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Scottish Covid-19 Inquiry

Day 26

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1 Tuesday, 19 March 2024
2 (9.45 am)
3 THE CHAIR: Good morning, Ms Bahrami.
4 MS BAHRAMI: Good morning, Lord Brailsford. Our first
5 witness this morning is Judith Turbyne, who is the CEO
6 of Children in Scotland.
7 MS JUDITH TURBYNE (called)
8 THE CHAIR: Good morning, Ms Turbyne.
9 A. Good morning. Very good to meet you.
10 THE CHAIR: Very good to meet you too. When you're ready,
11 Ms Bahrami, please proceed.
12 MS BAHRAMI: Thank you, my Lord.
13 Questions by MS BAHRAMI
14 MS BAHRAMI: Good morning, Ms Turbyne. Please could you
15 tell us a bit about your background?
16 A. Yes, I'm currently the CEO of Children in Scotland.
17 Prior to that, I spent a while working with the Scottish
18 Charity Regulator, so I've worked a little bit in the
19 public sector, and prior to that I worked in
20 international development, again in the charity sector.
21 So I've spent most of my working life in the charity or
22 third sector.
23 Q. Thank you. Could you tell us a bit about Children in
24 Scotland, what the organisation does generally?
25 A. Yeah. So Children in Scotland just celebrated its

1 30th anniversary, although you can trace it back
2 slightly further, if you're willing to, but its formal
3 30th anniversary. It came together on the realisation
4 that across Scotland there were really a lot of
5 different kinds of organisation working for and with
6 children and young people and that actually there is
7 strength in bringing people together, both in terms of
8 learning and developing good practice and policy,
9 challenging when things are not going quite right, so
10 just having, you know, that group of people together.
11 So it is a membership organisation. We've got about
12 450 members at the moment, and that's both statutory
13 partners and non statutory partners. It works in
14 a variety of different ways with that membership and at
15 the heart of everything we do are the voices and views
16 of children and young people as well. So I don't know
17 if you want me to go a bit into the work that we do.
18 Q. I'll ask you about each of those
19 A. Right.
20 Q. and then feel free to expand as you see fit.
21 Now, I understand you work with children and young
22 people aged between zero and 26.
23 A. Yeah.
24 Q. Why that age range?
25 A. So that is a wide age range and you would find in our

1 membership most people have shorter age ranges. Some
2 people only work with early years, some people work with
3 children, some people work with young people, and
4 I think the choice was to try and take an age range that
5 took into account its young people leaving care and
6 still having a certain level of protection, so it was
7 time to cover these transition periods between early
8 years young children, children, young people and then
9 young people who are just becoming independent.
10 So that's why the age range is quite big and I think
11 I said somewhere in my statement that that means that we
12 are sometimes not the experts in each part of that
13 journey, but we are somebody who can bring together
14 organisations who work in each part of that journey.
15 Q. Okay. Thank you. So the protections offered to young
16 people leaving care continue until the age of 26?
17 A. Yeah, yeah, in some ways, in some specific things, yeah,
18 yeah.
19 Q. Thank you.
20 A. But particularly, if you think about a young person
21 leaving care and transitioning into being independent,
22 that's all happening early 20s, and there's some legal
23 protections but there's also some informal need to
24 support that young person as they take those independent
25 steps.

1 Q. Thank you. And you mentioned the importance of
2 children's voices. That's a focus for your charity.
3 Why is that so important and from what age do you try to
4 make sure children are heard?
5 A. Well, we would say it's from any age. You know, if you
6 look at UNCRC and what that actually means,
7 incorporating the rights of the child into Scottish law,
8 it enshrines in that, in those articles, the right to be
9 heard and the right to participate in decisions that
10 impact on you. Therefore it's from any age and, of
11 course, that is much more difficult when you're talking
12 about early years and babies, but there are
13 organisations like Starcatchers, who are a member and
14 who we work quite closely with, that do that work in
15 a beautiful and very creative way.
16 So we would say it's important because, if you don't
17 listen to the people who are going to be impacted by the
18 policies, you might absolutely miss a trick. And it's
19 not that one young person will have all the answers,
20 it's not that two young people will have all the
21 answers, it's not that two children will have all the
22 answers, but what they will do, if you bring them
23 together, is really point out what it is that they need
24 and then you can work with that to find out how you can
25 translate that into policy. And if you don't have that

1 voice in the room, what can t.
2 End to happen we've all seen it in different
3 ways, in different policy environments us
4 very well intentioned adults, thinking that we are still
5 children I still think I'm 27 but unfortunately it's
6 not true we make decisions and we miss something. We
7 miss something important. And because the context in
8 which we live and work is massively changing all the
9 time, it is these children babies, children and young
10 people who can really understand that context and can
11 translate that for you in a real way that means your
12 policy is embedded in that experience and not just sort
13 of made up by people who know lots of good things but
14 maybe don't know but don't know everything.
15 Q. Thank you. Now, I want to look now to the different
16 services and the different areas in which you work,
17 starting off with additional support needs. Could you
18 provide a brief overview of the services that Children
19 in Scotland provides, specifically in respect of
20 additional support for learning?
21 A. Yeah. So we have a number of specific services I'm
22 just going to find the page so I get it all in the right
23 order. So the Enquire service, that's a service that's
24 been running for I think 25 years now and it is
25 a service that is supporting those parents and carers

1 and people supporting children and young people to
2 understand what children and young people's rights are,
3 in terms of additional support for learning, and to
4 support them through that process. And it's very much
5 an information service but it's a supportive information
6 service because you can imagine, if you come into that
7 service, you may be at a stage where you're really
8 finding it difficult to navigate the situation which
9 you're in. You're maybe worried about the provision
10 your child is getting, you're looking for clarity,
11 you're looking for support. So it's a service that
12 offers information and supportive information along
13 those lines.
14 In order to sort of upskill other parts of the
15 sector on that, there's also sort of an outreach element
16 to that service, so it can really work with different
17 partners so that they understand in depth, you know,
18 what the rights are and how they can be realised really.
19 And because this is pitched at parent and carers really,
20 because they're the ones that are generally going
21 through that process, we also realise there's a very big
22 need for children and young people themselves to see
23 themselves in that work. So we have the Reach part of
24 that service, and that is directly for children and
25 young people, and what it does is that just translates

1 into information into you know, as easy to access as
2 possible. It has lots of children and young people's
3 voices in that space and what it does is allow children
4 and young people to see themselves but also to be able
5 to understand and to therefore enter the conversation
6 with their parents, carers, educational provision, in
7 a much more informed way. So that's the Enquire
8 service.
9 Q. Okay, and I think that runs a helpline.
10 A. Yes.
11 Q. During the pandemic, what was the impact on the
12 helpline? Did you see a change in volumes, topics,
13 those contacting you?
14 A. Yeah. No, it became well, first of all, we had
15 suddenly the impact the direct impact as an
16 organisation, which we had to massively pivot how we did
17 that because we were very much office based and had
18 a lovely little helpline place, where people sat, and
19 then we had to kind of, you know, do it from home and we
20 pivoted quite quickly, which was great. I think there
21 was a challenge for the staff there because one of the
22 joys of all being together in a space is giving support
23 because some of these calls can be quite upsetting if
24 somebody is going through an upsetting period in their
25 life, so that support element, we had to work out how to

1 do that.
2 In terms of how the call line was used and it is
3 a call line, but we also respond in written ways, so
4 we'll get emails as well because some people don't like
5 to do it verbally and also because it just gives us
6 better scope. We can't run the helpline every day, we
7 don't have enough staff, so other people can come in and
8 give us their challenge or what they're thinking about
9 or what they want to know about by email what we saw
10 was just, yes, a massive change in topics. So it was
11 right you know, what happened to children and young
12 people, particularly with additional support well, we
13 might talk about that whole intersectionality and how
14 COVID impacted on different children and young people in
15 very different ways.
16 But children and young people with additional
17 support for learning requirements were probably one of
18 the most, you know, significantly hit groups,
19 particularly in the educational environment, and so
20 there was just a lot of calls about, you know, "What are
21 my rights here?", "What can I do?", "I'm really worried
22 about how my child is faring in this world", "I'm not
23 sure ... ". And, you know, this is one side of the
24 story. But a bit of worry about not being heard, not
25 being listened to and of course understanding the great

1 strain that was on the educational profession and the
2 school settings and so on but just a worry there
3 was a lot of worry about, "My child really should be in
4 a hub because I'm not I can't they're not
5 learning, they're not doing anything. I cannot give
6 them the infrastructure they need". You know, some
7 quotations around, "For me, my child ..." you know,
8 this is one example from an autistic child, where it was
9 really a big separation between home and school for
10 some children that's not true. It kind of overlapped
11 a big separation between home and school. Once there
12 was no school, it was just home and there was no way of
13 getting any kind of learning going on, so how was that
14 stimulated?
15 And because it was really difficult for teachers
16 to you know and we can see again some amazing
17 examples of very good practice but a lot of teachers
18 finding it difficult at the start to get to grips with
19 how to engage with children and young people virtually.
20 There wasn't that kind of individualised support that
21 people need, particularly if they have additional
22 support needs. That kind of went by the wayside, and so
23 there was just a lot of calls around that and, "What are
24 my rights and what can I do and who can I talk to?", so
25 there was an upsurge of that.

1 There was and we can get the figures very
2 specifically to you if that's necessary. There's some
3 in my paper, but we have very many more about the
4 numbers and it did go you know, there was times when
5 it peaked, obviously, because of what was going on in
6 the external environment.
7 Q. Thank you. You've mentioned there that I'm aware
8 that you have a number of studies or you have
9 information on various topics. Did you collect that
10 information through analysing helpline numbers or was
11 there some element of anecdotal evidence gathering or
12 did you commission formal research? What mechanisms
13 did you use to gather impacts?
14 A. Yeah. One of the very best ways of gathering
15 information is by just being, you know, systematic in
16 how you record what's going on with the helpline and the
17 emails, and so that is an ongoing thing for us so that
18 we can track, if there's an emerging theme, what can we
19 do because individual cases, that's fine if it's one
20 individual case, you want to deal with that case, but if
21 there's an emerging theme, you want to deal with that
22 theme. So we tried to make sure that what we're doing
23 is capturing that information through the helpline,
24 through the emails that were coming in, and using that
25 to inform anything that we take to the next level and

1 talk about and so on.
2 So that's a big part of what we do and you would see
3 that information in sort of consultation responses that
4 came out after the pandemic from Enquire and from
5 Children in Scotland as a whole. So that is the meat
6 really of the information that we had. But obviously we
7 have other sources of information, some of it being
8 because one of the great ways of adding richness to that
9 information is that kind of more qualitative kind of
10 information that you get and we work and I think
11 again it's in the to a degree it's in the
12 statement we work with we support the
13 Inclusion Ambassadors, and they're a group of young
14 people of secondary school age from different kinds of
15 secondary settings different kinds of settings who
16 have additional support needs, and they worked through
17 the pandemic. We worked with them through that
18 pandemic, so there's a lot of good information coming
19 through that source, so when you have emerging themes,
20 you can then take them to a group, like the
21 Inclusion Ambassadors you can talk to them, you can
22 learn from them and you can build a bit more depth into
23 what we're hearing because sometimes one comment or one
24 you know, isn't enough information, so that kind of
25 information as well.

1 And then, on top of that, there were some specific
2 pieces of work that we either took part in or we led
3 we did work because we co support the CPG on Children
4 and Young People with YouthLink, and they commissioned
5 research. That was from the organisations that, you
6 know, are members of the CPG, so that was quite a wide
7 range not just additional support for learning, but
8 that would have come out there; a piece on participation
9 throughout the pandemic which was really much more
10 focused on what does participation look like during the
11 pandemic and were we listening to children and young
12 people's voices, and that was good. And there was other
13 pieces of work through our participation and engagement
14 work that added richness to what went on, so, yeah.
15 Q. Thank you. I do want to come on to speak about the
16 Inclusion Ambassadors and the CPG, the Cross Party
17 Group, study. Before that, I wonder if you could please
18 tell us about the key impacts experienced by pupils with
19 ASN as a result of the Scottish Government's strategic
20 response to the pandemic.
21 A. Yeah, so I'm just going to get to my page. I think one
22 of the most important things to always reinforce is that
23 for children and young people, like any group across
24 society, the impacts were extremely different depending
25 on where you were sitting and what you were doing.

1 Q. Yes.
2 A. So I've talked about people with additional support for
3 learning, people living in poverty, people from black,
4 ethnic and Asian minority backgrounds, so specific
5 groups where there would have been the likelihood of
6 a bigger impact. So that is very important because it's
7 not I was just reflecting before I came in here and
8 there's some quite nice comments from our Changing our
9 World group and we might come back to them as well
10 during the pandemic, who again reflected on a lot of
11 these different themes, saying that what they felt was
12 that they at the beginning they felt they wouldn't be
13 able to adapt and then they did adapt. They didn't want
14 to have to adapt and they didn't enjoy it but they
15 adapted and they were resilient enough to get through
16 that period. And so there's a lot of children and young
17 people who will have done that and they may need some
18 support with their well being, there may be some, you
19 know, impacts, there may be some educational impacts for
20 some people, but there's a level of resilience, but
21 that's because of their different supports that comes
22 from their different environment. Whether it be family,
23 carers, the wider community, they've got these supports
24 there.
25 For children with additional support needs, again

1 there would be a varied impact depending on where they
2 were sitting and which families they were sitting within
3 because, again, you can have someone with additional
4 support needs who has somebody in the house who is an
5 expert at sort of helping schools do you know? so
6 it's not like it's a blanket everybody impacted, so
7 I just think it's always important to remember that.
8 Q. Sure. I mean, for example, what impact did school
9 closures have on
10 A. Yeah. I think school closures were particularly of
11 a high impact for children and young people with
12 additional support for learning needs, particularly
13 depending on what their needs actually were. But
14 I think for many people you had a de facto closing down
15 of their rights under additional support for learning,
16 so suddenly, if they had a support worker, they wouldn't
17 have one anymore; if they had you know, they didn't
18 have the supports they would normally have in school.
19 There wasn't differentiated learning for them. And
20 I think at the very beginning particularly and
21 I think I touched on this earlier but teachers were
22 finding their feet. Some were brilliant from the start,
23 don't get me wrong, but some were finding their feet in
24 terms of, "How do I actually engage with this
25 community?".

1 We were expecting a whole cohort of teachers to
2 suddenly become experts at virtual learning, and that's
3 a skill in itself. So that was difficult enough with
4 people for whom learning was relatively easy. So
5 a group of learners who need additional support to be
6 able to learn, they were not getting the additional
7 support, they weren't getting that kind of
8 differentiated support, they were feeling often quite
9 a disconnect between themselves and the school
10 setting again, not all of them, but that would have
11 been the case for quite a number of children and young
12 people, and feeling that yeah, sort of disengaging
13 from that learning journey, and I think that
14 particularly happened at the start of the closures. And
15 of course then what happens is it's quite difficult
16 you're always running to catch up then because you've
17 kind of lost a few you would have lost a few children
18 and young people at the very beginning of that quite
19 difficult journey. So, yeah, people would have felt
20 disengaged.
21 I think there was one of the things that people
22 talked quite a lot about was the impacts were higher
23 when people didn't feel they were getting the
24 information they needed. So there's always that thing
25 that sometimes there's something about feeling in

1 control of what's going on, and I think a lot of
2 children and young people across the board felt out of
3 control in terms of what was actually going on for them.
4 And I think particularly children with additional
5 support for learning needs, who would not have who
6 would have had additional support to help them on that
7 journey, they felt even more probably out of control.
8 Again not all of them, but quite a number of them.
9 And then the information coming out, the
10 communication coming out, wasn't always as clear as it
11 might have been and that made that journey more
12 difficult. Of course, as we know and again I always
13 like to say, you know, you could see in different parts
14 and different settings some really good examples of
15 practice but, of course, the general thing was
16 people the school settings were struggling to deal
17 with the children and young people as a whole and
18 therefore children with additional needs, additional
19 support needs, were kind of a little bit left to their
20 own devices and not covered in the way they normally
21 would have been covered by the rights they should have
22 under ASL in this country.
23 So I don't know if that answers your question ...
24 Q. Yes, thank you. It sounds as though perhaps better
25 communication would have alleviated things somewhat even

1 if that communication was to say that, "There is nothing
2 to communicate", perhaps at that point rather than
3 leaving the children wondering. Would you agree?
4 A. I certainly think that -- I mean, it's easy to say,
5 right, because we know how difficult it is sometimes
6 when you're in that kind of -- you're responding to this
7 massive crisis, but there is, I think -- particularly
8 with children and young people and probably particularly
9 with children and young people who are in a particularly
10 vulnerable situation, there's almost no such thing as
11 overcommunication -- do you know what I mean?
12 because, like, you won't always hear it the first time
13 and you won't always absorb it the first time, and we're
14 all like that, even as grown adults, but, you know, so
15 there is that. But also it's the communication and it's
16 the style of communication. So, as you can absolutely
17 imagine, it's quite difficult when you're in that "Let's
18 get the information out there" -- it's not always in
19 a way that children would really understand or engage
20 with, and because I think that participation piece at
21 the beginning wasn't as great -- so if you think about
22 the education, that's probably where we should have
23 prioritised children and young people's engagement.
24 Very difficult to do at the time because people were
25 only just learning how to do virtual engagement. For

1 us, that was a whole learning journey. But how to
2 really engage with children about what they need to
3 hear, how they need to hear it, just getting them to
4 check off certain parts of communication. So that could
5 have been stronger. So, I think, yes -- I'm not saying
6 it would have been easy, but I think the
7 communication -- you know, good communication would have
8 been better and again I think it also didn't just vary.
9 So you've got national communication, but I think
10 even at the level of local authorities and at the level
11 of schools, some schools were much better at it than
12 others, as you would imagine, because they're all
13 different -- you know, in different places with
14 different kinds of school communities. And I think
15 there's some really good examples of where schools
16 really tried to, you know, engage because they're the
17 ones who children and young people are being going to
18 engage with at that level. So -- but, yes, it was
19 a varied practice, but, yes, in general there could have
20 been clearer and better -- more accessible and
21 better pitched communication, I think, throughout that
22 process.
23 Q. Thank you. You mentioned that students didn't have the
24 additional supports that they would have had in the
25 classroom. Were any steps taken -- was anything put in

1 place to try to support them remotely? I can imagine
2 adjusting -- well, as you've said, adjusting to online
3 learning was difficult for everyone -- online
4 communication was difficult for everyone so then online
5 learning for children with additional needs would have
6 been difficult. Was anything put in place to assist
7 that in place of or instead of support workers?
8 A. I think the answer to that is "Not really", and, again,
9 there may be examples, so absolutely happy if somebody
10 comes back and says, "There was a really good example
11 here of where this happened". But in general there was
12 a de facto suspension -- not a legal suspension of
13 those -- of what would have been in place normally for
14 children in that situation. And so, if children were in
15 hubs, they would have -- they wouldn't have maybe got
16 specific support but there would have been
17 a realisation, particularly if they're in a hub in their
18 local school, and the school would have been able to
19 support. But I think what you were seeing was
20 a de facto suspension of that support, yeah.
21 Q. How did teachers deal with that because presumably the
22 support workers would help children stay focused and
23 engaged, to not be distracted, to keep up with lessons,
24 deal with behavioural issues, so, in the absence of
25 that, how did -- I don't know, maybe it's not something

1 you can comment on, but, if you can, how did teachers
2 respond to that and, you know, maintain the focus and
3 concentration themselves?
4 A. Yeah, well, probably I can't give a very nuanced answer
5 to that, but I think what I would say was that I would
6 never underestimate that challenge for teachers. And
7 I think what happened generally was they tried to do
8 a good enough job, you know, and some of them were
9 absolutely sterlingly brilliant and some -- you only
10 have to look at my son's learning to realise that even
11 across the secondary thing, he had teachers who were
12 amazing -- and I will not name any names -- but others
13 who were really struggling to get that piece.
14 So, in that context, what you could see was they
15 would engage with the ones who were engaging and they
16 would try to engage -- you know, they would try to bring
17 people back on, but it was very, very difficult to do
18 remotely because they didn't have the power to talk to
19 the student because, if the student wasn't talking --
20 you know, you don't have -- they're sitting in their
21 homes or wherever they're sitting and they have the
22 choice of engaging and not engaging and there's no --
23 you can't really encourage it in the same way. That
24 virtual space is not going to do it so much and email,
25 whatever, it's very difficult. So I think teachers

1 tried but it wasn't an easy thing to do in that virtual
2 space.
3 I think one of the things is learnings hopefully
4 we will never be in that situation again, but some of
5 the learnings that will be helpful I think going forward
6 is that, you know, the teachers who were better able to
7 deal with, you know, a wide range of learners were those
8 who had those virtual skills and had, you know, bit by
9 bit honed these skills actually through lockdown and
10 beyond. So how do we make sure that that is something
11 that all teachers have because it's not just useful for,
12 you know, a pandemic, it's useful if a child has to go
13 away for a you know, there's other ways that we could
14 use that at other points. There will be other times
15 where it will be a very useful skill, so how do we build
16 on those skills and make sure the teachers have those
17 skills because some of them really do and some of them
18 would not have had these skills. And then we were
19 asking a lot, weren't we, for them to suddenly become
20 experts at virtual learning when all they've done their
21 while life is stood in front of a class and interacted
22 with children.
23 So I think to answer your question at a very high
24 level, what you would see is just a level of
25 disengagement because it was difficult to use the normal

1 mechanisms to try and bring children and young people
2 back in.
3 Q. Thank you. You mentioned hub schools. What were the
4 impacts experienced by pupils with additional support
5 needs in relation to accessing those places in hub
6 schools?
7 A. Again that's a very mixed picture, but through the
8 Enquire line and also through the Inclusion Ambassadors
9 and so on, what you were finding was the definition of
10 "vulnerable child" was sometimes a little bit I think
11 it's difficult to say, but it seemed to vary between
12 different areas and it was hard for you if you hadn't
13 if your child wasn't classed as vulnerable, it was hard
14 to make a case that your child was vulnerable. And
15 actually that's a difficult situation to put you in,
16 "Yes, I've got this really vulnerable child", but
17 actually the vulnerability was in the learning rather
18 than perhaps in the circumstance, but that wasn't
19 necessarily one of the criteria that was taken into
20 account in terms of hub schools. So I think what you
21 found was children who probably could have benefitted
22 from being in that space not being able to because of
23 the definitions, and again a bit of a varied picture
24 across the country, yeah.
25 Q. Thank you. So given that really it seems that it

1 came down to where you were you know, how fortunate
2 you were to be somewhere where your child's
3 circumstances fit the criteria. How do you think in
4 future we could ensure greater uniformity so that it's
5 not essentially a postcode lottery?
6 A. It's a great question. I'm not sure you can ever avoid
7 it completely because, however good your criteria are,
8 the interpretation of that criteria will probably vary
9 from place to place. But, again and again this is
10 easy in hindsight but perhaps a little bit more
11 thinking through particularly that ASL bit at the start,
12 in terms of how do you you know, what are these
13 criteria and sort of allowing because it might depend
14 on which area you're working in. You might have
15 slightly different circumstances, you might want to
16 widen that criteria, and that might be okay, but there's
17 particular groups of people that you know are going to
18 be impacted by something like that, so additional
19 support for learning so a bit more thinking through
20 that at the start.
21 And a bit more input again that participation and
22 engagement piece of how this could work well. But it's
23 absolutely true that you could give everybody in this
24 room a criteria and they might interpret it in
25 a slightly different way and all you can do to try and

1 keep people on track is then to inspect that. You don't
2 want to go down that line because you're going to end up
3 having too many resources spent on something that's
4 useful. But you have to have clear criteria, you have
5 to have time and that's very difficult during
6 a pandemic, to have the time to develop the criteria.
7 But also perhaps the revisiting of that, and I would
8 have to say I would have to reflect on that with
9 colleagues, how much that happened, but you can imagine
10 there probably was a space to have a review of that, you
11 know, like at some point to see, "Are we getting this
12 right? Are there people who are feeling excluded from
13 this? Should we be having conversations with them?".
14 And even in that world, if you get all that right, it
15 might still be that somebody falls outwith that
16 criteria. So then the question becomes more, "You've
17 got a hub school. What do we do with these children who
18 are not included there but still have some support
19 needs? How can we use that virtual environment
20 differently to include them in their learning?".
21 Q. Do you think that local authority resources, in terms of
22 finances and space, impacted how some local authorities
23 interpreted the criteria, so, you know, if funds were
24 very limited, they maybe prioritised children who had
25 difficult living situations over those with better

1 living situations who were just cognitively or
2 emotionally affected by not being there? And if that's
3 the case, do you think more funding could be part of the
4 solution, if more funding was available?
5 A. If more funding was available! I'm always wary about
6 saying, "Yes, give more money", because I sort of
7 realise that there's not always not more money to give,
8 but generally I think the space is less of an issue when
9 you've got I suppose depending where you are, but
10 mostly you would have the places that you could use
11 because you would not be using the schools for other
12 things.
13 There's a bit of a question about the costs around
14 some of that, but, you know, that's fine. But there's
15 obviously a case that, if you had more resources, you
16 could staff that hub in a different way, you could
17 support teachers in a different way to sort of turn
18 over because it was quite difficult, I think, for
19 schools to manage that as well. So I think, yes,
20 resourcing could be part of it. But sometimes we go to
21 the resources when actually what we need to do is just
22 to go back and say, "How would this have ..." you
23 know, because if we had magnificent resource, we
24 probably could have had a very different model of how we
25 did this.

1 So it's not that I'm saying just throw money at it;
2 I'm saying, yeah, a bit of extra resource would have
3 been good, but the extra resource that would probably
4 have been really good as well is that time to reflect
5 and whatever, which is something that really goes in
6 a time of crisis often because you're just running to
7 keep up. So how do we reserve that thinking and
8 reflecting time so that you first of all, you get
9 your criteria, you work out what's but then you have
10 the time to go and refine it as you go and not be stuck
11 because this was said at the beginning, which is what
12 will tend to happen because you don't have the time to
13 do the appropriate reflection and so on.
14 Q. Could engaging more and earlier with third sector
15 organisations help there with the consideration,
16 planning and review of the needs?
17 A. I think it has to be a partnership, absolutely, and if
18 you look at each local authority area will have some
19 really and they'll have strong partnerships already
20 through planning partnerships and so on where the third
21 sector are very involved. And there was a degree of
22 co operation, but, absolutely, I think there is
23 something to be said for that collaboration piece,
24 putting that front and centre. And of course what we
25 know about that collaboration piece, it sometimes means

1 at the start it takes slightly longer to get off the
2 ground because people often talk about collaboration
3 like it's easy, but, you know, we could sit in a room
4 and we fundamentally agree, but actually it takes three
5 days to come to the, "But what does this look like?".
6 So actually collaboration does take a little bit of
7 time, but actually investment in that in the start
8 probably gives you additional resource because the one
9 thing that did happen one of the good things that
10 happened during the pandemic was a bit more of that
11 agility around funding models and so on, so it allowed
12 organisations to do it differently.
13 So if you have that collaboration piece very much
14 front and centre at the beginning, then what you can
15 probably do is you can leverage different kinds of
16 resources in different ways to play different roles and
17 it has to be a partnership. When it's a pandemic, it
18 has to be a massive partnership to try and get this to
19 work.
20 Q. Thank you. What impact did the Government's strategic
21 response have on transition planning for pupils with
22 additional support needs?
23 A. Particularly older ones, you mean, sort of moving into
24 housing?
25 Q. Yes, so from maybe primary school into secondary school

1 and then from secondary school onwards to and then
2 out of education.
3 A. Yeah. I think, when you look at the journey of a child,
4 a young person, particularly a child and young person
5 with additional support needs, transitions are real key
6 moments that are often extremely difficult. It depends
7 on the child and it depends on what particular
8 challenges they are facing, but that moving from one
9 place where perhaps a lot of work has been done to make
10 them feel safe, included, on a good learning journey,
11 when everything goes well to move from that to
12 something else, that's scary. I think we all remember
13 moving from primary to secondary and being well,
14 maybe not in this room, but I was absolutely terrified
15 and I was a very academic child and quite delighted with
16 school. So that transition is a very anxiety making
17 time for children and young people. And similarly, for
18 those moving out of whichever secondary setting they're
19 in into whatever comes next, that can be a very big,
20 scary place for people to be.
21 And these so these I think were groups of people
22 who when we talk about the different impacts on
23 population, the impacts would have been even sharper for
24 those children making those transitions, and it will be
25 interesting in a couple of years to sort of trace that

1 disengagement perhaps from secondary school to children
2 who have moved at that time because I think it was very
3 difficult for children to get a foothold into their
4 secondary experience. And, again, as I've said,
5 sometimes when you it's not that it's not
6 unsurmountable, you can do something about it
7 afterwards, but if you've lost "lost" but if
8 a child has become disconnected at that early stage,
9 it's actually sometimes quite difficult to bring them
10 back.
11 So I think that transition phase is really
12 difficult, and it was very difficult to do something
13 about it in lockdown because there wasn't much option to
14 bring children out of their space, their comfortable
15 space well, hopefully comfortable space, not
16 always at home or in their home setting and show them
17 what they were coming into and building relationships.
18 We all know in that new experience, when you are
19 facing a new world, one of the things that really helps
20 you is those links that you build with your teachers,
21 with if you have a support worker, with your support
22 worker, with your peers, and none of that could really
23 happen. And that's very you can make it happen
24 virtually but it is much more difficult. It takes a lot
25 of time to build those trusting relationships. So that

1 was one area that I think was highly impacted. And I'm
2 not sure there's an easy solution to that, but I think,
3 when planning for something like this in the future, in
4 particular what do we do about these transitions, what
5 do we do about supporting children and young people
6 through these transitions because fundamentally they
7 are you know, it's a very, very it's a very
8 vulnerable time for any child or young person and
9 particularly for somebody with additional support needs.
10 Q. Thank you. Can you tell us about the impact of the
11 pandemic and the response to the pandemic on attendance
12 and attainment for pupils with ASN, with exams taking
13 place remotely? You know, it was difficult for all
14 children. What were the particular challenges and do
15 you have an idea of attainment results for children with
16 ASN?
17 A. Again, I think this will be more of an anecdotal answer,
18 but we can go back and get more specific figures for
19 you.
20 Q. Thank you.
21 A. But I think the evidence suggests that a level, with
22 a level of disengagement not with all children and
23 young people, but a level of disengagement for young
24 people kind of hitting that and particularly hitting
25 exam times, I think you found quite a lot of children

1 withdrawing or withdrawing to the extent that not really
2 flourishing in that space, and I think that would be
3 true at that exam level but very much true at all levels
4 in terms of their ability to really fulfil their
5 potential.
6 And what you saw on going back, you know, moving
7 back into school, was that the gap between children with
8 additional support needs and children who didn't have
9 the same challenges was that the gap was widening. And
10 it's sort of not a surprising result, but it's
11 a saddening result because, obviously, again, how to
12 invest in those children and young people and bring them
13 back up to where they would have been is quite
14 a challenging thing to do. So, yes, I think it had an
15 impact on once you're disconnected from your learning
16 journey, it's quite difficult then to really fulfil your
17 potential, whether it be through some kind of
18 examination.
19 One of the things that was interesting, though, and
20 on the flip side of that was one of the learnings and
21 I know it's been taken into account as we go forward,
22 thinking about education and education reform for
23 some children who are not, you know, big into exams, you
24 know, the changing of the way some of that was done was
25 quite interesting.

1 Q. Okay.
2 A. So even for children who didn't have additional support
3 needs, that thing is like the exam and the way that
4 that happens and the anxiety that that produces, you
5 know, the change to a different kind of approach was
6 quite interesting for some people and they found that
7 quite a positive way of having themselves judged
8 academically by their teachers, who knew them well and
9 so on. So there's a flip side to that and some learning
10 of what the best mix of all that is as you go forward.
11 Q. Thank you. In relation to that, you touched there on
12 the ongoing impacts that the differences in
13 attainment and attendance and engagement can still be
14 seen. I think you mention in your statement there are
15 more part time timetables now and a continued lowering
16 of support. What levels are you seeing that continue at
17 and are there any proposals for addressing that? Are
18 there any strategies that have been created to try to
19 address that, to increase this?
20 A. Yeah, so particularly around the gap and
21 Q. Yes, and part time timetables. Lower support levels.
22 A. Yeah no, it is very interesting because you are
23 seeing an ongoing disengagement. You're seeing ongoing
24 disengagement where it's not just part time, where
25 people have disengaged completely from school. In terms

1 of numbers, I'm not going to give you numbers because
2 I'll give you the wrong numbers, but it's a significant
3 shift at the moment towards that. Clearly, of course,
4 for some children that might work quite well,
5 a part time timetable. Maybe for some children we need
6 to think of that as a way forward. But for many
7 children what they're missing out on is a fulsome
8 education, a fulsome learning journey.
9 I think the problem is particularly around
10 additional support for learning, one of the challenges
11 is, if you look at the action plan that goes alongside
12 additional support for learning, it's quite a good
13 action plan, it's really it's great, you know. It's
14 founded in good thinking and this is where I will
15 come to resources because I think there is a challenge
16 around resourcing that. We can't just expect teachers
17 to, you know, be able to do all of that without the
18 sufficient resource to be able to do that.
19 Now, again, I know we're in an era where we have to
20 think about how we're going to get that resource and how
21 we're going to prioritise that resource, so I'm not
22 being glib about this, but there is something very
23 important about going you know, we've really moved
24 back on support levels from quite a number of years ago,
25 we're not even back at the levels we had then, so we

1 really need to invest in that area of work because
2 that's where you can actually support children on their
3 journey to not only be learning but to be probably
4 enjoying their learning or at least some of it, you
5 know, and to be more enthusiastic about that, to want to
6 come into school and to do their you know, to do what
7 they can in order to take the next steps in their
8 journey.
9 So without that investment and that investment,
10 you know, it was pre pandemic that the levels had gone
11 down in terms of the investment in that support piece
12 and without that investment, it's very difficult to see
13 that changing any time soon because we know the stress
14 on the teaching you know, the overall teaching
15 complement and support workers that are in school at the
16 moment.
17 So how do we and some of it is about
18 prioritisation. I say it's never too late to look at
19 the thing as a whole, but some of this is actually about
20 that resourcing of that piece of the puzzle because,
21 without that, it's the sort of it's the thing that
22 oils the system, that makes it possible for our children
23 and young people with additional support needs to really
24 be supported through their learning journey.
25 Q. Thank you. I want to ask you about the physical and

1 behavioural aspects of schools re opening, things like
2 mask wearing, physical distancing, ventilation, bubbles
3 and testing. What impacts did children with additional
4 support needs feel in respect of those things?
5 A. Yeah. I think that they were particularly
6 that's a group that were particularly impacted by that
7 stuff. You know, some people were kind of like, "It's
8 all a big ..." not a joke, but, you know, just get
9 on with it and it's fine. For many people that's quite
10 anxiety provoking, the anxiety around particularly if
11 you had an ill relative or a vulnerable relative at home
12 or if you had a granny or a grandad, all these things
13 that were quite anxiety provoking. There would be an
14 over representation of people that would be highly
15 anxious about that kind of stuff amongst that cohort and
16 so it meant that that step was really difficult. So
17 that's why you found some children or young people who
18 maybe weren't disengaged, finding it difficult to go
19 back and go back to school and to be in that environment
20 that felt quite risky and, yeah, kind of just being
21 quite worried about what that meant for them but also
22 what that might mean for their loved ones at home and so
23 on.
24 So I think it was a group that was particularly
25 impacted by that. Now, again, how do you balance all

1 that because clearly, for many children, getting back to
2 school was absolutely the very best thing ever, you
3 know, but the fact that the people who were children
4 and young people with additional support needs who were
5 less likely to go back to school because of a lot of
6 these measures, so that meant again that the gap you
7 know, that kind of allowed that gap to slightly develop
8 in terms of just, you know, their learning journey and
9 what they were able to do after that because then it was
10 quite difficult for teachers to manage children back at
11 school. And then children who weren't attending
12 school because that, again, is a sort of double
13 you know, how do you engage with those children. So,
14 yeah, I think that did have a significant impact on
15 a particular cohort within children and young people
16 with additional support needs.
17 Q. Thank you. I want to now move on to the
18 Inclusion Ambassadors group. You touched on it briefly
19 but could you give us an overview of their role and who
20 forms the group?
21 A. Yeah. So they were formed I'm just going to get the
22 date 2016. Education Scotland wanted to engage
23 with because one of the great things you can do with
24 participation engagement is engage over the longer term,
25 not just have a short term bit of participation here,

1 you know engage over the long term so you can learn
2 together about things. So they wanted to form a group
3 of children and young people secondary school pupils
4 and from other settings actually, who had additional
5 support needs, so that they could learn together and
6 that could influence what they did and how they did it.
7 So they formed that and we supported the work from
8 the beginning, as Children in Scotland, but there came
9 a point when Education Scotland said, "Hmm, I think this
10 probably sits better with Children in Scotland than with
11 Education Scotland", so we took over so they now
12 we facilitate the work so we support the group.
13 They, as I say, come from a variety of settings.
14 Some come from specialist settings, some come from
15 traditional secondary schools, and they all have
16 additional support needs and really work together with
17 us. We support that learning, to kind of look at
18 different you know, different areas that's
19 challenging for them, but also trying to not just look
20 at the bad stuff because it's very easy always to look
21 at the bad stuff, but also to try and look at what best
22 practice might look like in those settings in terms of
23 additional support needs.
24 Q. Thank you. How was the group funded? Is it funded
25 through the Government

1 A. Yeah.
2 Q. or do you have to do fundraising?
3 A. No, we don't, not for that. No, that's fully funded,
4 which is lovely because, as you can imagine, funding at
5 the moment is [sighs]. So, yeah, that's fully funded
6 because it's something that's an ongoing piece of work.
7 I don't know how long that will last for. But because
8 good participation and engagement work and again all
9 these things cost money it does cost a chunk of money
10 because you want to do it well, you want to properly
11 support your young people, you want to make sure that
12 they feel supported, you have enough staff to support
13 them, you do it in a safe way, in a safe environment, so
14 all that is quite you know, it does take a bit of
15 funding. So, yes, it's fully funded.
16 Q. How many children and young people are involved with the
17 group?
18 A. It does vary from time to time. I think we had some
19 numbers in here. There's sort of about 20 members at
20 any given time. A lot of them, they stay often when
21 somebody comes on to the group, they do stay for quite
22 a long time during their journey. Obviously, once
23 they've moved on, they go through it, but then other
24 people will go off for other reasons and they're no
25 longer so it does get regenerated, but it's around

1 20 people at a time, yeah.
2 Q. And what are the membership requirements?
3 A. They have to be enthusiastic, they have to want you
4 know, this is not for everybody. You're sort of sitting
5 around talking about, you know, what it is that you want
6 and need and whatever, so they have to have additional
7 support needs because it is that specifically what the
8 group's about, so and they have to really be want
9 to because in a way they're you can never get
10 somebody to represent their whole community, but they
11 have to be able to then go back to they have to want
12 to go back to their schools or their setting and talk
13 about what's going on and try to learn from that. So
14 it's quite an easy criteria to meet, but, you know, not
15 everybody comes forward, as you can imagine, for that
16 kind of role, so, yeah.
17 Q. And are they all secondary school pupils?
18 A. Yeah, it's a secondary school programme. It would work
19 well for primary school as well but at the moment we're
20 not resourced to do that so and we don't have extra
21 money so because it would be a lovely thing to see it
22 through the whole journey really, yeah.
23 Q. Thank you. Do you know how frequently the group met
24 between January 2020 and December 2022?
25 A. I think the figures we have, between March 2020

1 and December 2022, 20 times. Actually it says "over
2 20 times", so quite a lot, but that would have been
3 all pretty much all virtual. A lot of it would be
4 virtual. So we spent a bit of time at the beginning of
5 the pandemic, both with the Inclusion Ambassadors and
6 Changing our World, which is our advisory group, really
7 working out how to do participation engagement work
8 online because we'd always done it face to face. That
9 was just what we did. I think we did the odd thing
10 online so how to do it well online, and it took us,
11 you know, a few weeks to kind of work that out, and once
12 we had worked that out, pretty much everyone was online.
13 And even now what we do is two out of every three would
14 be online, but we do get together because if you
15 getting together gets the richness. So, yeah, 20 times
16 over that period, yeah.
17 Q. How does that compare to pre pandemic figures? Was it
18 broadly the same?
19 A. I think it was slightly higher slightly higher, yes,
20 but I can check that for you. I think it's slightly
21 higher because that's quite a lot really, that's almost
22 once a month no, it's not. My maths has just failed
23 me. (overspeaking inaudible) Yeah, I'll check that
24 because, you know, it's good to have continuity but
25 you're also aware that you're taking children and young

1 people out of their day to day, so I will check that.
2 I think it's slightly higher.
3 Q. Thank you. I want to move on now to the
4 Resolve service. Can you tell us a bit about that,
5 please?
6 A. Yeah, so Resolve is a mediation service and so but
7 again around additional support needs, so it supports
8 when there's a bit of a dispute between a family,
9 a parent, a carer and the education establishment, the
10 local authority. They are a mediation service that
11 supports both parties to try and come to a conclusion.
12 Now, obviously, if both parties have to want to come
13 to a conclusion have to want to come to a mediation
14 so it has to be something that people are willing to do
15 and not everybody is, but if they're willing to come to
16 that, then Resolve will take that on and hopefully come
17 to a stage where they can come to an agreement about
18 what is going to happen for the child, you know, where
19 their school provision is going to be, and hopefully
20 they can move that forward. Now, in every case, as you
21 can imagine, that doesn't happen, but that is the
22 intention of the service and it does have good results,
23 so, yeah.
24 Q. Thank you. And what were the challenges of that being
25 delivered online in terms of safety, confidentiality,

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1 reading emotions, managing emotions, that in person
2 would be much simpler? How did you deal with those
3 online?
4 A. I will channel my inner [redacted], who runs the
5 service.
6 Q. Sorry, apologies.
7 A. Oh, sorry.
8 MS BAHRAMI: My Lord, I wonder if we might have a comfort
9 break at this point.
10 THE CHAIR: By all means.
11 MS BAHRAMI: Sorry apologies, my Lord, I misunderstood.
12 There's been a breach of the restriction order.
13 THE CHAIR: Oh, has there? I think I heard a name mentioned
14 but it was only a first name, to be perfectly candid.
15 A. Oh, I didn't know. Sorry, it's just
16 MS BAHRAMI: May we have a brief adjournment so that we can
17 check the position?
18 THE CHAIR: Yes, by all means. By all means check it out.
19 Sorry about that, Ms Turbyne.
20 (10.43 am)
21 (A short break)
22 (10.46 am)
23 THE CHAIR: Right. Ms Bahrami, I understand the problem has
24 been sorted.
25 MS BAHRAMI: Yes.

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1 THE CHAIR: Don't worry about this at all, Ms Turbyne. It
2 wasn't your fault. No harm done.
3 When you're ready, Ms Bahrami.
4 MS BAHRAMI: Thank you, my Lord. Ms Turbyne, would you like
5 to continue there? So we were speaking about the impact
6 on mediation services and the challenges of delivering
7 that online.
8 A. Yeah. There were some particular challenges around that
9 because, as you can imagine, people, when they've
10 reached that stage, are often quite emotional about what
11 is going on, and one of the strengths one of the
12 things that helps a mediation often is to take people
13 out of their normal day to day into a space that feels
14 a bit safer perhaps or just at least a bit different
15 from their day to day lives, and that was impossible
16 because, you know, you just had to do it online in the
17 home. Also there's a real thing about confidentiality
18 in that space because you might not know who's listening
19 to that. And so all you could do was mitigate that to
20 the best of your ability and try to make sure that you
21 were being, you know, as safe as you possibly could be.
22 So there were some real challenges to that. You had
23 to take a bit of an approach that this case you know,
24 very urgent, "You really need to deal with this. The
25 family is ready. The local authority is ready. We'll

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1 go ahead with this and try to put the mitigations in
2 place", and really learn how to work with that emotion
3 on an online space, which again was a bit of a learning
4 for people because it isn't you know, it isn't the
5 same. It's quite difficult sometimes to read the body
6 language. If somebody is getting if somebody is
7 escalating, it's quite difficult sometimes to bring it
8 down. It's easier or it can be easier face to face.
9 Sometimes, you know, I think people feel a little
10 bit more liberated to be to say things in certain
11 ways when they're online because, you know, they're not
12 face to face with somebody and there's something quite
13 powerful about seeing us all as humans in a room trying
14 to mediate a situation and not as little boxes on
15 a screen and to being a bit of distant to that. So,
16 yeah, some real challenges there.
17 As I say, it was a bit of a learning curve for the
18 service and for people who worked in that service. The
19 evidence is that it worked well. What we did learn from
20 it was that one of the things that it's very
21 time consuming for families who are sometimes in
22 difficult situations to always come you know, it
23 depends where you're doing the mediation to always
24 come and move from the home. So some of the prep we
25 still can do online now, so that helps with that. That

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1 kind of frees up the airtime and makes it a wee bit
2 easier. But of course we would have gone back to
3 in person around the nitty gritty of the mediation
4 because that's easier. So there were some positive
5 learnings from it, but it was challenging, and I think
6 you can never say that you'd mitigated all of the
7 difficulties that might have occurred, but, on the
8 whole, the service was very happy with the result. But
9 it was a bit of a learning curve for us, yeah.
10 Q. Thank you.
11 THE CHAIR: Ms Bahrami, you have about ten minutes left.
12 MS BAHRAMI: Thank you, my Lord.
13 With an eye on time, I'd like to move on to the
14 mental health impact. Could you tell us a bit about the
15 mental health impacts on children and why the impacts on
16 children were different to adults? Were there different
17 presentations of the impacts?
18 A. Yeah. I think, you know and this is something that
19 you could talk about for a good few hours on its own.
20 I'm assuming you'll be coming back to this with a number
21 of people. There are real moments in children's and
22 young people's lives where sort of isolation, lack of
23 peer support, an inability, perhaps you know,
24 particularly if you're living in difficult family
25 circumstances and perhaps your safety net was elsewhere,

1 where you suddenly can become much more particularly
2 if you're prone to that again, as I say, this will
3 not be true for everybody. There might even be children
4 and young people who had positive impacts from, you
5 know, not engaging in, you know, in certainly but
6 mostly, for many children and young people, particularly
7 for people who perhaps had social anxiety in the first
8 place, sort of removing themselves again from that space
9 or being removed from that space they didn't remove
10 themselves being removed from that space, not making
11 these peer relationships can lead to that social
12 isolation.
13 Then there is that whole journey that a young person
14 can go on, particularly if they're developing
15 emotionally, hormonally, all the different things, where
16 things become quite internalised and that can become
17 quite a very difficult thing for a child and a young
18 person to deal with. And at the same time there's less
19 support out there, you're actually having to deal with
20 that more and more. Again, there will be children and
21 young people who will have had support in different
22 ways, either in the home or outwith the home, but there
23 will be many children who will have been left with this
24 quite difficult social anxiety.
25 Now, it doesn't mean that everybody is going to have

1 serious mental health problems going forward, but
2 I think what it means is that there is for some
3 children and young people, there are going to be impacts
4 that we won't even necessarily see the impacts of that
5 for a number of years. You know, I think for some young
6 people it's going to take a while for them to really
7 work through what's going on with them. For some
8 children we've talked about children who didn't like
9 it and had a tough time, but, you know, will be okay and
10 will come out the other side and will have different
11 experiences on that, and then you will have the people
12 who have had serious impacts, where they've been
13 perhaps become socially isolated, their anxiety has
14 become grooved into something deeper, something more
15 difficult. And then, of course, what you're finding now
16 is that it's difficult for those children and young
17 people to get their impacts [sic].
18 Now, I will say there's lots of adults also who will
19 have suffered similarly because there will be adults who
20 are walking that fine line to keep themselves mentally
21 healthy and isolation will have really not helped with
22 that at all. But for children and young people, because
23 they're on that very fast journey we know what it's
24 like for a child, a year is a very long length of time
25 for them and they have missed those connections that

1 they would normally make, and that would have helped
2 them in their emotional journey and will have helped
3 them in building their resilience as a child, as a young
4 person and as a young adult.
5 And, again, I think, when you look at children and
6 young people, it's in certain moments as well that it's
7 more difficult. And again, some of this I would love
8 to go back and do another PhD and look at some of these
9 elements because I think for some children there will
10 be who are going through that transition phase,
11 a different element, are going you know, going
12 through puberty different impacts because of both the
13 physical and mental changes that they're going through.
14 And that normally would be a bit messy, let's face it,
15 but they would have other supports out there that would
16 be helping them, you know, behave do indulge in
17 the behaviours that would help them get through, some of
18 them good, some of them bad, but that would help them
19 learn how to deal with those different emotions, so,
20 yeah.
21 Q. In terms of perhaps in future trying to identify those
22 children that should be prioritised in terms of getting
23 help, do you think that in terms of the ongoing
24 impact, the ability to recover do you think things
25 like geography, family finances, family education

1 levels are these predictors of the ability to bounce
2 back essentially or can it not be divided or recognised
3 in that way?
4 A. I think that's a great question because, of course,
5 there's always the there are outliers in all of this,
6 so there's going to be children and young people who
7 have got all the supports and all the you know, and
8 all you would say the predictors would say,
9 "You'll be fine", and they won't be fine, so there will
10 be outliers to that. But I think if you wanted to find
11 where the largest number of children and young people
12 who are who might be impacted on this, I think you do
13 go back to that intersectional approach; you know, who
14 were those who were living in poverty and didn't get out
15 the house at all and didn't have anywhere to go, who
16 were the children with additional support needs, who
17 were the children who were living who already were
18 showing signs of mental vulnerability, let's say, who
19 weren't you know, their well being wasn't great.
20 There are indicators that would allow you to
21 identify children, but that doesn't mean you shouldn't
22 be alive to the possibility that there's other children
23 out there that will be similarly impacted and they're
24 just unlucky because the combination of genes and
25 environment and everything else will have a serious

1 impact on them. But I think, yes, looking at that
2 intersectionality of people who are most vulnerable,
3 that's where you get your best indicators of who is
4 going to be most impacted.
5 Q. Thank you. Briefly looking at impact to community
6 services, you state that one of the main challenges for
7 children was the lack of structure and socialisation.
8 Why is structure and socialisation so important for
9 children generally and then, more specifically, for
10 children with additional support needs and perhaps those
11 that are disadvantaged in other ways, socio economic
12 background, care experience, live with disabilities?
13 Could you tell us a bit about the impact on them
14 specifically and the consequences the long term
15 consequences of not having access to those opportunities
16 and services?
17 A. Yeah. I think there's a real there was a real
18 challenge to children and young people from having
19 school was taken away but everything else was taken away
20 as well, and we know that part of making a child
21 resilient or helping a child be resilient you're
22 never going to make them but supporting that journey
23 towards resilience is having different ways of
24 expressing themselves, exploring the world you know,
25 all these different things which are so important. And

1 very often school will be a small part of that for some
2 children and it will be the external activities that are
3 a massive part of that.
4 And I think what you find what you find is if,
5 like, children have no access and there's lots of
6 children who don't have access, we know that, but
7 there's lots of great examples of children who perhaps
8 are not engaging even in the school environment but who,
9 maybe through the youth environment and the sort of more
10 informal youth sector, where there's lots going on and
11 it's maybe a bit more their bag that that allows them
12 to go on a healthier journey towards resilience and so
13 on.
14 And it's about I think people finding out their own
15 self worth, it's about people having what their value
16 is in the world, and children and young people find that
17 in loads of different ways. For some children, school
18 is a massive part of that. For other children, it's
19 their hobbies and activities. For other children, it's
20 being the best gamer in the world. Whatever it is,
21 there's something that helps them, and you find children
22 who tend to be more resilient and healthy if they have
23 some way of being able to engage in those kind of
24 activities. And when through the pandemic, what you
25 found was you had the school, the school shutting down

1 and the informal activities shutting down, but the
2 schools opened but the informal activities didn't till
3 much later, you know, so there was a bit of a lag with
4 that as well. And perhaps we could have been better and
5 quicker about thinking about how to open these spaces,
6 and some of it was about opening, you know, church halls
7 and scout halls and, you know, whatever like just the
8 facilities and then getting the safety around that
9 for the people who were doing the thing.
10 So and I've just mentioned two of the most
11 traditional ones, but there's loads of other different
12 kinds of settings, the dance dance halls, where
13 people go and learn their dancing, or music you know
14 all sorts of places where that came on much later. And
15 actually that might be a good learning for the future
16 because I think, for even children that perhaps were
17 disengaging from school, another route back into
18 engaging in school might have been through these more
19 informal ways because they would have been engaging with
20 their peer group in another way and that might have
21 brought them back in.
22 So I think it's that child development is
23 a fascinating subject, but there does have to be some
24 way of children exploring who they are in the world and
25 what their value is to that world and what makes them

1 such a valuable human being.
2 Q. Thank you.
3 THE CHAIR: You've run out of time, Ms Bahrami, I'm afraid.
4 MS BAHRAMI: I'm sorry, my Lord, I didn't hear.
5 THE CHAIR: You've run out of time.
6 MS BAHRAMI: Thank you. I was just finishing. I just
7 wanted to ask Ms Turbyne if there's anything that we
8 haven't covered that you would like to highlight.
9 A. No, I think that's been great. There's probably lots of
10 other things I could say. I just think, you know, the
11 best thing that we can do from having such an experience
12 that we've shared all together is to really have that
13 constructive learning piece, and that's certainly what
14 we'd want to contribute to as Children in Scotland, so,
15 yeah.
16 MS BAHRAMI: Thank you very much.
17 A. Thank you.
18 THE CHAIR: Thank you very much indeed, Ms Turbyne.
19 A. Thank you.
20 THE CHAIR: Very good. 11.15 then.
21 MS BAHRAMI: Thank you, my Lord.
22 (11.00 am)
23 (A short break)
24 (11.17 am)
25 THE CHAIR: Good morning, Mr Caskie.

1 MR CASKIE: Good morning, my Lord.
2 THE CHAIR: Your voice was a little bit broken up there.
3 I don't know
4 MR CASKIE: I think it might be my voice rather than the
5 recording.
6 THE CHAIR: Right. Now, we have Mr Purdie this morning
7 MR CASKIE: That's correct, my Lord, yes.
8 MR ALLISTER PURDIE (called)
9 THE CHAIR: Good morning, Mr Purdie.
10 A. Good morning, my Lord.
11 THE CHAIR: When you're ready, Mr Caskie.
12 MR CASKIE: Thank you, my Lord.
13 Questions by MR CASKIE
14 MR CASKIE: Would you tell the Inquiry your name please?
15 A. My name is Allister Purdie.
16 Q. And you're here in your capacity as ...?
17 A. I'm the director of operations for the Scottish Prison
18 Service.
19 Q. You provide details you've provided us with a witness
20 statement which for the purposes of the Inquiry is under
21 reference SCI WT0454 000001.
22 A. Yeah.
23 Q. In your witness statement, at paragraph 3, you provide
24 details of your extensive experience in the
25 Prison Service. I understand that you started as

1 a prison officer in November 1998.
2 A. That's right, Mr Caskie, yeah.
3 Q. You were then in a series of promoted posts until your
4 current appointment. When did that happen?
5 A. That was in March 2020, Mr Caskie.
6 Q. Just at the point at which the pandemic struck?
7 A. Just right at the start.
8 Q. Right at the start. Well, I'll ask you a little bit
9 about that. Latterly, you ended up as a governor in
10 a number of prisons sequentially?
11 A. Yes, before I took up this role, I was a governor at HMP
12 and YOI Cornton Vale, the governor of Grampian Prison
13 and the governor of HMP Shotts.
14 Q. So you have extensive experience in the Prison Service?
15 A. Yes.
16 Q. And you're now essentially involved at a strategic
17 level, as I understand it; is that correct?
18 A. Yeah, I'm responsible to the chief executive of the
19 Scottish Prison Service for the safe delivery of custody
20 and care for individuals across the Scottish
21 Prison Service and the oversight of private contracts
22 that support the delivery of service to the Scottish
23 Prison Service. That's the escort service and one of
24 our private prisons.
25 Q. Which one?

1 A. That's HMP Addiewell.
2 Q. Okay. Are you involved again at a strategic level in
3 the management of Addiewell or are you involved in the
4 day to day running of Addiewell?
5 A. At a strategic level, Mr Caskie.
6 Q. Okay. Again, in the witness statement at paragraphs 6
7 and 7, you provide general information about the
8 Scottish Prison Service, about it being an executive
9 agency and so on.
10 A. Yes.
11 Q. I don't think it's necessary to go through that.
12 I should say to you today you're going to be asked
13 questions about impacts from COVID rather than
14 implementation or decision making, although
15 a significant part of your witness statement deals with
16 those latter matters. You'll be asked back to discuss
17 those on a different occasion.
18 A. Okay.
19 Q. At paragraph 9 you say that there are 13 publicly
20 managed prisons and two custody care units and two
21 privately managed prisons. Then you provide useful
22 information about the scale of the operation. You say
23 there are 7,900 individuals, roughly, in custody
24 A. Correct.
25 Q. and you have a staff complement of about 4,500.

1 A. That's correct, yeah.
2 Q. So it's roughly half a staff member is to each prisoner?
3 A. Yeah, that's correct. There's only one change to my
4 statement, Mr Caskie. HMP Kilmarnock came back into the
5 public sector at the weekend so we only have one private
6 prison now in Scotland.
7 Q. Which is Addiewell?
8 A. HMP Addiewell.
9 Q. At paragraph 11 you talk about the vision and mission,
10 which is to develop a person centred asset based
11 approach; yes?
12 A. Yes, that's correct.
13 Q. Okay. At paragraphs 10 and 11 together, you say that
14 the main function, apart presumably from keeping people
15 in custody, is rehabilitation and integration of the
16 population?
17 A. Yes, that's correct.
18 Q. You then, at paragraphs 12 through to 20, provide
19 information really about the Government during the
20 pandemic. You talk about clinical advisory groups and
21 the Strategic Oversight Group and so on. They're not to
22 do with impact so I'm not going to ask you about those
23 today.
24 A. Okay.
25 Q. I do want to ask you something which crosses the line

1 from impact into well, crosses the line at
2 paragraph 19, when you talk about the COVID 19 hub.
3 A. Yeah, it was
4 Q. Can you just tell us in general terms what that was?
5 A. Yeah, it was the initial hub that was set up to try and
6 control the flow of information and guidance that was
7 coming in at the time from Public Health Scotland, from
8 Scottish Government and from across our healthcare
9 providers, so that we could make some sense of what was
10 happening, take that advice, create it into operational
11 guidance, and that hub would then distribute that
12 communication across to our sites in Scotland. And also
13 it acted as almost like an absorption of questions, what
14 people were doing, what guidance was in place and how we
15 should actually facilitate movements to courts, for
16 example, and how we could facilitate movements to
17 hospital. So it acted as an information and
18 communications hub.
19 Q. It sounds to me from the description that it was
20 a two way filter. You are receiving information from
21 Scottish Government and filtering that down to specific
22 users, as it were, and you were also receiving
23 information up and factoring that in. Can I take you to
24 paragraph 20? You explain a bit more there about the
25 hub. Tell us how it worked.

1 A. We had three or four senior people in that hub and, as
2 you say, Mr Caskie, it acted as a two way flow of
3 information, so we did have to report in to the
4 Scottish Government about the status of our prison, the
5 status of the health within our prison, so the
6 individuals, and they would also co ordinate with their
7 agencies, with the police, regarding escorts, with the
8 courts, regarding escorts to the court, and with our NHS
9 colleagues about the movement across the estate. So we
10 had people in that room, physical people with
11 telephones, communicating in a two way
12 Q. And at paragraph 22 you indicate that one of the people
13 who weren't in that room was Police Scotland.
14 A. Yes, that's correct.
15 Q. You communicated with them by telephone?
16 A. Yes, that's correct.
17 Q. Is that correct?
18 A. That's correct.
19 Q. And again would that be a two way communication process?
20 A. Yes, that's correct.
21 Q. And then "until we got online [as read]". Tell me about
22 the move online.
23 A. It initially started through technology allowing us to
24 do conferencing calls through the telephone system.
25 Once we developed an electronic digital platform, we

1 were able then to actually communicate on the digital
2 platforms to our partners, either in NHS or police or
3 across our agencies, so we were able to do that as the
4 pandemic moved forward.
5 Q. When you say "digital platforms", do you mean either
6 Zoom or the equivalent of Zoom?
7 A. It was Teams, where there was a various amount of
8 platforms at the time. Some agencies used Zoom, some
9 used Teams and others used I can't remember a few
10 other different platforms.
11 Q. Right. Now, in paragraph 22, you talk about how you fed
12 information back to the Scottish Government. How
13 frequently were you doing that?
14 A. At the outset, Mr Caskie, that was three times daily.
15 There was three briefings that we had to provide
16 Scottish Government. As the pandemic started to move
17 forward, those briefings became daily and that continued
18 throughout the course of the pandemic. At times when
19 there were outbreaks, we provided more detailed
20 briefings on the specific case or the specific
21 establishment where the outbreak had happened.
22 Q. And then at 27 the reason I'm able to jump is because
23 this isn't about implementation, it's about impacts, but
24 we need some background in order to properly understand
25 the impacts. So at 27 you talk about the pandemic plan.

1 Tell us about that again in general terms.
2 A. The pandemic plan was a plan that had been developed
3 over a number of years to work with any significant
4 infection and it had been the framework had been
5 tested through things like bird flu and different flu
6 pandemics like that. But we then it was built and
7 developed in conjunction with Public Health Scotland,
8 with our NHS colleagues, and we used that as a framework
9 of guidance to communicate through to our establishments
10 and to the people who were delivering the service that
11 that was how we should be keeping people safe and how we
12 should be using our standard operating procedures to
13 make sure that things were as safe as they could be.
14 They provided a guidance. It was our guidance document
15 for our service at the start.
16 Q. Then at paragraph 28 you indicate that that was kind of
17 broken down according to the local area; is that
18 correct?
19 A. Yeah.
20 Q. Tell us about that.
21 A. Without going too far into structures, Mr Caskie, there
22 was a National Coronavirus Response Group that then
23 cascaded that information to Local Coronavirus Response
24 Group, which is a multi agency, and they were run by the
25 governors. At that time that communication would flow

1 down there and it had to be specific because travel
2 restrictions were coming into local authority areas and
3 different guidance was in play across our estate. So it
4 couldn't be one piece of communication; it had to be
5 developed by local corona response groups, whether it be
6 to close down our visits, for example, because travel
7 restrictions were in one area and not another, so that's
8 how it changed
9 Q. So what you mean by that is, if I'm a prisoner in
10 Barlinnie but my family are in Edinburgh and there's
11 differences in the tier that we were
12 A. Yeah.
13 Q. then the prison had to be aware of that and take
14 cognisance of it in, for example, day release or work
15 parties?
16 A. Yeah, absolutely. All of that.
17 Q. If I can move on to 37, this is in the passage which
18 deals with "Those in our Care", and I note that in the
19 statement you refer to prisoners as "those in our care"
20 rather than "prisoners" or "those in custody" generally.
21 Does that reflect something of the attitude within the
22 organisation?
23 A. Yes. Mr Caskie, it's a recognised term for the
24 organisation to refer to the people, those in our care,
25 who we look after.

1 Q. You talk about a specific difficulty that you faced
2 at 37, which was cell sharing. Tell us how you dealt
3 with that.
4 A. Just to put it in context, at that time there was 8,000
5 people in custody. Approximately a third of the
6 Scottish prisons actually have two people and more in
7 their cells, so you can imagine, in terms of trying to
8 stop the spread of a pandemic, the first thing we had to
9 do was look at that group of people who were sharing
10 cells to see what capacity we had across the
11 organisation and, if we could, remove the amount of
12 people who were sharing cells to try and give people
13 personal space and stop the spread of the pandemic. So
14 that was the first part of our assessment across the
15 Prison Service.
16 Q. I also understand that within the prisons you also set
17 up what might be called "bubbles".
18 A. Yes.
19 Q. What was in the community called "bubbles"? Can you
20 tell us how that worked in prisons in general? I'm
21 thinking now in particular of smaller prisons.
22 A. Yeah, smaller prisons are made up with a number of small
23 wings which actually lent themselves to people living in
24 isolation almost in households or bubbles so that they
25 were separate from the rest of the population. That

1 allowed socialisation for small groups of people, it
2 allowed access to facilities, sharing facilities,
3 hand washing, but it also allowed us to put in place as
4 best a regime as we could for people living in
5 a household without isolating them. So we were able to
6 provide small periods of recreation, periods of exercise
7 and time in the fresh air for small groups of people on
8 an almost rotational basis when we started to close down
9 our prisons to small bubbles.
10 Q. I'll ask about a specific problem in relation to that in
11 a moment or two, but, in the smaller prisons, what size
12 were the bubbles, roughly?
13 A. The bubbles could be from five to ten in smaller
14 prisons.
15 Q. And how did that work in the large prisons such as
16 Barlinnie or Saughton?
17 A. Far more difficult, Mr Caskie. You can imagine, there's
18 1,300 people in an establishment, the establishment is
19 a Victorian design, it doesn't allow itself to be
20 naturally segregated, so some of the bubbles were much
21 larger in our larger establishments, but we followed the
22 same principles. Some of the bubbles could be
23 20/30 people and even sometimes there were up to 40,
24 I think, when we still continued to receive people from
25 the courts.

1 Q. Now, you also say at paragraph 40
2 THE CHAIR: Are you passing from bubbles, Mr Caskie?
3 MR CASKIE: I am, unless there's anything my Lord wants me
4 to take up.
5 THE CHAIR: Well, there's something I want to ask about
6 bubbles.
7 Mr Purdie, it's probably my fault, but you
8 mentioned, in answer to a question Mr Caskie put to you
9 a moment or two ago, that you introduced bubbles and
10 then you explained that they varied in size depending on
11 the nature of the establishment, I understand that.
12 Were bubbles or did bubbles become the common practice?
13 Were they used in all of your establishments?
14 A. Yes, my Lord, in all the establishments small, medium
15 and large establishments.
16 MR CASKIE: But in larger establishments, the bubble was
17 bigger?
18 A. Was bigger.
19 THE CHAIR: I understand that.
20 So basically you moved from the pre pandemic model,
21 whereby your inmates were housed in wings and things
22 like that, into a system whereby people were living in
23 smaller bubbles, and I understand that the size of these
24 bubbles varied; is that correct?
25 A. Yes, that's correct, my Lord.

1 THE CHAIR: That's what I wanted to clarify. Thank you very
2 much for that.
3 MR CASKIE: You also explained, I think and clarify this
4 if you can you rotated things like people getting out
5 for exercise. Take that as an example. Tell me how
6 that worked.
7 A. Yes, it was almost like there had to be
8 establishments had to put in place a timetable because
9 previously large numbers of people would take part in
10 activities , purposeful activities and exercise, so when
11 they became smaller households, they had to be almost
12 rotated through a day. So, for example, a larger area
13 or a house block may have had one period of exercise
14 during a day of a given time. That would then be split
15 into perhaps eight sessions of exercise, so on
16 a rotational basis people would have time in the fresh
17 air for their health.
18 Q. You also I think used prisoners involved in as
19 cleaners in the prisons. Explain about that.
20 A. Yeah. When we closed down part of our purposeful
21 activity to try and stop the spread of the virus through
22 our prisons, what we did was we utilised those in our
23 care on hand who had already been trained in cleaning
24 activities . So we upped the cleaning parties and we
25 then put in place a constant regime of cleaning across

1 our areas and our regimes in every prison.
2 Q. Presumably because you had available labour?
3 A. We had available labour, we had equipment and we had
4 people who were trained and, therefore, that served two
5 purposes. It kept people engaged in purposeful activity
6 and it also provided a safeguard for the prisons and
7 helped prevent infection control spread, sorry.
8 Q. At paragraph 41 you say there was a lot of anxiety
9 rather than unrest among prisoners. Tell us about that.
10 A. I mean, from the outset nobody knew what we were facing.
11 We had faced in the Prison Service our experience was
12 dealing with things for a few days, perhaps not
13 a prolonged period. The anxiety of the virus, the
14 potential of some of the media stories about what
15 a likely impact on that on our estate could be, was
16 causing our staff and was causing the people in our care
17 real anxiety. They were hearing it from the media; they
18 were hearing it from their family.
19 Our staff were trying to update our population about
20 where we were and what any likely outcomes or
21 restrictions would be to the regime, as I've talked
22 about, closing the regime down, stopping people going to
23 work, and that in itself the anxiety levels unsettled
24 our population quite badly. It really unsettled
25 everybody because there was uncertainty across the

1 estate.
2 Q. I'll ask more about stopping work and things like that
3 later. You go into more detail about that later in your
4 witness statement. But the next thing which you seek to
5 address is "Physical Health of those in our Care", and
6 you begin by talking about the age profile of your
7 prisoners and how that changed at paragraph 44.
8 A. Yeah. There's lots of research and lots of evidence
9 that will show you that the age of the population has
10 increased. By the statistical data I've provided, it's
11 doubled. It used to be 32.7 years was the average
12 and it's doubled to 37.4 years. But that only tells
13 half of the story because of a lot of our population
14 that come in have multi health problems, have underlying
15 health problems and conditions. Again there's lots of
16 research and evidence that shows you that there's
17 that increased risk for someone's health who is in
18 prison is probably five times greater than the normal
19 population.
20 Q. Five times. Now, I also understand that "average" is
21 perhaps not the best measure, that there is a skewing
22 A. Yes.
23 Q. in the age bands. There are lots of people who go
24 into prison at a young age and then come out and don't
25 come back or don't come back for a long time, but

1 there's also people at the other end. Tell us about
2 that.
3 A. There are people who come in, in terms of statistically ,
4 and get long sentences sentences have increased.
5 They've increased quite significantly but there's
6 also a growing number of elderly people and old people
7 coming in from historical offences, and that has
8 statistically I don't have the statistic at hand,
9 Mr Caskie, and I could provide them to the Inquiry, but
10 that has increased significantly over the last five to
11 ten years. So that profile of people, 50, 60, 70 and
12 above, has significantly increased.
13 Q. The next thing in your statement and I'm now looking
14 around paragraph 46 of your witness statement you
15 talk about the need for shielding by certain of those in
16 custody. Tell us about that.
17 A. The assessment was a joint assessment. Our healthcare
18 colleagues provided us with information that identified
19 125 people across the estate who had significant
20 underlying health problems, who would be required to
21 shield, as per the public guidance was. We approached
22 the 125 people in confidence and asked them to try and
23 understand this was a potential consequence and said,
24 "As a result of that, we would have to isolate you
25 because there's a real risk to your health".

1 Only 35 I think across the estate chose to isolate.
2 The others took the option to remain in circulation and
3 continue to follow what was then the regime within the
4 bubble. So that was the original assessment that was
5 carried out by our healthcare colleagues who work inside
6 the prisons.
7 Q. Was there ever any attempt to take the 35 and group them
8 together, as it were, or how were they dealt with as
9 part of your bubble?
10 A. Yeah, they were dealt with as individuals, Mr Caskie,
11 because a lot of the discussions, people felt safe, they
12 felt comfortable within the bubble or the household they
13 were with, they felt they had family contact at that
14 time that would still be at that establishment, so
15 taking people and moving them to another establishment
16 and cohorting them was not an option because the
17 individuals at that time wished to stay and remain in
18 that establishment and stay beside the support and the
19 contact that they had. So that was the outcome of the
20 discussions that we had with the 125 people. So the
21 option to move them all as a cohort into one single
22 place didn't wasn't a good option.
23 Q. I'm taking this out of sequence slightly but it's
24 a convenient place to take this evidence. You spoke
25 earlier about rotating, for example, exercise times.

1 How would that fit with individuals who were shielding?
2 A. It meant that we had to build time in during that day,
3 that we had to have time for the individual to have time
4 in the fresh air on their own, access to telephones at
5 the early stage, before we put mobile phones in, and
6 access and contact to whoever needed to support that
7 individual, whether it be a healthcare person for their
8 medication or any other support. So we had to build in
9 time for those individuals outwith the rest of the
10 people in the bubble or the establishment being in the
11 vicinity.
12 Q. So you have a group let's say a bubble of, let's say,
13 15 in a medium sized prison, one of whom is shielding,
14 how does that how is that managed within the prison
15 in terms of that individual getting exercise, not being
16 discriminated against and not being seen as advantaged?
17 A. Yeah, we'd physically have to lock the other 14 people
18 up, allow the individual that time and space, the same
19 as the other 14, and then lock the individual back up
20 and then allow the other 14 people to come out, for
21 example. That's how we did it. There had to be that
22 safe time in isolation themselves.
23 Q. You say at paragraph 49, you deal with something that
24 you've already to some extent referred to, and that's
25 the consistency of messaging so that people were getting

1 information from television, from family and so on about
2 the pandemic and its impact. What was the prison doing
3 in terms of advising those in your custody and also your
4 staff?
5 A. The National Coronavirus Response Group, part of our
6 make up was a head of communications for the
7 Scottish Prison Service and also on that group was
8 Public Health Scotland, was our Prison Healthcare
9 Network, was our NHS colleagues and colleagues who were
10 tuned into the Five Nations calls at the time and also
11 the World Health Organisation. So the information that
12 came and the guidance that came there would be taken, it
13 would be created by the National Coronavirus Response
14 Group and that would then be disseminated down to the
15 local establishments or areas and form of guidance,
16 communication or any other medium for that to be
17 communicated to our staff and the people in our care.
18 Q. Can I go to paragraph 51? You talk there about physical
19 activity and you neatly slide that into infection
20 control. Again, can you tell us about that?
21 A. I think in terms of our it provided us a real
22 safeguard that we could ensure that we had really robust
23 cleaning procedures in our establishments. We had
24 a willing group of people who were able and trained, as
25 I said sorry if I've covered this before who were

1 keen and wanted to be out, wanted to be active and
2 wanted to be engaged and have that association with
3 their peers and with the staff as well. And that
4 provided a real focus for a number of our prisoners
5 through the pandemic, that that gave them a purpose, it
6 gave them a routine and it allowed us obviously to have
7 a real good robust cleaning schedule across our estate.
8 Q. Paragraph 52, you talk about a constant almost 12 hour
9 cleaning cycle yes? going on within the prison,
10 but over the page you talk about at 53, I think it
11 is you talk about a core day. Tell me about a core
12 day. What do you understand that to be?
13 A. At the outset of the pandemic prisons typically work
14 three shifts. They work an early shift, a back shift
15 and then there is a 8 till 5 core period where staff
16 work as well. To reduce the spread of the pandemic we
17 collapsed that shift to almost a 7 till 7 time, and it
18 varied in different establishments, but it was almost
19 like a 12 hour core day that was condensed, that reduced
20 the footfall coming into the establishment and it
21 sorry with the purpose to prevent the spread of the
22 virus both coming into the prison and going out. So we
23 condensed the day.
24 Q. I think for prisoners, probably, the most important part
25 of the day might be the exercise period. What was the

1 exercise period pre pandemic?
2 A. Exercise periods can vary across prisons, but typically
3 it would have been an hour in the fresh air at midday
4 and then, in the summer months, people are able to have
5 time in the fresh air in the evening as well. But
6 typically it would be an hour and time in the fresh air
7 around midday, after the morning purposeful activity
8 session had finished.
9 Q. Is the morning purposeful activity session always
10 inside?
11 A. No, it can be outside because we have gymnasiums, we
12 have football fields, we have recreation areas that
13 allow people access to that, so pre pandemic those would
14 have been used for those purposes, whether it's
15 football, sports activities, but typically most of them
16 would be in purposeful activity work parties or
17 re offending behaviour programmes or education.
18 Q. Tell me about the work parties. What kind of things do
19 they do?
20 A. Prior to COVID, people would be engaged in anything from
21 manufacturing wooden benches for large retailers, they
22 would be involved in arts and crafts, they would be
23 involved in the basic core services of the prison, which
24 could have been the catering in the kitchen, they could
25 be involved in the cleaning parties that existed, they

1 could be involved in the laundry laundry parties
2 within the prisons as well. They actually that's
3 just a range, but they vary from the size and the space
4 and activity available across prisons. But that's
5 a range of what's available.
6 Q. Were there activities and we'll come on to this when
7 we're talking about education and so on but were
8 there activities which essentially just stopped?
9 A. Yes, there were. Our offending behaviour programmes,
10 where you had to have people in close contact, in close
11 vicinity, they closed. Large work parties, where there
12 was 20 or 30 people working close together, had to close
13 down. We closed down to what we call "the essential
14 services" and the essential services were our cleaning
15 parties, our laundry parties, our catering parties.
16 That was predominantly the essential services to keep
17 the prisons functioning.
18 Q. Okay. Then at paragraph 55 you talk about
19 COVID 19 related deaths in custody and you provide some
20 basic statistics there. Can you just give us the
21 numbers at this stage?
22 A. Yeah. Unfortunately there was 16 who passed in our
23 care.
24 Q. One six?
25 A. One six. 16 people, over a three year period, and that

1 was from 2020. I think we had five in 2020, we had nine
2 in 2021 and two in 2022. That was a breakdown over
3 a three year period.
4 Q. And since 2022?
5 A. There's been no COVID deaths since
6 Q. Okay. Do you have a formal protocol well, presumably
7 you have formal protocols in place when a death occurs?
8 A. Yes, we do. The first thing that we would do is have
9 a death in prison learning outcome review and then
10 there's a formal fatal accident inquiry that takes place
11 following any death in custody.
12 Q. In terms of communicating with families, what should
13 happen?
14 A. There should be early communication with the family.
15 There should be contact from either a senior member of
16 the establishment, usually the governor, usually
17 followed up by your chaplaincy or anybody who was close
18 to the individual or the family would be involved in
19 that communication.
20 Q. And would you arrange for example, if it's going to
21 be someone who was close, might that be another prisoner
22 or would it always be a prison officer?
23 A. We could bring the family in to the establishment if
24 they wished to speak to the individual who was close
25 who was still in prison as a prisoner, someone in our

1 care, but it's typically somebody that's worked with
2 them, either in their employment or the SPS or one of
3 our agencies who have been working closely with the
4 individual.
5 Q. You say at 58 that the first couple of deaths were older
6 men who were isolated and, probably because of the
7 nature of their offences, didn't have contact with their
8 families. How would that be different?
9 A. I think, in terms of the people who had passed away,
10 sadly, we knew from our visits contact, we knew from our
11 data, that those individuals didn't have any
12 communication, they didn't have any family support. In
13 fact I'm not sure I don't know the specific details,
14 Mr Caskie, but they didn't have any real outside
15 contact, so their friendship groups and their peers
16 because these individuals had spent quite a considerable
17 time in custody had been built in and around the
18 prison setting. So we knew that for the first couple of
19 deaths. That was the individual status of the ...
20 Q. Right. So you're talking there about the first few
21 deaths. At paragraph 60 you talk about the next few
22 deaths and you said typically a governor or a chaplain
23 or a member of the senior management team would initiate
24 early contact with the family.
25 A. Yes, that's correct.

1 Q. We heard evidence before Christmas from a gentleman who
2 lost his son whilst in prison and the mechanism you
3 describe did not reflect his experience at all. Have
4 you had the opportunity to review what was said at that
5 time?
6 A. I haven't personally and I'd really apologise if that
7 has not happened. I've not had the opportunity to
8 either formally review it or actually look at the
9 details of that case, Mr Caskie.
10 Q. The person who sadly passed away was in custody at
11 Addiewell. Would that make a difference in terms of
12 your involvement?
13 A. It would in the death in prison learning outcome because
14 our death in prison learning outcomes for the public
15 sector have a specific format. Addiewell have
16 a different format. They have to meet the same standard
17 but they have a different way to do it. They have to
18 procure somebody in to carry that out for them as well.
19 But we would still expect it's a director, it's not
20 a governor, that's in charge we would still expect
21 a director or a deputy director to follow that contact
22 with a family and follow that through. And, apologies,
23 I don't have the details because I've not spoken to the
24 director who was there at the time, who no longer works
25 for the company.

1 Q. How are you making the, "He no longer worked for the
2 company"?
3 A. It's just it's a fact, Mr Caskie. They have changed two
4 or three directors in the last few years.
5 Q. Right. There will also be another inquiry into the
6 death in Addiewell that I'm talking about. Can you
7 explain what that would be?
8 A. Yeah, that would be a fatal accident inquiry, Mr Caskie,
9 and that then will be a more in depth and a forensic
10 look at the circumstances surrounding the specific death
11 you're talking or the other 15 in relation to COVID.
12 And that then looks at learning outcomes and what we can
13 do or other agencies that work with people can do to try
14 and prevent this in the future. That will be scheduled
15 some time in the future.
16 Q. I'm looking now at 63, and at 63 you talk about or
17 around 63 you talk about information that you got in
18 your first week in the job about potential deaths in
19 custody. What was that information at that time?
20 A. It was a statistical analysis from our health colleagues
21 and from across the Five Nations and it was a raw figure
22 at the time that looked at the number of people in
23 custody, the likely impact that a pandemic would have in
24 what is a high risk residential area, and that's what
25 prisons were designated as. It was a figure of

1 600 potential deaths across an organisation was
2 a statistic that came through a forum to myself from one
3 of the Five Nations call, which had a significant
4 impact, I have to say, when you're told something that
5 can potentially happen in your system.
6 Q. Okay.
7 THE CHAIR: Can I ask you a question about that, please,
8 Mr Purdie? You said in the event of a pandemic you
9 were given this information. It was obviously very
10 early in the pandemic, but you said in the event of
11 a pandemic there could be the amount of deaths that
12 could occur. Of course it is to some extent
13 hypothetical. Do you remember or do you not what sort
14 of pandemic was envisaged because, of course, as we all
15 know, a pandemic can occur from a variety of diseases
16 and, as I understand it, we'll be hearing evidence about
17 this at some stage. We've already heard some in this
18 Inquiry, in fact.
19 There are various types of viruses. There are
20 pneumonic viruses, there are enteric viruses and so
21 forth, and they have or tend to have very different
22 mortality rates. Therefore the figure I'd be
23 interested to know what sort of pandemic. Was it
24 already talking about COVID, which is a pneumonic virus,
25 or was it talking about well, what was it talking

1 about, if you remember? You may not remember, in
2 fairness to you.
3 A. Yeah, I actually can't remember. I don't think it was
4 the developed COVID virus that we then went on to try
5 across the country. Then there was a lot of
6 speculation, my Lord. There was a lot of speculation
7 what the virus could be, what the strain could be, what
8 the potential so it was a hypothesis of a number of
9 likely outcomes at that time, and that's my recollection
10 at the time. The thing that struck me was the
11 astonishing figure.
12 THE CHAIR: Yeah. No, no, I'm not criticising you at all.
13 It's just that, whoever produced the report, it would be
14 interesting to know how they came up with the figure in
15 front of you, what sort of virus. If it was possible
16 for you by yourself or have someone else to have a look
17 at that report and if it did stipulate or state what
18 sort of virus it was or was envisaged or that the
19 figures were based upon, more accurately, I'd be
20 grateful if you could write to my staff and let us know
21 that information, please.
22 A. Will do, my Lord.
23 THE CHAIR: Thank you.
24 MR CASKIE: If I can just go back to your own personal of
25 the impact that had had on you personally. You've just

1 been appointed as director or head of operations in the
2 Scottish Prison Service and you receive a report which
3 says a pandemic in the present might result in
4 600 deaths, about by my rough back of the fag packet
5 calculation, about 8% of the prison population. How
6 did you personally react to that?
7 A. I was somewhat astounded, to be honest, and the
8 magnitude of what that could have meant to 600 people
9 and families and people who had built up relationships
10 over years and I was actually really astounded with
11 it, Mr Caskie. It took me aback and, if I didn't say it
12 was overwhelming at the time, I would not be telling the
13 truth. It was overwhelming to be faced with a statistic
14 like that.
15 Q. Is that seared into your brain?
16 A. It's clearly had an impact on me, yeah.
17 Q. At paragraph 64, you talk about that and then you go on
18 and say that it's a great relief that it was 16 and
19 not 600.
20 A. Hmm.
21 Q. You then go on to refer to presumably your own
22 reflections as to what led to it being 16 and not 600.
23 A. Yeah, I mean
24 Q. It's the second part of the paragraph I'm looking at.
25 A. Yeah. I'm not sure you can ever be content that anybody

1 dies in your care, so please can I put that in context
2 right away, but in terms of the support, how we
3 approached it, we always had focus in our mind, from our
4 chief executive down, to protect people, to keep them
5 safe and to communicate and be as open and honest as we
6 can because we knew we'd have to put in place
7 restrictions and restrictions within a prison can
8 sometimes have a negative impact on control. But from
9 the outset we had that mindset to make sure it was
10 clear, our communications were clear and the support
11 that was put in place to protect and save people's lives
12 was at the forefront of everything that we did.
13 Q. You say that:
14 "It was not me, nor the chief executive, it was the
15 staff and prisoners on the ground who respected the
16 rules, they took advantage of the support in place.
17 They respected the restrictions and guidance that was
18 ever changing. And it's a credit to their attitude and
19 approach that this helped save people's lives and keep
20 them safe. There's absolutely no doubt about that."
21 Is that a typical response from prison management to
22 how prisoners are behaving? Was it different? Was it
23 different then?
24 A. There was a sense of community, if I could explain, and
25 prisons during the pandemic, probably mirroring what

1 happened in society, in our villages and our towns,
2 people came together within prisons because they
3 understood there was a common aim, and the common aim
4 was to keep them safe, was to keep their families safe,
5 both our staff who were coming in every day and going
6 back to their families and those in our care, who at the
7 time were socialising in a small bubble, they were
8 restricted from their family. So there was a common aim
9 from everybody to follow the guidance, take the support
10 that was on offer, understand the legitimacy of what was
11 happening and then act responsibly. That doesn't always
12 happen within a prison environment.
13 Q. Indeed might it be regarded as somewhat unusual in your
14 experience?
15 A. I think the word "unprecedented" gets used quite a lot
16 for the pandemic, and the sense of community
17 togetherness was unprecedented in my 35/36 years in the
18 Scottish Prison Service during the pandemic.
19 Q. Okay. Thank you. You then, at paragraph 65, talk about
20 changes to the rules that were introduced and, again,
21 that's to do with implementation so we'll do that on
22 another day. But at paragraph 69 you give a specific
23 rule change about isolation for 14 days. Was that
24 a rule to require individuals to isolate?
25 A. Yes, it was. We typically, under the prison rules,

1 we have different rules that allow us to isolate people
2 for different reasons, but sometimes it can be custody,
3 sometimes it can be their own safety, sometimes it can
4 be healthcare. The specific isolation , when the
5 guidance required that, we had to then change the rules
6 and the legislation to allow us to do that legitimately .
7 Q. And that's the prison rules had to change
8 A. The prison rules.
9 Q. Well, colloquially known as "the prison rules"?
10 A. Yes, "the prison rules".
11 Q. That was to permit you to say to a prisoner, "You're
12 being locked up in your cell or in a cell for 14 days"?
13 A. Yes, it allowed us to do it at the time for a household
14 because, typically , if you take your example previously,
15 if there were 15 people and one or two were positive, we
16 would have to isolate the household, so the change in
17 the prison rules allowed us to isolate the household not
18 just an individual , as the rules would allow us to do in
19 normal times.
20 Q. So previously the situation had been that you had the
21 ability for good reason, one would assume, to isolate an
22 individual but it became more collective during lockdown
23 and that was a reflection of the bubbles?
24 A. That's correct.
25 Q. At 71 and 72 you talk about testing, when testing came

1 in . Was testing ever compulsory?
2 A. We tested on admission compulsory for people on
3 admission from prisons, and normally it would be part of
4 an outbreak. We would test and make it I say
5 "compulsory". We would encourage people. Some people
6 refused to be tested during that. But it was voluntary
7 for our staff and it was voluntary for our prisoner
8 population during normal association time within the
9 prisons . But we did test people or we encouraged people
10 to be tested. We couldn't compel people or take any
11 action if somebody refused to be tested on admission,
12 for example, or on return from another establishment or
13 a hospital .
14 Q. So if I 'm a prisoner and I have a hospital visit , which
15 is essential I'll ask you about hospital visits in
16 general in a moment or two but if I do have
17 a hospital visit and I go to the hospital and I come
18 back in, do I get tested at that point?
19 A. We would ask people to be tested. We would encourage
20 them to be tested at that point but we could not compel
21 or force anybody to be tested.
22 Q. But everyone in prisons was offered the opportunity to
23 test when they came in?
24 A. Yes.
25 THE CHAIR: Do you have any

1 A. That was about September
2 MR CASKIE: Sorry.
3 A. Initially that was about September 2020 we introduced
4 that because we didn't have a testing protocol at the
5 early outset of the pandemic. So roughly it's
6 September, I think, Mr Caskie, 2020.
7 MR CASKIE: Sorry, sir, I interrupted.
8 THE CHAIR: No, it's all right. I interrupted.
9 Do you have any knowledge of the uptake of that
10 offer of a test on return from hospital or admission?
11 A. I don't have the statistics , but the majority of
12 those of prisoners or those in our care took the
13 opportunity to be tested.
14 MR CASKIE: You say "the majority". Was it a good majority?
15 A. A good majority, sorry. A good majority took it up.
16 Q. You'll be aware that we've heard evidence about care
17 homes. That didn't happen when people were being
18 transferred from a hospital into a care home. Do you
19 have anything that you can usefully say about that? If
20 you don't, just say "I don't".
21 A. I don't.
22 Q. That's fine.
23 I come back from hospital and I test positive. What
24 happens to me?
25 A. You'd have then been isolated for the period whatever

1 the guidance was. If it had been 14 days, you would
2 Q. I am going back to a cell that's shared.
3 A. We wouldn't have put you back to a cell that's shared.
4 We would have found you an individual cell and we would
5 have placed you in there on your own in isolation.
6 Q. How do I get my food?
7 A. Staff would bring it to the door. Staff would go in
8 PPE, would bring that to the door. Whether it be your
9 medication, whether it be your food or anything you
10 needed, staff would bring to the door, Mr Caskie.
11 Q. Okay, 77, you're talking about vaccinations now. Was
12 the vaccination regime that was rolled out inside the
13 prison estate a mirror of what was happening on the
14 outside?
15 A. Absolutely. It was an absolute mirror of what was
16 happening on the outside as well. We have NHS staff who
17 work in every one of our establishments, so we then had
18 the ability to be able to mobilise the staff locally and
19 to be able to carry out those vaccinations, so it
20 mirrored what was happening in the community.
21 Q. So we know that on the outside the deciding factor as to
22 when one was vaccinated was age. Did that also apply in
23 prison?
24 A. Yes, that's exactly what happened. We followed the
25 guidance as well, from the age profile that was

1 a priority at the start, and we worked through that
2 exactly as the community was doing.
3 Q. Right. I want to ask you about the "exactly". You said
4 earlier that prisons were a residential establishment
5 which was recognised as high risk. Was any weighting
6 given to that in terms of inside the prison? So was it
7 simple age full stop or were there any or age and
8 health?
9 A. It was age and health, Mr Caskie, and perhaps sorry
10 if I've not explained that properly as well because
11 if the 125 people with underlying health conditions
12 would have been offered the vaccination as well so
13 there was a health assessment that took place as well as
14 the category of age.
15 Q. Would they be offered before if you have
16 a 60 year old who has an underlying health condition and
17 you have a 60 year old who doesn't have the underlying
18 health condition, what happened in the community? Was
19 it that person number one got vaccinated first? Did
20 that happen in prison?
21 A. Yes.
22 Q. Again, I ask this question because I don't recall what
23 the answer was: was any weighting given to the fact that
24 prisoners per se were living in a high risk environment?
25 A. No.

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1 Q. Nothing at all?
2 A. No, it was individual health risk assessment and then
3 the guidance from age profile.
4 Q. The next thing you talk about is NHS appointments, and
5 we know that NHS appointments in the community, for all
6 but the most extreme cases, dried up. I'm in prison and
7 I'm receiving essential cancer treatment, what happens
8 to me?
9 A. During the pandemic there would be that individual
10 assessment, first of all, to see the place of care of
11 where they were given their treatment was still open
12 and, if it was, then there would be an assessment of how
13 that individual could be taken there and back safely as
14 well. So it was carried out individually. But first of
15 all we had to then check to see if the appointment was
16 still going to take place.
17 Q. When the appointment is still going to take place
18 because it's very important. Did your transport agency,
19 who I understand are called "GEOAmey"
20 A. Yes.
21 Q. do they still take me?
22 A. Yes.
23 Q. And am I risk assessed in terms of handcuffs and things
24 like that?
25 A. Yes.

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1 Q. And given the requirement in general to have 2 metre
2 distancing, how is that dealt with?
3 A. We had developed protocols with our Public Health
4 colleagues about how PPE would be used to facilitate
5 escorts. So we had a range of PPE that people would
6 utilise, if they were transferring people to the cancer
7 appointment, as you used. And also there would be that
8 localised assessment to the ward they were going in that
9 would then decide what of any other measures they had
10 to take. But we had a recognised and a standard set of
11 PPE that we had agreed that was fit for the purpose to
12 carry out hospital escorts.
13 Q. You mentioned PPE, and that's the first time we've
14 mentioned PPE. I should have mentioned it earlier.
15 Tell me about PPE in the prison firstly.
16 A. I suppose early months was a bit like everybody else;
17 what should we be using, what standard should we use,
18 what are we facing, what would combat any risks. But in
19 the prison setting we already had things like hand gels,
20 we already used gloves for our searching procedures
21 anyway, so we had quite a considerable stock of those
22 localised items. But when it became clear about the
23 specifications and the type of PPE that we required, we
24 used our Scottish Government contacts and contracts, as
25 well as locally, when things were difficult to source

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1 we used them early and we bought in bulk and we stored
2 them within our central stores, which is in Fauldhouse
3 as well, and those were then distributed across the
4 establishments, so that's how we handled it.
5 Q. We've heard some evidence of standard PPE essentially
6 not being designed for women. Did the Prison Service
7 take cognisance of that in the PPE that your women staff
8 were using?
9 A. We took advice from Public Health Scotland and Health
10 Protection factory exactly about a PPE that would be
11 suitable for all our staff and all people in our care
12 and for our contractors to use and escorts, so we got
13 a specification of masks, goggles, aprons, gloves, that
14 would be utilised from anybody at any time. We did take
15 advice for people who had difficulty lip reading, for
16 example, so we were able to secure some masks that were
17 clear, but we didn't do something specifically for
18 women.
19 Q. You're saying "for all our staff". It's quite often the
20 case that when it's said, "This is for all of the
21 staff", what it means is, "This is for all of the
22 typical staff who are men".
23 A. No, all our staff group all our staff group, whether
24 they were operational, non operational and as well we
25 actually we made sure that people who were coming

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1 into our prison, agencies or education provider or
2 escort provider, were following that as well, so it was
3 everybody.
4 Q. You then move on in the witness statement to
5 paragraph 82, where you're talking about mental health
6 and well being. I'll be quite frank with you. Quite
7 a bit of the material that you've produced is
8 counter intuitive. I don't mean it's wrong, it's just
9 surprising some of it is surprising. What do you
10 think I might have found surprising? What's the oddness
11 or what did you find surprising, if anything?
12 A. I found surprising that people, who are already isolated
13 in prison and then you restrict them even more and you
14 restrict family contact and you restrict access to what
15 would be a normal daily regime, typically in prisons
16 cannot be the most reasonable or understanding so
17 I could understand why people would think, "Why was
18 there not a reaction inside your prison to restricting
19 people who typically have broken the law and we've taken
20 that choice to put them in there? Why did they comply?
21 Why were they so reasonable? Why did they have that
22 understanding?". I would be asking that question as
23 well, and it comes back to the feeling of safety,
24 community, understanding and trying to ensure that
25 people were safe.

1 Q. And do you think that was something that was picked up
2 on by those in custody?
3 A. Absolutely. A lot of our longer term prisoners and our
4 longer term staff have lived and worked with each other
5 for quite a considerable time, so whilst there's
6 professional relationships there as well, there was
7 a greater understanding that everybody was facing the
8 same risk here and everybody had to contribute to
9 success, if you want to call "success", about keeping
10 people safe and stopping a virus spread. That was the
11 common aim that was prevalent across all the
12 establishments.
13 Q. For prisoners pre pandemic and presumably post pandemic,
14 you provide both medical mental health support and what
15 might be called "non medical mental health support".
16 What happened to that during the pandemic?
17 A. It was difficult, to be honest, to meet because our
18 health services were stretched. They were pushed to the
19 limits. They were involved in other activities. But,
20 wherever possible, colleagues in our NHS continued to
21 provide whether it was one to one support with people
22 in the establishments, but that proved to be difficult
23 during the pandemic.
24 Q. What about less formal mental health support? You see
25 talk a bit about that at 87 and 88.

1 A. Yeah, yeah. In essence it was trying to keep people
2 mentally tuned in. So it might seem simple things now,
3 sitting in front of a table here, but it was puzzles, it
4 was games, it was in cell activity, it was just like
5 a sense of a number of our establishments have media
6 systems that we could use, so we utilised, you know,
7 sessions that can be beamed through televisions. It
8 could be a selection of films, it could be a selection
9 of information or guidance or whatever. So we utilised
10 lots of things that could stimulate individuals whilst
11 their life in prison was basically restricted.
12 So we did that to the best of our ability, and it
13 might seem simple and I have mentioned and things like
14 that, but things like bingo actually worked for
15 a community, and at times you can play bingo when people
16 are locked up behind their doors because you can still
17 call the numbers. So it may seem simple and it may seem
18 quite a strange thing to say in an inquiry, but things
19 like that was the extremes that were happening within
20 the establishments, to try and keep people stimulated.
21 Q. You give a graphic description of the volume of noise
22 when bingo was being played. Tell us about that.
23 A. It was only my experience in one of the establishments
24 and I did, through the pandemic, as you can imagine,
25 visit establishments very regular, and it just astounded

1 me that there was a pin drop while this activity was
2 happening, while I was in one of the establishments. So
3 it was astounding, that's all, and it was just so quiet.
4 Q. Paragraph 89 you're talking about. Paragraph 90, you
5 talk about this people becoming closer together.
6 Again, tell us about that.
7 A. I think it was a sense of well, there's a practical
8 thing that helped that work. Typically in prison
9 there's a regime, that people will go for a morning
10 activity, they'll come back to a residential area, so
11 they'll go from where they live to work in an area with
12 different staff, then they'll come back to the staff who
13 are working in that area, so people were closer
14 together physically closer together for that core
15 day. So that in itself added time to what people could
16 do, develop, work together and build their relationship,
17 where typically a lot of things in prisons are
18 transactional. People move to visits, they move to
19 their work party, they go to the gymnasium, so it can be
20 quite transient. A lot of that was stopped, so it
21 actually meant people were physically in the same area
22 for a fair percentage of that time for that day, and
23 that in itself encouraged the growth and development of
24 relationships.
25 Q. Because it was the same prison officers they were

1 dealing with all day
2 A. Yeah.
3 Q. and the same prisoners?
4 A. And there was consistency.
5 THE CHAIR: You have about ten minutes, Mr Caskie.
6 MR CASKIE: I'm doing my best, my Lord.
7 You talk about regime change over the course of
8 lockdown and so on at 92. Tell us about the changes in
9 regime.
10 A. Initially , as I said, we stopped all our non essential
11 work activity and services. We stood that up as quickly
12 as we could, when the restrictions were changing, but
13 what we tried to do was do it in smaller numbers. So
14 rather than just allow everybody to go back to
15 a gymnasium when numbers we utilised small wing
16 gymnasiums, small areas, for example, that we were able
17 to build up the activity again in smaller numbers but
18 safer. So we did that. We went through a process from
19 closing it down to a gradual build up till through the
20 end of the pandemic we were able to have that
21 normalisation, so it fluxed over the course of the first
22 two years at least, when the restrictions were in place.
23 That was the same for visits. There were times we
24 were allowed to have visits because we designated our
25 visit area as an indoor public place and we had agreed

1 that with our Public Health colleagues, so we were able
2 to utilise that. But, as I explained earlier , at times,
3 when travel restrictions were in place, families
4 couldn't come to the visits , so it had to bend and
5 change given the guidance.
6 Q. You talk about physical visits at 97 and on and you
7 indicate there that, in March 2020, physical visits were
8 suspended. And then in paragraph 98 you say that
9 physical visits fully resumed on 26 April 2021, so
10 that's 13 months roughly.
11 A. Yeah.
12 Q. Well, 12 months.
13 A. Yes.
14 Q. Those of us who weren't in prisons, imprisoned, were
15 going out for walks and were socially distanced meeting
16 people. Why were prisoners different?
17 A. Perhaps I should explain that, Mr Caskie. That meant
18 that all restrictions within the visits were removed at
19 that time. We were able to run our visits as they
20 did as you would in the community. We had people
21 we restructured our visit rooms, people were physically
22 distant, they had to wear masks at times, but they still
23 allowed that face to face visit. But we had our PPE in
24 place and we had safe protocols.
25 So April is the date that all those restrictions

1 were lifted , but physical visits did take place, but
2 with the pandemic protocols in place and safety measures
3 to make sure people could do that safely. So that
4 perhaps explains that a bit better.
5 Q. Okay. At paragraph 100 and for quite a while thereafter
6 you talk about mobile phone technology. You explain
7 about the practicalities for the Prison Service in terms
8 of organising that. That's to do with implementation.
9 Tell me what happened with mobile phones for me as
10 a prisoner.
11 A. You would have been given a mobile phone. Previous to
12 that, you would have pre approved numbers that we have
13 that you would use from an area phone. We made sure
14 that those pre approved numbers were placed on to
15 a mobile phone. You'd have been given a mobile phone in
16 your cell , somebody would explain how it works to you,
17 they would have told you that "Your numbers are on it"
18 and explained to you that the phone has outgoing calls
19 on it but not incoming calls and then the security
20 procedures. People were given 330 free minutes to then
21 use to contact their family. So, as a prisoner, that
22 would have been explained to you right across the estate
23 individually .
24 Q. So would I have a number of telephones logged in on my
25 phone when I received it and I could use 330 free

1 minutes a month?
2 A. Yes, we pre loaded them on to that phone, and that was
3 the recognised numbers that people in our care had been
4 using pre pandemic, and then we allowed them to
5 gradually change that if and when, and we would normally
6 do anyway, if new people or new family members came on
7 to that list . So initially we pre loaded it, gave it to
8 those in our care with the minutes already on it and
9 they could use it .
10 Q. Paragraph 108, you talk about some prisoners being quite
11 surprised when a prison officer turned up and gave them
12 a mobile phone. Tell me about that.
13 A. I mean, in practical terms, the prison stops us using
14 communication devices. It's against the law to bring
15 a communication device into a prison. That's the
16 standard position. So some prisoners found that, after
17 years of us taking phones off them and basically going
18 through a conduct issue, that we would now be handing
19 people mobile phones for them to use and to be able to
20 contact, so they found it quite a departure from our
21 normal practice.
22 Q. And both the fact that they were able to use the mobile
23 phone and the fact that they were being given mobile
24 phones, did that impact on the individual prisoner's
25 mental well being?

1 A. All the feedback we've had from those in our care and
2 our population said it helped them greatly during the
3 pandemic. It gave first hand contact, direct contact,
4 at any time with their family because previously you
5 could only use phones when the prison was open because
6 these were in typical landing areas as well. So they
7 had flexibility and freedom to contact their family
8 across the day at a time that suited them and their
9 family, and it allowed them privacy, more privacy than
10 they'd ever had, because, if you're talking on
11 a communal phone in an area, that's not perhaps as
12 private as in your own cell, in your own time, and that
13 was hugely welcome for the population.
14 Q. And at paragraph 110 you talk about drug seizures. This
15 was particularly the aspect that I thought was
16 counter intuitive. Just tell us about that.
17 A. My experience would have said that at a time where you
18 lock people up for prolonged period of time, there would
19 be a high risk of people lapsing into substance misuse
20 and then the risk of people's health and death
21 increases That was not the case. We didn't experience
22 that. We didn't experience an upsurge. We didn't
23 experience statistically moving up. On the ground
24 people weren't reporting that. I kind of have a few
25 ideas. Perhaps supply routes were disrupted for drugs

1 coming into prison, the same as communities were
2 disrupted. Perhaps physical contact being reduced
3 didn't allow prisons drugs to come into prison.
4 People were not able to go out and throw stuff across
5 our walls or our fences because they were not allowed
6 out. So there's a number of measures there that stopped
7 the supply of drugs coming in. So it didn't eradicate
8 it, but it stopped the supply, which thankfully meant we
9 didn't have an outcome or an impact that typically you
10 would have expected.
11 Q. Possibly apart from family visits, the most important
12 thing to many prisoners will be the offending behaviour
13 programmes because they're progress to the door, to
14 getting out.
15 A. Yes.
16 Q. What happened to the offending behaviour programmes?
17 A. Given the high risk of small groups of people being in
18 a confined space in an area together, if you could
19 envisage almost like a small classroom where most of the
20 work took place and focus work, we had to set them aside
21 for quite a period. But then we started to build them
22 up again gradually, when it was safe to do so, in
23 smaller numbers. But initially we had to close them
24 down because they were high risk.
25 Q. Okay. There are two other areas that I want to speak to

1 you about, and I can do that very quickly. You talk
2 about the early release scheme that was introduced.
3 Just, in broad terms, tell us what that was.
4 A. Given the threat and the risk to the virus spreading
5 through the prison, we initiated an early release
6 programme on the authority of the Scottish Government
7 that released hundreds of prisoners earlier than they
8 would normally have been released, so it reduced the
9 risk of pandemic spreading across the estate.
10 Q. You had very strict criteria as to who might get early
11 release and I think across the prison estate you
12 identified I'm looking at paragraph 132 445 people
13 to be released. In fact 348 were released. What about
14 the other 100?
15 A. They were assessed as being too high a risk to release
16 into the communities.
17 Q. But I thought the risk assessment had been carried out
18 in order to identify the 445.
19 A. It had been. That was an initial group from an initial
20 set of criteria. Then there was localised assessment by
21 the governors and the team because a lot of information
22 can be dynamic and there can be intelligence at local
23 level that would exclude someone being released. So
24 there was a veto by the governors, who were able to
25 carry out a local assessment after there had been

1 a larger assessment to create that 400 plus.
2 Q. You deal in some detail with changes in shift patterns
3 and regime change and also SPS staff at 139 through to
4 148 in your statement. You had to change the work
5 pattern. Tell me about that.
6 A. We changed that in March 2020. We had to alter it to
7 keep our prisons safe. We had to ask our staff to be
8 flexible and change work and life arrangements to
9 accommodate the safe running of our prisons, and that
10 wasn't taken lightly because people have childcare
11 support, they have school issues, they have family
12 support that they require to have in place. So we had
13 to ask our staff to be flexible in very, very short
14 timeframe and to be able to adapt their lives to come
15 and work different shift patterns.
16 Q. You've provided a very detailed witness statement.
17 Do you adopt all of that witness statement?
18 A. Yes.
19 Q. You also indicated to me prior to the hearing that there
20 were a few specific groups of individuals that you wish
21 to thank for their involvement.
22 A. Yeah, I mean, first and foremost I hope it's come
23 through in my statement but the people in our care
24 would be the first people often maligned, often not seen
25 as responsible citizens of Scotland, but if it wasn't

1 for their understanding and their forbearing and their
2 understanding that restrictions were being put in place
3 and imposed upon them in an isolated environment they
4 acted responsibly, so I think that has to be recognised
5 and it's hugely significant. It's something that
6 I haven't seen to the extent over my 36 years in the
7 Scottish Prison Service, so I think that has to be
8 acknowledged. And our staff group who were front line
9 every day, working with our NHS colleagues. Our
10 partners were in there, they did their best and they had
11 the safety of everyone at the forefront of their mind on
12 a daily basis. They changed their work approach, they
13 were flexible and they adapted and flexed and bent at
14 a time where their family life was being changed and
15 their work life was being changed and, if it had not
16 have been for that, then our organisation and the
17 Scottish Prison Service and the people we look after
18 would have been in a different place. So I'd like to
19 pay tribute to both our population and our staff group
20 and our partners who supported us to do this and achieve
21 this.
22 Q. The other two groups that you mentioned to me before the
23 hearing were those involved as third sector sorry, as
24 second sector partners, for example, education
25 A. Yeah.

1 Q. and also your third sector partners.
2 A. Yeah.
3 Q. And you specifically identify in your witness statement
4 families outside.
5 A. Yeah.
6 Q. Is there anything specific that you want to say about
7 them, apart from extend your gratitude?
8 A. Really extend my gratitude. I did mention
9 Family Outside because they were hugely supportive in
10 trying to provide a consistent change in message to
11 families who come to our establishments, both on the
12 website and both physically on site, when they came in,
13 and to our partners who really were not our employees
14 but adapted our safety procedures when they came into
15 our establishments and contributed to the overall
16 safety, and I think it's only right that I acknowledge
17 that in my statement, Mr Caskie.
18 Q. Those are all the questions I want to ask you and we're
19 slightly over time. Is there anything else you need to
20 say?
21 A. Not at this point.
22 Q. Thank you. I'm sure you'll be invited back to talk
23 about implementation.
24 A. Okay.
25 MR CASKIE: Thank you very much.

1 A. Thank you.
2 THE CHAIR: Thank you, Mr Purdie, for your evidence and
3 I look forward to seeing you again at a later stage.
4 A. Okay, thank you.
5 MR CASKIE: Thank you, sir.
6 THE CHAIR: 1.30, then, ladies and gentlemen.
7 (12.34 pm)
8 (The short adjournment)
9 (1.33 pm)
10 THE CHAIR: Good afternoon, Ms Bahrami.
11 MS BAHRAMI: Good afternoon, my Lord. My Lord, our next
12 witness is Rami Okasha, chief executive of Children's
13 Hospices Across Scotland.
14 MR RAMI OKASHA (called)
15 THE CHAIR: Thank you very much indeed. Good afternoon,
16 Mr Okasha.
17 A. Thank you. Good afternoon.
18 THE CHAIR: Good afternoon. Very good. Right. When you're
19 ready, Ms Bahrami, on you go.
20 MS BAHRAMI: Thank you, my Lord.
21 Questions by MS BAHRAMI
22 MS BAHRAMI: Mr Okasha, good afternoon. Thank you for
23 joining us. Could you please tell us a bit about your
24 own background and the background of CHAS, Children's
25 Hospices Across Scotland, please?

1 A. Yes, of course. No problem at all. I'm the chief
2 executive of CHAS, Children's Hospices Across Scotland.
3 I was appointed and took up the role just before the
4 pandemic in February 2020. Prior to that I had worked
5 for CHAS for a year in a role delivering
6 transformational change around services and before that
7 I was the executive director of strategy and improvement
8 at the Care Inspectorate, where I was responsible for
9 designing systems of scrutiny, assurance and improvement
10 across all social care and social work services in
11 Scotland.
12 CHAS is a charity that supports children with
13 life shortening conditions. We provide unwavering care
14 to those children and their families on every step of
15 their journey, and that includes medical, nursing,
16 social work, family support from hospices in children's
17 own homes and in hospitals in partnership with the NHS.
18 Q. Thank you. There may be a perception among some that
19 and you've addressed it somewhat in your answer there
20 but there might be a perception amongst some that CHAS
21 mainly deals with children who have conditions and are
22 at the end of their life, but that isn't quite the case.
23 Could you tell us a bit about palliative care more
24 broadly and the difference between that and end of life
25 care and the sort of durations that you are involved in

1 children's lives?
2 A. Absolutely. This is one of the big differences between
3 palliative care for children and for adults. Often, for
4 adults, we think about palliative care in the last
5 months or perhaps year of life, but for children
6 palliative care is understood to be from the point that
7 a child is diagnosed with a life shortening condition to
8 the point that they die or indeed transition into
9 adulthood, and that can take years. So often the
10 families we are working with, we are working with over
11 an extended period of time, and the purpose of
12 palliative care is to help children to live well and
13 then to support them to die well when the time comes.
14 Q. Thank you. Now, you have two CHAS has two hospices.
15 Do the hospices have both private and shared rooms?
16 A. No, all the hospices have single rooms for children, all
17 of the rooms in both hospices are directly accessible to
18 the outdoors and, when we got on to some of the
19 practical issues around the pandemic, that became an
20 extremely important point.
21 Q. Great. Thank you. You mention that one of the
22 consequences of the pandemic was a reduction in bed
23 capacity at the hospices. Why was there a reduction in
24 bed capacity given that the rooms are single rooms?
25 A. The main reason was the need to maintain social

1 distancing and the rooms are close together actually.
2 And also the children who are there often are not just
3 staying in their room, they are enjoying the experiences
4 around the building, which is designed to be a homely
5 environment. And so, to maintain social distancing, we
6 needed to zone the buildings to create spaces where
7 families could be, and whilst we normally are able to
8 support eight families at any one time, during the
9 pandemic we reduced that down and consequently increased
10 the amount of care we provided in children's own homes.
11 Q. Yes. You say that the number of home visits doubled
12 compared to pre pandemic figures. How was CHAS able to
13 meet that increase in demand for home visits?
14 A. Well, I think I'm not sure we were able to meet the
15 full demand because the burdens of caring for a child
16 who is very ill 24/7 are significant and during lockdown
17 many other supports came away, so I think there were
18 many families who were not able to get all the care they
19 might want. But we increased our care through the
20 ability to flex our workforce, to ask our nursing staff
21 to work in a different way and to work in the community,
22 and I have to say that the flexibility and willingness
23 of staff to go above and beyond to meet the needs of
24 families was remarkable.
25 Q. Right. Thank you. And you tell us in paragraph 24

1 about the virtual hospice service that you started,
2 offering both clinical and non clinical support. Was
3 the clinical support provided on a one to one basis or
4 did you have set sessions that everybody would attend?
5 A. No. Support from whether it was from a nurse,
6 a doctor or a pharmacist or another healthcare worker
7 would have been one to one support. There were some
8 group activity sessions for some of the things that were
9 less clinically focused and more therapeutic based.
10 Q. Because we've heard from others, not children and not
11 related to CHAS, that contact with clinicians and with
12 other healthcare professionals just ended and they
13 weren't able to ask questions, they weren't able to have
14 that contact that they had before. So you were able to
15 facilitate that. How willing were the health
16 professionals to work with you on that? How did you
17 find arranging that because, presumably, the pressure on
18 them to, you know, meet greater needs within a set time
19 had increased as well. So how was that? How easy or
20 straightforward was it to arrange one to one sessions?
21 A. Relatively easy from the point of view of the
22 willingness of clinicians to support those and what we
23 did was we put in place a structured programme of what
24 we call "kindness calls", which was really a form of
25 triage, I suppose, which involved nursing staff

1 contacting families that we support to just ask how they
2 were and understand what they need and try to follow up
3 where there was something identified. So that might be
4 a family just at the edge, who just needed a respite
5 break in a hospice, it might be a family struggling to
6 access a service that they hadn't otherwise previously
7 done and it was a way of understanding the needs of
8 families. And I have to say that worked well. We were
9 able to also we had a number of staff who were
10 themselves clinically vulnerable and they were able to
11 work in that way without exposing themselves to
12 face to face care. So it worked well from both I think
13 the perspective of the people using the service and the
14 people providing the service. But I would say that it
15 was not as it was a poor substitute for the delivery
16 of face to face care.
17 Q. Thank you. And you touched on it there you also
18 had an element of therapeutic play. Was that an
19 on demand service that patients and families could
20 access in their own time or did you also have scheduled
21 sessions for those?
22 A. Both actually. And therapeutic play is a really
23 important part of children's palliative care. With
24 older people's palliative care, often that is associated
25 during a period of cognitive decline. With children

1 this palliative care is provided during a period of
2 cognitive development, so enabling and facilitating
3 children to learn, to play and do what children do is
4 hugely important. It's a core part of what would be
5 considered good children's palliative care. So we were
6 able to provide some of that support from our own staff.
7 We have a team of activity staff within CHAS and we also
8 worked with other charities, including the Hearts and
9 Minds charity, to provide some online clown doctor
10 visits, which was a way of providing light relief for
11 families during a time of a lot of gloom and worry.
12 Q. Thank you. Moving on from there, you mention that, in
13 order to support the impact of the pandemic on the NHS,
14 CHAS stepped in to support the stepdown care from
15 hospital and stepped in to fill care packages that had
16 collapsed. Could you firstly tell us what is meant by
17 "stepdown care" and then tell us why these care packages
18 had collapsed and how CHAS was able to step in to help?
19 A. Of course. So stepdown care is where a child is in
20 hospital and is able to come out of hospital but needs
21 to be somewhere a little bit more supportive than home
22 before they get home. So a child might have gone into
23 hospital for an operation and be physically well enough
24 to leave hospital but not physically well enough to be
25 at home full time. So our hospices are able to provide

1 that level of stepdown care with one to one nursing care
2 under medical supervision. So that supports children to
3 come out of hospital because generally the last place
4 anyone wants a child to be is in hospital.
5 In terms of packages of care, many of the children
6 we support have what are called "packages of care" in
7 place, so that would be something assessed by the local
8 authority, often delivered in partnership with the NHS,
9 to provide very often a team of people to be round
10 a child where they need 24/7 care. So that might be
11 someone for example, a ventilation worker, who could
12 support a child who was ventilated to be able to breathe
13 and keep the airway clear. And certainly during the
14 pandemic, there were that workforce was not all able
15 to work. Some were clinically vulnerable, some became
16 unwell, some had caring responsibilities at home.
17 So there were children for whom the essential
18 supports provided by the NHS or local authorities were
19 simply not there, so we were able in a number of cases
20 to provide nursing staff to both deliver care as part of
21 that team around the child and also train up newly
22 recruited healthcare assistants who would be coming to
23 work with that child and we were able to do some of the
24 training with those staff to help them understand how to
25 care for a particular child.

1 Q. You mentioned that some of your workforce were
2 clinically vulnerable as well. How were you able to
3 prevent that from interfering in your ability to meet
4 this gap that had emerged in the NHS?
5 A. It was very difficult and particularly in the early days
6 there was a lack of clarity around which conditions or
7 circumstances for an individual might be vulnerable. So
8 I remember discussions early in the pandemic about the
9 degree to which pregnancy was a factor that needed to be
10 considered in deploying the workforce. And ultimately
11 we tried to follow as much of the guidance and practice
12 that the health boards adopted in this regard but also
13 tried to have a really understanding approach and were
14 able to have one to one conversations with staff to
15 understand their circumstances, and that was both the
16 clinical situation of our own staff who were vulnerable
17 but also where they were at home with someone living
18 with someone who was themselves vulnerable or where they
19 had caring responsibilities which simply prevented them
20 being able to do what they normally did. So flexibility
21 as an employer was the key in being able to allow as
22 many of our staff as possible to continue working.
23 Q. That's very helpful. Thank you.
24 Moving on from there, you mentioned that
25 restrictions on social contact and the closure of

1 your shops had a significant effect on your
2 fundraising abilities. You also state that UK and
3 Scottish Government funding was critical to your success
4 and you say that, when the funding came, it was
5 bureaucracy free. How important was that, that the
6 funding was bureaucracy free, to your ability to help
7 children and families? If you had to be dealing with
8 bureaucracy, would that have made a big difference in
9 your response time, the range of services you could
10 offer?
11 A. Yes. I mean, it would have made a difference.
12 I wouldn't want to overstate that. CHAS, although we
13 work very closely with the NHS, we're not part of the
14 NHS and the majority of our funding comes from voluntary
15 donations from the generosity of the public and often
16 those are funds raised in events which bring people
17 together, so many of them had to stop. So, as an
18 organisation, we were making sure that we could pay our
19 staff every month and that we were meeting our financial
20 obligations and the policies and covenants around
21 reserves that we have in place. We would have not been
22 able to continue delivering services in the way that we
23 did and to the extent that we did without the additional
24 Government funding that came in to compensate for the
25 lack of fundraising possibility and the ability to use

1 the furlough scheme in respect to some of our staff.
2 Q. And how important was the timing of that funding?
3 Did it arrive at a good point? Did it take too long?
4 A. Yes, it did. It took too long and it barely(?) arrived
5 at the right moment in time. What I would say is that
6 once the money had been provided by the Treasury and
7 that had come through bar no consequentials, decisions
8 were made quickly at that point, but both governments
9 should have worked together earlier to recognise that
10 this is hospice care, both children and adult's
11 hospice care, is a core public service, but it is not
12 funded in the same way as other core public services.
13 It is funded through the generosity of the public, and
14 when the ability to obtain that funding breaks down, as
15 it did during the pandemic, then an alternative
16 provision is required otherwise the service can't
17 continue.
18 Q. So in future, this, in your view, should be something
19 that's front and centre of the minds in the minds of
20 those responsible for public health?
21 A. I think it's critically important and I would say
22 critically important with a pandemic situation as well
23 as in a pandemic situation.
24 Q. You go on to talk about national guidance and you say
25 that, initially, national guidance didn't consider the

1 needs of hospice environments generally and, more
2 specifically, didn't consider the needs of children and
3 you had to then adjust the general guidance that was
4 available or interpret that. How easy or difficult was
5 it to interpret and adjust the guidance for use in
6 children's hospices or in the community in a palliative
7 care role?
8 A. It was possible, but it did require a lot of thinking,
9 and part of that is that the hospice provides a high
10 degree care for children with a high degree of
11 acuity, a high degree of clinical need, but is also
12 a homely environment. So we needed to be safe, we
13 needed to keep our staff and children and families safe,
14 but also wanted to try and provide as homely an
15 environment as possible. And much of the guidance
16 I think was initially written with the perspective of an
17 acute hospital in mind, where the intention is not to
18 provide a homely environment; the focus is on delivery
19 of a clinical service. So it did require us to read
20 several sets of guidance, so for hospitals, for care
21 homes, for community settings, and say, "Well, actually
22 how do we apply this?". And ultimately we used the best
23 judgment that we could to balance the need to deliver
24 a good service with keeping people safe.
25 Q. Were you able to contact any Government departments or

1 teams to highlight the need for hospice specific which
2 also took the needs of children into account?
3 A. We did raise that and later on in the pandemic we
4 identified a contact at Health Protection Scotland who
5 was able to provide excellent and consistent advice, so
6 became a named person that we could contact with queries
7 and questions and took the time to understand the
8 service so we didn't need to explain everything lots of
9 times over. They were able to provide very, very
10 effective advice, but it took some time for that to be
11 put into place.
12 Q. So would you then think that one of the things we could
13 focus on in the event of a future pandemic would be to
14 ensure these relationships are set up from the outset?
15 Would that relieve a lot of anxiety for people and make
16 the work of third sector organisations more
17 straightforward?
18 A. Yes, I think it would and I think it speaks to
19 a slightly wider point as well, which is to understand
20 and recognise what service, who is providing what
21 service to whom and that not all public services are
22 provided by the public sector and actually there are
23 other players, often the voluntary sector, who are
24 critical in providing public services and delivering
25 them. And so understanding the nuances and complexities

1 of that is really important from the outset and I would
2 say that, again, that is a lesson that is not just
3 applicable to a pandemic situation but more broadly to
4 how services are planned and delivered across the
5 country.
6 Q. Thank you. You then go on in paragraph 47 to state that
7 guidance required that children that died at home with
8 "COVID" on their death certificate be placed in body
9 bags before transfer to your bereavement suite and that
10 families weren't able to see their children again after
11 they died. Was it parents' choice to have their
12 deceased child transferred to your bereavement suite or
13 was that mandatory in some situations and beyond
14 parents' control?
15 A. No, definitely not mandatory, but it is often a choice
16 and I would say it was a distressing circumstance. And
17 often when we work with families for a long period of
18 time, often parents and sometimes children themselves
19 have questions about saying, "Well, where will I be at
20 the end? What will happen when I die? What will happen
21 when my child dies?", and knowing in advance where
22 a child might be is hugely important. So a bereavement
23 suite is a under normal circumstances is a cold room
24 which would allow a child, after they'd died, to be
25 together with their family, to lie in a bed in a cold

1 room for a period of time between the child dying and
2 the funeral, and it would allow the family to see the
3 child, to say "Goodbye" to the child and spend time
4 together. It's hugely important in the bereavement that
5 follows and in the coping that becomes necessary.
6 So it was very difficult in the small number of
7 children who died with "COVID" on their death
8 certificate where families were not able to say
9 "Goodbye" in the way that they might have planned or
10 wished, but certainly there were there was at least
11 one family who wished nonetheless to come to the
12 Rainbow Room with their child to be in the place that
13 they had planned for their child to be, even though they
14 couldn't actually see them and couldn't undo the body
15 bag.
16 Q. Were there any families who, after they'd taken that
17 decision, regretted it and wanted to be with their
18 child's body and, if so, what happened then? Do you
19 think there should be exceptions to allow parents to be
20 with their child at that point?
21 A. I think the alternative would be that a child would be
22 taken to a mortuary quickly, from home, so I'm not sure
23 if parents would have regretted that. I can't speak to
24 that. But I think what I can say is that some rules can
25 go out the window when a child is dying and we have to

1 weigh up what is the greater harm caused, and I think
2 that there are certainly parents who would have wished
3 to have had more time with their children at end of life
4 during the pandemic than they had, where their child
5 died from COVID, and would have been willing to take the
6 risks associated with that. But people stuck by the
7 rules and that put families often in impossible choices
8 and forced them into impossible choices.
9 THE CHAIR: Is it fair to say this is a very difficult
10 subject, obviously, Mr Okasha but if we're talking
11 about possible advice that could be tendered by this
12 Inquiry, much might depend on the circumstances, by
13 which I mean the nature of the disease causing the
14 pandemic, as to how much discretion could ever be
15 granted. Obviously we're dealing with a disease which
16 actually has a relatively low mortality rate. If, for
17 example, a future pandemic involved the disease with
18 a much higher mortality rate, then it might not be
19 advisable to allow any discretion. Do you accept that
20 as a proposition?
21 A. I do. I think that's very fair. This has got to be
22 situational.
23 THE CHAIR: Yes. Thank you.
24 MS BAHRAMI: Thank you.
25 Now, you say in your statement that children with

1 life shortening conditions and their families were
2 already going through a terrifying time and the pandemic
3 brought additional stress and worry. We've spoken about
4 how CHAS dealt with the volume of guidance, but how did
5 the volume and issues of interpretation of guidance and
6 the rate of change impact children themselves and their
7 families? How did they find it?
8 A. I think it was difficult. Many of the families of
9 children with life shortening conditions live in
10 difficult circumstances. Many a disproportionate
11 number live in poverty and the guidance often that was
12 produced was fairly technical. Many of the families
13 that we support have children with rare diseases, where
14 the impact of COVID on that child was would have been
15 unknown. And so I think families did worry a lot about
16 trying to keep their children safe, and we saw that
17 actually, that, even before lockdown, many families were
18 choosing to self isolate well before March 2020 when
19 COVID was in the news. We noticed a number of families
20 who had planned respite stays in a hospice who felt that
21 they didn't want to come because they were staying at
22 home now. I think that reflects a sense of uncertainty,
23 worry and the natural desire that parents have to
24 protect their children and to keep them as safe as
25 possible. So I think that was difficult in terms of

1 understanding it.
2 I think there were then some consequences of the
3 guidance and regulations for people that were very
4 difficult for families to work with. There was one
5 example I know of a family who described the impact of
6 lockdown on them being that, because they were not able
7 to leave their flat, they weren't their son was not
8 able to use the bicycle the specially adapted bicycle
9 that he had, which helped keep his muscle tone and, as
10 a result of that, lost the muscle tone that he had. So
11 there were impacts on children's physical and emotional
12 development as a result of lockdown that I think were
13 not thought of at the point that lockdown regulations
14 were considered.
15 Q. Thank you. I'll come on to that in more detail as well.
16 Next in your statement you talk about the
17 difficulties of accessing PPE, COVID 19 tests and
18 vaccines from the outset, particularly for hospices,
19 being outside the NHS system. Do you have views on how
20 those things could be made easier in future? Would it
21 be a case of incorporating hospices into the NHS system
22 or do you have other thoughts on how that could be
23 improved?
24 A. Yes, I think that's really important and it comes back
25 to the point about recognising that a range of providers

1 provide public services, not just the NHS, important and
2 wonderful though that is. The experience that we had in
3 CHAS was that initially it was very difficult to get PPE
4 and we were not able to order PPE through the normal
5 supply chains that we might have used to order other
6 clinical supplies because we hadn't ordered that type of
7 PPE before. That changed once a more national supply
8 chain was introduced through NHS National Services, and
9 that worked very, very well. We were able to order
10 supplies quickly.
11 But what I would say is that, initially, this only
12 was available to social care providers. Now, with the
13 way the range of our services work in CHAS, our at home
14 services are classified and regulated as a social care
15 provider and our hospices as an independent healthcare
16 provider, so we were able to obtain PPE for our at home
17 services but not our hospice services, which seemed to
18 me to be an ill thought out route. Now, that resolved
19 itself but not quickly enough, and I think that is
20 a learning point for future.
21 With regard to vaccinations, I mean, that was an
22 important point. We were at one point in a position
23 where our staff who work in Robin House in the west of
24 Scotland were able to obtain vaccines alongside NHS
25 staff but our staff in Rachel House were not. They're

1 based in the east of Scotland. So clearly there was
2 a lack of consistency across the piece in relation to
3 vaccines.
4 I think testing worked relatively well. There were
5 no real challenges with obtaining testing through NHS
6 routes.
7 Q. Thank you. Similarly, in relation to vaccines for
8 unpaid carers, you mentioned that not all unpaid carers
9 were on the priority list because not all are known to
10 their GPs. How could that be addressed in future?
11 Are you aware of any organisation that does have a full
12 list of all unpaid carers or does such a thing not
13 currently exist?
14 A. Not that I'm aware of. I think this is an area where
15 lots of different voluntary sector organisations can
16 play an important role in helping identify families.
17 It's not something that we could do in CHAS alone, but
18 there would be in combination with other charities,
19 I'm sure the voluntary services would be able to help
20 statutory services develop a more comprehensive list
21 that could be used in future.
22 And I think clarity about the eligibility criteria
23 and the hierarchy of eligibility for future vaccination
24 programmes would be very important, and I think, allied
25 to that, it's got to be part of what we've got to

1 think about is what it is a vaccination programme is
2 trying to achieve, and I think Government has to be very
3 clear about what the intents are, and that is if the
4 intent of a vaccination programme is clear, then the
5 hierarchy follows.
6 Q. Thank you. Now, at paragraph 78 of your statement you
7 state that:
8 "Some families reported feelings of decreased worth,
9 as the narrative around the virus 'only' seriously
10 affecting those with underlying health conditions took
11 hold there was a sense for these families that the
12 authorities were more resigned to these deaths."
13 Could you expand on this? Were there other things
14 that contributed to this belief amongst families?
15 A. That's a really interesting question. There may well
16 have been. I mean, I think what I heard from families
17 was that the public messaging, particularly in the early
18 days of the pandemic, was along the lines of, "For most
19 people this will be a mild disease unless you have
20 serious underlying health conditions". And, of course,
21 if you don't, then that's a reassuring message, but if
22 you do have serious underlying health conditions, that's
23 an even more worrying message, and I think families felt
24 is that they were not always being spoken to or
25 considered and that there was greater value being placed

1 on those who do not have underlying health conditions
2 than those who do. I realise that the messaging was an
3 attempt to be reassuring but it didn't always have that
4 effect.
5 You asked what else might lead families to think
6 about that and I'm speculating, but I do know that there
7 are many families of children with complex needs or with
8 disabilities who see and live in a world that is not
9 always designed for their children and where the needs
10 of their children are not always understood and taken
11 account of, and I think that is a day to day reality
12 that many families live with and is the backdrop to how
13 a lot of things that they hear will be understood and
14 interpreted.
15 Q. That's helpful, thank you.
16 Now, I understand that the families CHAS supports
17 received shielding letters at different times, some
18 didn't receive these letters and that generally families
19 felt the letters didn't contain enough information for
20 children in high risk groups. Do you have any thoughts
21 on how that issue could be addressed in the event of
22 a future pandemic, you know, particularly given that
23 early on not much was known about the virus?
24 A. I think that's right. I mean, the shielding list,
25 I suppose, was there to act out of an abundance of

1 caution because it was introduced relatively early,
2 before the full before as much about the virus was
3 known as is now. But certainly there were families that
4 we support and who know each other, who were saying,
5 "Well, I've not had a shielding letter but you have and
6 we've got similar conditions that we work with", so
7 there was an inconsistency both in the issue of letters
8 and in the timing of letters.
9 I think one of the challenges with this group of
10 families is that many of the conditions that we see are
11 rare. Some do not have formal diagnoses and so it's
12 very difficult to know how a shielding list might have
13 been built. But I would certainly be very happy in any
14 future pandemic to try and be a point of contact to help
15 identify families who haven't received a shielding
16 letter but thought they might have, and perhaps if there
17 had been some way of the many organisations who work
18 with vulnerable families across Scotland being able to
19 nominate or identify families who really ought to be
20 considered for shielding, that might have been helpful.
21 Q. Yes. And on the issue of trying to get shielding
22 letters in time, when restrictions started easing, some
23 parents you mention were uncomfortable at the thought of
24 going back to work and were anxious, but they didn't
25 have shielding letters so had concerns about proving

1 this. Was there any avenue open to them to try to get
2 such a letter, whether through their GP or some other
3 organisation?
4 A. I think through the GP would have been the likely avenue
5 but I can't speak to that in detail.
6 Q. Okay, thank you. Now, you've mentioned today that some
7 families decided to self isolate early on, before
8 national lockdowns, and you've mentioned that in your
9 statement, but you also mention that other families felt
10 entirely differently and they thought that, the limited
11 time their children had left, they should be able to see
12 family members and do certain activities. Are you aware
13 of a view among families of a need for more flexibility
14 and, as his Lordship has pointed out, it might be that,
15 given the nature of a pandemic, it's not possible for
16 there to be flexibility but is there generally did
17 families have a view that they should have more
18 flexibility than they had so that, if they wanted to see
19 certain family members, that that should have been
20 allowed and, if they wanted to isolate for longer, that
21 that should have been supported?
22 A. Some families definitely did feel that they would have
23 wished to have more flexibility about seeing a wider
24 range of family members in the limited time that they
25 had available or to make sure that their children had

1 experiences before they died. I can't generalise around
2 that. It's a very individual set of choices that
3 parents will make and many factors, I'm sure, would have
4 weighed on that at different times.
5 I think that in relation to the choice about
6 shielding for longer or remaining home for longer,
7 I think there's something qualitatively different about
8 that than making choices about taking risks. This is
9 actually about families who the people who know their
10 children best know what is likely to cause them
11 ill health and harm and were trying to do everything
12 they could to prevent that. And I think the ability
13 to in many cases, employers were very flexible and
14 understanding of the circumstances of people who were
15 not able to return to work or had to continue working
16 from home, but that wasn't universal and there were
17 certainly families who were put in impossible positions
18 and making very difficult choices.
19 Q. Do you think that other things could have been done to
20 help those families that you mentioned that wanted to
21 isolate for longer, to help them feel more content and
22 confident about measures being restrictions being
23 eased and to feel more confident about going out in
24 society or do you think that just their experiences
25 would have always been such that they would never have

1 felt confident anyway?
2 A. I'm not sure it's always about confidence. I think it's
3 about recognising that parents are experts in their own
4 children and will have a greater understanding of the
5 likely impact of a respiratory condition on the children
6 that they are caring for and there were children
7 there were families I know, who spoke to me and to CHAS,
8 who said, "I know that if my child gets this, it will
9 have an impact on them because they have an underlying
10 respiratory condition", so I think it was more than
11 confidence and worry. I think it was the fact that
12 there were parents who were having to choose between
13 going to work and keeping their child safe, and that is
14 not a position that any parent should have to be in.
15 Q. Thank you. You also speak about surgeries being delayed
16 and you mentioned just earlier about children not being
17 able to make use of specialist equipment because of the
18 restrictions. Could you tell us some more about the
19 physical and emotional consequences of delayed surgeries
20 and not being able to use equipment on children that you
21 support and how that compares to otherwise generally fit
22 and healthy children?
23 A. I think that the impact of delayed healthcare can be
24 felt immediately, it can be felt in the medium term and
25 it can be felt emotionally, and all those things played

1 out. I mean, children did receive healthcare during the
2 pandemic and there were children who needed to be in
3 hospital who were in hospital, so it is important to
4 recognise that this probably applies to, I suppose, what
5 we might call the second order of things, so things that
6 are not urgent but things that are still necessary and
7 desirable to support children.
8 I think the impacts that were greater than delayed
9 access to healthcare were the difficulties for children
10 who were at home for extended periods of time, in small
11 flats, in large families, who were not able to get
12 outdoors and for whom their physical and emotional
13 development was absolutely impacted. I spoke to a mum
14 recently actually who described and said that, "People
15 have to understand that, even after lockdown ended, it
16 took me a year to be able to leave my house", and she
17 said, "That was because my daughter had become
18 accustomed to being in the house and was frightened
19 herself of leaving". So the impact on the mental health
20 of children was very significant as a result of
21 lockdown.
22 Q. Thank you. I want to move on to home learning once the
23 schools were closed. Now, some of the families that you
24 support, as well as having a child with a life limiting
25 condition, will have other children as well. How did

1 the families with one child and also those with multiple
2 children how did they cope with home schooling during
3 periods of closure?
4 A. I think generally with some difficulty. There were
5 families who were home schooling who were trying to be
6 a parent and a carer for their child 24/7 and being
7 a people assistant for their child and trying to work
8 from home, and doing those four things is not easy and
9 doing it continuously is really hard. And the impact on
10 parents was very, very significant and I think it comes
11 to what I would say is the overwhelming impact of having
12 a child with very complex needs who requires care
13 24 hours a day. It is non stop, it is exhausting, it is
14 continuously demanding, and if you are, in particular,
15 a single parent, there was often during the pandemic
16 and during lockdown there was often no help available,
17 literally nothing, and so that was hugely, hugely
18 wearing for families.
19 I think for families where there are more than one
20 child, very often siblings become de facto carers for
21 their ill child and, you know, their own experience of
22 growing up is impacted and was impacted during the
23 pandemic.
24 Q. Were schools able to provide any sort of assistance for
25 those families when they were teaching virtually or ...?

1 A. I think the situation varied from different places.
2 I've certainly heard from parents who say that
3 individual teachers went out of their way to support and
4 help them to provide materials for them to use at home
5 but that the system didn't always understand the needs
6 of the parents. And I suppose, you know, often, where
7 a child was at home, not in a hub school or not
8 returning to school after the schools re opened because
9 the family was protecting that child or the school
10 couldn't meet the needs of that child because of their
11 particular needs, there would have been a if that
12 child had been at school, there would have been a range
13 of supports available in terms of people support
14 assistance, which were not available if that child was
15 at home, not able to go to a hub school or not able to
16 return after schooling. I think some parents have noted
17 and said to me that, even in those circumstances, the
18 funding continued for the support to be available at the
19 school that funding was in place, but it wasn't
20 delivered in the child's home. And I think there are
21 some examples of where people's support was provided in
22 a cluster, where there was a small group of families who
23 were supported by a people support assistant within the
24 school, but that wasn't generally provided at home, if
25 at all.

1 Q. Okay. Thank you. Following on from that, there's one
2 aspect, the support provided in classrooms by
3 assistants, but also children might have input from
4 allied health professionals, like speech and language
5 and physiotherapy to just be able to carry out basic
6 functions. How did the withdrawal or closure of those
7 services impact children's ability to access education?
8 You know, did you was there regressions in speech, in
9 the ability to sit upright, to pay attention? How did
10 those withdrawals of service impact?
11 A. I'm not sure I can speak to the detail of that, but
12 certainly it is the case that families talked about
13 community physiotherapy being harder to access during
14 the pandemic and at times not possible. We have a small
15 number of physiotherapists in CHAS who were supporting
16 and supported as many families as they could, but
17 certainly I think that was a missed service, and I think
18 the same would be the case in speech and language
19 therapy but I'm not sure I'm qualified to comment
20 specifically on the physical impacts around that.
21 Q. Sure. Thank you.
22 Do you have any thoughts on how support for families
23 could be improved in the future in respect of home
24 schooling?
25 A. I think understanding that, even when schools re opened

1 and when hub schools were in place, they were not
2 physically suitable for all children. So there were
3 some children, for example, who have respiratory
4 problems where there are aerosol generating procedures
5 that might require them to be in their own room for that
6 procedure to take place, with staff wearing full PPE,
7 which wasn't provided. There were differences between
8 the PPE arrangements for staff who were delivering
9 healthcare to a child and staff who were working in
10 a school with a child, and so the physicality of the
11 buildings was not always suitable for children.
12 I think underlying that is something that I've heard
13 from parents, which is there was a tension between the
14 medical advice they were receiving, which was
15 "Be cautious", and the educational advice they were
16 receiving which was, "Schools are open again. Why
17 don't you come back?". And parents were confused
18 sometimes which advice do they follow, medical advice,
19 educational advice? And the I spoke to a mum last
20 week who said that during the pandemic she had had to
21 make choices to be "unsupportive to my daughter's
22 education in order to keep her safe".
23 Q. Yes. And in fact you say in your statement that parents
24 felt the needs of their children with life shortening
25 conditions were not considered by the Government when

1 planning the return to classrooms. To what extent was
2 the general guidance that was provided useful to those
3 families, if at all?
4 A. I think that was the view of many families. I can't
5 speak for all, of course. I think some examples of
6 where the guidance was not always meeting the needs of
7 those families would be in relation to children who were
8 not returning to school, perhaps because they required
9 aerosol generating procedures that couldn't be provided
10 in school, but their siblings were. So their siblings
11 were going to school, being exposed to other children
12 and potentially transmission of the virus and then they
13 were coming home. So there were parents who were making
14 decisions and some parents who I think made decisions
15 for their siblings not to go back to school when the
16 siblings could have gone to school because of the impact
17 on the ill child at home, and that I think was not fully
18 teased through. So had, for example, there been
19 a different approach or a more bespoke approach put in
20 place, where required, around PPE within schools for
21 those who were in contact with children who were
22 vulnerable, either ill children or siblings, I think
23 more children would have been able to access education
24 more quickly.
25 Q. Were you able to you mentioned that you established

1 connections with a certain Government department.
2 Were you able to utilise those relationships to
3 highlight these issues and concerns?
4 A. We certainly spoke to and had a very open relationship
5 with civil servants and with ministers. They were, in
6 my experience, very willing to listen and to respond and
7 to involve the right civil servants in Government.
8 There were times when we offered advice and thought
9 that or offered advice and that advice wasn't sought
10 or taken up. But in the main I found the Civil Service
11 to be responsive during that period.
12 Q. Okay. Do you know, were the siblings of seriously ill
13 children given places in hub schools or is your view
14 that they should have been if they weren't?
15 A. I can't speak to that. I don't know.
16 Q. Okay, no problem. Thank you. In paragraph 124 we've
17 spoken about how the guidance was general, but in 124
18 you mention or commented that:
19 "... guidance for children with 'additional needs'
20 was too broad and did not always consider those children
21 with complex health needs...", and so on.
22 Is this a reference to specific guidance or is it
23 a reference to the general guidance not being
24 appropriate enough?
25 A. I think this is speaking to guidance around schools and

1 the kind of things we've talked about around how
2 siblings and [broken audio] might be accommodated. And
3 I think what was [broken audio] have rare and unusual
4 medical conditions and [broken audio] there is no easy
5 access to advice for schools about how to support those
6 children. [Broken audio] and wishes [broken audio]
7 those circumstances where parents were really listened
8 to and involved in planning the best outcomes for
9 families [broken audio].
10 Q. You say that parents felt that national guidance [broken
11 audio] and that, had there been national guidance, it
12 [broken audio] for risk assessments and to actually
13 carry out risk assessments and create individual plans.
14 Are you aware of families [broken audio] contact local
15 authorities to have a lack of [broken audio]?
16 A. I'm not [broken audio], it's not something that families
17 have spoken to me about, but I would imagine [broken
18 audio], yes, parents are [broken audio] for their
19 children often.
20 Q. Yes, and on that basis I take it you wouldn't be able to
21 comment on the uniformity of families' experiences
22 across the country in putting those things in place?
23 A. I think only to say that often I will have heard from
24 families and families will have come to CHAS where
25 things haven't worked well, and there will be many

1 examples, I'm sure, of where things have worked well,
2 but often the things that I tend to hear about are those
3 where families have had more difficult experiences.
4 Q. Hmm hmm, thank you. Now, at paragraph 115 you say that:
5 "... parents were anxious to emphasise the right of
6 their child to an education as enshrined in the
7 United Nations Convention on the Rights of the Child
8 and the right to reach their full potential safely, as
9 enshrined in GIRFEC. They did not want their child to
10 miss out on education time, but they felt they had no
11 choice [but to keep them off school]."
12 Why was it that they felt they had no choice?
13 You've spoken a bit about it already, but ...
14 A. I think the parents I've spoken to had genuine and real
15 and credible fears that, if their child contracted
16 COVID, that it would have a devastating impact on their
17 health, and that was particularly the case with children
18 who have respiratory or underlying respiratory
19 challenges or difficulties. And so parents were
20 choosing as to whether they should keep their child at
21 home and safe or go to school and educated. And I've
22 certainly spoken to parents who made the decision to
23 keep their child safe at the expense of their child's
24 education, but felt that that was the lesser of two
25 evils. And that I think is a real problem that will

1 impact on those children for the rest of their lives
2 and, in the case of siblings, perhaps for longer again.
3 Q. You've touched on some children requiring
4 aerosol generating procedures.
5 A. Hmm hmm.
6 Q. You also mention that some children are ventilated and
7 need a separate room and that was one of the issues in
8 children returning to school, the lack of that. Were
9 those spaces available prior to the pandemic?
10 A. Well, I can't speak to every school. I suppose prior to
11 the pandemic, then, there would have been no need for
12 a separate space. Those children you know, if
13 a child requires suction, that could have happened in
14 a room with other people. It was really only because of
15 the guidance around the risk of the formulation of
16 droplets from those procedures and the contracting of
17 COVID from that that it became an issue. So it may well
18 be that there will have been some schools that
19 physically could not have accommodated that but
20 I imagine there are some that could.
21 Q. So with children that do have respiratory conditions,
22 often or my understanding is that often, even during
23 flu season, they are more significantly impacted and
24 will be hospitalised, admitted to hospital, as a result
25 of contracting a flu that perhaps their sibling

1 contracted and was perfectly fine continuing. So even
2 in those given that even at those times they wouldn't
3 have had a separate room for these children to have
4 those procedures carried out
5 A. That's not my understanding that is my understanding,
6 that that wouldn't have necessarily have been the case.
7 In the same way, in our hospices, where there are
8 children who are ventilated or require suction, you
9 know, that can be done that doesn't require a special
10 space necessarily to happen. The differentiating factor
11 in relation to COVID was the increased risk of
12 contracting COVID as a result of aerosol particles being
13 generated and being in the air. So that wouldn't
14 necessarily have I think the issue was COVID specific
15 during that.
16 Q. I think it's in your statement or perhaps we've heard
17 from someone else that some schools had other rooms for
18 children with behavioural issues and additional needs
19 there and they used those additional rooms to isolate,
20 to provide a calm environment for those children.
21 Do you think more use should have been made of those
22 rooms for children that required aerosol generating
23 procedures?
24 A. Well, it certainly sounds sensible. I mean, I think the
25 key point in this is that, for children with exceptional

1 healthcare needs and that's what these children
2 have exceptional circumstances need to be made, and
3 by that I mean schools need to work with families to
4 understand the art of the possible and to do anything
5 that supports children to be safe and able to access
6 their education. And I think there was variation across
7 the country in the degree to which that happened.
8 THE CHAIR: Ms Bahrami, you've got 15 minutes.
9 MS BAHRAMI: Thank you, my Lord.
10 Q. With that, do you think that issues of prioritisation
11 come into play here, that behavioural needs were in some
12 cases perhaps being put ahead of essential physical
13 health needs? And do you think if that's the case,
14 do you think that, where guidance stipulates that
15 a separate room is needed for an aerosol generating
16 procedure or ventilation, that the guidance should place
17 an obligation on schools or other education providers to
18 provide such a setting; for example, adding a portable
19 cabin on campus or in some other way setting up that
20 space?
21 A. I think that would be very reasonable. We're talking
22 about a very small number of children with
23 life shortening conditions who require
24 aerosol generating procedures. I think that
25 adaptations physical adaptations to schools are

1 obviously dependent on the school that's there. But
2 I think, stepping back, a more broader point is that we
3 should expect children who have life shortening
4 conditions to be able to play a full part in society, to
5 receive an education, and that is important in its own
6 right but it is also important because the rate of
7 medical advance means that many children are living much
8 longer and will live into early adulthood. These are
9 children who are entitled to an education. They didn't
10 receive it during COVID and they should have.
11 Q. Yes. Presumably the impact for those children of
12 missing that part of their education is more profound
13 than on children that are otherwise fit and healthy.
14 Does it, in your experience, have more of an ongoing
15 effect or is it limited to the gap in education?
16 A. I think it's a question for an educationalist. I would
17 imagine that missing education for any child will have
18 an impact on their development. I think what is
19 important and what was specific to the children that we
20 work with in CHAS is the intensity of care needs that
21 those children have and the fact that, if you live in
22 a very small house or flat and are there the whole time,
23 educating and caring for your child, it is hugely
24 physically demanding on the parent, and I suspect that
25 that is not the circumstances which will lead to the

1 best educational outcomes for children.
2 Q. Thank you. Did you have any feedback from parents about
3 the willingness of schools and local authorities,
4 Scottish Government, to meet the extra needs of their
5 children?
6 A. I certainly heard parents praise teachers for producing
7 materials, for adapting materials, providing lesson
8 plans for parents to deliver, but I also heard parents
9 saying, "But I struggled to do that because I'm also
10 trying to look after other children, I'm also trying to
11 work from home and I'm a single parent. I can't do all
12 this".
13 Q. Thank you. Now, is there anything that we haven't
14 spoken about today that you would like to address?
15 A. I think the thing that I would want to say is that,
16 although the number of children with life shortening
17 conditions is small, it is hugely important to think of
18 the impact on them of decisions. Where a child has
19 a short life, they and their parents try to squeeze it
20 all in and, for many of us, COVID was a really tough
21 time and we lost time together with our families and
22 loved ones. When time is also short for a family, it
23 has a concentrating effect and the impact of regulations
24 and lockdowns, whilst very understandable, has an impact
25 on this group of families that was not always considered

1 or thought through. And so that may be for very
2 understandable reasons because we were, as a society,
3 learning so much in such a short space of time, but
4 I think the learning from this pandemic is that the
5 implications for these families need to be considered to
6 make sure that the health, emotional and educational
7 impact is minimised and that families are supported as
8 much as possible, and I think there are many families
9 who felt that they were not supported as much as they
10 ought to have been.
11 MS BAHRAMI: Thank you very much.
12 THE CHAIR: Yes, thank you very much indeed, Mr Okasha.
13 Very good. You've got one more witness, Ms Bahrami.
14 We'll come back we're a little bit early if we can
15 between about 10 to or 5 to 3.
16 MS BAHRAMI: Thank you, my Lord.
17 (2.36 pm)
18 (A short break)
19 (2.56 pm)
20 THE CHAIR: Good afternoon again, Ms Bahrami.
21 MS BAHRAMI: Good afternoon, my Lord. My Lord, we now have
22 Helen Malo of Hospice UK.
23 MS HELEN MALO (called)
24 THE CHAIR: Thank you very much indeed. Good afternoon,
25 Ms Malo.

1 A. Good afternoon.
2 THE CHAIR: Ms Bahrami, when you're ready.
3 MS BAHRAMI: Thank you, my Lord.
4 Questions by MS BAHRAMI
5 MS BAHRAMI: Good afternoon, Ms Malo. Please could you tell
6 us a bit about your own background and the background of
7 Hospice UK.
8 A. Of course. So I'm Helen Malo. I'm the senior policy
9 and public affairs manager for Hospice UK and Scotland.
10 So Hospice UK is the national charity for hospice and
11 end of life care. We're a membership organisation, so
12 all charitable hospices in Scotland are part of our
13 membership. My role in Scotland certainly at the
14 start of the pandemic, I was the only Scottish based
15 member of staff for Hospice UK and my role is really
16 about working very closely with all Scottish hospices,
17 supporting them to have a national voice for the sector,
18 supporting them to try and prioritise palliative care
19 and hospice care in Scotland at a national policy level.
20 Q. Thank you. And can you tell us a bit about the work
21 that Hospice UK does? I understand there are
22 16 charitable hospices across Scotland that are members
23 of Hospice UK and they support 22,000 people a year,
24 both providing palliative and end of life care. Can you
25 tell us a bit more about that and also speak about

1 we've heard in terms of children what this difference
2 means, but in terms of adult care, the difference
3 between palliative care and end of life care?
4 A. Yeah. So maybe if I start with that and then talk
5 a little bit more about hospice care specifically.
6 Q. Thank you.
7 A. So palliative care is care for patients when with an
8 illness when a cure is no longer possible. At
9 Hospice UK we often refer to the World Health
10 Organisation definition of "palliative care", and I can
11 read it out, but that's about "having an approach which
12 improves the quality of life of patients and their
13 families facing the problems associated with
14 life threatening illness through the prevention and
15 relief of suffering by means of early identification and
16 impeccable assessment and treatment of pain and other
17 problems, physical, psychosocial and spiritual [as
18 read]".
19 So it's really about having holistic care of
20 a patient, having a team approach to supporting their
21 needs. So it might be around pain relief or relief of
22 other physical symptoms, like breathlessness, but
23 equally it might be around psychosocial support or
24 spiritual care. And it's really embedded it's about the
25 needs of not just the individual but their family and

1 their loved ones and it's really about affirming life
2 and supporting people to live their best life as fully
3 as possible.
4 Then end of life care is part of palliative care.
5 It can be commonly understood as care in the last year
6 of life, but, equally, it's quite context dependent and
7 other people might refer to it in terms of when someone
8 is recognisably in the process of dying, and that might
9 be in the last months and weeks and days of life.
10 Then, more specifically, about hospice care, so
11 that's hospice care is a really vital, important
12 provider of palliative and end of life care, and in
13 Scotland they provide support, you know, direct to
14 patients but also to their families and loved ones.
15 I think people are very familiar with, sort of in their
16 local communities, their local hospice, they're very
17 well known institutions, but perhaps they're not always
18 aware of all the care that they provide. So hospices
19 will provide in patient care, but actually the majority
20 of the care that they provide across Scotland is out in
21 the community, so most hospices will have community
22 teams where they'll visit people at home, they'll
23 provide outpatient appointments, a lot more some
24 virtually as well and day therapy services.
25 There are other services as well that they don't

1 all provide the same services, but there's a wide range
2 of support for patients and their families, like respite
3 services, bereavement, counselling, sort of
4 compassionate community type initiatives, like
5 befriending services out in the community. They might
6 do drop in information services or welfare support. So
7 it's really again, it's that holistic care of the
8 individual and their families.
9 But hospices are so they're charities, so our
10 members are the charitable hospices, and so they're
11 not part of the NHS but they're really important
12 partners in the wider health and social care system. So
13 as well as providing direct care, they'll also provide
14 clinical expertise and support to other members of
15 health and care staff, so to GPs, district nurses, to
16 colleagues in hospitals, so providing that expertise and
17 palliative care advice. They'll provide strategic
18 leadership locally around palliative care. They provide
19 education and training and they really support the NHS
20 and statutory services, so they'll help patients to stay
21 at home and to avoid unnecessary admissions to
22 hospitals. So they are a really vital part of the wider
23 health and care landscape in Scotland.
24 Q. Thank you. You state in the penultimate paragraph of
25 page 1 that not every health board in Scotland has

1 a charitable hospice and the NHS and other partners
2 provide specialist palliative care in areas,
3 geographical areas, where there isn't a hospice. Now,
4 typically third sector organisations complement
5 NHS services or meet a need where the NHS can't, but it
6 seems that, in the case of hospices, it's the other way
7 around, that the third sector meets this need and, where
8 it can't, where it isn't possible, then the NHS steps
9 in; is that correct?
10 A. I think the hospice sector, it's a unique sector, so it
11 does provide an essential core service palliative
12 care is an essential service to provide to people in
13 Scotland and there is a mixture of how that is
14 delivered across Scotland, so both charitable hospices
15 and then also NHS services, as you say. I think that's
16 partly reflected in just the hospice movement and how
17 that's evolved historically over time. And, I mean, if
18 you looked at a map of Scotland and where the hospices
19 are, the majority of hospices are around the central
20 belt and you do have a few other hospices scattered
21 across Scotland, but they very much evolved based on
22 community need and sort of the drive and energy and
23 determination of local communities to raise the funds
24 and have a hospice in their local community.
25 So they are it is a unique sector. There isn't

1 another part of the Health Service where so much of
2 a core service is provided by the voluntary sector, but
3 it does mean there's you know, you live in one part
4 of Scotland, you might have a local charitable hospice;
5 you live down the road in a different area and your
6 needs might be met by the NHS.
7 Q. And given that set up and how integral it is and, you
8 know, I'm aware that, as a charitable hospice, there not
9 being the NHS provision as well does that make
10 funding even more vital than for other third sector
11 organisations?
12 A. Yeah, absolutely. So for charitable hospices, on
13 average, just over a third of their funding comes from
14 statutory sources and then nearly two thirds has to be
15 fundraised by their local community, so through
16 charitable donations, through shops, through, you know,
17 people running marathons and doing all the support that
18 people will have heard of. And then the impact during
19 the pandemic with the restrictions that were brought in,
20 that overnight that essential funding stream a large
21 part of it just stopped. So with shops having to close,
22 with not being able to have big events and fundraising
23 events, then that had a catastrophic event, you know,
24 impact on the sector because their services were still
25 of vital importance. People were still dying of all

1 the, you know, cancer and heart failure and all the
2 other reasons that people in Scotland are dying, their
3 care was still absolutely needed, but their funding
4 revenues had been dramatically cut because of the
5 restrictions.
6 Q. So how were they able to continue their services? How
7 were they able to compensate for that?
8 A. So, I mean, we were very thankful that
9 Scottish Government did provide emergency funding for
10 the hospice sector, so Hospice UK and hospices in
11 Scotland worked together to ensure that there was
12 a commitment from Scottish Government. So it related to
13 Hospice UK in England, at Westminster level, secured
14 commitment for emergency funding for hospices and then
15 there was consequential funding which came through to
16 Scotland and then the Scottish Government thankfully did
17 commit to passing that on to hospices. Without that,
18 the hospices would have had to cut services or they
19 wouldn't have been able to continue.
20 So we're very thankful that that provided some
21 short term stability for the sector. I mean, the impact
22 and broader challenges around funding and the
23 sustainability of the sector are ongoing, so there are
24 certainly issues around the funding of the hospice
25 sector which need to be looked at in the long term, but

1 during the pandemic we were grateful for the support
2 from Scottish Government.
3 Q. Thank you. We've heard from a number of organisations
4 and individuals who stated that they found it difficult
5 to keep up with the volume of guidance, the frequency
6 with which it was issued and to fully understand the
7 intended meaning, and we've heard from CHAS to some
8 extent on this. But in the case of hospices there was
9 an additional difficulty because the guidance, at least
10 initially, didn't refer to hospices. Did there come
11 a point where the guidance did start including hospices
12 and, if so, when was that?
13 A. Yeah, and I think I mean, the question the points
14 that you and others have raised about the volume of
15 guidance absolutely was reflected in the hospice sector.
16 That was certainly, when I was talking to hospice
17 staff, that was one of the biggest challenges for them
18 to deal with, was just the sheer amount of guidance
19 coming out and how rapidly it changed.
20 Then, as you say and point out, the additional
21 challenge is that it's not clear where hospices fit and
22 for a long time hospices weren't necessarily
23 specifically mentioned in the guidance. And it's quite
24 hard to specifically pin down when exactly because
25 there's so many different strands of guidance around

1 visiting and testing and who is a key worker and
2 vaccinations and infection control.
3 I think it was towards the end of 2020 and then sort
4 of into 2021 where there started to be a bit more
5 clarification around, you know, specifically mentioning
6 hospices or that this perhaps not in the guidance,
7 but having confirmation, follow up from
8 Scottish Government, that this does also apply to
9 hospices. But then there was an additional challenge
10 where sometimes guidance would mention hospices but the
11 unique context that hospices work in wasn't fully
12 understood. So there might be examples where guidance
13 around infection control would put hospices in with sort
14 of social care providers, but actually a lot of what
15 hospices do and maybe their in patient units are more
16 akin to an acute hospital setting. So there was,
17 I guess, an issue with hospices not being mentioned in
18 the guidance and then, even when they were, a lack of
19 understanding of the context that they were working in,
20 which was very challenging for staff.
21 Q. Yes, thank you. Until the point where they did start
22 being mentioned, how did your adult member hospices go
23 about the task of translating the guidance for hospices
24 and what was the impact of that additional work
25 requirement on them?

1 A. I mean, speaking to hospice staff, it was a massive job
2 and I know, in some hospices, someone was telling me
3 that they had one of their consultants couldn't do
4 face to face clinical work because they needed to be
5 shielding, so in essence it was their full time job to
6 go through guidance and it could come out you know,
7 multiple times a week the guidance would change, so they
8 would have to sit down and go through it and then try
9 and translate it and think through how does that apply
10 to hospices and at a specific context.
11 I think hospices spoke very positively around their
12 local links with Public Health staff, like, and
13 infection control sort of advice within their local
14 health board areas, but they're very much reliant on
15 their local relationships that they have with
16 Public Health teams. It wasn't that there was
17 a specific clear structure or mechanism for them to get
18 that advice. And I know some of them have said, you
19 know, several months into the pandemic they managed to
20 get a named contact within Public Health Scotland and
21 then that would be their go to person, and just having
22 that link was really helpful.
23 But up until that point, it was really challenging
24 and then the impact for them was just the sense of
25 uncertainty and are they doing the right thing and

1 confusion and feeling people said, you know, they
2 felt like hospices were several steps behind, that they
3 were constantly on the back foot. So it was a huge
4 stress on staff and I think it just goes back to perhaps
5 the wider system not having that understanding of the
6 unique context that hospices work in.
7 Q. Thank you. Now, you go on to set out in the first
8 paragraph of page 2 that Hospice UK was involved in
9 clinical leadership, the development of national
10 guidelines, local protocols, in local and national
11 planning and in contributing to the research community's
12 rapid response to the pandemic. Could you tell us,
13 please, a bit about the ways in which Hospice UK
14 contributed to that?
15 A. Yeah, I can. I mean, I think my briefing actually says
16 "hospices" as opposed to "Hospice UK" but I'll talk
17 about both if that's helpful.
18 Q. Thank you.
19 A. So Hospice UK, certainly I really saw us as an
20 organisation coming into our own around that supports
21 and clinical leadership I think we had a really
22 important role because we work across the UK in terms of
23 bringing hospice staff together, so we had a weekly
24 we called it a " Clinical echo", like an online webinar
25 or online educational thing, where 300 hospice staff

1 from across the UK would join each week, where we would
2 share emerging guidance and national learning and have
3 that safe space where the sector could come together and
4 talk about the challenges that they were facing and
5 what's happening across the UK.
6 We also clinical colleagues of mine set up
7 I think it was a fortnightly clinical meeting with nurse
8 leads from across the Four Nations to share sort of
9 learning and how practice was changing across you
10 know, changes to visiting guidance or infection control
11 and communication and education and how it impacts
12 hospices.
13 Certainly, in England, Hospice UK was involved in
14 that national guidance. We didn't in Scotland in the
15 same way, but hospices in Scotland were very involved
16 in so they fed into national guidance, so they
17 provided because they are experts in palliative and
18 end of life care, they fed in and provided clinical
19 leadership around some of the national guidelines, so
20 around symptom control, around alternatives to standard
21 palliative care drugs, around some of the visiting
22 restrictions. And then locally also hospice staff would
23 feed into local guidelines. I know staff at Edinburgh
24 hospices fed into guidelines sort of COVID guidelines
25 across the Pan Lothian region. So, yeah, I think their

1 clinical expertise and leadership was very helpful at
2 both a national and local level.
3 Q. Thank you. Further on in paragraph 2, you speak
4 about I understand that hospices are regulated by
5 Health Improvement Scotland and you say that some
6 hospices felt burdened by Health Improvement Scotland
7 while others found the ground team helpful. Could you
8 expand on that? What was it that worked and what was it
9 that didn't work well and how could that be improved in
10 future?
11 A. Hmm hmm. I think so some of the so from
12 conversations I had with hospice staff about
13 Healthcare Improvement Scotland, there was like in
14 all the things that we'll probably cover today, there
15 was variation across Scotland, so people's experiences
16 and different hospices' experiences differed. I would
17 say the general feeling towards HIS from hospices was
18 more negative than perhaps some of the other bodies,
19 that they felt that perhaps HIS was a bit late to act or
20 a bit unsure of their role and how that fitted in with
21 other agencies in Scotland.
22 I mean, some of the practical examples that hospice
23 staff gave was around every time there were changes to
24 the infection control manual, HIS wanted them to update
25 all their standard operating procedures across the

1 hospice, and that could be sort of 14 separate
2 documents, and then, a couple of days later, things
3 would change and then they would have to go back and ...
4 So it was around like the burden of what they were
5 expected to do and I think hospices or some hospice
6 staff felt they could take a bit more of a pragmatic
7 approach. But, equally, I had positive stories as well
8 around HIS and perhaps, at individual levels, of
9 individual staff in HIS being helpful and being on the
10 end of the phone if they needed them.
11 Certainly one hospice, who I think was inspected by
12 HIS quite early on during the pandemic, they felt that
13 HIS was understanding of the situation and didn't want
14 to place too much burden on hospice staff. So I think
15 it was a mixed picture across different maybe
16 different parts of HIS but also across different
17 hospices.
18 Q. Thank you. In the next paragraph you mention the
19 Scottish Government palliative care policy team and
20 being able to contact them to have advice and
21 communication from them. Was advice and guidance
22 available from that team from the outset or did it come
23 later on?
24 A. I would say from the outset, I think. So civil servants
25 in the palliative care policy team were very helpful, so

1 they were available if hospices or Hospice UK had
2 queries, they would try and so it wasn't so much that
3 they were issuing guidance; it's more we could go to
4 them to ask for clarification. So some of those things
5 that we were talking about around the guidance not being
6 clear, we could approach their team and they would try
7 and find out the answer or be helpful or I mean,
8 later on in the pandemic they were helpful in terms of
9 connecting hospices with the national clinical director,
10 Jason Leitch, for a query around visiting guidelines,
11 for example. So, I mean, hospice staff have certainly
12 spoken warmly of the support that they got from civil
13 servants.
14 Q. Thank you. Now on page 3 you state that more people
15 were being cared for in the community. Am I correct in
16 understanding that adult hospices had to reduce the
17 number of beds that were available within hospice
18 buildings?
19 A. So, I mean, it varied from hospice to hospice. So some
20 did reduce beds. This might be because they were trying
21 to move to all single rooms, so trying to reconfigure
22 things within the hospice building to facilitate
23 visiting or to help with infection prevention and
24 control. Some others or so shifted their capacity, so
25 they saw that there was greater need in community

1 settings, so they, yeah, closed beds or moved staff so
2 that they had greater support and capacity in the
3 community settings.
4 Q. Were staff who worked within the hospice buildings kept
5 separate from those who worked in the community or could
6 it vary from shift to shift where an individual member
7 of staff was working?
8 A. I mean, I don't know the specifics so it would probably
9 vary from hospice to hospice. Anecdotally I know that
10 they talked about having separate teams or two teams for
11 different aspects and not wanting to mix them together.
12 And also I know of one hospice where, within the hospice
13 building, the clinical sort of the in patient bit of
14 it was kept separate from maybe more of the admin
15 support or the non clinical section, so they were
16 certainly following the guidance at the time, but, you
17 know, trying to adapt it and work it for their own
18 individual context.
19 Q. Thank you. Do you have an idea of how long staff would
20 spend in patients' homes? Was it, you know, less than
21 an hour? Would it be half a day, a full day, overnight?
22 A. I don't I mean, I don't have specific timings or
23 things like that. What I did hear from staff was that
24 their visits into people's homes were taking longer than
25 they did prior to the pandemic. So this might be

1 I mean, some of the reasons for that some of them are
2 just practical reasons, like having to put on all the
3 PPE before going in, and in some areas people staff
4 had said that, before COVID, before the pandemic, other
5 healthcare providers might have been doing more of the
6 tasks, but actually, if some other healthcare
7 professionals weren't going in or social care
8 professionals weren't going in to do some aspects of the
9 work that they would have done prior to COVID, that
10 meant there was more for hospice staff to do.
11 Q. Are you aware of how they approached infection control
12 within people's homes within the community settings?
13 A. I mean, they followed again, followed the guidance at
14 the time. So I don't know if I can talk you through the
15 specifics of that, but certainly wearing the PPE,
16 following the social distancing, minimising contact,
17 supporting families as well. I mean, there was guidance
18 for community settings at the time, so I suppose they
19 would have been looking at the specific guidance around
20 infection prevention and control at that time.
21 Q. They didn't develop their own practices? They largely
22 followed the national guidance; is that correct?
23 A. I mean, I don't they would have followed the national
24 guidance, but then, again, it's the sort of translating
25 it into the hospice context and working out your own

1 procedures to follow within that. But I don't -- again,
2 because hospices are independent charities, so they'll
3 all, you know, have their own approaches to do, and
4 I don't have that level of detail.
5 Q. Sure. Thank you. Did the member hospices feed back to
6 you their perception, either objective numbers that they
7 maybe derived somehow or their subjective perception of
8 how successful the infection control measures were and,
9 you know, whether -- keeping the two workforces, where
10 there was the case, separate, whether that prevented
11 outbreaks within a hospice?
12 A. We don't -- so Hospice UK doesn't have data on that.
13 I think my impression from talking to people was that
14 infection control was very well managed and it's
15 something, you know, that hospice staff have experience
16 in. So it's -- yes, there were additional measures
17 being brought in by COVID, but they have the care that
18 hospices provide. It's generally very good, excellent
19 care. They're regularly inspected anyway. They're
20 quite used to following these procedures and protocols.
21 They have good links in with local infection control
22 teams and Public Health teams. There were some examples
23 of outbreaks, but I think anecdotally these were small,
24 these were well managed. Certainly it wasn't perhaps
25 what you saw in some other settings or care home

1 settings, for example. That wasn't the case for
2 hospices.
3 Q. For the staff, what was the impact of going round the
4 different houses -- and I think some made visits to care
5 homes as well -- what was the impact of that on the
6 staff members?
7 A. I can talk -- I think I heard a lot from hospice staff
8 who -- so perhaps from their community teams who were
9 going out to people -- to visit people at home.
10 I think, certainly at the start of the pandemic, they
11 felt a lot of pressure and a burden of responsibility.
12 I remember like a community team leader saying she was
13 haunted by the memories that she has of that period,
14 where she was asking her team, her colleagues, to go
15 into people's homes. This was before vaccinations. It
16 was before the full understanding of the risks of COVID.
17 I think hospice staff have such a strong -- like
18 wanting to do right by the patients and families that
19 they support, so they were seeing that in some areas
20 other staff weren't going in. So certainly sometimes
21 hospice staff said that they were the only people
22 sometimes going into someone's home, but they could be
23 described as a lifeline for patients and families. But
24 they felt that burden of responsibility, that weight of
25 responsibility, that conflict between wanting to

1 continue to support patients and families but worried
2 about their colleagues and the risks that they were
3 taking and worried about the risks to their own families
4 and how to keep them safe.
5 So I think there was probably a lot of conflicted
6 feelings and stress that they felt. I think, as well,
7 in the very beginning, it was unclear in terms of the
8 guidance about who could go into people's homes and sort
9 of the caring role, who was covered by that. They
10 didn't want to do the wrong thing as well, so there was
11 that pressure that they felt.
12 Q. Given the increase in patients being at home, was that
13 viewed positively? Did patients and families prefer to
14 be at home or would they have rather been in the hospice
15 setting?
16 A. I think -- so I can't speak on behalf of patients and
17 families but I can share what hospice staff have said to
18 me about the impact on patients and families. Certainly
19 they're -- I think typically hospices saw less
20 in-patients and more people in the community. Staff did
21 talk about families being worried about -- not wanting
22 to go into an in-patient unit, be it a hospital or
23 a hospice. I think they were worried about not being
24 able to have the support from family members, so
25 visiting being restricted, and a bit of fear about going

1 into an in-patient setting.
2 So I think you're asking, yes, was it seen positive,
3 like the shift in terms of people being treated at home,
4 and I think -- so even prior to the pandemic there is
5 a demographic shift in terms of where people are being
6 cared for and are dying in Scotland, so more people are
7 dying at home and then COVID hit and that rapidly
8 accelerated a shift that we're already seeing.
9 I think a key thing for me is that we don't know
10 what people's experiences of being cared for and dying
11 at home during the pandemic have been like. I mean, one
12 of the things I would hope this Inquiry perhaps -- you
13 know, you're hearing directly from families -- that you
14 get a sense of that because so many more people were
15 dying at home but there wasn't more capacity. There
16 weren't more staff necessarily supporting them and in
17 some areas we know that social care staff either weren't
18 going into people's homes or perhaps people were scared
19 to let carers come in to support them.
20 So there was this shift, but we don't know what
21 people's experiences were, even though we know at
22 a general level that a lot of people do say they would
23 prefer to be cared for and die at home. But that comes
24 with the caveat that, you know, the support needs to be
25 there, the staff needs to be there, the resource needs

1 to be there and, certainly from a hospice perspective,
2 they're a key provider of that care, but they needed to
3 be supported to be sustainable and well resourced.
4 So it's a complex area and I think I would hope
5 that there would be learning from the pandemic about
6 people's experiences in the community, not least because
7 that demographic shift is continuing. The need for
8 palliative care is growing in Scotland, so there will be
9 more people who need palliative care and there will be
10 more people in the community who need palliative care,
11 so how can we meet that need in the best way? How can
12 we resource and prioritise palliative care and all the
13 sectors that deliver palliative care, including
14 hospices?
15 Q. I want to move on to the virtual support that hospices
16 were able to provide. You mention that some had to
17 invest in the IT infrastructure. How easily were they
18 able to meet that cost and how quickly could they put
19 the infrastructure in place? And once that was done,
20 were all the patients able to interact through the
21 online services?
22 A. I think it was a mixed picture, again, like many things.
23 So I know of one hospice who said that they definitely
24 needed to invest in their IT infrastructure. They
25 needed to install a fibre optic cable up the hill to

1 reach the hospice because they said, prior to that, they
2 could only do two Zoom calls at the time, like the
3 infrastructure just wasn't there. And this is where,
4 overnight, a lot of services shifted to providing more
5 virtual support. So where hospices felt they couldn't
6 deliver face to face care and support safely, many, if
7 not all, shifted to providing that more virtual support.
8 But they didn't as we were saying, didn't necessarily
9 have the infrastructure or the equipment to support
10 that. So I know so some hospices would pay for that
11 out of their own funds, out of their reserves I know
12 some hospices did get some grant money to pay for
13 I don't know if it was iPads or other tablets to support
14 some of the virtual consultations.
15 So it was challenging and I think some of that
16 the technology was unreliable and I think it was
17 there have been positives and negatives of moving to
18 more of a virtual model during COVID and I think, on the
19 positive side, it meant hospices could continue the
20 support to patients that they otherwise could not
21 provide. So it was really important for them to carry
22 on supporting patients and families and some even said
23 that they were reaching more patients than perhaps they
24 would have done in the past, so people who perhaps
25 wouldn't have been able to come to the hospice in the

1 past because they were too unwell to travel, now, since
2 they shifted to more of a virtual model, they could
3 provide support to them.
4 So there were definite positives, but on the other
5 hand there were negatives in terms of some patients and
6 families found it hard to sort of use a virtual model.
7 They might not have had access to a smartphone or
8 a tablet to do that. I think some staff really
9 struggled with the shift to virtual. I mean, palliative
10 care, it's a very hands on it's very tactile. You
11 know, palliative care nurses are hugely warm and they
12 like to hug people, and it was a difficult shift
13 sometimes to maintain the essence and ethos of hospice
14 care digitally. Though it did help them continue to
15 support patients and families, it also we talk about
16 digital exclusion it can exacerbate existing
17 inequalities if people don't have access to the
18 technology or find it hard to use.
19 Q. You go on on page 3 to state that hospices were able to
20 recruit and train additional volunteers to provide
21 bereavement support. What was the background of those
22 volunteers and did they visit people in their own homes
23 or did they provide support virtually?
24 A. I mean, on that specific example, I'm not sure what the
25 backgrounds of the volunteers were. I would have to ask

1 the individual hospice. But I did see hospices reaching
2 out and recruiting volunteers to provide bereavement
3 support, to provide you know, delivering shopping to
4 families or support with meals. And I think one of the
5 strengths of hospices is how well loved and regarded
6 they are within their community and how embedded they
7 are within the community, and I think some of the
8 learning perhaps from the pandemic is how quickly
9 hospices were able to mobilise that community response
10 and how volunteers in hospices really stepped up during
11 the pandemic. So I think that's perhaps a positive and
12 a testament to hospices and how well they are part of
13 their local communities.
14 In terms of volunteers, it sort of varied. So,
15 I mean, volunteers in hospice shops obviously would have
16 had to stand down or volunteers around, you know,
17 fundraising events and things like that, and I think
18 some had less you know, wanting to protect their
19 volunteers and not perhaps wanting them to come into the
20 hospice or having lots of direct face to face contact.
21 But they did have a wide variety of roles in their
22 I mean, they're a crucial part of the hospice sector, so
23 without them you wouldn't be able to deliver the care
24 that hospices do.
25 Q. There seems to be a difference there between the

1 recruitment of volunteers and the recruitment of paid
2 staff because later on, at page 6, you mention that the
3 retention and recruitment of paid staff was an issue for
4 some hospices. Are you aware of the reason for that
5 difference?
6 A. I think with paid staff so it was an enormously
7 challenging environment that they were having to work in
8 and it's an environment that had very quickly changed.
9 So I remember hearing from nurses in in patient units in
10 hospices just describing how quickly that changed. You
11 know, in patient units are busy bustling places normally
12 and you walk into a hospice, it's very warm and
13 welcoming and it very quickly changed, so people being
14 in single rooms and having to restrict who was coming in
15 and staff having to wear all the PPE, and also, with all
16 the testing and staff going off sick or staff having to
17 isolate, staffing was a challenge and difficult to
18 maintain staffing levels, with some staff being on
19 furlough as well. So that all puts extra pressure on
20 the staff who remain. So it was very challenging for
21 staff to do that and in some areas, yes, hospices said
22 they had issues around recruitment and retention.
23 Q. So perhaps the pressures on volunteers were less than
24 the pressures on paid staff and that had an effect on
25 retention

1 A. I mean, they're doing different roles as well, so
2 yeah, I think they're two different things.
3 Q. Thank you. You state that hospices needed to put some
4 people on furlough to save money but it also created
5 discord within teams between staff who were still at
6 work and those who were furloughed. Would it have been
7 more beneficial to have a rule for hospices that would
8 have allowed furlough funds to be used to keep staff
9 working?
10 A. I don't think so, as Hospice UK, I don't think we
11 have a specific view on that and I think the majority of
12 hospice staff who were furloughed, it was either roles
13 like retail managers or people who organise fundraising
14 events, so roles that, practically speaking, weren't
15 happening, but then it was also staff who perhaps were
16 more vulnerable or at risk or shielding who were
17 furloughed, so I think it would have been probably hard
18 to do that. But I think there was definitely an impact
19 on staff and the workforce and morale around the
20 introduction of furlough and that was quite hard for the
21 staff themselves and also managers to manage that
22 situation.
23 Q. You speak in your statement in relation to PPE about how
24 some NHS boards initially didn't deem hospices an
25 initial service or didn't assist or prioritise them in

1 respect of PPE, and this was despite the fact that the
2 health board itself wouldn't have had palliative
3 services in that area. What was the impact of that on
4 patient care?
5 A. So, yeah, I mean PPE, that is certainly an area where,
6 again, it varied markedly across different hospices and
7 different parts of Scotland, but, as you say, hospices
8 are providing an essential service, but because they're
9 not within existing NHS structures, then it does vary in
10 terms of for some of them they're just outside those
11 standard supply chains. It does vary, so some are more
12 embedded in the existing structures and they had an
13 easier time accessing PPE, but others, so the one that
14 you mention, that was an example of one hospice where,
15 yeah, their local health board had they found it very
16 hard to engage and be part of that supply chain, but
17 they said that as soon as I mean, it took some time,
18 but eventually the health boards had deemed them an
19 essential service. I think that was just local
20 terminology. But when that had happened, then they were
21 suddenly you know, doors were opened and they found
22 it a lot easier to access PPE.
23 But I did so certainly for some hospices in some
24 parts of Scotland it was enormously difficult having the
25 supplies of PPE that they needed to provide essential

1 care to patients and their families. They were having
2 to have daily huddles trying to work out where they
3 could get access to PPE that they needed to continue to
4 see patients, so it and for some it took months until
5 they got a reliable supply chain for PPE.
6 Q. Did it impact clinicians' ability to have direct contact
7 with patients?
8 A. I did hear I heard from one hospice who said, yes,
9 they essentially did have to ration the available PPE
10 that they had, so they had to think about what patients
11 could come into the hospice or which staff could go out
12 and see patients. So it did in that way, yes, it did
13 impact clinical decisions and the care that they could
14 provide.
15 Q. Do you think, in terms of lessons to be learned for the
16 future, that it's important that the essential service
17 nature of hospices is understood from the outset by
18 everyone?
19 A. Yes, yes. So I think definitely. I think within local
20 structures, hospices need to be understood and valued,
21 that they do provide essential services for patients and
22 families and it needs to be clear how and where they
23 access PPE, and we'll probably come on to talk about
24 vaccination and testing as well, but how they are part
25 of or where how the mechanism locally works to make

1 sure that they have access to what they need. And
2 I think because there was variation across Scotland,
3 so in some areas it did work much better or it worked
4 fine, so that shows it can work.
5 Q. Yes. You also mention that some hospices received
6 donations of PPE that weren't actually suitable for
7 hospice use. Could you explain why they weren't
8 suitable?
9 A. I think I heard from some staff where, you know,
10 obviously the local communities were incredibly generous
11 and businesses and everything, so they did receive a lot
12 of donations. I think some had mentioned that like the
13 visors had gaps in or masks that were homemade weren't
14 suitable for them to use always, but other donations
15 would have been and they certainly you know,
16 I remember one hospice saying that their local dentist
17 offered supplies for PPE when it was announced that
18 dentists were closing. And then they were like, "All
19 right, we're going to now phone round all the dentists
20 in our local area and get supplies for PPE that way".
21 But, yes, for some hospices it was a constant juggle
22 and trying to get access to the PPE they needed.
23 Q. You also mention that there were issues delays of
24 weeks or months for staff to get their vaccines because
25 they weren't initially on the NHS booking system. Did

1 that impact the care they were able to provide to
2 patients?
3 A. I don't know if it changed the care that they were able
4 to provide, but, I mean, it meant that staff weren't
5 supported and protected in the same way that NHS staff
6 were. So perhaps I don't know what if there were
7 higher levels of sickness or anything, but it meant
8 their staff weren't protected in the same way and
9 perhaps they would have to isolate more.
10 I think that's as I say, the vaccination, that's
11 another example where in some parts of Scotland and for
12 hospices it did work well and they were able to access
13 vaccinations at the same time as NHS staff and that
14 worked fine, but then, in others, you know, we'd got
15 confirmation from the Scottish Government that hospices
16 should be included in health and care staff and the
17 guidance around vaccinations but locally the mechanism
18 wasn't there. So they might have needed an NHS email
19 address to access the booking system but they didn't
20 have that, so then but no one had thought about that
21 in advance so they had to again, it's like who you
22 knew or your local networks or you just happened to hear
23 there's slots available and then the hospice can try and
24 find staff to fill them. Some staff said it felt a bit
25 shambolic or chaotic and it wasn't a structured process,

1 in some areas.
2 Q. Thank you. That's perhaps another learning point, that
3 when these things are being rolled out, they look beyond
4 just NHS email addresses and so on?
5 A. Yeah, and recognise again that hospices and voluntary
6 sectors are providing vital care and support, so, as
7 well as statutory services, NHS services, think across
8 the whole system and the different sectors that provide
9 care, and how practically can you support staff working
10 in those sectors?
11 Q. Thank you. You mention under heading 7 that initially
12 some hospices stopped visitation altogether. Given that
13 family members wouldn't be there to assist patients
14 perhaps, how did that affect overall staff workloads?
15 Did staff have more responsibilities then at that point
16 or ...?
17 A. If there were restrictions?
18 Q. Yes, if family members weren't able to visit patients in
19 hospices, did that impact staff work levels?
20 A. So the majority of hospices did continue visiting
21 throughout the pandemic. There were a minority of
22 hospice services at the very start of the pandemic
23 who when they're trying to interpret the guidance and
24 work out how they could do this, allow visiting safely
25 for patients and families that are trying to work out

1 the best way to do that, so there were, yeah, a small
2 minority where that was stopped.
3 I mean, the changes sort of restrictions to
4 visiting, that is certainly the area that had the
5 biggest impact on patients, on families and on staff, so
6 it's the bit which the area that people talk about
7 with the most distress certainly.
8 I don't know in terms of like the impact your
9 specific question was around workloads, so it certainly
10 impacted the working environment that staff worked in
11 and how they felt about it. You might well come on to
12 that separately. I don't know if it created more work.
13 I know they would have to they did well, some
14 staff in in patient units did say that if patients
15 weren't having the same level of visitors because of the
16 restrictions or that was restricted, that they would be
17 working in different ways. So they would be trying to
18 support provide more support for that patient because
19 they're not having the visitors coming in, that they
20 would be they would spend a lot of time sitting down
21 with them and they talked about making gifts for family
22 members or writing letters, they talked about trying to
23 facilitate FaceTime calls as well, but actually how hard
24 that can be sometimes, just some of the logistics of it,
25 and how distressing it is when it takes multiple

1 attempts for a family member to actually connect with
2 the patient. So probably it did have an impact on their
3 workload or the way they were working, but, yeah, the
4 greater impact was the distress caused to patients and
5 families and staff.
6 Q. Thank you. In the case of the hospices that did stop
7 visitation altogether, was that a consequence of their
8 interpretation of the guidance or did they think that
9 the guidance wasn't adequate and they wanted to take
10 these extra measures?
11 A. I think the ones who have shared with me what happened,
12 it was about them trying to work out how they could
13 continue to allow visiting safely and also one said that
14 they were trying to follow the ethos of the narrative at
15 the time, which was to minimise contact and to protect
16 the NHS. There was different interpretations of the
17 visiting guidance, so different hospices would interpret
18 it differently and would allow different levels of
19 visiting in terms of how many people could visit, if
20 that's one or if that's two, for the length of time that
21 they could visit, whether it's a named person. But
22 that's also partly because I mean, hospices, again,
23 they're all different. They're all independent
24 organisations. Their buildings are very different. So
25 some have lovely new shiny buildings which have direct

1 access from patient rooms to the outside, they've got
2 more single occupancy rooms, so perhaps it's easier
3 well, it was easier for them to facilitate visiting in
4 a safe way compared to others perhaps in older buildings
5 or more multiple occupancy rooms. But absolutely like
6 hospices were trying to do the best that they could for
7 patients and families, and they know how important the
8 support for families is at the end of life and
9 maintaining those contacts, so they were trying to do
10 everything they possibly could to facilitate that within
11 the constraints during the pandemic.
12 THE CHAIR: 15 minutes, Ms Bahrami.
13 MS BAHRAMI: Thank you, my Lord.
14 You've mentioned that the visitation not being
15 allowed particularly had an impact on the psychological
16 well being of patients and their families. Were you
17 told about any specific examples of situations where
18 this arose? Are you aware of any instances that were
19 particularly difficult for individuals?
20 A. I think I mean, staff did talk about specific
21 examples. I think it's the kind of thing that just
22 really stuck with them. I mean, the whole ethos of
23 hospice and palliative care is that you do everything
24 you possibly can to support the individual and their
25 family, so hospice staff are used to bending over

1 backwards for patients and families. And they talked
2 about, you know they're seen as enablers but then all
3 of a sudden they felt like they were gate keepers and
4 they were having to prevent that, and they found that
5 very distressing.
6 I think some of the examples that they gave were
7 so an individual who has three grown up children but
8 their visiting policy at that point in time was just to
9 allow two people to visit at the end of life, and then
10 how does anyone make that decision? So, yeah, they
11 found that very challenging and that patients and family
12 members would challenge them on decisions and hospice
13 staff aren't used to having those conversations. So
14 there were I think, yeah, there were specific
15 examples which have clearly stayed with staff and very
16 much impacted them and were distressing.
17 Q. Thank you. Does Hospice UK have a view on whether
18 visitation rights at the end of life should be enshrined
19 in law?
20 A. I think some of the learning from the pandemic is just
21 how important it is to remain in contact with families
22 and loved ones. We don't have a specific view around
23 whether enshrining this in law is the best way to go
24 about it. I think we'd have to look at any if there
25 were specific proposals, look at the detail in that and

1 think about how that would apply to the hospice setting.
2 I think, whatever mechanism there would be, it needs to
3 maintain the person centred approach and keep
4 a flexibility and make sure that hospice staff would
5 still be able to make decisions based on their own
6 judgment and on the individual circumstances of that
7 patient and their family.
8 Q. Thank you. Now, under heading 8 you state that there
9 was a lot of uncertainty at the start and staff were
10 having to adjust to different sets of expectations but,
11 "Some frontline staff felt like they were working with
12 'their hands tied behind their backs' and not being able
13 to make their own decisions or have agency in their
14 roles". Could you explain or give examples of what's
15 meant here?
16 A. So that's kind of like what I was just talking about
17 with the visiting, where them as palliative care
18 professionals pride themselves in being very
19 person centred and very holistic in their approach, but
20 because of the constraints and the restrictions, they
21 were unable to care for patients and their loved ones in
22 the way that they are used to and that they would have
23 liked to do. And that might be around visiting, it's
24 also things like just wearing all the PPE makes
25 communication difficult, not being able to touch people

1 in the same way just having to work in a very
2 controlled a very different environment staff said
3 was very challenging and sort of challenged the whole
4 ethos of palliative care and how they pride themselves
5 as hospice care staff .
6 Q. Thank you. You go on later on to talk about families
7 feeling abandoned by health professionals and hospice
8 referrals going down potentially as a result of people
9 not seeking the support they needed and so consequently
10 changes in condition not being picked up or acted upon.
11 Does Hospice UK or any of the member hospices have
12 thoughts on how this could be addressed and avoided in
13 future?
14 A. I mean, I think that's a really big question, a really
15 important question. I think there's something around
16 making sure that hospices are integrated into the wider
17 health and care system, that people aren't missed.
18 I think it was for different reasons as well. You know,
19 there was a fear factor there of people not wanting
20 perhaps to go to their doctor. It's also around they
21 couldn't get GP appointments or speak to their GP.
22 There's lots of different perhaps reasons of why it is,
23 but we know how important it is that people are seen and
24 that they get the support that they need. We know how
25 important early intervention is in palliative care, so

1 I think learning needs to be there needs to be
2 learning from it and it needs to be prioritised going
3 forward.
4 Q. Thank you. In the final paragraph under heading 9 you
5 say that poor communication by some care professionals
6 was demonstrated by a number of things, including the
7 inappropriate use of DNACPR orders. Could you expand on
8 the inappropriate use and are you able to give any
9 examples of inappropriate use?
10 A. I think so this came from one of our member services,
11 that they had I think they'd seen it within care
12 homes. I think there's definitely like there's
13 strong evidence in terms of how important it is that
14 there is advance care planning or future care planning,
15 like people are thinking ahead to what their needs are
16 at the end of life , and that includes looking at
17 DNACPRs. But during the pandemic I think it was hard
18 for with everything happening for clinicians to
19 always have those conversations with patients and
20 families .
21 So the examples which I heard from these members of
22 staff was that they had seen examples where that didn't
23 happen and it was left to social care staff to have
24 these conversations with patients and with families , but
25 that they hadn't been supported to have these really

1 difficult conversations so they weren't handled in the
2 best way and that that did have an impact on patients
3 and on families and on staff themselves and did cause
4 distress. So I think it goes back to, I mean, generally
5 needing to be more open around death, dying and
6 bereavement and having those conversations, but also
7 making sure that staff across all settings are supported
8 and have training in how to do that.
9 Q. Yes. And on the topic of communication you also state
10 there that:
11 "It was hard for patients and families to not be
12 able to speak with or get the information they wanted
13 from wider health and care professionals."
14 Why weren't they able to speak to those
15 professionals or get the information they needed?
16 A. I mean, I don't think I can speak for other
17 professionals. I certainly the examples that hospice
18 staff shared with me and I don't know how widespread
19 this is or if it's an issue across Scotland but
20 certainly that it could be challenging for patients to
21 access their GP. So one talked about a patient having
22 to wait 17 hours to speak to their GP and that GPs
23 weren't doing home visits. And I know there were issues
24 around social care supports as well, and I think
25 services so community services were under enormous

1 pressure. So with the shift in where people were being
2 cared for , that has a natural knock on effect to
3 services and staff . But hospice staff did really feel
4 that that has had a long term impact on patients and
5 families and that some talked about a breakdown of
6 trust with healthcare professionals, and that's the lack
7 of communication and people being worried that their
8 loved one might their care was missed or they didn't
9 get the care and the support that they needed, and
10 that's had a real long term impact on sort of people's
11 bereavement and grief and just their feelings towards
12 healthcare professionals and their sort of resilience
13 and mental health.
14 THE CHAIR: Ms Bahrami, you only have five minutes now,
15 I have to tell you.
16 MS BAHRAMI: Yes, my Lord. Thank you.
17 On the issue of things being missed, you raise the
18 issue of late diagnosis. You state that hospices saw
19 people being diagnosed and given a terminal diagnosis
20 much later in their disease trajectory with far more
21 people in their 30s and 40s having terminal conditions.
22 Presumably, prior to screenings being suspended or
23 cancelled, people of those ages would have had their
24 conditions caught at an earlier stage. I wonder if
25 that's correct and, if it is correct, whether Hospice UK

1 and the individual hospices perhaps have a view on
2 whether such screenings should be prioritised and
3 permitted to continue without interruption in the event
4 of another pandemic.
5 A. I think so. So staff consistently hospice staff have
6 consistently said to me, yes, they are now seeing, as
7 you say, patients who have been diagnosed late. They're
8 seeing younger patients. And I think that's probably
9 for a variety of reasons.
10 So I think we know people weren't able to access the
11 services and treatment that they did prior to the
12 pandemic. We know that things were potentially missed,
13 when you talk about screening. Even things like moving
14 more to virtual consultations and support, I think
15 perhaps it's harder sometimes to pick up on things.
16 Certainly some staff have raised that.
17 So I think it's again, there does need to be
18 learning from that and the impact that we've seen from
19 the pandemic and think about how we can prioritise
20 making sure that everyone gets access to the care that
21 they need. I've said before how, with palliative care,
22 early intervention is really important or certainly
23 staff said, yes, they have seen patients that they felt
24 like, perhaps if it had been picked up earlier, that
25 individual wouldn't have been in that situation. So,

1 yes, I think it does need to be prioritised going
2 forward.
3 Q. Thank you. I wonder, is there anything that we haven't
4 covered today that you would like to highlight or
5 emphasise at this point?
6 A. I think just a final thing is, I mean, to me I mean,
7 I'm not front line staff but I work very closely with
8 them. I'm just really impressed by how the hospice
9 sector did step up, how they did continue delivering
10 care to patients and families in very challenging
11 circumstances, and I think that there's learning to be
12 had, not just, you know, if there was another pandemic,
13 but actually in Scotland there's population changing
14 happening, there is an increased need in palliative
15 care. How will we be able to respond to that growing
16 need for palliative care? Like, what learning can there
17 be from how we had to respond to the increased need
18 during COVID? How can we also apply that to the growing
19 need for palliative care and all the services that
20 provide that vital support, including hospice care?
21 MS BAHRAMI: Thank you very much.
22 A. Thank you.
23 THE CHAIR: Yes, thank you indeed very much, Ms Malo. I'm
24 very grateful. Tomorrow morning at 9.45.
25 MS BAHRAMI: Thank you, my Lord.

1 (4.09 pm)
2 (The hearing adjourned until
3 Wednesday, 20 March 2024 at 9.45 am)
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