the truth about their relative's cause of death, that the usual process for certification of deaths was departed from.

The Inquiry must investigate potential violations of Article 3, the prohibition on torture, inhuman and degrading treatment. Relatives will speak of their loved ones lacking food, water and hygiene; that there was inadequate, inappropriate, absent or delayed medical attention, that welfare attorneys' views were not listened to when it came to medical treatment; that there was inadequate staffing to provide proper care, resulting in residents suffering unnecessarily. We urge

the Inquiry to consider whether, in light of people's lived experience, the inspection and regulatory regimes were fit for purpose to prevent or remedy these harms.

The Inquiry must also consider the impact of the restrictions that were put in place in care homes on the rights of residents and their loved ones to a family life under Article 8. We expect the evidence will demonstrate that no proper efforts were made towards maintaining relationships and that people's health declined as a result.

When you come to hear from the decision-makers and those who implemented the decisions and the restrictions, we want you to ask: did those people take a human-rights-based approach? Did they consider that the result of their decisions and the restrictions that followed would be the situations that the Inquiry is going to hear about in this first tranche of hearings? Fundamental to a human-rights-based approach are accountability and a guarantee of non-repetition. Most of all, what this group wants the Inquiry to ensure is that no family member, no care home resident and no care worker in the future has to go through what they and their loved ones suffered during COVID-19.

I'm obliged, my Lord.

THE CHAIR: Thank you very much indeed, Ms McCall.

We are again ahead of schedule but I think we will take the break now, which is when it is scheduled. Can I ask you please -- it's now 10.55, so could you be back, please, at 11.15?

(10.56 am)

(A short break)

(11.19 am)

THE CHAIR: Right. Next we have Independent Care Homes Scotland, Mr McKie.

Opening statement by MR MCKIE
for Independent Care Homes Scotland

MR MCKIE: Good morning, everybody. Good morning, my Lord. Thank you very much. I would like to echo the thanks of some of my colleagues for allowing us core participant status and also for enabling us to make this submission today. My name is David McKie. I am with a firm called Levy & McRae, and my team working with me in this are Duncan Hamilton KC and, at Levy & McRae, Stacey Fox, who is with me this morning, Raymond Gribben and Olivia Robertson.

I represent a group called Independent Care Homes Scotland or "ICHS", as I shall refer to them. They're a distinct group comprising 11 independent care home operators within Scotland. ICHS was set up to form a distinct voice for the independent care home sector

and to provide evidence and submissions to this Inquiry.

Two statistics best explain why ICHS can assist the Inquiry: first, about a third of all deaths registered as due to COVID-19 were from within care homes; secondly, about three-quarters of care homes looking after elderly residents in Scotland are operated by independent providers. Listening to the independent care sector is accordingly a central part of understanding the COVID tragedy. Our focus is to put that essential experience and evidence before the Chair and indeed before the public.

First of all, ICHS wish to express their profound and sincere sympathy to the families of those who died or are otherwise affected by the COVID-19 pandemic. The members of ICHS were responsible for both staff and residents during the pandemic. Those staff were the primary point of contact for families of those in care. The passage of time cannot be allowed to obscure or to diminish the trauma and the tragedy of what occurred. This Inquiry, rightly, has at its core the family members and friends who lost loved ones due to the pandemic. ICHS members were at the front line and dealt with many elderly residents who fell ill and in many cases tragically lost their lives. That burden was an extraordinary one and at times intolerable for staff to

carry.

This Inquiry will look at processes, structure and decision-making. It is right to do so, but none of that can ever be allowed to distract the Inquiry from the human aspect of this tragedy. That sense of hurt, grief and confusion which defined the experience many had in trying to understand and accept the inability to visit sick and dying relatives was real. It remains real for most. If this Inquiry cannot get to the heart of why those making decisions and implementing national policy made the choices they did, it will have failed.

Families and friends who had become an essential part of daily life for many care homes were barred from entry due to Government restrictions. Those people were not able to say goodbye to relatives in their last hours or to comfort them and maintain essential human contact with those they loved.

ICHS's role in this Inquiry will be to give evidence, make submissions and seek both clarity and accountability. That starts in these first Impact Hearings by listening to the voices of those families and residents. It will then be about explaining as well as possible what decisions were being taken and which agencies and authorities were driving those policies. It will be about shining a light on areas of confusion

throughout the pandemic response and ensuring that the public have access to the truth of what was happening. It will also be about making sure, as we look to the future, that there is no misunderstanding about the relationship between those making the laws and regulations and those charged with the responsibility for implementing on the ground. ICHS members approach this Inquiry with humility and with an openness to learn. What this Inquiry should insist upon is that those in power and the key decision-makers at the time do so also.

By way of background to those who are unaware, ICHS employ thousands of staff. Those are the people in care homes looking after residents day and night. Accordingly, the group had many staff and residents directly and indirectly affected by the pandemic, both in terms of their own physical and mental health and in their care and interactions with residents and their own families. The pandemic was very tough for most, but for those staff it was at times a burden almost too great to bear. The statements and testimonies of some of those staff will be submitted and we hope will be made public.

During the pandemic, care homes endeavoured to adhere to ever-changing guidance from Central and Local Government and regulatory bodies. ICHS intend to

provide evidence on how such changes affected key decision-making and, at this Impact stage, in relation to how that landscape profoundly affected staff both on the ground and at managerial levels. It will also consider carefully and respond to any evidence disclosed by the Inquiry to assist the Inquiry to reach conclusions or make recommendations for the future. ICHS is committed to being a constructive part of ensuring that the recommendations for change are practical, informed by reality and will deliver for the public the greatest benefit. That means ensuring that a vibrant independent care sector with decades of experience and daily responsibility for residents is at the heart of policy formation, not simply a passive recipient.

ICHS is well placed to assist this Inquiry. It collectively operates 156 care homes around Scotland. The members of ICHS employ in the region of 13,000 staff within the health and social care industry. They are here not just to ensure a voice for the independent sector, but to represent staff, families and residents based on a vast collective pool of expertise and experience.

One of the key aims of the Inquiry is to investigate the strategic elements of the handling of the pandemic.

That is expressed in the remit as being "in care and nursing homes: the transfer of residents to or from homes, treatment and care of residents, restrictions on visiting, infection prevention and control, and inspections". All of the investigations into the key strategic elements had a direct impact on employees within the ICHS group who provided front-line care for the most vulnerable members of society. They were placed in a position of increased risk of infection. Care home employees required to adapt to the ever-changing circumstances and were expected to implement novel changes required by amendments to guidance from both Government at all levels and regulatory bodies. They were expected to do so instantly and constantly. They were required to care for elderly and vulnerable patients, many of whom had cognitive difficulties and did not necessarily understand what was happening.

It fell on the shoulders of those people to deliver the impossible difficult news to family members and friends who could not visit. As a consequence, the need for external communication with families was massively increased. Families unable to visit had a legitimate and desperate need for constant information about their loved one. Ensuring continuing lines of information

amid-a global pandemic was exceptionally tough. Beyond that and on a daily basis, the care had to continue. This was a pandemic which hit the elderly and infirm the most significantly. This included situations where, if infected, COVID often led to a rapid deterioration and in many cases death. Employees were deeply scared not just by the number of deaths but by the isolated nature of those last hours for too many. Nothing this Inquiry can do will remove those memories and fully heal those scars.

We anticipate that evidence will be led during the Inquiry both in written and in some cases oral form from employees of ICHS members. It is likely that witnesses of ICHS can provide vital insight which will assist the Impact Hearings, including in the following areas of scrutiny: one, the distinction between the private and public sector.

ICHS witnesses can address the key differences in the private and public sector which arose during the pandemic. There were a variety of guidelines not only across health boards but across local authorities and from Central Government which appear to have led to diverse approaches between the public and private sectors. It was felt by some of our members the priority appears to have been provided to the public

sector which was at times detrimental to the private sector and their ongoing operations during the evolving circumstances. One such example was the use of NHS terminology and guidance. It was often lengthy and confusing, but this confusion was added to by the use of acronyms or lingo which was not used by private care home operators. Another example is the introduction of weekly testing of care home staff in the independent sector which wasn't required by those operating in the NHS. It is hoped that the evidence which care home witnesses provide under this topic can identify lessons to be learned by the health and social care sector moving forward.

Two, the impact of the Government's guidance, Central Government. ICHS members have profound concerns across a range of the decisions made by Government. Those we understand will be explored in later hearings but they are made in this submission because of the significant impact they had on residents, staff and families. These issues include: one, whether care homes should have been closed to visitors earlier than March 2020; two, the delay in introduction of weekly testing for all Scottish Care home staff; three, a six-day delay in April 2020 between England stopping NHS hospital discharges without testing and Scotland

also doing so; the decisions of Scottish Government and specifically the failure to lift visiting restrictions in the summer of 2020; attempts by the Scottish Government to shift responsibility on to the independent care sector; delays between Government announcements and policy implementation and their impact on employees within the sector.

Timing of updates. Key witnesses will be able to explore the direct impact on the handling of frequently changing Government guidance. That is not simply in relation to the content of that guidance but also on matters of practical implementation. Witnesses have identified key issues in the timing of the Government guidance which had a direct impact on their individual work, their colleagues' work, on their residents and, as a consequence, on families. For example, one factor which hindered the sector was the announcements routinely being made on a Friday evening. Administrative staff members who were required in order to implement the guidance and who do not typically work on weekends were required to work extra hours and on their days off to implement any key changes.

The impact of local councils. Members within this group operate around the whole of Scotland in both rural and urban areas. The impact that local governments had

through issuing their own guidance and measures for restrictions within their community had a significant effect on the management of individual care homes. Given that some of the members operated nationwide across Scotland, there were a variety of different national and local guidelines that they required to review and provide specific advice in each local area and to each care home to try to comply with the current measures being implemented. This had a direct impact on the capacity of already pressurised managers within each individual care home as well as area managers for the whole of Scotland, who had a variety of diverse measures to address.

The level of support afforded to care homes varied from one local authority to another. ICHS witnesses will be able to provide examples of both positive and negative experiences when reaching out and asking for help from their local council. Some were more hands—on than others and we're conscious that the Chair, as noted in the preliminary hearing, would like to understand regional differences when considering impact, and that's something we're hoping to be able to assist with.

The impact of regulatory bodies. Care home operators in Scotland are regulated by the Care Inspectorate. They regulate care homes for adult

care providers. During the pandemic, care home managers were required to report to the Care Inspectorate as normal. In May 2020, the Scottish Health Minister raised her concern that private care homes were not following Government guidance. As a result, the NHS Care Home Support Team was set up. NHS staff were redeployed to become infection control specialists, referred to as "inspectors". These inspectors comprised nurses who were trained in other medical disciplines and completed a training course to become infection control specialists. The majority of the nurses had little prior experience in infection control and this created tension between care home employees with many years of such experience and those inspectors.

ICHS members have care home staff specifically trained in infection control as standard practice. That is so precisely because care homes are particularly susceptible to the spread of flu and viruses. Moreover, the impact on elderly residents of such infection is disproportionately serious when compared to the general population. Care home staff already understood the importance of controlling infections, limiting the spread and managing the risks. They had specific protocols in place to do so and staff were trained on an ongoing basis. The advice of inspectors was often

inconsistent with care home infection control policies or the advice given by other members of the Care Home Support Team. This created confusion, contradiction and obstruction for ICHS members and their employees.

Staff and residents were also impacted by the delay and disconnect between the public announcement of weekly testing for all care staff in Scotland, made in May 2020, and the actual delivery of this testing, which didn't happen until the end of June 2020. By that time the first wave of the pandemic was receding. In a context of worry and anxiety about the pandemic, the public identification of the urgent need for such testing, raising that expectation for families, staff and residents, required immediate action. Instead the delay created concern that the necessary safeguards for all were not being implemented.

Equipment. ICHS members will also speak to the difficulties they faced in procuring PPE and the stress and sometimes fear that this caused their staff. Guidance changed during the pandemic in relation to the types of PPE staff were required to wear. When this happened, demand dramatically increased and it was often very challenging for private care home providers to locate and secure what they needed to protect their staff and residents.

The principal purpose in the formation of ICHS, its participation in this process, is to ensure the integrity of the Inquiry's investigation and to provide transparent evidence to assist the Chair in making his recommendations for the bereaved families involved. ICHS members had employees who were at the forefront of the health and social care sector and the COVID—19 pandemic had a direct impact on their lives. Care home staff endeavoured to adhere to all measures and guidance which was constantly changing, all while trying to provide the best possible care to their residents.

Working in a care home during the pandemic has been described by staff members as "being in the trenches". They weren't just carers for the residents, they tried to protect them from a deadly virus and they held their hands when their family members could not. They witnessed first hand unimaginable loss of life. Many staff members are still struggling to process what happened and how to ensure it never happens again. For staff and for families, that is what this Inquiry must deliver.

Thank you.

THE CHAIR: Thank you very much indeed, Mr McKie.

Now, the next core participant to speak is Long Covid Kids Scotland. Mr Webster is back again.

Good morning, Mr Webster.

Opening statement by MR WEBSTER
for Long Covid Kids Scotland

MR WEBSTER: My Lord, the children of Scotland should be able to thrive and look forward to a positive future. Long COVID, the long-term illness caused by COVID-19, has blighted that prospect for too many. For too many long COVID presents a seemingly insurmountable obstacle to an engaged, fulfilling and productive life.

The Inquiry has embarked upon its listening project, Let's Be Heard. In an adult world, the voice of children is too often ignored, disregarded or belittled. I ask all of us in this room today to pause and think back. Did we hear the voice of children in the decision-making on masking, school mitigations, examinations or immunisation or is our recollection that children were simply told how it was going to be?

For reasons I find unfathomable, we have been precluded by the Inquiry from allowing the voice of a child to be heard in these opening statements. Bearing in mind that we appear to have the technology to do so -- and if we don't, that of itself must be a matter of concern -- and bearing in mind also that the Inquiry has already claimed the privilege as the masters of its own instance to play its video in its opening

statements and, perhaps more vexing of all, that my learned friend Mr Gale said yesterday that the Inquiry in its Let's Be Heard outreach wanted to hear from children so adults are not speaking on their behalf, to be denied the opportunity to present our opening remarks in the manner we would wish risks the perception of a tin ear on the part of the Inquiry as it takes its first steps. We can only hope this error of judgment, for frankly that is what it is, will not be repeated. So it falls to me, my Lord, to read the words of a child:

"Many months ago we all became ill with coronavirus and very soon we became very ill. Some of us became seriously ill and had to stay in hospital. Our symptoms looked a bit different to the ones that grown ups seemed to get so our parents didn't always know what was wrong with us straightaway. Coronavirus doesn't only affect children like us, many of our parents got ill too, so we've had to stay at home and tried to look after each other but many of us got worse and needed extra help from doctors. Our parents were often scared. It seems like a long time ago that we felt well and could do some of the fun things we liked to do. We're still at home and we're still unwell. Many of us are still in bed lots of the time. It can be boring, annoying, frustrating and tiring and we miss our friends. We miss

feeling well.

"One day a group of doctors and grown-ups who were ill just like us called our really long illness 'long COVID'. Long COVID means that you're still ill after many months and you never know how you feel when you wake up or try to play favourite games. One day you might feel okay and the next you might feel terrible again. Sometimes you might feel okay and terrible in the same day. It's very confusing. Having long COVID is weird because it didn't exist last year. We're the first people to have lots of different things go wrong with us."

The child goes on:

"We didn't feel like this before we got coronavirus. We felt like you. Now we all have long COVID and nobody knows what to do. Our parents are working together to get us some help and that's why we're telling you our story. We want to feel better again and when we ask when we will feel better, nobody can tell us when that might be. It's making us sad."

Well, a recitation of common symptoms, my Lord, exhaustion, cognitive impairment and chronic pain for long COVID, truly fails to convey the true lived reality of this disabling and devastating illness. The Inquiry has been offered and we trust will hear from those with

that lived experience, of children and young persons housebound, bedbound and isolated, distraught, humiliated and suicidal, of professional scepticism, indifference and inaction in response, of the struggle to gain recognition, respect and action.

Long Covid Kids is a grass roots organisation formed by individuals who have borne the burden of that lived experience and who have become disillusioned and frustrated by the slow, inadequate and frankly reprehensible response by Government, national and local, to the long-term illness caused by COVID-19. They are the citizens who continue to suffer from the effects of the disease, who either are or look after those who are at greater risk of morbidity upon reinfection with COVID-19.

There are overall 250 families supported by Long Covid Kids in Scotland with a child suffering from long-term symptoms having contracted COVID and there are believed to be around 10,000 children and adolescents suffering from long COVID in Scotland. They are entitled to answers to many questions but, above all, they're entitled to know whether their suffering and their sacrifices and their fate was avoidable.

So for that purpose, amongst others, this Inquiry must engage in a robust, probing and challenging and

unrelenting critical analysis of what those entrusted with their care in Government and our Health Service did and failed to do to recognise and act upon the risks of long COVID. This Scottish Inquiry proceeds alongside that undertaken by Baroness Hallett. It has chosen to set its own course, one that is different from that taken by the UK Inquiry, although the final destinations may not be too far apart.

For reasons that are understandable, but not necessarily optimal, this Inquiry has chosen to defer its consideration of decision-making until experiences and recollections have been recorded. However, when the time comes for analysis, the expectation must be that the Inquiry will look at the peculiar nature of the Scottish response, that of the Scottish Government, Scottish local authorities and Scottish health boards. The possibility of long-term post-viral illness was, as I said yesterday, well known before the pandemic. The question that has been asked of Baroness Hallett is that: if long COVID was foreseeable, why was it not foreseen? In this Inquiry, I ask in addition why was it not foreseen by our Scottish elected representatives and our Scottish health and education officials exercising their responsibilities for the care, well-being and education of the children and young people of Scotland?

One of the recurring themes the Inquiry will hear from those with a lived experience of long COVID is the struggle for recognition of the illness and recognition of the need for specific diagnoses, focused treatment and sympathetic support for those who continue to suffer; a professional scepticism that manifests itself in abject indifference to need.

As we've heard, Baroness Hallett has already been referred to the then Prime Minister's Boris Johnson's apparent scrawled response to the Department of Health and Social Care's call for recognition and support for people with long COVID, "Bollocks", and to his apparent admission in his witness statement to the United Kingdom Inquiry that he did not, at least initially, believe that long COVID truly existed.

What we ask is for this Inquiry to ascertain whether our First Minister, our Scottish Government, our health boards and local authorities were any better. Did they challenge? Did they gainsay? Did they follow the science? Or were they indifferent? Were they acquiescent? Were they supine in challenging such attitudes? Did they recognise the risks and consequences and the needs of individuals? And, most importantly, did they act? If they didn't, why not? Are they guilty of the same attitude to long COVID that

found its expression in the crude term that I've referred to?

So as we embark upon our evidential hearings, I pose not a comprehensive list but some questions in the light of the lived experience of many who question the adequacy of the preparation and the response to the pandemic. Standing along the delayed recognition of long COVID and the struggle for recognition, was any planning undertaken by the Scottish Government, Scottish local authorities or NHS Scotland with particular regard to the effect of the pandemic on the health and, as we'll consider later, education of the children of Scotland? If so, did it include consideration of the effects of long-term illness for children? If not, why not?

Did the Scottish Government and others distinctly and proportionately weigh the effect of the pandemic on children and young persons in formulating its initial public health response to the pandemic? Again, if not, why not?

Did the Scottish Government and others review, appraise and re-appraise and revise its response in the light of the lived experience of long COVID in children and in the light of the emerging evidence of harm in research? If not, why not?

Did decision-makers in the Scottish Government and NHS Scotland adequately warn the public of the risk of developing long COVID and take the disease into account in public health communications? Once again, if not, why not? And if they did, to what extent was that in response to patient advocacy rather than action initiated from a following of the science?

Concerns as to long-term consequences of COVID-19 were appearing in social media in March of 2020. Public Health England's first published advice came in September 2020. Was there a distinctly Scottish approach?

Those who have struggled against professional indifference and scepticism to highlight the issue of long COVID in children deserve at the very least an answer to these questions.

For too many their experience has been of little or no accessible designated paediatric diagnostic testing, treatment or support for children and young persons suffering long COVID. So did NHS Scotland and individual health boards recognise and respond to the distinct needs of children and young persons with long COVID as knowledge expanded? Again, my mantra: if not, why not?

Bearing in mind that the risk of long COVID remains

for all of us, including the potentially crippling employment and economic consequences of personal disability and that which might flow from having to care for a child with long COVID, did the Scottish Government and NHS Scotland ensure, in the light of what was known by the end of 2020, that long COVID will be the subject of appropriate data collection and modelling to enhance our knowledge of the disease and the methods of treatment of long-term sequelae?

Our children, on whom the burden of responding to a future pandemic will fall, deserve assurance that the learning need has been acknowledged and acted upon. Scottish children with long COVID, that is to say those who continue to suffer, deserve to have some accountability if it is not.

Beyond information-gathering, did the Scottish Government and NHS Scotland ensure, in the light of what was known by the end of 2022, that NHS Scotland was adequately informed, funded and resourced to provide the specialist help and support that this cohort of sufferers continues to meet? If not, why not?

So as we embark upon the work of the Inquiry, I again, as I did yesterday, exhort the Chair never to lose sight of the specific goal. This Inquiry must

conclude with pellucidly clear findings of fact as to how children and young persons' interests and rights as regards long-term illness were considered, weighed and acted upon, if at all, both in pre-pandemic planning and then in response to the pandemic.

In his opening remarks, counsel for the Scottish Government made reference to its Four Harms dashboard and to equality issues being included in the assessment made for each of the Four Harms. Well, we'll wait to see what that actually means in reality.

It will, my Lord, only be with an understanding of what was considered and what was ignored, what was weighed and what was discounted and what was done and what was not done that lessons can be learned for the future. So, again, there needs to be rigour in ensuring the Inquiry gives careful and discrete attention to this cohort of affected persons.

We look forward to the Inquiry producing background research directed to long COVID in children and young persons in like manner as it has already produced background research papers for other areas. Again, there needs to be understanding of the practical consequences of long-term COVID-related illness and the steps taken to avoid and mitigate the same and there needs to be an understanding that long COVID is an

ongoing and escalating threat to Scotland's public health. It is debilitating, life-altering and can be life-threatening. So there needs to be accountability, accountability for failures, oversight and indifference.

The stated aim of the Inquiry and your Lordship's point of reference at all times is to establish the facts of the strategic response to the pandemic in Scotland and to ensure that lessons are learnt from that response. Only on hard facts will the Inquiry be in a position to ensure that those who have failed the children and young people of Scotland will learn lessons for the future. We should be able to look at the report of the Inquiry and fairly conclude whether their suffering was avoidable.

Although the Inquiry is constrained by its terms of reference to consider matters other than planning over only the period of 2020 to 2022, it is in the area of long COVID that it is likely to have its greatest immediate impact. Long COVID is still prevalent, children are still contracting it and, with every infection, a number will suffer the extreme effects of this awful and debilitating condition. The Inquiry has the ability not only to reduce the impact of future pandemics but also impact Scottish children now and in the immediate future. We need to ask ourselves whose

child, grandchild, nephew or niece might this Inquiry save from the iniquities of this devastating illness.

My Lord, I can't speak for all of the core participants in this Inquiry. There are many able advocates in this room and you will no doubt have the benefit of the best of their advocacy, as you will, I have no doubt, from the Inquiry team. However, if I might venture, I suspect there is one common desire from many, if not all, of us. This Inquiry will hear evidence that at times will be harrowing. It will hear evidence that at times will be shocking. It may hear evidence that will frankly be scandalous. But through it all there will be a desire for the truth to be established.

The task ahead is daunting and it will be long. My learned friend Mr Gale, in his opening statement yesterday, made an idiomatic reference to As You Like It. May I, in similar vein, be so forward as to venture a personal and hopefully enduring point of reference for your Lordship as he begins his task. It's a line from The Merchant of Venice, "But at the length, truth will out".

My Lord.

THE CHAIR: Thank you very much indeed, Mr Webster. All this Shakespeare. Perhaps appropriate on St Crispin's

Day.

Now, I think National Health Service National Services Scotland. That's a mouthful. Ms Doherty, thank you.

Opening statement by MS DOHERTY for NHS National Services Scotland

MS DOHERTY: Thank you, my Lord. I am Una Doherty and I appear today on behalf of NHS National Services Scotland, NHS NSS for short.

NHS NSS welcomes this Inquiry to establish the facts of and learn lessons from the strategic response to the COVID-19 pandemic in Scotland. The toll that the pandemic took was a significant one. NHS NSS extends its sympathy to the witnesses who will give evidence on the impacts of the pandemic. NHS NSS has arranged to be represented throughout the Impact Hearings and will pay close attention to the evidence given.

NHS NSS is conscious that, although the Inquiry team is aware of the organisation NHS NSS, the wider public watching and listening today may not know what it is or does or why it is a core participant in this Inquiry. This opening statement, therefore, contains a brief introduction to the organisation, explaining its roles and its interest in the Inquiry.

NHS NSS is a non-departmental public body

accountable to the Scottish Ministers. It was created in 1974 to provide national strategic support services and expert advice to Scotland's NHS. Its headquarters are in Edinburgh but it has staff based at a number of locations in Scotland. It consists of a number of different units providing a wide range of services. The services currently provided by it include those given by the following units: National Procurement and Logistics; Practitioner and Counter Fraud Services; Antimicrobial Resistance and Healthcare Associated Infection Scotland; Central Legal Office; Digital and Security Services; Health Facilities Scotland; National Screening Division; Programme Management Service; Scottish National Blood Transfusion Service; and NHS Scotland Assure.

Prior to 1 April 2020, NHS NSS also provided a service called Health Protection Scotland. Elements of that service moved from NHS NSS on 1 April 2020 to become part of a new organisation, Public Health Scotland. While within NHS NSS, Health Protection Scotland planned and delivered specialist national services aimed at protecting the people of Scotland from infectious and environmental harms. One part of Health Protection Scotland prior to 1 April 2020, the Antimicrobial Resistance and Healthcare Associated Infection Team, remained in NHS NSS and is now known as

"Antimicrobial Resistance and Health Associated Infection Scotland".

Although it is not primarily a public-facing organisation, services provided by NHS NSS have had a role in the pandemic response. Its roles during the pandemic response included the following:

Programme management services to a range of programmes, including the commissioning and decommissioning of the Louisa Jordan Hospital, Test and Protect and the COVID-19 vaccination programmes.

Leading the mobilisation of construction partners, including for the Louisa Jordan Hospital and providing technical oversight on mechanical, electrical and water systems at the Louisa Jordan facility.

Development of therapeutic convalescent plasma treatments.

Procurement and logistics of personal protective equipment.

Procurement, development and operation of digital platforms for Test and Protect and the COVID-19 vaccination and COVID-19 status certification programmes, including publicly accessible apps and web platforms.

Procurement and logistics for PCR testing.

Procurement and logistics for lateral flow devices

and point of care testing.

Commissioning and operation of the National Contact Centre, providing support to Test and Protect, COVID-19 vaccinations and COVID-19 status certification.

Operational delivery of the UK national and local testing programmes in Scotland, working with the UK Health Security Agency, local authorities, health boards and the Scottish Ambulance Service to ensure access to appropriate COVID-19 testing for the population.

Working with other bodies on the production of infection prevention and control guidance.

NHS NSS looks forward to playing an active and useful part in the Inquiry, my Lord. It will wish to learn from the issues that the Inquiry examines. If there are recommendations made by the Inquiry, NHS NSS may be involved in facilitating actions required by some recommendations. As a public body, NHS NSS understands the responsibility it owes to the Inquiry and to the people of Scotland and it will support the Inquiry's work in any way it can.

Thank you, my Lord.

THE CHAIR: Thank you very much indeed, Ms Doherty.

Now, we are again in the position, as we were yesterday, this time even more extremely, that we've done all the core participants that were allocated to

the morning session. It is a bit early to take lunch. I'm going to have to ask Mr Pugh if he is ready to speak at the moment. I think actually, to be sensible about this, I should put the burden on Mr Bowie as well because we can easily get both of you done before we take even then, I think, an early lunch. Is that all right with both of you?

MR PUGH: Absolutely, my Lord.

THE CHAIR: Good, thank you. I'm very grateful for your co-operation. Mr Pugh first then. You're for the NHS Territorial Health Board and Special Health Boards. There's some terrible acronyms kicking about here!

MR PUGH: I don't think it's an acronym.

THE CHAIR: No, it's not actually.

Opening statement by MR PUGH for NHS Territorial Health Board and Special Health Boards

MR PUGH: I appear along with Cat MacQueen Advocate on the instructions of the NHS Central Legal Office on behalf of the Health Boards, as they've been termed, in their application for core participant status.

My Lord, the Health Boards welcome this Inquiry, which will allow a full exploration of the facts of the pandemic in Scotland as they relate to health and social care, including the response of the NHS. This opening statement will be the first time that the Health Boards,

in the sense that they are collectively formed for this Inquiry and the UK Inquiry, have spoken publicly so I would like to explain some relevant background.

My Lord, each of the health boards we represent is an independent NHS board in terms of the National Health Service (Scotland) Act 1978. They've grouped together for the conduct of both this and the UK Inquiry due to a commonality of interests.

14 territorial health boards have responsibility for planning and commissioning services, including primary care, and for the delivery of front-line NHS services to local populations, together with providing secondary and tertiary care in Scotland's hospitals.

The five special health boards provide care and support throughout Scotland, including ambulance provision, the national 24-hour helpline in the shape of NHS 24, the state hospital, the National Waiting Times Centre and the education of NHS staff. Each board is funded by and reports directly to the Scottish Government, although their management structures vary across the country.

My Lord, the ethos behind the Health Boards' participation in this Inquiry is to strive for both learning and improvement. Through their participation and with that ethos to the fore, the Health Boards hope

to benefit the future care of the Scottish people. The Health Boards are grateful to you, my Lord, for granting both core participant status and leave to appear at these Impact Hearings and look forward to assisting the Inquiry in its important work. The Health Boards anticipate active participation in the Inquiry's work on the terms of reference relevant to health and social care.

My Lord, following identification of the SARS-CoV-2 virus in early 2020, healthcare providers throughout the UK, indeed the world, strived to obtain knowledge of the virus, how it was transmitted, its effects on humans and its effective treatment. The resulting COVID-19 pandemic has represented the biggest challenge ever to face the NHS in Scotland. On 17 March 2020, the Cabinet Secretary for Health and Sport acknowledged the scale of the challenge in a speech to the Scottish Parliament, where she said:

"The scale of the challenge is, as the First Minister has said quite simply, without precedent.

"The response to COVID-19 requires a swift and radical change in the way our NHS does its work. It is nothing short of the most rapid reconfiguration of our health service in its 71-year history.

"That's why today, under sections 1 and 78 of the

National Health Service (Scotland) Act ... I am formally placing our NHS on an emergency footing for at least the next three months."

From March 2020, therefore, the Health Boards required to implement key changes in practice and policy to create additional capacity for COVID-19 patients and to manage infection prevention and control within the existing NHS estate. They had to do so while continuing emergency, maternity, cancer services and urgent care, all of which have been maintained alongside many other services throughout the pandemic.

Initial changes saw, for example: non-urgent surgery, treatments and appointments suspended together with some screening policies paused; the increase in the number of intensive care beds from 173 to 585, with the result that NHS critical care capacity was not breached; increase in the NHS workforce. For example, during the first wave in 2020, 4,880 student nurses were deployed, 575 junior doctors had their registrations accelerated and recently retired staff were invited to return to work; and the adoption of digital solutions. For example, the number of video consultations increased from about 300 per week in March 2020 to more than 18,000 per week in November 2020.

The initial changes also saw, of course, the

implementation of a strategy set out in the Cabinet Secretary's speech on 17 March for reducing delayed discharges from hospital. The impact of that strategy, where it resulted in discharge to care homes, has presented one of the most fundamental questions regarding the health and social care response to the pandemic, which question this Inquiry will doubtless explore in detail when considering Term of Reference (g).

As the pandemic began to take hold in Scotland, there was a rapid scaling-up of testing capacity and contact tracing, together with the implementation of the Test and Protect strategy published by the Scottish Government in May 2020.

By January 2021, Scotland had the capacity to test 77,000 people per day with 36% of that capacity coming from NHS Scotland laboratories. May 2020 also saw the introduction of a requirement for enhanced professional and clinical care oversight of care homes by senior health board staff, operating within multidisciplinary teams and alongside local authority officers, and that requirement has of course been referred to by a number of core participants already, my Lord.

Later, the course of the pandemic saw the rapid development and scaling-up of the vaccine programme

once, on 8 December 2020, vaccines became available and were first administered in Scotland. The Health Boards delivered vaccines across a wide variety of locations to reach as many people as possible. By September 2021, more than 7.9 million doses of vaccine had been administered in Scotland.

My Lord, none of these changes nor others too numerous to mention here would have been possible without the extreme hard work and dedication of the employees of the Health Boards. Exceptional effort and skill were shown not only by those employed in front-line services, infection prevention and control and health protection roles, but also by those who supported and enabled them, from porters and cleaners all the way through to administrative personnel. Healthcare staff and managers found new ways of working and of collaborating with colleagues and other agencies to ensure that, as a whole, the healthcare system has been able to withstand the pressures of COVID-19. The Health Boards wish to take this opportunity publicly to thank their employees.

The extraordinary lengths to which NHS staff went during the pandemic was of course also recognised by the public throughout. Who could forget clapping for carers every Thursday night? Of course recognition of the hard

work and dedication of those key workers comes with acknowledgement of the sacrifices they made. One need only recall stories of front-line staff being unable to return to loved ones at the end of their shifts for fear of infecting them to understand the extent of such sacrifice.

The emotional and physical toll upon those caring for people dying without their family and friends around them was huge and the media images of those working in high-risk areas, dressed fully in PPE, caring for such seriously ill patients will live long in the collective memory.

In that regard, the early pandemic saw difficulties in obtaining the correct PPE, even in high-risk areas, and this is again an issue that this Inquiry will set out to investigate fully.

While the impact of the pandemic has been felt by all and while it will take time to recover, the deepest wounds are with those who have either lost loved ones or who continue to suffer physically and mentally due to the virus. The Health Boards wish at this early stage to express their deepest sympathies to those so affected.

The Health Boards have not yet recovered from the impact of the pandemic and on current estimates are

unlikely to do so for some time. The delayed impact on diagnosis of certain conditions combined with the emotional and psychological toll of the pandemic and its knock-on effect on services is unlikely to be fully understood for some time. COVID-related conditions such as long COVID fall to be managed alongside the risk that new variants will again result in a surge of required hospital care.

My Lord, I set out in the following paragraphs the way that the Health Boards will seek to assist this Inquiry. I'm not going to read that out in detail. It suffices to say that at the moment, my Lord, the Health Boards' commitment, both in these Impact Hearings and beyond, is to assist the Inquiry in its important work. For present purposes, that means listening to the evidence of impact, which we will do with care. It is only by an understanding of what worked well and what did not work well that the boards will be able to improve the healthcare for the Scottish people.

Thank you again, my Lord.

THE CHAIR: Thank you very much indeed.

Now, Mr Bowie, thank you.

Opening statement by MR BOWIE
for Public Health Scotland

MR BOWIE: Good afternoon, ladies and gentlemen.

I represent Public Health Scotland or "PHS" for short. In these brief opening remarks, we thought it would be helpful to make some comments about first who PHS is and what its role was in the pandemic —— we're conscious that some of those watching and listening may not have heard of the organisation before now —— and, second, what PHS' purposes is in attending at these Impact Hearings today and in the coming weeks.

Before I do that, at the outset PHS wishes to express its gratitude to the Inquiry for being granted leave to appear at these hearings and, of course, to recognise and acknowledge the incalculable loss and suffering that have been endured by the people of Scotland due to this awful pandemic.

In our view, it is right therefore that the Inquiry has decided to begin the evidence by hearing from people across Scotland about the impact the pandemic had and continues to have on their lives.

Who then is PHS, what is its role and what is its purpose at these hearings? Since 1 April 2020, PHS has been Scotland's lead national agency for improving and protecting the health and well—being of the Scottish public. Central to its responsibility are the areas of health protection, health improvement and health inequality in Scotland. It played a key role during the

pandemic, particularly in the context of health and social care. It had a significant involvement in, for example, guidance, contact tracing, vaccines and advising and supporting the Scottish Government in its public health messaging. Alongside this and no less importantly, public health leaders within each of Scotland's 14 territorial health boards took many of the practical steps at local or community level to support the control of the pandemic.

Unfortunately, since 2020, for most of us, terms like "contact tracing" have become part of common everyday speech. In attending these hearings, PHS will benefit from hearing first—hand the impact that such measures had on ordinary people.

PHS is committed to listening and to learning the appropriate lessons, all with a view to doing better in the future. PHS will also do everything it can to assist the Inquiry to fulfil its terms of reference.

PHS is looking forward to playing a full role in the Inquiry as it proceeds. As a national public body, PHS keenly understands the responsibility it owes not just to the Inquiry but to all of the Scottish people and it will do everything in its power to meet those responsibilities.

Thank you.

THE CHAIR: Thank you very much indeed, Mr Bowie.

We're still only at 12.13. It's Ms Domingo, I think, that appears on behalf of the Scottish Women's Rights Organisations. Are you able to speak now? Do you want to speak now?

MS DOMINGO: I will be 20 minutes.

THE CHAIR: Well, you're allowed to be 20 minutes, there's no need to apologise for that, and I'm very grateful for you being prepared to be inconvenienced by being taken out of time.

MS DOMINGO: Thank you, my Lord.

Opening statement by MS DOMINGO
for the Scottish Women's Rights Organisations

MS DOMINGO: My Lord, I am Deirdre Domingo and these submissions are made on behalf of five Scottish charities, Close the Gap, Engender, JustRight Scotland, Rape Crisis Scotland and Scottish Women's Aid. They are collectively described in this Inquiry as "the Scottish Women's Rights Organisations".

The idea that COVID—19 was a great leveller that impacted everyone equally should be firmly dispelled. The most vulnerable, disadvantaged and marginalised communities in society suffered disproportionate adverse outcomes, not only from the virus but also from Government policies implemented to manage the pandemic.

Pre—existing discrimination and inequalities were exposed and exacerbated. The Scottish Women's Rights Organisations have been at the forefront of efforts to promote gender equality and to protect the rights of women, children and young people, particularly those who experience domestic abuse. Individually and collectively, our clients are significant voices advocating for women's rights and equality in Scotland.

Our clients welcome their designation as core participants in this Inquiry. They have recently provided a joint written statement giving a broad overview of the key impacts of the pandemic on women in the context of this portfolio. Two representatives of the Scottish Women's Rights Organisations will provide evidence to the Inquiry next week to discuss these issues. Each organisation hopes in the coming months to provide the Inquiry with a more detailed organisational statement that reflects on their unique experience during the pandemic and the experiences of the women and communities they support.

While each organisation is separate, they share the view that the pandemic and the Government's strategic response to it had an unequal and disproportionate impact on women, children and young people, particularly those who experience domestic abuse and intersecting

forms of discrimination and marginalisation.

This opening statement addresses the key areas of impact on women under four broad headings: first: domestic violence and gender-based violence. The "Stay at home" measures overlooked that for many people home was not the safest place to be. One of the consequences of the imposition of lockdown and isolation rules was a rise in domestic abuse and violence.

As explained by Scottish Women's Aid in their written submissions to the Equalities and Human Rights Committee of the Scottish Parliament, anxiety about Coronavirus, frustrations related to quarantine, economic uncertainty due to loss of jobs, harmful consumption of alcohol or other stresses do not cause domestic abuse. Domestic abuse is a pattern of behaviour that instills fear and it is used by abusers to maintain control. Measures taken to address the pandemic, including lockdowns, early release of prisoners, closure of schools, working from home, reduction in the work of courts and closure of some services and transition of others to remote provision provide additional tools for abusers to exercise that control and they remove the opportunities for women to seek help.

It is recognised that men can be subject to domestic

abuse. However, most abuse victims and survivors are women. Women experienced an intensification of domestic abuse during the pandemic, with increases in the frequency and severity of domestic abuse instances. Women and children were subject to heightened monitoring and control by abusive partners or family members. There was an increase in stalking and harassment from ex-partners and an increase in abuse through online platforms and through manipulating child contact arrangements.

For children and young people living with coercive control during the lockdown, the impact is yet to be fully understood. The places where they felt safest, schools, nurseries, sports or after-school clubs or the homes of grandparents or other family members, were all taken away. The pandemic simultaneously increased the risk of harm to women and children and made access to safe spaces, vital services and support from family and friends much more difficult. Being at home all day meant that the time alone to speak freely to a support worker or to the police was dramatically limited.

The pandemic also exacerbated pre-existing strains on services at a time when the funding environment over a period of many years had made service provision increasingly difficult. There was higher demand on

support services, such as those provided by Rape Crisis Centres, local Women's Aid services and JustRight Scotland, and our clients experienced unprecedented contact volumes while operating with reduced capacity. Data from May 2020 showed that calls to Scotland's Domestic Abuse and Forced Marriage Helpline were up 70% from the previous year and there was an increase in web chat and email contact, with email numbers almost doubling.

The pandemic created significant barriers to reporting sexual violence, which is an already vastly under-reported crime. If sexual violence took place in circumstances that infringed prevailing lockdown restrictions, victims were even more reluctant to report their experiences.

The suspension of court proceedings meant that the ability of victims and survivors to access the justice system was greatly reduced. There continues to be a large backlog of cases and significant delays. Rape Crisis Scotland has commented on the delays caused by COVID-19 as follows:

"From the outset, Rape Crisis Scotland raised significant concerns about the impact of the significant backlog caused by COVID-19-related court closures on the health and well-being of survivors of sexual crimes."

This is supported by findings from the Scottish Centre for Crime and Justice Research, which evidences the significant and harmful toll that uncertainty and delays have had on the mental health of survivors. Access to legal services and representation was also impacted as legal advice agencies had reduced and limited capacity and many solicitors were no longer providing legal aid services due to funding issues.

Women from black and ethnic minority backgrounds and those who experience intersecting inequalities were particularly impacted. The no recourse to public funds condition is felt disproportionately by women and it can increase vulnerability to other forms of exploitation, including trafficking and physical or sexual abuse. It can trap women in abusive relationships, particularly where they depend on the perpetrators of abuse and are unable to leave because of a lack of accessible options, including safe refuge spaces. This is compounded where women have uncertain immigration status.

The second area is health impacts and housing. Increases in domestic abuse and gender-based violence have, in many cases, significant negative impacts on health, housing, education and employment outcomes. In the written evidence to the Equalities and Human Rights Committee, JustRight Scotland stated that heightening

mental health problems and exacerbating psychological distress are reported amongst already vulnerable and traumatised survivors of domestic violence. With reduced support services buckling under the increased demand, Women's Aid describe a perfect storm for these vulnerable women.

Despite the NHS remaining open for those who needed urgent care, victims and survivors experienced difficulties in accessing crucial healthcare services during the pandemic. Lockdown increased the risk of homelessness and insecure or unsuitable housing for women, including for women seeking to leave abusive partners. There was an increase in women seeking crisis accommodation at a time when women's refuges were full and, because housing allocation processes were frozen, there was an inability to move women and children into permanent housing.

For women subject to the no recourse to public funds condition, it was more difficult to access housing or refuge spaces. This increased the risk of destitution and homelessness and put them at higher risk of exploitation and harm.

The long-term gendered nature of the health impacts of COVID-19 remain unknown. Evidence suggests that women are more likely to suffer from long COVID and to

be admitted to hospital with complications of COVID-19. Women are experiencing significant mental health impacts from the pandemic and are almost twice as likely to report that their mental health worsened during the pandemic. The Mental Health Foundation links women's role as carers directly to increased levels of stress, anxiety and isolation. Living in poverty and experiencing gender-based violence are also linked to long-term mental health impacts. Although women are more likely than men to seek out medical advice, this is not reflected in their health outcomes. The UK has one of the largest female health gaps in the G20; that is the difference in outcomes between men and women for the same conditions.

The pandemic also presented specific gendered issues relating to healthcare, for example in relation to perinatal and maternity care. Women received inconsistent and sometimes contradictory advice. Access to prenatal care varied depending on the local health authority's individual policies and rules. There is evidence about limitations on choice during childbirth, women often had to attend medical appointments alone and lockdown restrictions impacted access to maternity wards for partners. This led to anxiety and distress for women and in some instances meant that they endured

traumatic experiences such as miscarriage alone.

The third area is front-line workers and workforce participation. During the pandemic, about 80% of key workers in the health and social care sectors were women. As front-line workers, women put their lives on the line to deliver vital care to patients and care home residents throughout the pandemic, but they were undervalued, underpaid and under-protected. The well-publicised shortages of adequate and effective personal protective equipment, PPE, disproportionately impacted women because there was a lack of PPE that was appropriately sized and fit-tested to suit women's faces and bodies.

My Lord, as stated yesterday on behalf of the Royal College of Nursing, a loose-fitting surgical mask is unlikely to provide protection in the context of a virus that is airborne and what was necessary was FFP3 masks, which require fit-testing. The failure to keep front-line workers safe by providing sufficient supplies of suitable PPE meant that they were at increased risk of contracting COVID-19 in their workplace and research indicates that healthcare workers were six times more likely to be infected with COVID.

Ten years of under-investment and cuts to public services meant that the health and social care

workforces were understaffed at the start of the pandemic. This significantly impacted the health and well-being of front-line workers through burnout, anxiety and depression and through exposure to unprecedented levels of death and grief. Not surprisingly, many health and social care workers are suffering from negative mental health consequences as a result. For social care workers, this was compounded by the comparative lack of recognition of the vital role they played during the pandemic, which alongside pre-existing poor paying conditions has contributed to low morale in the sector.

In terms of financial equality and labour market participation, the pandemic exacerbated existing gender inequality in Scotland. In a report published by Close the Gap on the impact of COVID-19 on women's labour market equality, it was reported that:

"Women's disproportionate responsibility for care and other domestic labour affects their ability to enter and progress equally in the labour market. Women are four times more likely to give up employment because of multiple caring responsibilities and are more likely to be in low-paid, part-time employment than male carers."

The closure of schools and nurseries during the pandemic meant that women bore the brunt of unpaid

childcare, home-schooling supervision and housework, which led to increased stress, particularly if juggled alongside paid work and particularly for single mothers.

Women, particularly those who experience intersecting inequalities, are more likely to face poverty and financial dependency as a consequence of the pandemic. Women were more likely to work in shut-down sectors such as hospitality or retail, they were more likely to be furloughed and for longer and they were more likely to have lost their job or had their hours reduced. This was especially the case for women from black and ethnic minority backgrounds, disabled women, younger women and low-paid women.

Finally, a lack of intersectional gender competence in decision-making. The Scottish Women's Rights Organisations submit that many of the unequal impacts of the pandemic on women were foreseeable and while there were aspects of the Scottish Government response that were welcomed, there were also failures by the Scottish Government to sufficiently consider the impact that the pandemic and lockdown measures would have on women and children.

It is vital that emergency response measures and decision-making recognise the overlapping drivers of vulnerability or disadvantage that contribute to women's

overall experiences. That is taking into account race, ethnicity, disability, age, location, sexual orientation, socioeconomic group and migrant status.

One of our client's key concerns is the accumulating impact that the increased risk of harm has on women and children in Scotland. It is the position of the Scottish Women's Rights Organisations that at all levels of decision-making during the COVID-19 pandemic there was a failure to apply an intersectional gender competent approach to the decisions being made, a lack of gender-sensitive, sex-disaggregated data on which to make decisions, and a failure to comply with the legal requirements of the Scottish specific duties of the public sector equality duty by mainstreaming equality and undertaking equality impact assessments in decision-making.

The lack of gender competence and the failure to recognise the differences between men's and women's lives had an impact on policy and decision-making across all services: health, justice, employment, welfare, education, children and families and housing and homelessness. These failures invariably delivered unintended negative consequences for women, particularly those who are already marginalised.

My Lord, I make a brief comment on the Inquiry's

work and expert evidence. For our clients, it is critical that the voices and experiences of women, particularly those who are at risk, are reflected in the Inquiry proceedings and taken into account when assessing the Scottish Government's strategic response and the broader impacts of the pandemic. The Scottish Women's Rights Organisations encourage the Inquiry to recognise that issues relating to gender and equality permeate all aspects of the impact of the COVID-19 pandemic. They are not stand-alone topics to be considered in isolation but, rather, they are systemic and should be central to all aspects of the Scottish Inquiry's proceedings.

Our clients are aware that the Inquiry has recently published a policy statement on taking a trauma-informed and human-rights-based approach to its work and that a separate statement on equalities will be delivered and published in due course. We welcome this intention and we will consider these documents carefully.

Our clients submit that it is vital that the Inquiry takes a gendered approach and an intersectional focus on equalities which can only be achieved by ensuring that the Inquiry has appropriate gender competence. The Scottish Women's Rights Organisations encourage the Inquiry to seek input from an expert or experts in

gender competence and intersectionality to help inform its work and processes and to meet its stated commitment to equalities. Our clients have made proposals in respect of expert evidence in our written submissions. It is not necessary to repeat these but we invite the Inquiry to consider the suggestions made.

To conclude, my Lord, there were many consequences of COVID-19 and the Scottish Women's Rights Organisations recognise the grief and loss experienced by so many bereaved families across the country and the impact on those who continue to experience effects from contracting COVID. For women, children and young people in Scotland, the pandemic has increased vulnerability and domestic abuse and there has been a recognised roll-back on women's equality and rights. In a parliamentary briefing on the Coronavirus Scotland Bill, Engender stated:

"When the safety nets put in place by the state are stretched to breaking point, it is women that are hit the hardest and this health crisis is highlighting gaps in UK social and economic policy in an unprecedented way. Without conscious effort, resources and focus from Government and policy-makers, the gendered impact of the pandemic and the consequent harms to women's health and well-being risks being a lasting legacy of COVID-19."

Thank you, my Lord.
THE CHAIR: Thank you very much, Ms Domingo.
Very good. It's almost 12.35 now. You will be pleased, Ms Doherty, we will not ask you to speak now.
Can I ask you to please be back at 1.35? Thank you.
(12.35 pm)
(The short adjournment)
(1.37 pm)
THE CHAIR: Good afternoon. Ms Doherty.
Opening statement by MS DOHERTY
for Healthcare Improvement Scotland
MS DOHERTY: Thank you, my Lord. I appear on behalf of Healthcare Improvement Scotland, "HIS" for short. As the Inquiry knows but the public at large may not, HIS is a body within the NHS in Scotland. It is a national improvement organisation within the Scottish health and social care landscape. Its purpose is to enable the people of Scotland to experience the best quality of health and social care with a specific focus on safety. There is no organisation elsewhere within the UK with an identical combination of functions.
HIS uniquely combines a range of statutory duties and other functions, including quality assurance, regulation, service redesign and strategic planning, evidence-based guidance, guidelines and standards for

health and care professionals and community engagement.
HIS works with over 100 partner health and social care organisations, taking a quality management systems approach in a range of different ways to strategically redesign and continually improve services. It provides advice and shares knowledge to enable people to get the best out of the services they use and to help services improve. It provides quality assurance that gives people confidence in services and support providers to improve, always making the best use of resources. HIS is not a healthcare provider nor is it responsible for the performance management of any NHS or social care body which provides care. More information about HIS can be found on the HIS website.
My Lord, HIS adjusted its work programme dynamically during the pandemic to accelerate some areas of work, refocus some and cease others. These were strategic decisions in the deployment of HIS' workforce, aimed both at directly supporting front-line services and at minimising unnecessary pressures at a time of emergency measures. HIS can give an account of its actions in response to the pandemic and the impact upon it of pandemic-related decisions.
HIS has a strong interest in both adding to and learning from the additional intelligence that will

emerge from the Inquiry to inform its future strategic and operational planning. It will be particularly interested in any recommendations made by the Inquiry in respect of health and social care improvement, quality management and safety of care. Specifically in relation to the Impact Hearings, HIS has arranged to be represented at the hearing for its duration. It appreciates the significant effect the pandemic had on the people of Scotland and will carefully consider all of the evidence given at the Impact Hearings and indeed at the Inquiry going forward. HIS will assist the Inquiry with its work and will work collaboratively with it.
Thank you, my Lord.
THE CHAIR: Thank you, Ms Doherty, very much.
Now, the next core participant is Scottish Hazards, Ms Lindsay.
Opening statement by MS LINDSAY
for Scottish Hazards
MS LINDSAY: Good afternoon. My Lord, I represent Scottish Hazards in this Inquiry along with Jim Keegan KC. Scottish Hazards are a registered charity in Scotland. The primary objective is the advancement of health and safety in the context of occupational health. They seek to provide specialist

information, advice, training and in-depth support to workers who do not otherwise have the protection of a recognised trade union. The sectors they assist in is broad and wide-reaching but includes those within the health and social care sector.
The COVID-19 pandemic was one of the most challenging times for workers in Scotland, in particular, those who were considered to be key workers and even more so for those within our health and social care sector. These workers were the ones who would be attending their workplaces on a day-to-day basis. They could not work from home and they were the workers that were coming into contact with patients and service-users who were either infected with COVID-19 or potentially infected. They were being placed at the biggest risk of contracting COVID-19 due to failings on the part of their employers to protect their health and safety.
Workers within the sector made some of the biggest sacrifices in Scotland. Their health was placed at risk due to exposure and many workers lost their lives. Their families were also placed at risk. Many employees felt frightened of the consequences of the pandemic, both on themselves as individuals and for their own families, and they were looking for somewhere to turn. That's where Scottish Hazards stepped in.

Scottish Hazards welcomes both this Inquiry and the human rights approach which has been put at the forefront. Sadly pandemic planning and response was not approached with the rights of workers in the focus, therefore this is a welcome shift.

Scottish Hazards are acutely aware of the experiences of the Scottish workforce. Those working within health and social care struggled daily in the same way everyone else did during the pandemic, but they were expected to continue working in an environment that was becoming more unsafe on a daily basis. Those who formed part of the non-unionised workforce who Scottish Hazards assisted were placed at unique risk as they didn't have anyone to speak up for them.

Pre-COVID, for a number of years, Scottish Hazards operated a helpline to offer advice, support and assistance through their casework. As outlined in the written submissions already provided, Scottish Hazards were very proactive in their response to worker safety during the pandemic and sought to shift their helpline to set up a dedicated COVID-19 helpline for vulnerable workers. They provided advice, assistance and, where necessary, took on casework to further employee interests.

They dealt with 460 cases or, rather, in excess of

460 cases during the pandemic. Each of these cases represented an individual who had experienced a significant issue during the course of their employment during the pandemic. They had nowhere else to turn for assistance and they sought guidance from Scottish Hazards. Each case represents a story to be told.

My Lord, I wish to highlight four areas which Scottish Hazards have identified as being key themes from their work during the pandemic and the first of those relates to Scotland's vulnerable workforce.

Scottish Hazards were receiving calls on a regular basis from employees with concerns in relation to their place of work and this was acute in terms of health and social care. There would often be calls from workers concerned about working conditions but they felt unable to vocalise this directly to their employers. They were looking for guidance but they sometimes didn't want Scottish Hazards to contact their employer directly out of fear of reprisal. They were scared to speak up in case they lost their jobs.

Scottish Hazards was able to step in and provide a voice to these individuals. During the course of the pandemic, Scottish Hazards reached out to approximately 50 employers to raise issues with them

directly and to get matters resolved. Sometimes this had to be done on an anonymous basis out of this fear. The work that Scottish Hazards did during the pandemic gave many workers an avenue to seek the advice they needed. They were giving people a voice.

The calls received were from a variety of individuals, many of whom were vulnerable, and that's not just in a clinical sense, but also from those who were some of the most disproportionately impacted upon within our workforce in Scotland, including women, workers of a black and ethnic minority background, those on precarious contracts, such as zero hours contracts, and the low-paid. These were issues that were acutely impacting upon those within the social care sector.

These workers were disproportionately impacted upon by COVID-19 due to difficulties in accessing sick pay when they became unwell and due to lack of support by their employers. Scottish Hazards were able to provide guidance and assistance to those vulnerable workers throughout the pandemic. They also did assess the clinically vulnerable within the workforce, where employers were unwilling to accommodate shielding or working from home measures despite Government guidance on this. This was a particular issue reported to Scottish Hazards from those working within the social

care sector, particularly privately.

There were general attitudes of employers in which care workers were expected to go out and do their job as normal, therefore their admin teams should be doing the same. They were essentially disregarding the guidance that was being placed for the safety of workers to suit their own business needs.

The second issue which Scottish Hazards would like to draw to the attention of your Lordship relates to lack of consultation with workers on COVID issues and the importance of doing so. Employees were reporting to Scottish Hazards through their helpline that they felt they were not being adequately consulted about changes to working practices throughout the pandemic. For example, Scottish Hazards were aware of casework in which care workers were being asked to increase times spent in service-users' homes, moving from providing essential welfare care to full care packages after these care packages had been scaled back as a result of the pandemic. They were then being forced to spend increased amounts of time in people's homes with no risk assessments being carried out.

There was work that was regarded as being essential by certain employers despite this not being the case and being contrary to Government guidance. Scottish Hazards

were there to assist these individuals. Changes were being made at short notice to employees' working practices and there was no risk assessments being undertaken. There was a disregard for the views of the employees, which was causing increased fears, insecurities, anxieties and uncertainty, all of this leading to work-related stress and mental health issues for employees.

Scottish Hazards consider that there was a serious lack of engagement and consultation with workers when employers were considering, planning and implementing COVID-19 control measures within the workplace. The impact was significant on employees. Without hearing the views and concerns of the front-line workers in relation to these control measures, employers were failing to adequately identify COVID-related hazards, resulting in unnecessary exposure of workers to COVID-19 and illness. This would then have a knock-on effect upon the service users they were attending to. The lack of communication by employers resulted in fear about this increased exposure and that would lead to these people seeking out advice from Scottish Hazards.

Third, my Lord, it has to be highlighted that there was a lack of workplace control measures and mitigation to reduce exposure to COVID-19. Health and social care

workers were placed in a difficult situation in respect of access to personal protective equipment. The issues in relation to access to PPE was widely reported in the press, particularly with issues surrounding procurement and the improper issuing of contracts. The issue to care workers on the ground was far more pressing though. They needed access to this equipment and they weren't able to get it, irrespective of who was being instructed to provide it.

It is easy to get drawn into the political discussions regarding this decision-making but I don't think this is the appropriate time for that and hopefully that will come during the course of this Inquiry. As a result of these shortages, health and social care workers were being left with no PPE, being required to re-use PPE or use inappropriate PPE and risk their own health whilst doing so. This is a serious issue which must be considered during the course of this Inquiry.

Employees were also highlighting to Scottish Hazards issues in relation to ventilation within their workplace. They had concerns regarding transportation; for example, care workers having to use public transport to visit multiple service-users with little regard to both the risk to them as an individual and the risk to

the service-users they were visiting. If you then take a step back further and look at the risk to the public at large, these things were disregarded. All of these made working within a health and social care sector for an employee more challenging and leading them to seek assistance from organisations such as Scottish Hazards.

The fourth matter which Scottish Hazards wish to highlight at this time was lack of enforcement in the broadest sense regarding the enforcement of laws and statutory guidance. Scottish Hazards do not consider that all employers within health and social care were taking the guidance and laws issued seriously. They were trying to bend the rules, so to speak, to suit their business needs with a complete disregard for their employees. This was a particular issue within some private social care settings. It's another flagrant disregard for the rights of the employee.

The Scottish Government used devolved public health powers to issue far-reaching measures that impacted on the safety of workers, which was welcomed, but they did not introduce adequate means to ensure those measures were being followed. Adequate penalties should have been included in the response, together with a way of policing the breaches. In addition the Scottish Government guidance could have gone further in

referencing, highlighting and stating the existing legal requirements placed on employers; for example, the need to adequately risk-assess is a well-established principle within our law that was not being undertaken.

Scottish Hazards bring an important perspective to the Inquiry which they hope will be of assistance in undertaking the terms of reference. First, they're able to provide evidence to the Inquiry from those who don't feel able to speak for themselves. As indicated, Scottish Hazards collected information on the cases they worked on throughout the pandemic. They are able to share these case reports to ensure that no individual story is omitted. They will be able to provide evidence from this casework which shows some of the issues that have been mentioned this afternoon. These are only touching the surface of the experience of the non-unionised workforce in Scotland.

Scottish Hazards can and shall assist the Inquiry in ensuring the voices of workers who feel they cannot speak for themselves are heard.

Secondly, Scottish Hazards were significantly involved in the Scottish Government's Covid Safer Workplaces Advisory Group. This group was set up in March of 2020 by the Scottish Government. Scottish Hazards sat as part of this group and they will

be able to share their experience of involvement in the group from a non−unionised workforce perspective.

The advisory group provided a platform for discussion and an opportunity for Scottish Hazards to raise the concerns of those on the front line who had been forgotten about by their employers.

Scottish Hazards would like to see the Safer Workplaces Advisory Group continue. There needs to be ongoing work done to ensure that the country is prepared in the event of a further pandemic. This valuable line of communication with the Scottish Government by way of the advisory group ensured that those who were not represented by a trade union were still included in that discussion.

In considering the assistance that Scottish Hazards can give to the Inquiry directly, two witnesses have been identified at this stage. The first of those is Ian Tasker, the chief executive of Scottish Hazards, and the second is Kathy Jenkins, trustee of Scottish Hazards. Both witnesses would be available, if called upon by the Inquiry, to provide experiences of non−unionised workers in Scotland. Such evidence would assist the Inquiry in better understanding the perspective of health and social care workers.

Scottish Hazards welcome the commencement of this

Inquiry and are grateful to the Inquiry both for their core participant status and for the opportunity to address the Inquiry this afternoon. It is hoped that Scottish Hazards are able to assist the Inquiry in fulfilling their terms of reference and it is hoped that there shall be acknowledgement given to workers in all sectors for the sacrifices made during the COVID−19 pandemic to ensure that the vital services of Scotland continued.

Scottish Hazards would like to see the Inquiry assist in the furtherance of workers' rights in line with the categories of the terms of reference. The lack of preparation for this pandemic led to strain on the part of employers and −− employees, rather. This additional strain contributed not only to the difficulties in being part of the workforce but also to their health.

Scottish Hazards played a part in assisting those who didn't have anyone else to help. COVID−19 has had a devastating impact on the health of some of those who contracted the disease and particularly those who have suffered from long COVID. The pandemic was treated only as a public health emergency and Scottish Hazards is of the view that COVID−19 should also be regarded as an occupational health matter for those who caught COVID−19

during the course of their employment. Recognition of long COVID as an occupational disease would allow workers to access various different benefits, such as industrial injuries benefits, and Scottish Hazards hope that the Inquiry will give consideration of that as far as it is allowed in the terms of reference.

To conclude, my Lord, it is essential that lessons are learned from this Inquiry to ensure the protection of workers' rights. It is essential that future plans and pandemic planning consider the workforce in Scotland. They cannot be forgotten about again. Scottish Hazards hopes to assist the Inquiry in any way they can and will provide any information required to do so.

Thank you, Ms Lindsay.

THE CHAIR: Thank you very much.

Lastly today, the Scottish Trade Union Congress, Mr Keegan.

Opening statement by MR KEEGAN
for the Scottish Trade Union Congress

MR KEEGAN: Thank you, my Lord. I appear with Ms Lindsay on behalf of the STUC. The STUC, as most of us know, is the independent body to which individual trade unions in Scotland affiliate their Scottish membership and it represents collectively over 550,000 trade union members

in Scotland.

As this is the first substantive hearing of this Scottish Inquiry, it is appropriate that we acknowledge immediately the very great sacrifice made by so many workers and their families in this pandemic. The STUC represents the collective voice of workers in Scotland. It is a key civic organisation that has engaged with successive Scottish governments since 1999. It is therefore uniquely able to gather information and offer advice because of its representative structures that cover and disseminate advice throughout public and private voluntary healthcare sectors in Scotland. It is able to receive direct reporting and feedback from key workers delivering essential services and it was involved in the establishment of the Covid Group that met with the Scottish Government.

Evidence will be given about the engagement between the STUC and the Scottish Government and about concerns that were communicated to the Scottish Government about levels of consultation and response by employers to the crisis caused by COVID: failures in the provision of PPE to a range of workers in health and social care; failures in the setting up and maintenance of an effective supply chain of PPE and associated equipment; inconsistency in planning and provision to protect

workers in high-risk groups, such as those with underlying health issues, disabled workers, black, Asian and minority workers; and ensuring that the system of testing and protecting was not hampered by employers failing to support workers to self-isolate without incurring financial loss.

Covid Group meetings continued throughout the pandemic until March 2022 and throughout that time the STUC and its affiliates were able to identify and raise concerns and report issues of potential breaches of guidance and regulations by employers, thereby providing Government with a valuable insight into the risk posed to key workers in carrying out their health and social care roles.

Workers and their families faced huge challenges in their private and working lives during the pandemic. The working population was significantly impacted, either by being forced to work from home, by being deprived of the ability to work and earn or by finding itself at the forefront of the response in providing health and social care, in transport, in retail, including pharmacies, and education.

People were hampered by shortages, access to services by restrictions placed on travel and social interaction and by lockdown. Some had to live in their

places of work and at every level people found themselves fearful of risk of contracting disease but were often placed at increased risk from the disease itself together with the stress and pressure of everyday living, studying and working through a public health crisis of mammoth proportions.

Workers in health and social care were in the front line of this national emergency so it's of paramount importance to acknowledge and understand the fear that would have been felt by many as they strived to provide care to patients and clients, to disabled people and the elderly, despite the known and as yet unknown risks that they faced. As death rates surged, our front-line health and social care workers, who were doing their best to preserve safety and life, inevitably sustained a very significant toll on their own lives, health and well-being.

We can now see that, in addition to the tragic early deaths, there has also been a significant toll on family lives impacted by long-term mental health issues, financial issues and relationship breakdowns, the cause of which was often exhaustion, disillusionment and burnout. This has been the outcome for many that soldiered on through all the challenges, notwithstanding that they had to cope with bereavement in their own

families, among their colleagues and friends, and labour under daily fear that they could be next to lose their lives.

It is self-evident that COVID-19 is a public health issue but it is not just a public health issue. It is an occupational health issue that constitutes the single greatest threat to occupational health and well-being in Scotland for decades. By the beginning of 2022, there had been well over 1 million COVID cases in Scotland and over 12,000 deaths following a positive test for the virus. COVID cases and the death toll continued to rise but have been mitigated by the vaccine programme. Long COVID is one of the many outcomes that is also rising and is self-evidently, I say, an occupational health issue. It is an issue that impacts on workers in health and social care. It should be recognised as an occupational health issue by governments, enforcement bodies and employers.

COVID and long COVID are not just community-based concerns. Evidence shows that COVID was, for a significant portion of the population, contracted and spread within places of work. That phenomenon was not recognised and continues to be ignored. Evidence will demonstrate widespread failure to report workplace-related outbreaks, continuing related illness

and death. Evidence will demonstrate that failures to record such events, inspect suspect workplaces and make targeted interventions increased the risk of exposure to the virus. Evidence will show that unnecessary exposure to risk has resulted in ill-health, in many terms long-term, for workers, their families and those being cared for and financial losses for workers and their families. The failure or refusal of governments to recognise the occupational health risk that is constituted by COVID has the effect of denying the opportunity for practical, legal redress.

Deficiencies in pandemic planning and resilience continues to have a significant impact on day-to-day life and work in Scotland. I consider that it is necessary to look at the malign impact of austerity on Scotland's ability to effectively implement planning and readiness for a pandemic during the decade that preceded COVID.

Pandemic planning in Scotland and indeed the UK was predominantly focused on influenza-type viruses. This is concerning because the existence of Coronavirus was already known about. Such outbreaks occurred in 2002, SARS, 2009, Swine flu, 2012, MERS. Exercise Silver Swan was delivered during the latter part of 2015 as a series of tabletop exercises across Scotland that focused on

health and social care, excess deaths, business continuity and co-ordination.

The report was published in April 2016 and the key findings can be found in page 9 of that report and I mentioned in my statement -- I don't need to read it out -- that part of the report.

Evidence will demonstrate that underlying -- sorry, underfunding in health and social care caused by austerity had a significant adverse effect on planning and readiness for the COVID emergency. Preparation requires not only planning but also the capacity and public services in health and social care. Public services are greatly diminished and weakened by years of budget cuts that impacted on the ability of our national and local governments to respond quickly and effectively to the sudden and devastating shock of a national emergency that has been COVID-19.

The initial response to COVID-19 also failed to consider and recognise the potential for aerosol transmission of the virus so that the health measures initially put in place focused on other precautions such as hand-washing rather than on the provision of equipment, such as masks for general public and PPE for front-line workers. That was the case notwithstanding recommendations that derived from UK exercises that took

place in 2016 and 2018, in particular Cygnus and Iris, about stockpiling PPE and the provision of training in the use thereof.

The trade union affiliates that are represented under the banner of the STUC are all able to bear witness to the impact of what can only be described as a lack of preparedness in every facet of life and government for the pandemic. The STUC intends to highlight the effects of this lack of preparedness on workers and their families in Scotland.

Evidence shows that from the outset of the COVID-19 pandemic, workers in health and social care immediately experienced a number of significant issues in the provision of care and in the impact on them physically and mentally and socially, as a high percentage of female workforce providing front-line care during such an extraordinary situation, which the Government, National Health Service, local authorities and private and third sector employers were evidently ill-prepared for. That placed a substantial strain on all aspects of family life, including but not limited to childcare and in making provision for childcare with relatives, all at great risk, so that health and social care workers could just carry out their critical roles as key workers, and many have not recovered from the stress and strain that

this brought to them.

One clear example of the lack of preparedness has been the substantial number of problems that were associated with the provision and access to supplies of PPE and the absence of guidance to workers and how best to protect themselves and others from the exposure and spread of the COVID virus. It was immediately apparent that the high level of uncertainty and anxiety put immense pressure on all areas of the health and social care workforce to access face masks and other protective clothing and to attempt to adopt social distancing. The practical difficulties associated with that created widespread anxiety and impacted substantially on the ability to avoid contracting and transmitting the virus.

At all sectors of the health and social care system, workers encountered delays in receiving adequate supplies. Some PPE had to be re-used, causing risk to the wearer and to others. There were fears about engaging with fellow workers, patients, clients and members of the public, who did not have or could not wear masks or PPE. The inclusion of face shields in PPE provision was thought to provide a higher level of protection but they were less accessible.

PPE was rationed and issues arose with accessing or achieving appropriate PPE fittings. Advice on provision

were often cost- or supply-driven as opposed to being based on the highest level of protection. Instructions on some PPE weren't even in English, which caused confusion and a lack of confidence about their correct use, and some PPE supplied to workers was out of date.

The quality of supplies was variable. Guidance associated with the use of PPE was mostly focused on providing care in acute hospital settings and health and social care workers outwith those settings and those in the community were vulnerable due to the lack of clear advice and equipment to protect themselves.

Health and social care workers had to work in uncontrolled settings, in homes where there was no control over ventilation -- I'm talking about private homes -- access to washing facilities, numbers of people present and overall conditions. Workers providing home care services did not have guaranteed access to appropriate rest areas or to the ability to prepare food and drinks for prolonged periods of work. The vast majority of health and social care workers take their uniforms home to wash them. However, the unknown risk of cross-infection caused them to worry about what might ensue from taking their clothes home, washing them with other clothes and being able to launder things on a reasonable basis without risk. The absence of any

guidance on this, amongst other things, added further to the stress that workers experienced.

Evidence about experience in almost all areas of working lives can be demonstrated in the impact summaries and statements that have been prepared for the STUC and by the STUC, and when I say "for the STUC", I'm talking about its affiliates. There are some examples that I can briefly go to because I see time is marching on, but there were some workers who had to work within a bubble, and I heard that mentioned earlier. But some people actually did separate themselves from their families and worked within nursing homes in order to provide care so that they were separated from their loved ones for long periods, but that didn't improve their access to decent wages in the aftermath. Other workers had to cope with transport issues that exposed them to a greater risk with the disease itself and in contracting it.

Other evidence will show a disproportionate impact on ethnic minority groups within the health and social care sector. This should have been avoidable, but failures to recognise and provide guidance about higher potential risk groups, such as those with comorbid health issues and BAME workers, left them exposed.

Whilst other parts of the NHS locked down and

minimised direct contact with patients, most workers in health and social care had to be in daily contact with the public, whether that was travelling to work or delivering care to the needy. GP patients who didn't have access to the GP practice or to A&E often transferred to local pharmacies and that increased the workload for pharmacists and that in turn caused difficulties within the pharmacies in which they worked. Within these pharmacies, there was also a lack of PPE.

I give these things obviously as examples, but one thing I want to stress upon -- I think I've stressed today -- is the complex situation which is faced by those who are experiencing long COVID conditions and the impact that that has caused on workers, and the STUC will provide evidence about that long-term impact upon workers, on their families, on their jobs and on their ability to continue to perform their daily lives and jobs.

The opening statement I've given is brief here, it's longer in print, but it provides only a brief overview of the level of experience which has impacted on workers throughout this pandemic. The STUC has a wealth of experience that it can offer to this Inquiry of the impact, of experiences and of the shortcomings in Government responses and I hope that the Inquiry will

listen carefully to everything that will be on offer and take it on board in making its final recommendations.

I'm sorry, this is much longer than it should have been, but there we go.

THE CHAIR: Very good. Thank you, Mr Keegan.

That brings us to an end of actually the opening submissions. As you know, we're not sitting tomorrow and that is because a number of core participants and their representatives require to attend hearings of the UK Inquiry in London tomorrow and, in the co-operation that has been shown between us, we're assisting by not sitting tomorrow, but we're back on Friday, where we will actually start evidence. So I look forward to seeing you all at 10 o'clock on Friday morning.

Thank you.

(2.17 pm)

(The hearing adjourned until
Friday, 27 October 2023 at 10.00 am)

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