

OPUS2

Scottish Covid-19 Inquiry

Day 2

October 25, 2023

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Wednesday, 25 October 2023

(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

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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

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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

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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

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

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

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

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

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

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

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

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

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

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

1 in real time is clearly always preferable.

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

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

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

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

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

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

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

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

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

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

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

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

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

6 According to the National Records of Scotland, as of
 7 9 October 2023, there were 17,991 deaths in Scotland
 8 where COVID-19 was mentioned on the death certificate.
 9 Each of those deaths and also the deaths where COVID was
 10 not mentioned not only represents an individual tragedy
 11 but has affected the friends, the family, the loved ones
 12 of each of those who died. No person, institution, no
 13 matter how powerful, whether it be in England, Scotland,
 14 Wales or Northern Ireland, can obstruct the search for
 15 truth.

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

25 The Scottish Covid Bereaved campaigned for this

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

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

19 I'm very much obliged.

20 THE CHAIR: Thank you very much, Ms Mitchell.

21 Now, the Care Inspectorate, Mr Macleod.

22 Opening statement by MR MACLEOD
 23 for the Care Inspectorate

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

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

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

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

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

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

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

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

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

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

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1 again reasonable, proportionate and justified.

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

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

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

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1 THE CHAIR: Thank you very much, Mr Macleod.

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

5 Opening statement by MR GRAY
 6 for Central Scotland Care Homes

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 in their homes and would ask the Chair to carefully
 2 analyse the evidence in this regard.
 3 CSCH is aware of research from Public Health
 4 Scotland published on 28 October 2020 and similar
 5 publications since that date which indicate that
 6 hospital discharges to care homes were a factor but not
 7 a significant factor in leading to outbreaks. According
 8 to the Public Health Scotland report, the most
 9 significant factor leading to outbreak was the size of
 10 the care home in terms of its number of residents. It
 11 ought to be determined, as far as possible, whether the
 12 decisions to discharge patients from hospital settings
 13 to care homes did in fact lead to greater instance of
 14 outbreaks. If it is ultimately concluded that size of
 15 care home was the main driver of outbreak instance, CSCH
 16 wants to know why that was the case. If indeed that is
 17 found by this Inquiry to be correct, it would suggest
 18 that the risk-based approach should be taken to
 19 management of future pandemics so that resources and
 20 support are appropriately concentrated in larger care
 21 homes where they would seem to be needed most.
 22 Turning to do not attempt cardio-pulmonary
 23 resuscitation (DNACPR) requests. The CSCH group wish to
 24 highlight their concerns about the use of DNACPR
 25 requests from healthcare professionals where it was not

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1 always apparent that the appropriate consultations had
 2 taken place. To be clear, where appropriate, such
 3 requests were declined by the members of CSCH.
 4 Similarly, some advanced care plans prepared between
 5 families and residents setting out the intentions for
 6 care towards the end of life were disregarded by
 7 hospital consultants. The assumption in the main was
 8 that COVID was the likely diagnosis and this limited
 9 treatment and intervention. Again, the impacts of those
 10 decisions on residents, care home staff and family
 11 members were profound and must be examined.
 12 Turning to the human-rights-based approach and in
 13 particular the right to life. The Inquiry is required
 14 to take a human-rights-based approach to its findings in
 15 fact and recommendations. At the preliminary hearing
 16 in August of this year, your Lordship reaffirmed your
 17 intention to do that from the beginning of proceedings.
 18 As part of this approach, the right to life will be in
 19 sharp focus during this Inquiry and in that regard our
 20 members would simply wish to remind the Inquiry that the
 21 right to life is universal, applies equally to all and
 22 does not diminish with age.
 23 Turning to co-operation with the Inquiry. As the
 24 Inquiry progresses, the members of CSCH intend to
 25 cooperate fully with the Inquiry team. It is hoped that

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

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

23 Thank you, my Lord.

24 THE CHAIR: Thank you very much, Mr Gray.

25 The next core participant is a group made up of

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

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

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

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

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

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1 inspection regime. They were let down by private care
 2 providers, who prioritised profit and reputation over
 3 their responsibilities to care for residents, to protect
 4 them and to tell the truth.
 5 As well as revealing the suffering of individuals
 6 and their families, we anticipate that the evidence in
 7 these hearings will point to a systemic failure of the
 8 model for the delivery of care in Scotland, for its
 9 regulation and inspection. We recognise that those
 10 concerns are for later hearings, but, as you listen to
 11 the witnesses describe their experiences, we urge you to
 12 be thinking of the questions that you should later put
 13 to those who made the decisions and those who
 14 implemented them. In due course, this group will be
 15 asking you to make recommendations that will ensure that
 16 the elderly and vulnerable are properly cared for and
 17 that what happened during COVID-19 cannot happen again.
 18 The bereaved want to know how it was and why it was
 19 that the virus was able to enter care homes when they
 20 were in lockdown ahead of the rest of society and how
 21 the virus was then able to spread like wildfire within
 22 the homes. The Inquiry will hear evidence that people
 23 were transferred into care homes from hospitals without
 24 testing. This happened at a national level with no
 25 obvious consideration given to local capacity or the

1 best interests of patients and residents. It was at
 2 a time when it appears no Scottish hospital had reached
 3 a level of capacity that might have signalled an
 4 imminent critical incident necessitating such a step.
 5 The Inquiry will hear evidence of staff travelling
 6 between care homes and to different parts of the
 7 country, including from England to Skye, with concerns
 8 that rules on self-isolation were not then followed.
 9 There will be evidence that care homes were entirely
 10 unprepared for a pandemic and that, once it began, staff
 11 were given little or no guidance and training on what to
 12 do.
 13 There were deficiencies in infection control, basic
 14 cleaning and hygiene. In one home, the alcohol-based
 15 cleaning products were locked in a cupboard to which
 16 staff were not permitted access by management. Instead
 17 they cleaned using air freshener.
 18 There will be evidence of a lack of PPE or staff not
 19 using it consistently and properly. There were lacks or
 20 no cross-contamination measures in place to prevent
 21 staff spreading the virus among residents. Staff were
 22 witnessed attending work while displaying symptoms.
 23 Once there was a COVID-19 outbreak in a care home,
 24 bereaved relatives were faced with a total lack of
 25 transparency about what was happening. Some learned of

1 an outbreak from Facebook rather than from care home
 2 management or staff. There was no proper testing regime
 3 within the care homes. When direct questions were asked
 4 about whether someone had tested positive, relatives
 5 were lied to.
 6 The situation was only exacerbated by the decision
 7 of Government that there should be a blanket ban on
 8 face-to-face visits with those in care homes. It is
 9 a natural human response to be as close as possible to
 10 a loved one in the final phase of their life. This was
 11 denied to care home residents and their relatives.
 12 While there is a recognition, of course, that measures
 13 to mitigate the spread of the virus and the risk of
 14 infection had to be implemented, bereaved relatives want
 15 to know why staff members were permitted to travel
 16 between their home and place of work, use public
 17 transport, spend time with their own families, all
 18 without taking protective measures, and yet still work
 19 closely with the vulnerable and elderly in care homes.
 20 Having listened to the witnesses' accounts, the
 21 Inquiry should be prepared to ask the decision-makers
 22 why alternatives were not considered or, if they were,
 23 why were they not approved. Why could families not
 24 nominate one relative to bubble with the resident to
 25 allow face-to-face contact to continue? Why did no one

1 consider the cultural impact of denying the island
 2 communities their tradition of collective caring?
 3 The Inquiry will hear that when relatives tried to
 4 contact their loved ones by video conference or
 5 telephone, their efforts were thwarted. Excuses were
 6 given about malfunctioning iPads, problems with the wifi
 7 network. The excuses kept changing. In some instances
 8 management told staff not to share with the outside
 9 world what was going on in a home. Some staff formed
 10 the view that management cared more about their
 11 reputation in the community and the protection of their
 12 business than they did about the residents, their
 13 families and the care workers who do the job not for the
 14 money but because their heart is in it. Some staff went
 15 behind management's back, risking their jobs to keep
 16 families informed.
 17 Families' calls went unanswered over days and
 18 sometimes weeks. On some occasions, when contact was
 19 made, families were treated with disdain, as if they
 20 were an inconvenience. Families were told their loved
 21 one was fine only to get a sudden hurried phone call
 22 that they were dying.
 23 Many families witnessed remotely a significant
 24 deterioration of their loved one's physical and mental
 25 health in lockdown that was nothing to do with COVID-19.

1 Some suspected their loved one was suffering from
 2 neglect, dehydration and starvation. Questions were
 3 asked and relatives were fobbed off.
 4 The blanket ban on visits meant that care plans
 5 could not be checked. The Inquiry will hear that when
 6 records were requested after a loved one's death,
 7 relatives found that the records were missing or
 8 incomplete. When relatives did manage to make contact
 9 over video with their loved one and witnessed for
 10 themselves the deterioration in their condition, there
 11 is evidence that at times their wishes about medical
 12 treatment were ignored or overridden. The reality for
 13 bereaved relatives is that some did not see their loved
 14 ones face to face again after the lockdown began. The
 15 right to visit during the last moments of life was not
 16 always granted and, if it was, it was restricted to one
 17 family member. Some residents died alone. Care home
 18 staff witnessed many excess deaths. They held people's
 19 hands as they died. That trauma will never leave some
 20 of them.
 21 After death, some relatives were not given all their
 22 loved one's belongings back. They expect they were
 23 burned in spite of having been quarantined. After
 24 death, some relatives were so concerned about what had
 25 occurred that they reported the death to the police.

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1 They want to know how it got to that stage.
 2 The Inquiry has promised to take
 3 a human—rights—based approach and hearing first from
 4 those impacted by the pandemic is a recognition of that
 5 approach in action and that is welcomed, but
 6 a meaningful human—rights—based approach goes far beyond
 7 that. The Inquiry must investigate whether the right to
 8 life under Article 2 was respected and protected. We
 9 anticipate the Inquiry will hear that people were
 10 pressured to agree to do not resuscitate notices, that
 11 people were not resuscitated even though no such notice
 12 was in place, that residents may have been neglected and
 13 left to starve, that families are not sure they were
 14 told the truth about their relative's cause of death,
 15 that the usual process for certification of deaths was
 16 departed from.
 17 The Inquiry must investigate potential violations of
 18 Article 3, the prohibition on torture, inhuman and
 19 degrading treatment. Relatives will speak of their
 20 loved ones lacking food, water and hygiene; that there
 21 was inadequate, inappropriate, absent or delayed medical
 22 attention, that welfare attorneys' views were not
 23 listened to when it came to medical treatment; that
 24 there was inadequate staffing to provide proper care,
 25 resulting in residents suffering unnecessarily. We urge

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

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

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

24 I'm obliged, my Lord.

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

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

5 (10.56 am)

(A short break)

7 (11.19 am)

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

10 Opening statement by MR MCKIE
 11 for Independent Care Homes Scotland

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

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

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1 and to provide evidence and submissions to this Inquiry.
 2 Two statistics best explain why ICHS can assist the
 3 Inquiry: first, about a third of all deaths registered
 4 as due to COVID-19 were from within care homes;
 5 secondly, about three-quarters of care homes looking
 6 after elderly residents in Scotland are operated by
 7 independent providers. Listening to the independent
 8 care sector is accordingly a central part of
 9 understanding the COVID tragedy. Our focus is to put
 10 that essential experience and evidence before the Chair
 11 and indeed before the public.
 12 First of all, ICHS wish to express their profound
 13 and sincere sympathy to the families of those who died
 14 or are otherwise affected by the COVID-19 pandemic. The
 15 members of ICHS were responsible for both staff and
 16 residents during the pandemic. Those staff were the
 17 primary point of contact for families of those in care.
 18 The passage of time cannot be allowed to obscure or to
 19 diminish the trauma and the tragedy of what occurred.
 20 This Inquiry, rightly, has at its core the family
 21 members and friends who lost loved ones due to the
 22 pandemic. ICHS members were at the front line and dealt
 23 with many elderly residents who fell ill and in many
 24 cases tragically lost their lives. That burden was an
 25 extraordinary one and at times intolerable for staff to

1 carry.
 2 This Inquiry will look at processes, structure and
 3 decision-making. It is right to do so, but none of that
 4 can ever be allowed to distract the Inquiry from the
 5 human aspect of this tragedy. That sense of hurt, grief
 6 and confusion which defined the experience many had in
 7 trying to understand and accept the inability to visit
 8 sick and dying relatives was real. It remains real for
 9 most. If this Inquiry cannot get to the heart of why
 10 those making decisions and implementing national policy
 11 made the choices they did, it will have failed.
 12 Families and friends who had become an essential
 13 part of daily life for many care homes were barred from
 14 entry due to Government restrictions. Those people were
 15 not able to say goodbye to relatives in their last hours
 16 or to comfort them and maintain essential human contact
 17 with those they loved.
 18 ICHS's role in this Inquiry will be to give
 19 evidence, make submissions and seek both clarity and
 20 accountability. That starts in these first Impact
 21 Hearings by listening to the voices of those families
 22 and residents. It will then be about explaining as well
 23 as possible what decisions were being taken and which
 24 agencies and authorities were driving those policies.
 25 It will be about shining a light on areas of confusion

1 throughout the pandemic response and ensuring that the
 2 public have access to the truth of what was happening.
 3 It will also be about making sure, as we look to the
 4 future, that there is no misunderstanding about the
 5 relationship between those making the laws and
 6 regulations and those charged with the responsibility
 7 for implementing on the ground. ICHS members approach
 8 this Inquiry with humility and with an openness to
 9 learn. What this Inquiry should insist upon is that
 10 those in power and the key decision-makers at the time
 11 do so also.
 12 By way of background to those who are unaware, ICHS
 13 employ thousands of staff. Those are the people in care
 14 homes looking after residents day and night.
 15 Accordingly, the group had many staff and residents
 16 directly and indirectly affected by the pandemic, both
 17 in terms of their own physical and mental health and in
 18 their care and interactions with residents and their own
 19 families. The pandemic was very tough for most, but for
 20 those staff it was at times a burden almost too great to
 21 bear. The statements and testimonies of some of those
 22 staff will be submitted and we hope will be made public.
 23 During the pandemic, care homes endeavoured to
 24 adhere to ever-changing guidance from Central and Local
 25 Government and regulatory bodies. ICHS intend to

1 provide evidence on how such changes affected key
 2 decision-making and, at this Impact stage, in relation
 3 to how that landscape profoundly affected staff both on
 4 the ground and at managerial levels. It will also
 5 consider carefully and respond to any evidence disclosed
 6 by the Inquiry to assist the Inquiry to reach
 7 conclusions or make recommendations for the future.
 8 ICHS is committed to being a constructive part of
 9 ensuring that the recommendations for change are
 10 practical, informed by reality and will deliver for the
 11 public the greatest benefit. That means ensuring that
 12 a vibrant independent care sector with decades of
 13 experience and daily responsibility for residents is at
 14 the heart of policy formation, not simply a passive
 15 recipient.
 16 ICHS is well placed to assist this Inquiry. It
 17 collectively operates 156 care homes around Scotland.
 18 The members of ICHS employ in the region of 13,000 staff
 19 within the health and social care industry. They are
 20 here not just to ensure a voice for the independent
 21 sector, but to represent staff, families and residents
 22 based on a vast collective pool of expertise and
 23 experience.
 24 One of the key aims of the Inquiry is to investigate
 25 the strategic elements of the handling of the pandemic.

1 That is expressed in the remit as being "in care and
 2 nursing homes: the transfer of residents to or from
 3 homes, treatment and care of residents, restrictions on
 4 visiting, infection prevention and control, and
 5 inspections". All of the investigations into the key
 6 strategic elements had a direct impact on employees
 7 within the ICHS group who provided front-line care for
 8 the most vulnerable members of society. They were
 9 placed in a position of increased risk of infection.
 10 Care home employees required to adapt to the
 11 ever-changing circumstances and were expected to
 12 implement novel changes required by amendments to
 13 guidance from both Government at all levels and
 14 regulatory bodies. They were expected to do so
 15 instantly and constantly. They were required to care
 16 for elderly and vulnerable patients, many of whom had
 17 cognitive difficulties and did not necessarily
 18 understand what was happening.
 19 It fell on the shoulders of those people to deliver
 20 the impossible difficult news to family members and
 21 friends who could not visit. As a consequence, the need
 22 for external communication with families was massively
 23 increased. Families unable to visit had a legitimate
 24 and desperate need for constant information about their
 25 loved one. Ensuring continuing lines of information

1 amid—a global pandemic was exceptionally tough. Beyond
 2 that and on a daily basis, the care had to continue.
 3 This was a pandemic which hit the elderly and infirm the
 4 most significantly. This included situations where, if
 5 infected, COVID often led to a rapid deterioration and
 6 in many cases death. Employees were deeply scared not
 7 just by the number of deaths but by the isolated nature
 8 of those last hours for too many. Nothing this Inquiry
 9 can do will remove those memories and fully heal those
 10 scars.
 11 We anticipate that evidence will be led during the
 12 Inquiry both in written and in some cases oral form from
 13 employees of ICHS members. It is likely that witnesses
 14 of ICHS can provide vital insight which will assist the
 15 Impact Hearings, including in the following areas of
 16 scrutiny: one, the distinction between the private and
 17 public sector.
 18 ICHS witnesses can address the key differences in
 19 the private and public sector which arose during the
 20 pandemic. There were a variety of guidelines not only
 21 across health boards but across local authorities and
 22 from Central Government which appear to have led to
 23 diverse approaches between the public and private
 24 sectors. It was felt by some of our members the
 25 priority appears to have been provided to the public

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 Thank you.

23 THE CHAIR: Thank you very much indeed, Mr McKie.
 24 Now, the next core participant to speak is
 25 Long Covid Kids Scotland. Mr Webster is back again.

1 Good morning, Mr Webster.
 2 Opening statement by MR WEBSTER
 3 for Long Covid Kids Scotland
 4 MR WEBSTER: My Lord, the children of Scotland should be
 5 able to thrive and look forward to a positive future.
 6 Long COVID, the long-term illness caused by COVID-19,
 7 has blighted that prospect for too many. For too many
 8 long COVID presents a seemingly insurmountable obstacle
 9 to an engaged, fulfilling and productive life.
 10 The Inquiry has embarked upon its listening project,
 11 Let's Be Heard. In an adult world, the voice of
 12 children is too often ignored, disregarded or belittled.
 13 I ask all of us in this room today to pause and think
 14 back. Did we hear the voice of children in the
 15 decision-making on masking, school mitigations,
 16 examinations or immunisation or is our recollection that
 17 children were simply told how it was going to be?
 18 For reasons I find unfathomable, we have been
 19 precluded by the Inquiry from allowing the voice of
 20 a child to be heard in these opening statements.
 21 Bearing in mind that we appear to have the technology to
 22 do so -- and if we don't, that of itself must be
 23 a matter of concern -- and bearing in mind also that the
 24 Inquiry has already claimed the privilege as the masters
 25 of its own instance to play its video in its opening

1 statements and, perhaps more vexing of all, that my
 2 learned friend Mr Gale said yesterday that the Inquiry
 3 in its Let's Be Heard outreach wanted to hear from
 4 children so adults are not speaking on their behalf, to
 5 be denied the opportunity to present our opening remarks
 6 in the manner we would wish risks the perception of a
 7 tin ear on the part of the Inquiry as it takes its first
 8 steps. We can only hope this error of judgment, for
 9 frankly that is what it is, will not be repeated. So it
 10 falls to me, my Lord, to read the words of a child:
 11 "Many months ago we all became ill with coronavirus
 12 and very soon we became very ill. Some of us became
 13 seriously ill and had to stay in hospital. Our symptoms
 14 looked a bit different to the ones that grown ups seemed
 15 to get so our parents didn't always know what was wrong
 16 with us straightaway. Coronavirus doesn't only affect
 17 children like us, many of our parents got ill too, so
 18 we've had to stay at home and tried to look after each
 19 other but many of us got worse and needed extra help
 20 from doctors. Our parents were often scared. It seems
 21 like a long time ago that we felt well and could do some
 22 of the fun things we liked to do. We're still at home
 23 and we're still unwell. Many of us are still in bed
 24 lots of the time. It can be boring, annoying,
 25 frustrating and tiring and we miss our friends. We miss

1 feeling well.
 2 "One day a group of doctors and grown-ups who were
 3 ill just like us called our really long illness
 4 'long COVID'. Long COVID means that you're still ill
 5 after many months and you never know how you feel when
 6 you wake up or try to play favourite games. One day you
 7 might feel okay and the next you might feel terrible
 8 again. Sometimes you might feel okay and terrible in
 9 the same day. It's very confusing. Having long COVID
 10 is weird because it didn't exist last year. We're the
 11 first people to have lots of different things go wrong
 12 with us."
 13 The child goes on:
 14 "We didn't feel like this before we got coronavirus.
 15 We felt like you. Now we all have long COVID and nobody
 16 knows what to do. Our parents are working together to
 17 get us some help and that's why we're telling you our
 18 story. We want to feel better again and when we ask
 19 when we will feel better, nobody can tell us when that
 20 might be. It's making us sad."
 21 Well, a recitation of common symptoms, my Lord,
 22 exhaustion, cognitive impairment and chronic pain for
 23 long COVID, truly fails to convey the true lived reality
 24 of this disabling and devastating illness. The Inquiry
 25 has been offered and we trust will hear from those with

1 that lived experience, of children and young persons
 2 housebound, bedbound and isolated, distraught,
 3 humiliated and suicidal, of professional scepticism,
 4 indifference and inaction in response, of the struggle
 5 to gain recognition, respect and action.
 6 Long Covid Kids is a grass roots organisation formed
 7 by individuals who have borne the burden of that lived
 8 experience and who have become disillusioned and
 9 frustrated by the slow, inadequate and frankly
 10 reprehensible response by Government, national and
 11 local, to the long-term illness caused by COVID-19.
 12 They are the citizens who continue to suffer from the
 13 effects of the disease, who either are or look after
 14 those who are at greater risk of morbidity upon
 15 reinfection with COVID-19.
 16 There are overall 250 families supported by Long
 17 Covid Kids in Scotland with a child suffering from
 18 long-term symptoms having contracted COVID and there are
 19 believed to be around 10,000 children and adolescents
 20 suffering from long COVID in Scotland. They are
 21 entitled to answers to many questions but, above all,
 22 they're entitled to know whether their suffering and
 23 their sacrifices and their fate was avoidable.
 24 So for that purpose, amongst others, this Inquiry
 25 must engage in a robust, probing and challenging and

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

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

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

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

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

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

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

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

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

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

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

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

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

25 Bearing in mind that the risk of long COVID remains

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23 My Lord.

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

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1 Day.
 2 Now, I think National Health Service National
 3 Services Scotland. That's a mouthful. Ms Doherty,
 4 thank you.
 5 Opening statement by MS DOHERTY
 6 for NHS National Services Scotland
 7 MS DOHERTY: Thank you, my Lord. I am Una Doherty and
 8 I appear today on behalf of NHS National Services
 9 Scotland, NHS NSS for short.
 10 NHS NSS welcomes this Inquiry to establish the facts
 11 of and learn lessons from the strategic response to the
 12 COVID-19 pandemic in Scotland. The toll that the
 13 pandemic took was a significant one. NHS NSS extends
 14 its sympathy to the witnesses who will give evidence on
 15 the impacts of the pandemic. NHS NSS has arranged to be
 16 represented throughout the Impact Hearings and will pay
 17 close attention to the evidence given.
 18 NHS NSS is conscious that, although the Inquiry team
 19 is aware of the organisation NHS NSS, the wider public
 20 watching and listening today may not know what it is or
 21 does or why it is a core participant in this Inquiry.
 22 This opening statement, therefore, contains a brief
 23 introduction to the organisation, explaining its roles
 24 and its interest in the Inquiry.
 25 NHS NSS is a non-departmental public body

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1 accountable to the Scottish Ministers. It was created
 2 in 1974 to provide national strategic support services
 3 and expert advice to Scotland's NHS. Its headquarters
 4 are in Edinburgh but it has staff based at a number of
 5 locations in Scotland. It consists of a number of
 6 different units providing a wide range of services. The
 7 services currently provided by it include those given by
 8 the following units: National Procurement and Logistics;
 9 Practitioner and Counter Fraud Services; Antimicrobial
 10 Resistance and Healthcare Associated Infection Scotland;
 11 Central Legal Office; Digital and Security Services;
 12 Health Facilities Scotland; National Screening Division;
 13 Programme Management Service; Scottish National Blood
 14 Transfusion Service; and NHS Scotland Assure.
 15 Prior to 1 April 2020, NHS NSS also provided
 16 a service called Health Protection Scotland. Elements
 17 of that service moved from NHS NSS on 1 April 2020 to
 18 become part of a new organisation, Public Health
 19 Scotland. While within NHS NSS, Health Protection
 20 Scotland planned and delivered specialist national
 21 services aimed at protecting the people of Scotland from
 22 infectious and environmental harms. One part of
 23 Health Protection Scotland prior to 1 April 2020, the
 24 Antimicrobial Resistance and Healthcare Associated
 25 Infection Team, remained in NHS NSS and is now known as

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1 "Antimicrobial Resistance and Health Associated
 2 Infection Scotland".
 3 Although it is not primarily a public-facing
 4 organisation, services provided by NHS NSS have had
 5 a role in the pandemic response. Its roles during the
 6 pandemic response included the following:
 7 Programme management services to a range of
 8 programmes, including the commissioning and
 9 decommissioning of the Louisa Jordan Hospital, Test and
 10 Protect and the COVID-19 vaccination programmes.
 11 Leading the mobilisation of construction partners,
 12 including for the Louisa Jordan Hospital and providing
 13 technical oversight on mechanical, electrical and water
 14 systems at the Louisa Jordan facility.
 15 Development of therapeutic convalescent plasma
 16 treatments.
 17 Procurement and logistics of personal protective
 18 equipment.
 19 Procurement, development and operation of digital
 20 platforms for Test and Protect and the COVID-19
 21 vaccination and COVID-19 status certification
 22 programmes, including publicly accessible apps and web
 23 platforms.
 24 Procurement and logistics for PCR testing.
 25 Procurement and logistics for lateral flow devices

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1 and point of care testing.
 2 Commissioning and operation of the National Contact
 3 Centre, providing support to Test and Protect, COVID-19
 4 vaccinations and COVID-19 status certification.
 5 Operational delivery of the UK national and local
 6 testing programmes in Scotland, working with the UK
 7 Health Security Agency, local authorities, health boards
 8 and the Scottish Ambulance Service to ensure access to
 9 appropriate COVID-19 testing for the population.
 10 Working with other bodies on the production of
 11 infection prevention and control guidance.
 12 NHS NSS looks forward to playing an active and
 13 useful part in the Inquiry, my Lord. It will wish to
 14 learn from the issues that the Inquiry examines. If
 15 there are recommendations made by the Inquiry, NHS NSS
 16 may be involved in facilitating actions required by some
 17 recommendations. As a public body, NHS NSS understands
 18 the responsibility it owes to the Inquiry and to the
 19 people of Scotland and it will support the Inquiry's
 20 work in any way it can.
 21 Thank you, my Lord.
 22 THE CHAIR: Thank you very much indeed, Ms Doherty.
 23 Now, we are again in the position, as we were
 24 yesterday, this time even more extremely, that we've
 25 done all the core participants that were allocated to

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1 the morning session. It is a bit early to take lunch.
 2 I'm going to have to ask Mr Pugh if he is ready to speak
 3 at the moment. I think actually, to be sensible about
 4 this, I should put the burden on Mr Bowie as well
 5 because we can easily get both of you done before we
 6 take even then, I think, an early lunch. Is that all
 7 right with both of you?
 8 MR PUGH: Absolutely, my Lord.
 9 THE CHAIR: Good, thank you. I'm very grateful for your
 10 co-operation. Mr Pugh first then. You're for the NHS
 11 Territorial Health Board and Special Health Boards.
 12 There's some terrible acronyms kicking about here!
 13 MR PUGH: I don't think it's an acronym.
 14 THE CHAIR: No, it's not actually.
 15 Opening statement by MR PUGH
 16 for NHS Territorial Health Board and Special Health Boards
 17 MR PUGH: I appear along with Cat MacQueen Advocate on the
 18 instructions of the NHS Central Legal Office on behalf
 19 of the Health Boards, as they've been termed, in their
 20 application for core participant status.
 21 My Lord, the Health Boards welcome this Inquiry,
 22 which will allow a full exploration of the facts of the
 23 pandemic in Scotland as they relate to health and social
 24 care, including the response of the NHS. This opening
 25 statement will be the first time that the Health Boards,

1 in the sense that they are collectively formed for this
 2 Inquiry and the UK Inquiry, have spoken publicly so
 3 I would like to explain some relevant background.
 4 My Lord, each of the health boards we represent is
 5 an independent NHS board in terms of the National Health
 6 Service (Scotland) Act 1978. They've grouped together
 7 for the conduct of both this and the UK Inquiry due to
 8 a commonality of interests.
 9 14 territorial health boards have responsibility for
 10 planning and commissioning services, including primary
 11 care, and for the delivery of front-line NHS services to
 12 local populations, together with providing secondary and
 13 tertiary care in Scotland's hospitals.
 14 The five special health boards provide care and
 15 support throughout Scotland, including ambulance
 16 provision, the national 24-hour helpline in the shape of
 17 NHS 24, the state hospital, the National Waiting Times
 18 Centre and the education of NHS staff. Each board is
 19 funded by and reports directly to the Scottish
 20 Government, although their management structures
 21 vary across the country.
 22 My Lord, the ethos behind the Health Boards'
 23 participation in this Inquiry is to strive for both
 24 learning and improvement. Through their participation
 25 and with that ethos to the fore, the Health Boards hope

1 to benefit the future care of the Scottish people. The
 2 Health Boards are grateful to you, my Lord, for granting
 3 both core participant status and leave to appear at
 4 these Impact Hearings and look forward to assisting the
 5 Inquiry in its important work. The Health Boards
 6 anticipate active participation in the Inquiry's work on
 7 the terms of reference relevant to health and social
 8 care.
 9 My Lord, following identification of the SARS-CoV-2
 10 virus in early 2020, healthcare providers throughout the
 11 UK, indeed the world, strived to obtain knowledge of the
 12 virus, how it was transmitted, its effects on humans and
 13 its effective treatment. The resulting COVID-19
 14 pandemic has represented the biggest challenge ever to
 15 face the NHS in Scotland. On 17 March 2020, the
 16 Cabinet Secretary for Health and Sport acknowledged
 17 the scale of the challenge in a speech to the Scottish
 18 Parliament, where she said:
 19 "The scale of the challenge is, as the First
 20 Minister has said quite simply, without precedent.
 21 "The response to COVID-19 requires a swift and
 22 radical change in the way our NHS does its work. It is
 23 nothing short of the most rapid reconfiguration of our
 24 health service in its 71-year history.
 25 "That's why today, under sections 1 and 78 of the

1 National Health Service (Scotland) Act ... I am formally
 2 placing our NHS on an emergency footing for at least the
 3 next three months."
 4 From March 2020, therefore, the Health Boards
 5 required to implement key changes in practice and policy
 6 to create additional capacity for COVID-19 patients and
 7 to manage infection prevention and control within the
 8 existing NHS estate. They had to do so while continuing
 9 emergency, maternity, cancer services and urgent care,
 10 all of which have been maintained alongside many other
 11 services throughout the pandemic.
 12 Initial changes saw, for example: non-urgent
 13 surgery, treatments and appointments suspended together
 14 with some screening policies paused; the increase in the
 15 number of intensive care beds from 173 to 585, with the
 16 result that NHS critical care capacity was not breached;
 17 increase in the NHS workforce. For example, during the
 18 first wave in 2020, 4,880 student nurses were deployed,
 19 575 junior doctors had their registrations accelerated
 20 and recently retired staff were invited to return to
 21 work; and the adoption of digital solutions. For
 22 example, the number of video consultations increased
 23 from about 300 per week in March 2020 to more than
 24 18,000 per week in November 2020.
 25 The initial changes also saw, of course, the

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

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

15 By January 2021, Scotland had the capacity to test
 16 77,000 people per day with 36% of that capacity coming
 17 from NHS Scotland laboratories. May 2020 also saw the
 18 introduction of a requirement for enhanced professional
 19 and clinical care oversight of care homes by senior
 20 health board staff, operating within multidisciplinary
 21 teams and alongside local authority officers, and that
 22 requirement has of course been referred to by a number
 23 of core participants already, my Lord.

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

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

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

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

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

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

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

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

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

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

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

20 Thank you again, my Lord.
 21 THE CHAIR: Thank you very much indeed.

22 Now, Mr Bowie, thank you.
 23 Opening statement by MR BOWIE
 24 for Public Health Scotland

25 MR BOWIE: Good afternoon, ladies and gentlemen.

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

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

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

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

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

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

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

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

25 Thank you.

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

2 We're still only at 12.13. It's Ms Domingo,

3 I think, that appears on behalf of the Scottish Women's
 4 Rights Organisations. Are you able to speak now? Do
 5 you want to speak now?

6 MS DOMINGO: I will be 20 minutes.

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

11 MS DOMINGO: Thank you, my Lord.

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

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

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

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

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

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

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1 forms of discrimination and marginalisation.
 2 This opening statement addresses the key areas of
 3 impact on women under four broad headings:
 4 first : domestic violence and gender–based violence. The
 5 "Stay at home" measures overlooked that for many people
 6 home was not the safest place to be. One of the
 7 consequences of the imposition of lockdown and isolation
 8 rules was a rise in domestic abuse and violence.
 9 As explained by Scottish Women's Aid in their
 10 written submissions to the Equalities and Human Rights
 11 Committee of the Scottish Parliament, anxiety about
 12 Coronavirus, frustrations related to quarantine,
 13 economic uncertainty due to loss of jobs, harmful
 14 consumption of alcohol or other stresses do not cause
 15 domestic abuse. Domestic abuse is a pattern of
 16 behaviour that instills fear and it is used by abusers
 17 to maintain control. Measures taken to address the
 18 pandemic, including lockdowns, early release of
 19 prisoners, closure of schools, working from home,
 20 reduction in the work of courts and closure of some
 21 services and transition of others to remote provision
 22 provide additional tools for abusers to exercise that
 23 control and they remove the opportunities for women to
 24 seek help.
 25 It is recognised that men can be subject to domestic

1 abuse. However, most abuse victims and survivors are
 2 women. Women experienced an intensification of domestic
 3 abuse during the pandemic, with increases in the
 4 frequency and severity of domestic abuse instances.
 5 Women and children were subject to heightened monitoring
 6 and control by abusive partners or family members.
 7 There was an increase in stalking and harassment from
 8 ex–partners and an increase in abuse through online
 9 platforms and through manipulating child contact
 10 arrangements.
 11 For children and young people living with coercive
 12 control during the lockdown, the impact is yet to be
 13 fully understood. The places where they felt safest,
 14 schools, nurseries, sports or after–school clubs or the
 15 homes of grandparents or other family members, were all
 16 taken away. The pandemic simultaneously increased the
 17 risk of harm to women and children and made access to
 18 safe spaces, vital services and support from family and
 19 friends much more difficult. Being at home all day
 20 meant that the time alone to speak freely to a support
 21 worker or to the police was dramatically limited.
 22 The pandemic also exacerbated pre–existing strains
 23 on services at a time when the funding environment over
 24 a period of many years had made service provision
 25 increasingly difficult. There was higher demand on

1 support services, such as those provided by Rape Crisis
 2 Centres, local Women's Aid services and JustRight
 3 Scotland, and our clients experienced unprecedented
 4 contact volumes while operating with reduced capacity.
 5 Data from May 2020 showed that calls to Scotland's
 6 Domestic Abuse and Forced Marriage Helpline were up 70%
 7 from the previous year and there was an increase in web
 8 chat and email contact, with email numbers almost
 9 doubling.
 10 The pandemic created significant barriers to
 11 reporting sexual violence, which is an already vastly
 12 under–reported crime. If sexual violence took place in
 13 circumstances that infringed prevailing lockdown
 14 restrictions, victims were even more reluctant to report
 15 their experiences.
 16 The suspension of court proceedings meant that the
 17 ability of victims and survivors to access the justice
 18 system was greatly reduced. There continues to be
 19 a large backlog of cases and significant delays.
 20 Rape Crisis Scotland has commented on the delays caused
 21 by COVID–19 as follows:
 22 "From the outset, Rape Crisis Scotland raised
 23 significant concerns about the impact of the significant
 24 backlog caused by COVID–19–related court closures on the
 25 health and well–being of survivors of sexual crimes."

1 This is supported by findings from the
 2 Scottish Centre for Crime and Justice Research, which
 3 evidences the significant and harmful toll that
 4 uncertainty and delays have had on the mental health of
 5 survivors. Access to legal services and representation
 6 was also impacted as legal advice agencies had reduced
 7 and limited capacity and many solicitors were no longer
 8 providing legal aid services due to funding issues.
 9 Women from black and ethnic minority backgrounds and
 10 those who experience intersecting inequalities were
 11 particularly impacted. The no recourse to public funds
 12 condition is felt disproportionately by women and it can
 13 increase vulnerability to other forms of exploitation,
 14 including trafficking and physical or sexual abuse. It
 15 can trap women in abusive relationships, particularly
 16 where they depend on the perpetrators of abuse and are
 17 unable to leave because of a lack of accessible options,
 18 including safe refuge spaces. This is compounded where
 19 women have uncertain immigration status.
 20 The second area is health impacts and housing.
 21 Increases in domestic abuse and gender–based violence
 22 have, in many cases, significant negative impacts on
 23 health, housing, education and employment outcomes. In
 24 the written evidence to the Equalities and Human Rights
 25 Committee, JustRight Scotland stated that heightening

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

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

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

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

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

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

1 traumatic experiences such as miscarriage alone.

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

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

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

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

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

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

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

1 childcare, home-schooling supervision and housework,
 2 which led to increased stress, particularly if juggled
 3 alongside paid work and particularly for single mothers.
 4 Women, particularly those who experience
 5 intersecting inequalities, are more likely to face
 6 poverty and financial dependency as a consequence of the
 7 pandemic. Women were more likely to work in shut-down
 8 sectors such as hospitality or retail, they were more
 9 likely to be furloughed and for longer and they were
 10 more likely to have lost their job or had their hours
 11 reduced. This was especially the case for women from
 12 black and ethnic minority backgrounds, disabled women,
 13 younger women and low-paid women.

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

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

1 overall experiences. That is taking into account race,
 2 ethnicity, disability, age, location, sexual
 3 orientation, socioeconomic group and migrant status.
 4 One of our client's key concerns is the accumulating
 5 impact that the increased risk of harm has on women and
 6 children in Scotland. It is the position of the
 7 Scottish Women's Rights Organisations that at all levels
 8 of decision-making during the COVID-19 pandemic there
 9 was a failure to apply an intersectional gender
 10 competent approach to the decisions being made, a lack
 11 of gender-sensitive, sex-disaggregated data on which to
 12 make decisions, and a failure to comply with the legal
 13 requirements of the Scottish specific duties of the
 14 public sector equality duty by mainstreaming equality
 15 and undertaking equality impact assessments in
 16 decision-making.

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

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

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

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

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

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

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

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

1 Thank you, my Lord.
 2 THE CHAIR: Thank you very much, Ms Domingo.
 3 Very good. It's almost 12.35 now. You will be
 4 pleased, Ms Doherty, we will not ask you to speak now.
 5 Can I ask you to please be back at 1.35? Thank you.
 6 (12.35 pm)
 7 (The short adjournment)
 8 (1.37 pm)
 9 THE CHAIR: Good afternoon. Ms Doherty.
 10 Opening statement by MS DOHERTY
 11 for Healthcare Improvement Scotland
 12 MS DOHERTY: Thank you, my Lord. I appear on behalf of
 13 Healthcare Improvement Scotland, "HIS" for short. As
 14 the Inquiry knows but the public at large may not, HIS
 15 is a body within the NHS in Scotland. It is a national
 16 improvement organisation within the Scottish health and
 17 social care landscape. Its purpose is to enable the
 18 people of Scotland to experience the best quality of
 19 health and social care with a specific focus on safety.
 20 There is no organisation elsewhere within the UK with an
 21 identical combination of functions.
 22 HIS uniquely combines a range of statutory duties
 23 and other functions, including quality assurance,
 24 regulation, service redesign and strategic planning,
 25 evidence-based guidance, guidelines and standards for

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

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

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

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

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

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

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

1 460 cases during the pandemic. Each of these cases
 2 represented an individual who had experienced
 3 a significant issue during the course of their
 4 employment during the pandemic. They had nowhere else
 5 to turn for assistance and they sought guidance from
 6 Scottish Hazards. Each case represents a story to be
 7 told.

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

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

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

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

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

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

1 care sector, particularly privately.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 be able to share their experience of involvement in the
 2 group from a non-unionised workforce perspective.
 3 The advisory group provided a platform for
 4 discussion and an opportunity for Scottish Hazards to
 5 raise the concerns of those on the front line who had
 6 been forgotten about by their employers.
 7 Scottish Hazards would like to see the Safer Workplaces
 8 Advisory Group continue. There needs to be ongoing work
 9 done to ensure that the country is prepared in the event
 10 of a further pandemic. This valuable line of
 11 communication with the Scottish Government by way of the
 12 advisory group ensured that those who were not
 13 represented by a trade union were still included in that
 14 discussion.
 15 In considering the assistance that Scottish Hazards
 16 can give to the Inquiry directly, two witnesses have
 17 been identified at this stage. The first of those is
 18 Ian Tasker, the chief executive of Scottish Hazards, and
 19 the second is Kathy Jenkins, trustee of
 20 Scottish Hazards. Both witnesses would be available, if
 21 called upon by the Inquiry, to provide experiences of
 22 non-unionised workers in Scotland. Such evidence would
 23 assist the Inquiry in better understanding the
 24 perspective of health and social care workers.
 25 Scottish Hazards welcome the commencement of this

1 Inquiry and are grateful to the Inquiry both for their
 2 core participant status and for the opportunity to
 3 address the Inquiry this afternoon. It is hoped that
 4 Scottish Hazards are able to assist the Inquiry in
 5 fulfilling their terms of reference and it is hoped that
 6 there shall be acknowledgement given to workers in all
 7 sectors for the sacrifices made during the COVID-19
 8 pandemic to ensure that the vital services of Scotland
 9 continued.
 10 Scottish Hazards would like to see the Inquiry
 11 assist in the furtherance of workers' rights in line
 12 with the categories of the terms of reference. The lack
 13 of preparation for this pandemic led to strain on the
 14 part of employers and -- employees, rather. This
 15 additional strain contributed not only to the
 16 difficulties in being part of the workforce but also to
 17 their health.
 18 Scottish Hazards played a part in assisting those
 19 who didn't have anyone else to help. COVID-19 has had
 20 a devastating impact on the health of some of those who
 21 contracted the disease and particularly those who have
 22 suffered from long COVID. The pandemic was treated only
 23 as a public health emergency and Scottish Hazards is of
 24 the view that COVID-19 should also be regarded as an
 25 occupational health matter for those who caught COVID-19

1 during the course of their employment. Recognition of
 2 long COVID as an occupational disease would allow
 3 workers to access various different benefits, such as
 4 industrial injuries benefits, and Scottish Hazards hope
 5 that the Inquiry will give consideration of that as far
 6 as it is allowed in the terms of reference.
 7 To conclude, my Lord, it is essential that lessons
 8 are learned from this Inquiry to ensure the protection
 9 of workers' rights. It is essential that future plans
 10 and pandemic planning consider the workforce in
 11 Scotland. They cannot be forgotten about again.
 12 Scottish Hazards hopes to assist the Inquiry in any way
 13 they can and will provide any information required to do
 14 so.
 15 Thank you, Ms Lindsay.
 16 THE CHAIR: Thank you very much.
 17 Lastly today, the Scottish Trade Union Congress,
 18 Mr Keegan.
 19 Opening statement by MR KEEGAN
 20 for the Scottish Trade Union Congress
 21 MR KEEGAN: Thank you, my Lord. I appear with Ms Lindsay on
 22 behalf of the STUC. The STUC, as most of us know, is
 23 the independent body to which individual trade unions in
 24 Scotland affiliate their Scottish membership and it
 25 represents collectively over 550,000 trade union members

1 in Scotland.
 2 As this is the first substantive hearing of this
 3 Scottish Inquiry, it is appropriate that we acknowledge
 4 immediately the very great sacrifice made by so many
 5 workers and their families in this pandemic. The STUC
 6 represents the collective voice of workers in Scotland.
 7 It is a key civic organisation that has engaged with
 8 successive Scottish governments since 1999. It is
 9 therefore uniquely able to gather information and offer
 10 advice because of its representative structures that
 11 cover and disseminate advice throughout public and
 12 private voluntary healthcare sectors in Scotland. It is
 13 able to receive direct reporting and feedback from
 14 key workers delivering essential services and it was
 15 involved in the establishment of the Covid Group that
 16 met with the Scottish Government.
 17 Evidence will be given about the engagement between
 18 the STUC and the Scottish Government and about concerns
 19 that were communicated to the Scottish Government about
 20 levels of consultation and response by employers to the
 21 crisis caused by COVID: failures in the provision of PPE
 22 to a range of workers in health and social care;
 23 failures in the setting up and maintenance of an
 24 effective supply chain of PPE and associated equipment;
 25 inconsistency in planning and provision to protect

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

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

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

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

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

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

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

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

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

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

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

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

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

1 health and social care, excess deaths, business
 2 continuity and co-ordination.
 3 The report was published in April 2016 and the key
 4 findings can be found in page 9 of that report and
 5 I mentioned in my statement — I don't need to read it
 6 out — that part of the report.
 7 Evidence will demonstrate that underlying — sorry,
 8 underfunding in health and social care caused by
 9 austerity had a significant adverse effect on planning
 10 and readiness for the COVID emergency. Preparation
 11 requires not only planning but also the capacity and
 12 public services in health and social care. Public
 13 services are greatly diminished and weakened by years of
 14 budget cuts that impacted on the ability of our national
 15 and local governments to respond quickly and effectively
 16 to the sudden and devastating shock of a national
 17 emergency that has been COVID-19.
 18 The initial response to COVID-19 also failed to
 19 consider and recognise the potential for aerosol
 20 transmission of the virus so that the health measures
 21 initially put in place focused on other precautions such
 22 as hand-washing rather than on the provision of
 23 equipment, such as masks for general public and PPE for
 24 front-line workers. That was the case notwithstanding
 25 recommendations that derived from UK exercises that took

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1 place in 2016 and 2018, in particular Cygnus and Iris,
 2 about stockpiling PPE and the provision of training in
 3 the use thereof.
 4 The trade union affiliates that are represented
 5 under the banner of the STUC are all able to bear
 6 witness to the impact of what can only be described as
 7 a lack of preparedness in every facet of life and
 8 government for the pandemic. The STUC intends to
 9 highlight the effects of this lack of preparedness on
 10 workers and their families in Scotland.
 11 Evidence shows that from the outset of the COVID-19
 12 pandemic, workers in health and social care immediately
 13 experienced a number of significant issues in the
 14 provision of care and in the impact on them physically
 15 and mentally and socially, as a high percentage of
 16 female workforce providing front-line care during such
 17 an extraordinary situation, which the Government,
 18 National Health Service, local authorities and private
 19 and third sector employers were evidently ill-prepared
 20 for. That placed a substantial strain on all aspects of
 21 family life, including but not limited to childcare and
 22 in making provision for childcare with relatives, all at
 23 great risk, so that health and social care workers could
 24 just carry out their critical roles as key workers, and
 25 many have not recovered from the stress and strain that

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1 this brought to them.
 2 One clear example of the lack of preparedness has
 3 been the substantial number of problems that were
 4 associated with the provision and access to supplies of
 5 PPE and the absence of guidance to workers and how best
 6 to protect themselves and others from the exposure and
 7 spread of the COVID virus. It was immediately apparent
 8 that the high level of uncertainty and anxiety put
 9 immense pressure on all areas of the health and social
 10 care workforce to access face masks and other protective
 11 clothing and to attempt to adopt social distancing. The
 12 practical difficulties associated with that created
 13 widespread anxiety and impacted substantially on the
 14 ability to avoid contracting and transmitting the virus.
 15 At all sectors of the health and social care system,
 16 workers encountered delays in receiving adequate
 17 supplies. Some PPE had to be re-used, causing risk to
 18 the wearer and to others. There were fears about
 19 engaging with fellow workers, patients, clients and
 20 members of the public, who did not have or could not
 21 wear masks or PPE. The inclusion of face shields in PPE
 22 provision was thought to provide a higher level of
 23 protection but they were less accessible.
 24 PPE was rationed and issues arose with accessing or
 25 achieving appropriate PPE fittings. Advice on provision

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1 were often cost- or supply-driven as opposed to being
 2 based on the highest level of protection. Instructions
 3 on some PPE weren't even in English, which caused
 4 confusion and a lack of confidence about their correct
 5 use, and some PPE supplied to workers was out of date.
 6 The quality of supplies was variable. Guidance
 7 associated with the use of PPE was mostly focused on
 8 providing care in acute hospital settings and health and
 9 social care workers outwith those settings and those in
 10 the community were vulnerable due to the lack of clear
 11 advice and equipment to protect themselves.
 12 Health and social care workers had to work in
 13 uncontrolled settings, in homes where there was no
 14 control over ventilation — I'm talking about private
 15 homes — access to washing facilities, numbers of people
 16 present and overall conditions. Workers providing home
 17 care services did not have guaranteed access to
 18 appropriate rest areas or to the ability to prepare food
 19 and drinks for prolonged periods of work. The vast
 20 majority of health and social care workers take their
 21 uniforms home to wash them. However, the unknown risk
 22 of cross-infection caused them to worry about what might
 23 ensue from taking their clothes home, washing them with
 24 other clothes and being able to launder things on
 25 a reasonable basis without risk. The absence of any

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1 guidance on this, amongst other things, added further to
 2 the stress that workers experienced.
 3 Evidence about experience in almost all areas of
 4 working lives can be demonstrated in the impact
 5 summaries and statements that have been prepared for the
 6 STUC and by the STUC, and when I say "for the STUC", I'm
 7 talking about its affiliates. There are some examples
 8 that I can briefly go to because I see time is marching
 9 on, but there were some workers who had to work within
 10 a bubble, and I heard that mentioned earlier. But some
 11 people actually did separate themselves from their
 12 families and worked within nursing homes in order to
 13 provide care so that they were separated from their
 14 loved ones for long periods, but that didn't improve
 15 their access to decent wages in the aftermath. Other
 16 workers had to cope with transport issues that exposed
 17 them to a greater risk with the disease itself and in
 18 contracting it.
 19 Other evidence will show a disproportionate impact
 20 on ethnic minority groups within the health and social
 21 care sector. This should have been avoidable, but
 22 failures to recognise and provide guidance about higher
 23 potential risk groups, such as those with comorbid
 24 health issues and BAME workers, left them exposed.
 25 Whilst other parts of the NHS locked down and

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1 minimised direct contact with patients, most workers in
 2 health and social care had to be in daily contact with
 3 the public, whether that was travelling to work or
 4 delivering care to the needy. GP patients who didn't
 5 have access to the GP practice or to A&E often
 6 transferred to local pharmacies and that increased the
 7 workload for pharmacists and that in turn caused
 8 difficulties within the pharmacies in which they worked.
 9 Within these pharmacies, there was also a lack of PPE.
 10 I give these things obviously as examples, but one
 11 thing I want to stress upon -- I think I've stressed
 12 today -- is the complex situation which is faced by
 13 those who are experiencing long COVID conditions and the
 14 impact that that has caused on workers, and the STUC
 15 will provide evidence about that long-term impact upon
 16 workers, on their families, on their jobs and on their
 17 ability to continue to perform their daily lives and
 18 jobs.
 19 The opening statement I've given is brief here, it's
 20 longer in print, but it provides only a brief overview
 21 of the level of experience which has impacted on workers
 22 throughout this pandemic. The STUC has a wealth of
 23 experience that it can offer to this Inquiry of the
 24 impact, of experiences and of the shortcomings in
 25 Government responses and I hope that the Inquiry will

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1 listen carefully to everything that will be on offer and
 2 take it on board in making its final recommendations.
 3 I'm sorry, this is much longer than it should have
 4 been, but there we go.
 5 THE CHAIR: Very good. Thank you, Mr Keegan.
 6 That brings us to an end of actually the opening
 7 submissions. As you know, we're not sitting tomorrow
 8 and that is because a number of core participants and
 9 their representatives require to attend hearings of the
 10 UK Inquiry in London tomorrow and, in the co-operation
 11 that has been shown between us, we're assisting by not
 12 sitting tomorrow, but we're back on Friday, where we
 13 will actually start evidence. So I look forward to
 14 seeing you all at 10 o'clock on Friday morning.
 15 Thank you.
 16 (2.17 pm)
 17 (The hearing adjourned until
 18 Friday, 27 October 2023 at 10.00 am)
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