OPENING STATEMENT

On behalf of

BEREAVED RELATIVES GROUP (SKYE)

The Bereaved Relatives Group (Skye) welcomes the start of this public inquiry.

This group is made up of people whose relatives died in care homes, as well as care workers who bore witness to the conditions in those homes. Their experiences span 5 different health boards including Scotland's island communities.

The members of this group welcome the Chair's decision to hear first from those directly impacted by the pandemic in the health and social care sector.

Their thoughts today are with their loved ones.

While everyone's situation is individual and their grief personal, the evidence in these hearings will reveal a commonality of experience among the bereaved. Care home residents and their families were let down. They were let down by the lack of planning and preparedness at a national and local level for dealing with a pandemic. They were let down by decisions made by government. They were let down by failures in the inspection regime. They were let down by private care providers who prioritised profit and reputation over their responsibilities to care for residents, to protect them, and to tell the truth.

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

The bereaved want to know how it was that the virus was able to enter care homes when they were in lockdown ahead of the rest of society, and how the virus was then able to spread like wildfire within the homes.

The Inquiry will hear evidence that people were transferred into care homes from hospitals without testing. This happened at a national level with no obvious consideration given to local capacity or the best interests of patients and residents. It was at a time when it appears no Scottish hospital had reached a level of capacity that might have signalled an imminent critical incident necessitating such a step.

The Inquiry will hear evidence of staff travelling between care homes and to different parts of the country, including from England to Skye, with concerns that the rules on self-isolation were not followed.

There will be evidence that care homes were entirely unprepared for a pandemic and once it began staff were given little or no guidance and training on what to do. There were deficiencies in infection control, basic cleaning and hygiene. In one home the alcohol-based cleaning products were in a locked cupboard to which staff were not permitted access. Instead they "cleaned" using air freshener.

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

Once there was a Covid-19 outbreak in a care home, bereaved relatives were faced with a total lack of transparency about what was happening. Some learned of the outbreak from Facebook rather than from care home management or staff. There was no proper testing regime within care homes. When direct questions were asked about whether someone had tested positive, relatives were lied to.

The situation was only exacerbated by the decision that there should be a blanket ban on face-to-face visits with those in care homes. It is a natural human response to be as close as possible to a loved one in the final phase of their life. This was denied to care home residents and their relatives. While there is a recognition that measures to mitigate the spread of the

virus and the risk of infection had to be implemented, bereaved relatives want to know why staff members were permitted to travel between their home and place of work, use public transport, spend time with their own family, all without taking protective measures, and yet still work closely with the vulnerable and the elderly in care homes.

Having listened to the witnesses' accounts, the Inquiry should be prepared to ask decision makers, why were alternatives not considered, or if they were, why were they not approved? Why could families not nominate one relative to "bubble" with the resident to allow face-to-face contact to continue? Why did no-one consider the cultural impact of denying the island communities their tradition of collective caring?

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

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

Many families witnessed, remotely, a significant deterioration of their loved one's physical and mental health in lockdown that was nothing to do with Covid-19. Some suspected that their loved one was suffering from neglect, dehydration and starvation. Questions were asked. Relatives were fobbed off.

The blanket ban on visits meant that care plans could not be checked. The Inquiry will hear that when records were requested after a loved one's death, relatives found that they were missing or incomplete.

When relatives did manage to make contact over video with their loved one, and witnessed for themselves the deterioration in their condition, there is evidence that at times their wishes about medical treatment were ignored or overridden.

The reality for bereaved relatives is that some did not see their loved ones face-to-face again after lockdown. The right to visit during the last moments of life was not always granted and if it was, it was restricted to one family member. Some residents died alone. Care home staff witnessed many excess deaths. They held people's hands as they died. That trauma will never leave some of them.

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

The Inquiry has promised to take a human rights based approach. Hearing first from those impacted by the pandemic is a recognition of that approach in action. And that is welcomed. But a meaningful human rights based approach goes far beyond that.

The Inquiry must investigate whether the right to life under Article 2 was respected and protected. We anticipate the Inquiry will hear that people were pressured to agree to Do Not Resuscitate Notices; that people were not resuscitated even though no such notice was in place; that residents may have been neglected and left to starve; that families are not sure they were told the truth about their relative's cause of death; that the usual process for certification of deaths was departed from.

The Inquiry must investigate potential violations of Article 3 – the prohibition on torture, inhuman and degrading treatment. Relatives will speak of their loved ones lacking food, water and hygiene; that there was inadequate, inappropriate, absent or delayed medical attention; that welfare attorneys' views were not listened to when it came to medical treatment; that there was inadequate staffing to provide proper care resulting in residents' suffering unnecessarily. We urge the Inquiry to consider whether, in light of people's lived experience, the inspection and regulatory regimes were fit for purpose to prevent or remedy these harms.

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

When you come to hear from the decision makers and those who implemented the restrictions, we want you to ask whether those people took a human rights based approach. Did they consider that the result of their decisions and the restrictions that followed would be the situations the Inquiry is going to hear about in this first tranche of hearings?

Fundamental to a human rights based approach are accountability and a guarantee of non-repetition. Most of all what, this group wants the Inquiry to ensure is that no family, no care home resident and no care worker in the future has to go through what they and their loved ones suffered during Covid-19.

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