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Scottish Covid-19 Inquiry

Day 28

March 21, 2024

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1 Thursday, 21 March 2024
2 (9.45 am)
3 THE CHAIR: Good morning, Ms Bahrami. I apologise, I had
4 been expecting Mr Dunlop, which is not your fault, I'm
5 sure.
6 MS BAHRAMI: Good morning, my Lord. Yes, we have two
7 witnesses this morning, first the Scottish Intensive
8 Care Society followed by the British Medical
9 Association. Mr Dunlop will be taking evidence from the
10 British Medical Association.
11 THE CHAIR: My programme had it the other way around, which
12 is why I was a little taken aback. I'm very sorry.
13 I apologise. That doesn't matter. Right. Thank you.
14 DR BARBARA MILES (called)
15 THE CHAIR: Good morning, Dr Miles.
16 A. Good morning.
17 THE CHAIR: Everyone ready to go?
18 MS BAHRAMI: Yes, my Lord.
19 THE CHAIR: Please start.
20 MS BAHRAMI: Thank you.
21 Questions by MS BAHRAMI
22 MS BAHRAMI: Good morning, Dr Miles. Please could you start
23 by telling us a bit about your own background and about
24 the Scottish Intensive Care Society, including which
25 members which professionals sorry are members

1 of the society?
2 A. So the Scottish Intensive Care Society is a professional
3 society whose membership consists of medical
4 professionals and people who work in allied health
5 professions. So we have members that are doctors,
6 doctors in training, nurses, dieticians, pharmacists,
7 physiotherapists. Everybody who is a member has
8 a connection with the Scottish critical care community,
9 works within the Scottish critical care community, and
10 the society was founded in the early 1990s to represent
11 and promote the specialty of intensive care in Scotland.
12 Intensive care is a relatively new specialty. It didn't
13 exist before the it's less than 50 years old well,
14 60 years old and we try and promote community and
15 collaboration, education and represent our members as
16 required.
17 I am a doctor in intensive care medicine and
18 anaesthesia. I work within an intensive care unit in
19 Glasgow as a consultant and I have done for the last
20 20 years or so.
21 Q. Thank you very much.
22 I want to start at paragraph 24. There you say that
23 "NHS service delivery was significantly disrupted".
24 Are you referring there to intensive care services or
25 other services outwith intensive care or both?

1 A. Both really. So much of normalcy was disrupted. As our
2 intensive care and critical care provision expanded in
3 many areas, that meant alternate ways of working
4 working in places that we didn't normally work and using
5 a staff base of people who didn't normally work in
6 intensive care. And other aspects of healthcare were
7 disrupted as they paused, altered what they did. Some
8 services continued with remote working. Other places
9 shut down. A lot of the planned operating capacity shut
10 down during the first wave of COVID.
11 Q. Thank you. You do say that ICU capacity was expanded to
12 levels never seen before in this country. How were the
13 plans to expand intensive care viewed by you and
14 colleagues? Was it welcome news or were there concerns?
15 Was it positive disruption or was it concerning?
16 A. I think there had been plans most people had some
17 plans to deal with potential expansion around flu issues
18 and we have seen some various flu outbreaks over recent
19 years, but we had never, I think, planned or experienced
20 the rapid expansion that was required in some areas, and
21 so I don't think that most people's plans were well
22 formed for having to expand at the pace that was
23 required in the end. The support that was given for
24 expansion was welcome but there was trepidation also
25 because we were going, to some extent, into the unknown.

1 Q. Thank you. At paragraph 26 you state that:
2 "Island critical care units, whilst normally not
3 funded to provide level 3 care, provided some level 3
4 care during the pandemic."
5 Firstly, please, would you tell us what's meant by
6 a "funded level 3 care bed"?
7 A. So levels of care, as we use them in critical care, were
8 defined by in the UK were defined by the UK Intensive
9 Care Society some years ago. Level 3 care refers to
10 care that can only be delivered by an intensive care
11 unit. The normal recommended staffing levels for that
12 are a one to one trained critical care nurse per shift
13 looking after that one patient, that the care is
14 provided by some clinicians who have experience in
15 critical care, intensive care medicine, and there's
16 a supporting team of professionals, pharmacists,
17 physiotherapists, who also provide essential care for
18 that patient. The funding refers to the funding for
19 those staff. You can have an empty bed in a critical
20 care unit but without the staff funding to put a patient
21 in that bed and deliver that level of staffing.
22 Level 2 care is normally what we refer to as "high
23 dependency care". It's in the definitions that were
24 applied during the pandemic, that was support for
25 patients who had failing organ systems, say, for

1 example, respiratory failure or circulatory failure
2 one single system that required support and required
3 a higher or potentially required a higher level of
4 nursing than they might get on a ward area.
5 Traditionally , level 2 care has two nurses looking after
6 one patient per shift .
7 Q. Now, you said islands don't usually have this and they
8 would usually transfer patients to mainland intensive
9 care units . Was the funding of level 3 beds carried out
10 in an effort to reduce the spread of COVID?
11 A. In terms of they didn't get they produced they
12 provided some level 3 care because they had no choice at
13 the time because there was it was difficult initially
14 in the first wave to arrange flight transport because of
15 the concerns. Because of the concerns around infection
16 spreading and how to do a flight transport for a patient
17 with COVID, the transfers took a little bit longer than
18 normal and so they had to provide that care until they
19 could transfer a patient . They didn't get extra
20 funding. It wasn't a planned delivery of level 3 care.
21 Q. How were they able to staff those beds? Presumably they
22 wouldn't have had ICU nurses, ICU consultants, junior
23 doctors
24 A. Well, they always have to provide some degree of
25 stabilisation and support until the patient can be

1 transferred off the island, so they have that provision.
2 They have high dependency units and anaesthetic doctors
3 on site which hope usually provide the stabilisation
4 and care until the patient is transferred.
5 Q. Thank you. Were those professionals were they
6 present at a sufficient level to allay any concerns that
7 there might have been about staffing in those units or
8 was it just , you know, "This is what we have to do until
9 we can reach the next stage"?
10 A. I haven't asked that question directly of those boards.
11 I'd need to ask the question directly to be able to
12 answer that. But in the initial waves of the pandemic,
13 I don't think people were moving to island boards to
14 work.
15 Q. Thank you. Please could you tell us about the situation
16 in which ICU patients, both from islands and on the
17 mainland, would be transferred to a different ICU
18 pre pandemic and during the pandemic?
19 A. So in the I suppose in the late 2015 to 2020, most
20 of the time the patients were transferred from one board
21 or one hospital in one board to another because they
22 required specialist care that was only available in that
23 other centre. So, for example, if they required
24 specialist cardiothoracic care or they required
25 specialist neurosurgical care, they may need to move to

1 another hospital to have that care delivered.
2 We didn't commonly move patients because we had run
3 out of capacity to we had no empty bed in that unit.
4 During the pandemic some units did reach even under
5 their expanded footprint, reach capacity and some
6 patients were transferred to another health board or to
7 another hospital within their own health board because
8 there wasn't, at that moment, an empty bed for them to
9 be placed in.
10 Q. Now, the public might think that the transfer alleviates
11 pressure from the transferring hospital but in fact it
12 puts pressure on the staff base; is that right?
13 A. Yeah.
14 Q. Could you
15 A. It 's not so say, for example, prior to in the
16 early 2000s, within the west of Scotland, we had
17 a transfer team which would move patients between
18 hospitals as required for intensive care transfers, and
19 that was outwith the staffing of the base hospitals.
20 When after some reorganisation that team was
21 disbanded that was the only team of its nature within
22 Scotland and it was disbanded in later years and it
23 doesn't exist anymore. So therefore transfers of any
24 nature, someone has to go with the patient and then
25 so therefore you are often taking if the sending

1 hospital has reached capacity, it may not have easily
2 spare staff identified to go with that patient and so it
3 often is difficult . And each transfer takes time, and
4 the issue for slightly more remote hospitals is it 's
5 quite a long way to the other hospital and so to get
6 there and get back takes additional time. So the
7 sending hospital loses some of its staff when it's under
8 a degree of pressure to hopefully relieve some of that
9 pressure.
10 Q. Yes, in the longer term.
11 A. In the long term, but it does mean you cannot
12 realistically send four patients in half an hour to
13 another hospital.
14 Q. Firstly , I wonder how that requirement for staff was
15 met. How were the responsibilities in ICU the level
16 of care maintained while those staff were sent or was it
17 that
18 A. I think each individual area would have had to find its
19 own solution to that and so I can't as I haven't
20 asked about it in detail , I can't say what each
21 individual area did or the society can't say about what
22 each individual area did. But most people would look to
23 what was available within their hospital and try to come
24 to the best solution they could at the time to send the
25 most appropriate patient person and staff with the

1 patient whilst trying to maintain the best care they
2 could.
3 Q. For the others.
4 You mentioned pre pandemic transfer would have taken
5 place for specialist care. Where an ICU unit wasn't at
6 capacity or perhaps it was but it was thought that this
7 patient would be better in a different setting would
8 fare better in a different setting but the staff
9 capacity wasn't there, did hospitals have to make
10 difficult decisions about whether they could just try
11 to manage a patient in their own ICU and delay transfer
12 or ...?
13 A. Sorry, I'm not sure I understand your point.
14 Q. So, for example, you said that a patient might prior
15 to the pandemic, a reason for transfer would have been
16 that the patient requires specialist cardiology care,
17 for example, and that's better provided in a different
18 centre. During the pandemic, if there was such an
19 instance where it wasn't a concern about bed capacity
20 but, rather, this patient might do better in a different
21 centre but there was an issue with the staff base, were
22 those transfers delayed or did a difficult decision have
23 to be made about whether the care needed could somehow
24 be provided in that centre?
25 A. That's again that's not a question I've asked of our

1 membership so to answer that for the entirety of the
2 community I'd probably have to ask that directly
3 Q. Sure.
4 A. but possibly, but to what extent we would need to
5 ask more detail from the membership.
6 Q. Sure. Are you aware of how vehicle contamination
7 decontamination was dealt with and who carried out that
8 work?
9 A. No, but the for any patient that's had an infectious
10 organism within any environment in healthcare, there's
11 a lot of decontamination of that environment that takes
12 place before another member of the public or another
13 patient can utilise that area. So ambulances and
14 aeroplanes had to be decontaminated more than usual
15 after and that process takes longer. Who did it and how
16 they did it ...
17 Q. We'll ask another organisation. Thank you.
18 Now, we're aware that aerosol generating procedures
19 were particularly risky during the pandemic. How were
20 those performed in shared ICU bays? Were they performed
21 in shared bays?
22 A. Yes, so the aerosol generating procedures what was
23 defined as "aerosol generating procedures" during the
24 pandemic were performed throughout in various areas
25 of the hospital. They were performed in ICUs, theatres,

1 high dependencies, some wards, and there was various
2 guidance about what you could do where at various points
3 of the pandemic, which slightly changed through the
4 pandemic. If you had a if a patient with an
5 infectious organism like COVID was having an
6 aerosol generating procedure, they ideally should be
7 well, they were placed in a single isolation room and
8 once say, for example, an area had a number of
9 patients with the same organism, they may be placed in
10 a shared bay and then aerosol generating procedures be
11 performed within that shared bay, but the patients all
12 had the same disease. The issue with that was that if
13 you there may have been empty bays in that area but
14 you couldn't utilise them for patients that didn't have
15 that condition and so they had to remain empty.
16 Q. Yes.
17 A. So it didn't make sometimes it made placement of
18 patients quite difficult because there may be capacity
19 in one area but it couldn't be utilised because of the
20 infection risk.
21 Q. So that presumably put more pressure on planning
22 A. Yes.
23 Q. and utilising spaces?
24 A. Separating patient groups required more areas and more
25 adaptation of those areas than we would normally

1 require.
2 Q. Thank you. At paragraph 32 you state that green
3 surgical HDU beds were created for those isolating for
4 two weeks to prepare for elective surgery or procedures.
5 What's meant there by "elective surgery"?
6 A. "Elective" means planned surgery as opposed to emergency
7 surgery. I suppose the example would be, when you are
8 placed on a waiting list to have surgery and then when
9 your surgery is prepared, you know you're having it
10 you elect to have surgery as opposed to have it as an
11 emergency.
12 Q. Did elective surgeries continue throughout the pandemic
13 without interruption or did it depend on the type of
14 elective surgery?
15 A. So that's not exactly our focus of interest but in
16 terms of the Scottish Intensive Care Society. We look
17 after patients after elective surgery sometimes but some
18 surgery I think continued my impression is that
19 some most health boards attempted to continue
20 providing some kind of elective surgery but a lot of
21 elective surgery was paused. But cancer surgery, say,
22 for example, people did prioritise through the pandemic.
23 Health boards would be able to tell you how much they
24 paused their elective surgery.
25 Q. Okay. So I have a few questions following on from that,

1 but I think maybe the health boards might be more
2 appropriate. I suppose a question for you, though,
3 would be: how much say did intensive care clinicians
4 have over when elective surgeries should take place?
5 You know, as the pandemic went on, did you have an idea
6 of how much capacity there might be and were you able to
7 raise concerns if you thought that we might not have an
8 ICU bed available following surgery?
9 A. I think there were ongoing conversations between
10 different groups about this on a daily basis.
11 Generally, I think all clinicians and all healthcare
12 people are keen to allow surgery to progress because
13 it's helpful to the patient, but it is actually also
14 quite difficult to predict how much capacity will be
15 available on any daily basis because there's always
16 a level of unpredictability about emergency work. So,
17 yes so sometimes I think there were difficult
18 conversations around that, but there were conversations.
19 Q. Thank you. The next question again might be better
20 suited for the health board so please do say. In
21 paragraph 37 you've mentioned the erection of temporary
22 buildings, such as tents, partitions and so on, to deal
23 with isolation capacity issues. Do you have knowledge
24 of the ease with which these things were arranged, the
25 costs, how soon they were able to take place or

1 should I
2 A. I think you would get more detail from health boards
3 around this, but they were by definition they
4 happened after the first wave because it took some time.
5 Nothing happens in a week. So most of these the
6 temporary buildings and the tents happened after the
7 first wave but some of the additional ventilation and
8 partitions, they were temporary things that could be
9 installed more rapidly, so some of those may have
10 happened more rapidly.
11 Q. Do you think that they were more useful than
12 transferring patients to other hospitals?
13 A. Transferring patients to other hospitals would require
14 people in the other place to have capacity also and so
15 I think that was a very capacity varied through the
16 pandemic. It wasn't the the areas that came under
17 pressure in critical care were not the pressure was
18 not equal at equal points of the pandemic. So it came
19 differently through each wave and say, for example,
20 some parts of Scotland had far more capacity issues than
21 other parts, just as the COVID spread differently
22 through the country, so you'd have to examine capacity
23 issues around different ways in the pandemic and look at
24 what was it's quite a complicated question to answer
25 and would require quite a lot of analysis of

1 information.
2 Q. Thank you. At paragraph 38 you state that:
3 "Essential staff could not always access a mask that
4 fitted them, meaning that they could not work in all
5 environments."
6 What effect did that have on staff morale and
7 patient care?
8 A. So the supplies of FFP3 masks changed as we attempted to
9 source. We used more so we needed to order more and we
10 had different manufacturers and different types
11 arriving, and then you had to fit each staff member to
12 the new type of mask and, if the particular staff member
13 did not fit any of the masks you had available at the
14 time, they could not work in a place where they were
15 required to wear an FFP3 mask. So that essentially
16 meant occasionally some staff who had the skill set to
17 be working in that area could not work in that area and
18 potentially then other staff replaced them with lesser
19 skill sets.
20 Q. Was that quite frustrating for some, to not be able to
21 provide the care that they're so used to providing?
22 A. I think rostering had never been dependent on masks
23 prior to this situation. It wasn't I think it
24 affected different members differently and sometimes it
25 was more of an issue than others, but people worked

1 round it to find solutions. They had no choice.
2 Q. And so, through careful rostering, were the effects on
3 patient care mitigated?
4 A. That's not a question I can answer because I didn't ask
5 people that specifically. It's an issue that people
6 raised but they didn't always comment on the
7 consequence
8 Q. Okay. So there were concerns about that but they did
9 their best
10 A. Yes.
11 Q. to deal with the situation.
12 A. Hmm.
13 Q. Thank you. At paragraph 39 you state that drug supply
14 levels were problematic throughout the pandemic. Was
15 this do you know whether that was a national issue or
16 an international issue? Was there a global shortage?
17 A. Yes. So the requirement for certain drugs increased
18 dramatically throughout the world so therefore it was an
19 issue that applied to lots of countries and also
20 manufacturing became problematic, I gather, in some
21 areas because, if the plants shut down for whatever
22 reason, then the supply wasn't coming through. So there
23 was a significant increase in demand for certain
24 sedative agents for ICUs and muscle relaxants and some
25 drugs that help support people's blood pressure. We

1 needed to use them more and it was and many countries
2 needed to use them more, and so the distribution of
3 those to areas of need I think we had a national
4 allocation system throughout Scotland but, as I think
5 our pharmacy members have pointed out in their
6 submissions, the need varied through each wave because
7 there wasn't the same number of critical care patients
8 in each wave in each board, and so dividing solely by
9 the board size perhaps did not meet the need as well as
10 dividing by the number of patients in that critical care
11 unit at the time.
12 Q. How did clinicians manage or deal with this problem?
13 Did you have to consider substitute
14 A. Yes, so I think there were substitute drugs available,
15 substitute methods, so people did what they could with
16 substitution and alternative agents.
17 Q. Did that have quite an impact on, again, staff morale?
18 A. In times of pressure, it takes up I think less head
19 space to use stuff that you're more familiar with. To
20 have to use stuff that you're less familiar with, that
21 isn't your normal practice, especially when you're
22 working with people a lot of people that are new to
23 the area because they've come in to provide you with
24 support, it probably would have been easier if we had
25 been able to stick to our normal drugs and our normal

1 practice more, but if you don't have that drug, you have
2 to make do with what you can substitute. And some of
3 the substitutes are equally valid drugs. They're just
4 not what you would normally use in routine practice.
5 Q. In terms of trying to prevent that in future, I take it
6 that it would be very difficult because you wouldn't
7 know what might be needed in the event of a future
8 pandemic or the numbers or individual conditions or
9 do you think there is a case for stockpiling certain
10 drugs?
11 A. There might I mean, that's a conversation that
12 happens quite there's quite a lot of ongoing drug
13 shortages now because of the various issues in the
14 world.
15 Q. Yes.
16 A. But you can have that on a national basis but then
17 the issues some of these issues, as you've touched
18 on, were international. So I'm not sure that's within
19 our scope to solve that problem but I think it possibly
20 is an area that could do with some examination.
21 Q. Thank you. You go on in the next paragraph to talk
22 about the shortage of fluids for renal replacement
23 therapy for continuous filtration and that some units
24 had to make more use of haemodialysis where they may not
25 have used that. Is the first method preferable to the

1 second and, if it is, why is that?
2 A. So I'd say "preferable" is probably not the right word.
3 "Usual" would be the right
4 Q. Okay.
5 A. Most intensive care units in the UK use continuous
6 filtration as their method of renal replacement therapy.
7 You can use haemodialysis, it's what renal units use for
8 the majority of cases, but they're not and there are
9 some intensive care units that use haemodialysis as
10 their routine care, but if most units are using
11 continuous filtration and then they can't do that and
12 they're far less familiar with haemodialysis and the
13 equipment involved and the technique, to switch between
14 one to the other is quite a significant learning hurdle.
15 Usually making that switch would involve a lot of
16 training and familiarisation with staff that would take
17 place over weeks to months, if not years, and some
18 people had to make that switch quite rapidly.
19 Q. Yes. So that was the main issue? Rather than
20 necessarily an effect on patient care
21 A. No.
22 Q. it was, again, staffing and resources and training?
23 A. And education and familiarity.
24 Q. Now, moving on to hospital oxygen, is oxygen created
25 using oxygen concentrators in hospitals or is it taken

1 from cylinders that are delivered or a combination?
2 A. So it's not normally delivered with oxygen
3 concentrators, although some of those were used in some
4 hospitals during the pandemic. Oxygen in a hospital is
5 usually delivered in a tank to a vacuum insulated
6 evaporator, a big tank that sits out the back somewhere
7 in the hospital, and it provides supply to a pipeline.
8 So most big hospitals have one of these tanks or more
9 than one of these tanks.
10 But the supply of oxygen to a hospital is what the
11 hospital would normally expect to have for its normal
12 capacity, for what it would normally do. In common with
13 the drug supplies, if you think of oxygen as a drug,
14 having to have so much more delivery, you are not
15 normally resourced to have that much more delivery, and
16 so some hospitals were using much more of their oxygen
17 than they would normally and the tank can only deliver
18 a certain amount of oxygen at a certain rate, and so
19 people were worried that they were going to reach the
20 limits of their oxygen supply and started thinking about
21 what they would do if that happened.
22 Q. Yes. To your knowledge, did it ever impact patient
23 care?
24 A. Not to my knowledge, but it is something as we could
25 tell from talking to our members, it is something

1 that it was discussed more than had ever been
2 discussed before.
3 Q. So another factor that was adding to the mental strain
4 on clinicians?
5 A. I think it was if the the more we converted
6 a lot of hospitals used some anaesthetic machines as
7 ventilators during the initial waves of the pandemic to
8 allow them to have enough ventilators to manage the
9 demand. Anaesthetic ventilators are usually run,
10 driven, by oxygen supply. It helps them go up and down,
11 deliver gas to patients. A lot of hospitals converted
12 those machines to run on air supply because they were
13 concerned that that extra oxygen utilisation would
14 denude their supplies.
15 Q. So difficult decisions had to be made to prioritise
16 A. So there you can the anaesthetic machines can run
17 on air. They just don't normally because on the long
18 term it's better for them to run on oxygen. So they
19 function effectively running on air, but that was work
20 that was done to preserve the oxygen supplies for
21 delivery to patients that might need extra oxygen in
22 wards and other parts of the hospital, in other ICUs.
23 Q. Thank you. Now, you state that staff with no training
24 or experience in critical care were redeployed from
25 other areas to ICU and HDU, and of course this meant

1 that they required additional support and additional
2 training. Did critical care clinicians have concerns
3 about this redeployment and was it helpful or efficient
4 to redeploy staff?
5 A. I think so in order to have expanded critical care
6 capacity as you have a set staff base of experienced
7 clinicians in a critical care or intensive care or high
8 dependency unit, if you wished to expand the capacity,
9 the only options are to ask for the help of colleagues
10 from other areas to help maintain a staff base or you
11 try and staff those extra numbers of beds with the staff
12 base you already have, which means you have we were
13 talking about there usually we have one critical care
14 nurse looking after one intensive care patient per
15 shift. If you then want to double your intensive care
16 numbers, if you don't get extra staff, you'll have one
17 critical care nurse looking after two or three, and that
18 has an impact on care in itself. So most areas ask for
19 the help of other colleagues as more people being better
20 than stretching the staff base to having the normal
21 staff base looking after extended numbers of patients.
22 Q. I suppose I'm thinking about the level of training and
23 support that a new person, a new nurse, for example,
24 might need, so whether that would take an experienced
25 nurse away from her allocated or his allocated bed for

1 longer, you know, while they support this person.
2 A. Yeah.
3 Q. So whether effectively one member of staff is being
4 split between two beds to support
5 A. Yes, it's not a perfect solution.
6 Q. But it was the only solution?
7 A. It's there's no immediate way of providing training
8 to someone within a few weeks' period that doesn't
9 involve the support of some of the existing staff, but
10 that's probably preferential to having the existing
11 staff base look after extended numbers of patients.
12 Say, for example even the very sick intensive
13 care patient, say, for example, we have to sometimes
14 we managed patients in intensive care with severe levels
15 of respiratory failure by turning them over so that they
16 are instead of lying on their back, they're lying on
17 their front. That takes a team of six to eight people.
18 So if you have more patients but you have kept your
19 original staff base, you then don't have the numbers of
20 people just to do that.
21 Q. Yes. Thank you. Do you think that something I don't
22 know if this is feasible. Do you think that something
23 that could potentially be done to prepare for future
24 would be that non critical care staff are given in
25 more typical times given critical care training and that

1 that is periodically refreshed so that, if they're
2 called upon in an emergency situation, whether it's
3 a pandemic or other emergency, that they could more
4 readily step into the role?
5 A. Yes, so I think various areas talked about that at
6 various stages of the pan but that requires resource
7 to train staff. It takes resource to allow staff to be
8 released to be trained it takes resource and so
9 you're taking the trainers away from what they are
10 normally working in and the staff to be trained away
11 from what they're normally working in, and currently
12 that may be problematic, but so I think it would
13 require some investment.
14 Q. Thank you. At paragraph 46 you say that both the
15 redeployed and core critical care staff found working in
16 ICU during COVID difficult and some have suffered
17 long term effects. Can you please tell us about those
18 long term effects?
19 A. I think from we asked that question specifically of
20 the membership when we were preparing the original
21 response to the Inquiry's questions. There was quite
22 a spread of effects. It varied per individual. But
23 I suppose the comments to pull out, so people were
24 concerned about their own health, their families'
25 health. Especially in the first wave, the pandemic was

1 an unknown quantity of what was going to happen to you
2 and therefore what might happen to your family. There
3 was stress and burn out. I think people felt
4 overwhelmed at times by what they had gone through and
5 some people felt they couldn't continue working in
6 critical care afterwards.
7 So after the first wave of the pandemic, most
8 critical care units started to see a loss of their staff
9 base more there's always some turnover of staff base
10 in any area, but there was an increase in that and, as
11 a result, a lot of critical care units lost a lot of
12 experience and so we can replace staff and we can
13 recruit new staff but building up those years of
14 experience takes time, and so most critical care
15 a lot of critical care units in Scotland reporting
16 seeing that they now have a less experienced staff base
17 with a different degree of skill mix and that affects
18 ongoing education needs and provision of care on a daily
19 basis. And why some of those experienced nurses
20 decide and clinicians and doctors and other
21 professionals decided to move on is complex, I think,
22 but the waves of the pandemic probably prompted some
23 people to make that decision.
24 Q. Yes, because I was going to come on to this later but
25 I'll ask you about it now. You state that, at

1 paragraph 56, the median reported loss in relation to
2 nursing staff was 42.5% and in relation to consultant
3 medical staff was 25%. These presumably have
4 a significant impact on care being provided in ICU. Are
5 hospital boards or others taking steps to try to
6 mitigate this?
7 A. So I think all health boards are trying to maintain
8 their staff base by recruiting new staff but and
9 consultants. I think people are attempting to replace
10 the consultant staff. I think later I may have referred
11 to the fact that there's in previous submissions,
12 there's not always the staff to replace one immediately
13 and so sometimes there are vacancies which await
14 filling.
15 It takes time for new staff to become as experienced
16 in critical care as some of the staff that have left, so
17 if there's a large number of staff leave at the same
18 time, therefore it takes time to build that experience
19 back up. And so there are people I think that want to
20 work within critical care but perhaps less than there
21 might once have been, and so I think this may not be
22 critical care may not be the exception here. I don't
23 know because I'm only speaking for the critical care
24 community. But I'm not sure that recruitment is as easy
25 in a lot of aspects of healthcare as it might once have

1 been.
2 Q. Thank you. Do you or the Scottish Intensive Care
3 Society have views on how this might be prevented in
4 future, this sudden departure?
5 A. So the Scottish Intensive Care Society and the Scottish
6 Critical Care Delivery Group did a workforce survey in
7 2020, trying to look at workforce factors that were
8 influencing the retention and plans for retiral of
9 consultant medical staff in the main. But workforce
10 planning is quite a complex area that probably I think
11 could do with more attention across healthcare.
12 Some of the issues that I think I refer to
13 I think some of the pension issues that were affecting
14 consultants have perhaps been alleviated since we sent
15 out the survey to a degree, but, yeah, the we how
16 to keep staff working in a high intensity environment
17 that is physically quite demanding, has a lot of night
18 work until they're 68 requires some thought, I think.
19 Q. You touched on the training of new staff. Before going
20 back to where we were, I want to ask you about
21 paragraph 58, where you say:
22 "Training of nursing students, medical students,
23 nursing, allied health professionals and medical staff
24 in training was adversely affected by the COVID 19
25 pandemic."

1 Would you please expand on this, including why it
2 was affected, the impact and how long the impact is
3 expected to continue?
4 A. So I think so the best people to ask about the
5 students would be the universities and the best people
6 to ask about the medical health professionals would be
7 NHS Education for Scotland.
8 Q. Okay.
9 A. But I think you could say that a lot of education stood
10 down, so I think the members have reported that, you
11 know, not all areas received medical students. Critical
12 care students usually have medical and nursing students.
13 Not all areas of Scotland retained medical and nursing
14 students, so their exposure to critical care disappeared
15 during waves of the pandemic.
16 Those in work, there wasn't the standard
17 education that would run for people during work was
18 suspended. Training courses were suspended, exams were
19 suspended, and exposure to different aspects of
20 healthcare changed a lot. So I think you would have
21 more information about from NHS Education for
22 Scotland, but many trainees doctors in training were
23 sent outside their area of training during the initial
24 waves of the pandemic to work and so weren't working in
25 what they were supposed to be training in. So how long

1 that effect is likely to be ongoing, I couldn't really
2 comment on. It's not our area of expertise, but it has
3 affected all the people in training and in education at
4 that point. I think the medical profession or allied
5 health profession wouldn't be alone in that, I think.
6 Q. Thank you. Going back to paragraph 47, you say that
7 "there was a proliferation of both valid and false
8 information" following other countries sharing their
9 experiences. There, are you referring to information
10 being shared between clinicians or broadly across the
11 general population?
12 A. Actually I think I was looking at our responses from our
13 membership, and I'll read out one of them because
14 I think it encapsulates the answer to that. So:
15 "One of the biggest challenges responding to an
16 avalanche of data opinion, advice good and bad, while
17 having to rapidly learn how to treat a new disease,
18 there was a proliferation of self appointed experts,
19 questionable sciences and in some cases downright fake
20 news driven by the rapid news agenda of the internet [as
21 read]."
22 I think other people have commented that some of
23 that news and some of that information led to some very
24 difficult conversations with patients and families about
25 some of this information that was not true.

1 Q. Thank you. Also in paragraph 47 you say that, where
2 staff disagreed with the rationale for guidance
3 changes you say that staff at sometimes didn't
4 understand the rationale for guidance changes. Where
5 that was the case, were they able to voice their
6 concerns and put forward their thoughts on what was
7 preferable or better?
8 A. Put forward their thoughts to who?
9 Q. Anybody. Was there anybody available to hear
10 clinicians' voices?
11 A. So most of a lot of the guidance that was coming out
12 around policy was coming nationally, so I suppose, as is
13 common, the individual clinician on the floor doesn't
14 always immediately get feedback to national level of
15 guidance.
16 Q. Yes.
17 A. So staff, I think, fed back their queries to their local
18 teams. I couldn't comment on whether they we haven't
19 asked our members did they feel that that is a comment
20 they made, but they didn't comment what they did about
21 it.
22 THE CHAIR: Might some assistance be given to you by
23 something you were looking at in a slightly different
24 context a moment or two ago? Paragraph 58 [sic] is your
25 reporting of, I think, questions you asked staff or

1 fellow clinicians. I don't have it in front of me at
2 the moment but it's coming up. I think it said that 30%
3 of clinicians in your speciality I've got the wrong
4 paragraph. It must be, yes, 59, I apologise.
5 "30% of members who replied to the '... Members
6 Consultation ...' felt that critical care views were not
7 adequately considered by [the] Scottish Government in
8 the COVID 19 response."
9 Does that by and large answer the question you were
10 posed, Doctor?
11 A. Yes, I think the question that was put to the society
12 was that question, critical care views which views
13 were not specified, and so we asked the question as it
14 was posed and that's what they answered.
15 THE CHAIR: Yes, I can see that. So a significant number,
16 30%
17 A. Yes.
18 THE CHAIR: of those that answered expressed criticism,
19 reservations, in relation to the degree of consultation
20 that your branch of the profession was given?
21 A. Yes.
22 THE CHAIR: Thank you.
23 MS BAHRAMI: Thank you, my Lord.
24 What would have happened if a clinician ignored
25 guidance they viewed as being inappropriate or less

1 appropriate in favour of something they regarded in
2 their clinical judgment as being preferable?
3 A. It depends what guidance you were referring to. So
4 there was guidance about patient placement, management
5 of infection control, guidance on therapies. So there
6 was various streams of guidance. If a clinician didn't
7 feel comfortable with the particular infection control
8 advice, PPE advice if you I don't think many
9 people would have disregarded the current advice
10 because but again that is an operational situation in
11 individual areas that we haven't I haven't got any
12 detail on and I'd be supposing what happened as opposed
13 to knowing.
14 Q. Sure. Would that have affected again staff morale or
15 the pressure on people in people's minds, having to
16 do something that they didn't understand the basis
17 for
18 A. Fully understand the rationale? Yeah, I
19 Q. and didn't agree with perhaps?
20 A. I think there's any guidance usually has a rationale.
21 It's sometimes I think we don't the rationale isn't
22 always as well communicated as it might be. But rapidly
23 changing information and rapidly changing guidance is
24 difficult for people to keep up with, and when you're
25 and there may have been valid reasons for that to

1 happen, but the rapidly changing advice meant that it
2 was difficult for anybody to know what was the current
3 guidance at that point. If it was different two weeks
4 ago and it's now different and it will be different in
5 another two weeks, it can be difficult to know what
6 you're supposed to be doing at that moment in time
7 because it takes time to distribute information to staff
8 members. We usually change guidance over a period of
9 time, distribute that information to the staff members
10 and we make sure that everybody understands it, but
11 speed of change was rapid and trying to make sure that
12 everybody was abreast of the current situation was
13 difficult .
14 Q. Yes, thank you. In paragraph 48 you say that:
15 "Lack of family visits and the lack of face to face
16 communication caused injury to patients and families and
17 staff ."
18 Can you explain what you mean there by "injury" and
19 how it affected patients and staff?
20 A. So when critical care staff care for a patient,
21 a patient is part of a unit usually. You're not
22 a separate individual ; you're part of a family group,
23 part of a social structure . Because of the nature of
24 critical care, there's a lot of family presence, a lot
25 of involvement with the family, and if the patient is

1 very unwell and unable to communicate, much of the
2 staff 's time is spent communicating with the family. We
3 learn about the patient from their family and the
4 patients need their family to support them at a time of
5 great stress for them.
6 To have no family presence was difficult . Staff
7 have never worked in an environment where there is no
8 family member present to tell them or talk to about the
9 patient, and communicating on a telephone is not the
10 same as communicating face to face. All the non verbal
11 cues of communication, all the are lost. So having
12 conversations in intensive care and critical care is
13 often difficult . It 's a time of great stress to the
14 patient and the family and support and considerate
15 communication face to face is our normal practice. To
16 have to do that by telephone was distressing . It was
17 distressing for the families , it was distressing for the
18 patients , it was distressing for the staff .
19 And having patients at the end of their life not
20 being able to have their family around them in the same
21 way was distressing for staff because that's not the
22 journey at the end of life that they would like to have
23 given to the patient and not what the patient wanted and
24 not what the family wanted either. So that was I think
25 one of the areas that all staff groups found most

1 challenging .
2 Q. What was visitation like in PICU and NICU, so the
3 paediatric and neonatal intensive care units? Was that
4 similarly affected? Were parents able to stay with
5 children? Were siblings allowed?
6 A. So the NICU I can't comment on because we did ask
7 some questions of the paediatric intensive care
8 community. We are mainly an adult intensive care
9 society. We do have some links with the paediatric
10 community in Scotland so we asked them some questions.
11 The visiting guidance changed throughout the
12 pandemic and changed there was some national guidance
13 and there was health board guidance on this and it
14 varied through the pandemic. My recollection would be
15 that paediatrics, because they if there was a child,
16 generally speaking, parents or a parent at least was
17 more likely to be able to be present, but how that
18 changed through the pandemic you would be able to look
19 at as you track the national visiting guidance from
20 NHS Scotland.
21 Q. Do you know so parents would have been allowed to
22 visit ?
23 A. I believe so.
24 Q. Do you know whether there would have been any beds for,
25 for example, breast feeding mothers to be able to

1 spend you know, to be able to feed on demand?
2 A. I that is not a question that we asked of our
3 society. So there will be people that can tell you the
4 answer to that but I think it 's not us.
5 Q. Sure. Thank you. You say at paragraph 48 that
6 sometimes a stark choice had to be presented to families
7 with regards to visiting their loved one at the end of
8 life or attending a funeral . Was this required by the
9 guidance and did clinicians have to have this
10 conversation with patients with families? Sorry.
11 A. Yes. So if your family member was at that point within
12 an environment that required a level of personal
13 protection equipment, to deem that you had not been
14 a COVID contact, I think, staff, in order to go into
15 that environment, would need to be wearing full PPE.
16 That was not always available in all areas to patients'
17 family members visiting, so if they went into that area
18 when the patient was sadly at the end of their life to
19 visit their family member, they would be deemed to be
20 a COVID contact and the advice at that point was that
21 they would go home and isolate. And if the funeral
22 occurred during that period of isolation , then the
23 advice would have been at that point that they should
24 not attend the funeral .
25 THE CHAIR: You have 15 minutes left, Ms Bahrami.

1 MS BAHRAMI: Thank you, my Lord.
2 You mentioned at paragraph 52 that staffing
3 pressures meant that staff did not always feel they
4 could deliver the quality of care they would aspire to
5 pre pandemic. Did this impact the levels of staff
6 leaving and did it impact people's morale and ability to
7 carry on during the pandemic, also affecting absence
8 levels perhaps?
9 A. I think it did impact staff. I think we can see from
10 our response that it did impact some staff morale. Most
11 clinicians want to deliver the best care that they can
12 under all circumstances, but under some circumstances
13 you can't deliver the care care was not entirely as
14 it would be normally. Say, for example, if you were
15 working with an expanded staff group, with people that
16 had kindly come to help you out in your time of need but
17 they didn't have that experience, so that's not it's
18 providing care but it's not providing care to the
19 standard that you would normally provide the care and
20 that was difficult for people. Yes, I think that may
21 have contributed to some I think we can see that in
22 the responses, that that may have contributed to some
23 people deciding that they wanted to move on.
24 Q. At paragraph 60 you mentioned that an end of life policy
25 can help ensure pain and distressing symptoms endured by

1 patients dying in ICU can be addressed. How could or
2 should this have been achieved?
3 A. So the context of that is I that's in the statement,
4 a response to a question that we asked of the society.
5 We have as a quality indicator for Scottish Intensive
6 Care Society Scottish critical care units, we have
7 one of the quality indicators in that all of those units
8 should have an end of life policy for those reasons.
9 The annual audit of the Scottish Intensive Care Society
10 Audit Group, which is published annually, has that
11 documented, who or who does not have an end of life
12 policy as a quality indicator. I believe that the vast
13 majority, if not nearly universally, critical care units
14 across Scotland do have an end of life policy. What
15 that it's not mandated what that that policy is
16 the same as the unit next door, but that they should
17 have one, and that's the detail of what the quality
18 indicator says could potentially be addressed in the
19 end of life policy that that unit has adopted.
20 Q. To what extent was it followed during the pandemic? Was
21 there enough time for these policies to be amended and
22 tailored and to be followed or were there periods where
23 it just hadn't been possible to follow that best
24 practice?
25 A. The end of life is individual for all patients and

1 should always be tailored to an individual patient's
2 circumstances. There's guidance from the GMC on
3 treating patients at the end of life, and this touches
4 upon when you should or should not have discussions with
5 patients and DNACPR and anticipatory care plannings. To
6 find out what happened in individual areas would be
7 in detail would be a separate piece of work. I think
8 the main comment that the membership had about end of
9 life was the lack of family presence at the end of life.
10 That was what they feel was the most challenging for
11 them.
12 Q. Was that difficult both for staff and for patients?
13 A. Oh, I think it was difficult for patients, family and
14 staff.
15 Q. Did clinicians feel that they had to step into that role
16 where family weren't present?
17 A. So I think when family can't be present, I think all
18 clinicians feel the patient will not be alone at the end
19 of their life. But, yes, I think a staff member being
20 the only person present at the end of a patient's life
21 is not what the staff or the family or the patient would
22 usually hope for or aspire to.
23 Q. Was some sort of counselling available to clinicians who
24 had to be in that situation?
25 A. It occasionally happens under normal circumstances, so

1 sometimes somebody has no family, sometimes somebody's
2 family is on the other side of the world, but it
3 certainly happened more during the pandemic.
4 Counselling, I think most there was people comment
5 in their submissions that there was at times some degree
6 of psychological support available, but it wasn't
7 necessarily available in the middle of the first wave
8 but became more available later on.
9 Q. Thank you. You mentioned CPR. Can you please comment
10 on the appropriateness of use of CPR in an ICU setting,
11 given the condition of the typical patient requiring
12 intensive care?
13 A. So there are some patients in intensive care units that
14 have a DNACPR complete, but not by no means all
15 patients in intensive care units. I think it's an
16 individual discussion and decision depending on the
17 circumstances of that individual patient's journey and
18 wishes.
19 Intensive care units, we'd like to have every
20 patient survive when they are admitted to an intensive
21 care unit but not every patient does survive, so we
22 recognise that some patients will sadly not survive
23 their intensive care admission. If a patient is dying
24 in intensive care without a do not resuscitate order,
25 we, the staff, will feel that they have to start CPR on

1 that patient, and so the when a patient is dying,
2 that's not necessarily of benefit to that patient or
3 particularly a dignified end to their life. So when
4 a patient is actively dying, a do not resuscitate order
5 will be completed so that that patient does not we do
6 not start doing resuscitation on a patient that that
7 will not be of benefit to them. So it will be
8 appropriate on occasion but it's not appropriate for all
9 patients.
10 Q. Just to be clear, when it's not appropriate, that's
11 because there is another there's something else going
12 on with the patient that, even if you were to
13 resuscitate their breathing and circulation, that that
14 would cause death, for example, a brain haemorrhage, so
15 it's not appropriate
16 A. So you're saying that it's not appropriate for some
17 patients because you're asking why it's not
18 appropriate for some patients?
19 Q. Yes. I just want to clarify that in case
20 A. So some patients not all conditions are reversible
21 and so some patients will sadly die of their underlying
22 condition. There are some conditions that are fatal
23 despite our best attempts, and under those
24 circumstances if the patient has a cardiac or
25 pulmonary arrest, resuscitation will not potentially

1 won't sometimes will not be successful and on other
2 occasions will not be of overall benefit to the patient
3 because they will still die of their underlying
4 condition. So these are the conversations that we have
5 with patients and family, depending on the
6 circumstances, around the individual circumstances of
7 that particular patient's condition.
8 Q. Thank you. The final thing I want to ask you about is
9 extra corporeal membrane oxygenation or ECMO. This is
10 a service that you say is provided in Aberdeen. How
11 many ECMO machines are there in Aberdeen?
12 A. I don't know.
13 Q. Okay.
14 A. You could ask that of NHS Grampian.
15 Q. Okay. Thank you. Is the geographical location of that
16 problematic? Is having this centre in Aberdeen
17 sufficient or would it be preferable to have, resources
18 allowing, more centres, especially in a pandemic time?
19 A. So the service in Aberdeen commenced after a national
20 planning exercise in 2020, so there was a lot of
21 discussion about that and those issues at the time, some
22 of which is probably still on you could refer to in
23 part of the planning exercise. I'm not I think that,
24 as I don't have within our membership, there would be
25 some views on that which would you could ask that as

1 a separate question and get a variety of opinions. So
2 I think we didn't ask the membership how many ECMO
3 beds they think there should be or whether they
4 should more ECMO should have been provided. I think
5 some members commented that they thought that perhaps
6 some more could have been provided during the pandemic
7 within Glasgow or Edinburgh, further within the central
8 belt. How practical that would have been, I don't know,
9 but it is a comment that some of the members made.
10 Q. Because presumably, given the issues with transfers,
11 transferring people to Aberdeen would have
12 A. Yes, I think the one exception to the transfer
13 circumstances is that, when a patient is accepted for
14 ECMO, the ECMO team will come down and collect the
15 patient because of the requirement to start the ECMO in
16 the referring centre and then bring them back.
17 Q. And, finally, is paediatric ECMO also carried out in
18 Aberdeen or do paediatric units have their own
19 A. The main the paediatric intensive care units are in
20 Edinburgh and Glasgow
21 Q. Yes.
22 A. so I think I'm not absolutely certain, but
23 I would I think that that is carried out in Glasgow
24 and Edinburgh, but, again, you could confirm that with
25 the appropriate health boards.

1 Q. Great. Thank you very much. Is there anything we
2 haven't covered that you would like to comment on at
3 this point or highlight?
4 A. I think generally people felt that the pandemic we've
5 never expanded critical care services to that extent
6 before and the expansion wouldn't have been possible
7 without many other parts of the healthcare service, many
8 other professional groups that all came and kindly gave
9 to us their assistance, but there isn't an unlimited
10 amount of expansion of critical care that can be
11 delivered.
12 Without staff is the issue more than equipment.
13 Equipment is certainly required, but without the
14 knowledgeable staff and experienced staff to operate
15 that equipment, there's a finite amount of expansion
16 that can be achieved. And I think as a society we
17 expressed our concerns that four times expansion was not
18 feasible, as was part of the Scottish Government's plans
19 at one point that that would not have been feasible
20 with the staff base that we had.
21 Q. Yes. Would that in terms of not being feasible,
22 do you mean it would have impacted patient care?
23 A. It would have impacted patient care. So if you haven't
24 got in order for intensive care to be effective, you
25 actually have to treat the patients in intensive care.

1 Just parking them in an intensive care unit doesn't
2 achieve the end points that the patient or the staff are
3 looking for. So you do need a level of staff in order
4 to effectively treat the patient, so, yes, it would have
5 adversely affected patient care.
6 MS BAHRAMI: Thank you very much.
7 THE CHAIR: Yes, thank you very much indeed, Dr Miles.
8 I appreciate that. 11.15. Thank you.
9 (10.59 am)
10 (A short break)
11 (11.17 am)
12 THE CHAIR: Good morning, Mr Dunlop.
13 MR DUNLOP: Good morning, my Lord. I have one witness this
14 morning, Dr Kennedy. For the benefit of your record,
15 his reference of the organisational statement is
16 SCI WT0424 000001.
17 THE CHAIR: Good. Right, thank you.
18 DR IAIN KENNEDY (called)
19 THE CHAIR: Good morning, Dr Kennedy.
20 A. Good morning, Lord Brailsford.
21 THE CHAIR: I think we're ready to go. When you're ready,
22 Mr Dunlop.
23 MR DUNLOP: Thank you, my Lord.
24 Questions by MR DUNLOP
25 MR DUNLOP: Good morning, Dr Kennedy. Could you provide the

1 Inquiry with your full name, please?
2 A. Yes, I am Dr Iain Kennedy.
3 Q. Thank you. You've provided the Inquiry with an
4 organisational statement on behalf of the
5 British Medical Association in Scotland. If I'm
6 correct what would I call it? Would I call it the
7 English division or the English and Welsh division?
8 I appreciate that they're involved in the UK Inquiry.
9 How would I distinguish between could you explain to
10 us essentially what's the difference between the
11 BMA Scotland office and the BMA offices that are based
12 in London?
13 A. Yes, so the BMA covers all four nations so
14 Northern Ireland, Scotland, Wales and England, and the
15 BMA is the overarching organisation, but we have
16 devolved nations within the BMA, obviously Scotland,
17 Northern Ireland and Wales. So BMA Scotland is
18 regarded is always called a devolved nation.
19 Q. Am I correct that there are BMA is involved in the
20 UKI proceedings as well?
21 A. I'm not sure about that.
22 Q. Could you tell me, how does the BMA sit alongside other
23 medical organisations that we may hear evidence from,
24 such as the royal colleges? How does that sit alongside
25 those?

1 A. Okay, so the BMA and the BMA in Scotland is a trade
2 union and it's a professional body. We have 17,000
3 members and, to give you an example, 3,000 of them would
4 be GPs. So we're quite different to the other
5 professional bodies in that we are larger, we have a far
6 greater membership and we also have a democratic mandate
7 to negotiate terms and conditions on behalf of all
8 doctors.
9 Many of these other bodies represent a small group
10 of doctors and including overseas doctors. The BMA in
11 Scotland represents, well, six branches of
12 practice: consultants, GPs, staff and associate
13 specialists, junior doctors, who will soon be called
14 "resident doctors", medical students and also retired
15 members, although the retired members committee is
16 a pan UK committee. There isn't a Scottish retired
17 members committee.
18 Q. Okay. Thank you. Whilst I appreciate you're here today
19 speaking on behalf of the BMA Scotland, what's your
20 particular specialism?
21 A. So I am a general practitioner. I have a special
22 interest in occupational medicine, so I work as a GP in
23 Inverness. We have four GP practices, Riverside in
24 Inverness, which has 10,000 patients, mainly a deprived
25 part of Inverness. We also have a smaller practice in

1 Inverness called "Dunedin", with about 2,500 to 3,000
2 patients; and we also have Foyers Medical Practice,
3 Loch Ness and Strathnairn, which is by the banks of
4 Loch Ness, obviously, and that's about 1,000 patients in
5 the rural hinterland; and Cromarty Medical Practice on
6 the Black Isle. So my organisation, Riverside Highland
7 Medical Group, has a mixture of urban and rural GP
8 practices.
9 Q. Thank you. Looking at the organisational statement at
10 paragraphs 1 and 2, you explain what positions you hold
11 within the BMA Scottish Council and GP committee
12 presently. Is it fair to say that you've sought
13 assistance of colleagues in the preparation of this
14 organisational statement?
15 A. Yeah, that's right. I became chair of BMA Scottish
16 Council in August 2022 and, during the time of the
17 pandemic, I was medical director of Highland Local
18 Medical Committee, which is affiliated to the BMA.
19 I was an ordinary member of Scottish Council, I was
20 a member of BMA Council across the four nations and
21 a member of the UKGP committee and a member of the GP
22 committee, but I wasn't close to the action, as it were,
23 in terms of decision making. I was very much an
24 ordinary member then.
25 Q. Can I take you to paragraph 17 of your statement which

1 is headed "Key issues and impacts for doctors". At
2 paragraph 17 of your statement, you identify that there
3 was a lack of appropriate PPE and risk assessments. Can
4 you tell me, in terms of particularly given your
5 awareness from the BMA, can you tell me whether there
6 was a difference in the lack of or adequacy of PPE
7 within different sectors of the medical profession,
8 whether that be primary care or secondary care?
9 A. Yes. So PPE was a significant issue for my members in
10 general practice and in hospitals and we were very
11 concerned about the adequacy of protection. In simple
12 terms, I'm talking about the fact that we were given
13 fluid resistant surgical masks, so the paper masks that
14 the general public would be very familiar with wearing
15 too, rather than respiratory protective equipment such
16 as FFP3.
17 Now, I've been surprised actually, speaking to
18 hospital colleagues, that even in the hospitals, in the
19 general medical and surgical wards, they were generally
20 using just using the surgical masks, and the FFP3
21 masks that we probably all should have had were reserved
22 for those in intensive care units and doing so called
23 aerosol generating procedures. So there was a complete
24 lack of adequate PPE in terms of respiratory protective
25 equipment in general practice and a relative lack in the

1 hospital sector.
2 Q. At that time, at the beginning of the outbreak or at the
3 beginning of lockdown in March 2020, was there
4 a difference between the way PPE was procured in primary
5 and in secondary care? So, for instance, I think we
6 heard evidence that hospitals secured the NHS secured
7 PPE for the hospitals. Is that your understanding or
8 can you comment on that?
9 A. So I'm a little unsure how PPE was procured, but I'm
10 assuming that my practice manager and nurses would have
11 done that in the usual way via the health board. So
12 I think general practices were procuring PPE through
13 health board structures.
14 Q. Well, if you're not familiar, I'm not going to ask you
15 to speculate.
16 Did the BMA do anything in terms of the concerns
17 that its members had in relation to lack of PPE?
18 A. Yes. My predecessor, who was chair of BMA Scotland at
19 the time, and the former national director of the BMA in
20 Scotland, so effectively the chief executive of the BMA
21 in Scotland, were in regular contact with the
22 Government, I think almost on a daily basis at the start
23 of the pandemic and certainly at least weekly
24 thereafter, and they made regular representation on
25 behalf of members about the inadequate PPE.

1 Q. And was anything done in light of those representations?
2 A. Not to the satisfaction of my predecessor nor to our
3 members.
4 Q. And why what was done and what was unsatisfactory?
5 A. I think the fundamental problem was that there was
6 a lack of recognition that COVID was an airborne disease
7 and, you know, we in the BMA referred to "droplet
8 dogma", which meant that fundamentally the wrong sort of
9 PPE, respiratory protective equipment, was supplied to
10 us. You know, the surgical masks that I've referred to
11 are good at preventing droplets going from healthcare
12 worker to patient but they do absolutely nothing in
13 terms of preventing air coming to the doctor. If I'm
14 wearing my mask, when I breathe, the air comes in round
15 the edges, it doesn't come through the mask, so the
16 fluid resistant surgical masks were relatively useless
17 in terms of protecting doctors and other healthcare
18 workers from COVID.
19 Q. Was that explained to the Scottish Government by the
20 BMA?
21 A. I believe it was on a number of times.
22 Q. In paragraph 19 of your statement, you also identify
23 that PPE was not always suitable due to not properly
24 fitting. The issue with PPE not properly fitting, did
25 that impact on particular groups of people more than

1 others that were working in medical care?
2 A. Yes. It's widely recognised that PPE has been designed
3 for the male body, for male heads, faces and bodies and
4 for white male heads, faces and bodies. So groups that
5 had particular difficulty were women, and women more
6 regularly reported to us that they had failed
7 fit testing for PPE, but also ethnic minority groups,
8 particularly those with beards and those with head
9 coverings, had greater difficulty with getting suitably
10 fitted PPE.
11 Q. You mentioned there "failed fit testing". Can you tell
12 us what fit testing is and what the consequences are if
13 someone fails a fit testing?
14 A. So I've never had a fit test myself so I can only go by
15 what people tell me, but I'm assuming that they go into
16 a room with somebody who actually fits a mask to their
17 face and checks that it fits, but I've never seen it
18 being done.
19 Q. Do you know what the consequences are if someone fails
20 a fit testing of a mask? Does that mean that they have
21 to use unsuitable masks or are they taken off their
22 duties? Do you know what the consequences are?
23 A. I can't say with authority what the consequence is.
24 Q. Just dealing with the fitting that didn't do you know
25 if the BMA did anything about the fact that what

1 you're telling us, that the masks were predominantly
2 made for males did they do anything about that?
3 A. Well, we fed that back first of all, we surveyed our
4 members and we surveyed our members regularly and we
5 shared that information with the Government both at
6 Scottish level and UK level, so we certainly shared that
7 information, but I'm not sure of what the outcome was of
8 us sharing that information.
9 Q. You deal with this at paragraph 19 of your statement.
10 I'll maybe just read it out:
11 "The impacts of the pandemic were not felt equally,
12 for healthcare staff or patients. UK wide data from BMA
13 surveys indicate that ethnic minority doctors more
14 commonly had to work without PPE, felt worried or
15 fearful about speaking out, and felt risk assessments
16 had been ineffective."
17 Can I just deal with those maybe on a point by point
18 basis? I think you've explained was it the beards,
19 was that the sole difference? You say that they have to
20 work without PPE. Was it simply beards or was there
21 anything else that impacted?
22 A. So numerous surveys done by the BMA demonstrate that
23 those in ethnic minorities and disabled groups and women
24 are more fearful generally in speaking up in the NHS in
25 Scotland. So there's a general theme there, not just

1 with COVID and not just with PPE, that those groups feel
2 more fearful and that, if they do raise concerns, that
3 they will receive some form of negative treatment. So
4 our ethnic minority members and disabled members did
5 tell us that more so that they felt their risk
6 assessments were inadequate, so they were more likely to
7 say their risk assessments were inadequate and they were
8 more likely to report ill fitting or failing a fit test.
9 The exact reasons, beyond being female and having
10 a female face, beards and head coverings, I'm unable to
11 comment beyond those areas.
12 Q. You may not be able to answer this question, but you
13 said that there was a perception that the risk
14 assessments were inadequate. I was going to ask you in
15 what respects. Is that because the risk assessments
16 were generic, without making specific provision for
17 people with different shaped faces?
18 A. What members have told us is it was more the outcome of
19 the risk assessment, so they would identify something
20 with the risk assessment but the appropriate action was
21 not thereafter taken, and that led to some of our
22 members calling it a "tick box exercise".
23 Q. So the risk assessments were undertaken but then they
24 weren't followed through on; is that essentially
25 A. That's what some of our members have told us.

1 Q. Thank you. Whose responsibility would it be to follow
2 through on those risk assessments, ensure that what
3 those risks assessments identified was done?
4 A. Well, under the Health and Safety at Work Act 1974, it
5 would be the employer's responsibility. So in hospitals
6 it would be the health board. In general practices,
7 where the majority are independent contractors like
8 myself, it would fall upon the employer, being me, the
9 GP partner.
10 Q. I'll move on to a topic, long COVID. At paragraph 18
11 and later at paragraph 41 you mention doctors suffering
12 from long COVID. Can you tell me generally, during the
13 period from March 2022 to the end of 2022, what
14 treatment was available for people receiving sorry,
15 people that were suffering from long COVID?
16 A. So there is no specific test for long COVID, which we
17 all understand to be COVID symptoms that go beyond
18 four weeks so there's no specific test. There's
19 a broad range of symptoms in long COVID and there's no
20 specific treatment. There's not a tablet or medicine
21 that we can use to treat long COVID.
22 Q. We might hear evidence that initially there was some
23 scepticism in relation to long COVID. In your opinion
24 has that been overcome, that scepticism?
25 A. Yes, and I think it's regarded as a syndrome that

1 affects many parts of the body. So it affects the
2 cardio vascular system, the respiratory system,
3 neurological, psychological and general symptoms. So
4 there's a broad range of symptoms with long COVID but
5 a recognised syndrome. But the two most commonly
6 reported symptoms are fatigue and brain fog.
7 Q. And sorry in your role in the BMA, are you still
8 practising as a GP
9 A. Yes. I practise every week in Inverness and all doctors
10 who work for the BMA are still practising doctors.
11 Q. Do you have patients coming in who have suffered from
12 long COVID or are suffering?
13 A. Yes, but not many. I can think possibly of maybe just
14 two that have mentioned long COVID while they've been in
15 about other things. I haven't actually dealt with
16 a patient that came in saying, "I'd like to discuss
17 long COVID", but I do have one or two patients and
18 I know of some doctors.
19 Q. You might not be able to assist us with the next
20 question, but do you have a view on the availability and
21 adequacy of treatment for long COVID?
22 A. Yes. As I indicated, there's not a specific test for
23 long COVID and there's not a specific treatment, so the
24 role of the doctor really is to exclude other causes of
25 fatigue, brain fog and the other general symptoms that

1 patients with long COVID get. So our role is to exclude
2 the other causes and then we would generally direct
3 patients with long COVID to rehabilitation services, so
4 they would generally see physiotherapists and
5 occupational therapists rather than a doctor because, by
6 the time we have given a diagnosis of long COVID, there
7 at the moment isn't a role for the doctor. But, of
8 course, as evidence changes, it may be that there would
9 require to be a doctor led service. But at the moment
10 it tends to be rehabilitation through physios and OTs.
11 Q. And when did that commence, do you know?
12 A. I remember it commencing quite early on, so a few months
13 I think into the pandemic, because I remember there was
14 quite a lot of debate about where long COVID services
15 would be hosted; would they be hosted in general
16 practice, would they be hosted in hospitals. So that
17 discussion happened quite early on in the pandemic, if
18 I remember correctly.
19 Q. Thank you. Moving on to paragraph 21, you say that
20 governments in the UK were not always providing clear
21 and adequate guidance on issues such as infection
22 control, shielding and the delivery of healthcare. This
23 particular Inquiry isn't is more interested in what
24 was happening within Scotland. When you say "the UK" as
25 in "the UK", do you include the Scottish Government?

1 A. Yes.
2 Q. Was the BMA raising concerns that its members had with
3 the Scottish Government about any lack of clarity in the
4 guidance?
5 A. Yes, continuously, on a daily basis at Scottish level
6 and definitely at UK level. My experience was there was
7 a lot of information coming in to our inboxes on a daily
8 basis, probably far too much information, to be honest,
9 but there were a number of occasions where the guidance
10 was completely lacking and the BMA lobbied the
11 Government on a number of occasions to produce guidance
12 on various aspects.
13 Q. You've said a couple of times there it was done on
14 a daily basis. Was that through groups that somebody
15 sat on or was that a mailbox or some form of dialogue,
16 a bridge, between the BMA and the Scottish Government?
17 Can you explain actually in practice how that daily
18 communication took place?
19 A. Yeah, so the communication took place predominantly
20 through my predecessor, the chair, and the national
21 director, and they did that via Teams meetings and also
22 by direct email communication. The relationships
23 with between the BMA in Scotland and the
24 Scottish Government are very good. There are lots of
25 communication channels. We don't always agree on things

1 but we always meet and the communication channels are
2 cordial.
3 Q. Do you know who that was with within the
4 Scottish Government? Was that the Chief Medical
5 Officer? Was it a civil servant? Do you know who the
6 communication line was with?
7 A. Yeah, so it would have been between the national
8 director and civil servants at the Scottish Government
9 Health Directorate. I think our national director would
10 have had direct communications with the Chief Medical
11 Officer and certainly my predecessor had direct
12 communications with the Chief Medical Officer on
13 a regular basis.
14 Q. Thank you. Moving on to paragraph 22 and I won't
15 take you through every paragraph but you identify
16 some relevant issues early on in your organisational
17 statement. You identify that there was a significant
18 impact on doctors' mental health and you explain that.
19 What I'm interested in knowing is whether or not the
20 pandemic had a significant impact on people who weren't
21 working in the medical profession, if it affected their
22 mental health. Can you assist us with that?
23 A. When you say "people not working in the medical
24 profession"
25 Q. Sorry, people in the street essentially; the every day

1 man or woman.
2 A. Yes, there's no doubt, having dealt with patients and
3 continuing to deal with patients, that the pandemic had
4 a massive impact on the population's mental health.
5 Increased levels of anxiety and depression,
6 significantly higher levels of psychological disease and
7 a huge impact on children as well.
8 Q. Were there any groups in society who were
9 disproportionately affected that you're aware of?
10 A. Yes, so I think the inequalities in Scotland came to the
11 fore and those who were more vulnerable came to the
12 fore. Early on the BMA identified well, the first
13 ten deaths of doctors in the UK all were from minority
14 ethnic groups, so we know that black Africans,
15 South East Asians, those from the Indian sub continent
16 and Filipinos were much more likely to be affected. We
17 also know that men and older men were more likely to be
18 affected. And paradoxically, with long COVID, it tended
19 to be females, I think in the sort of 40 to 55 age
20 group.
21 But in terms of the impact of COVID on the
22 population, there's no doubt that those in deprived
23 areas were much more markedly affected, living in
24 smaller accommodation, more crowded housing and less
25 able to access healthcare and particularly less able to

1 accessthe new remote ways of consulting.
2 Q. Okay, and I think there you were talking about COVID
3 generally. If I was to ask you about mental health in
4 particular , did that and we appreciate that there
5 were people that were shielding and so forth were
6 there particular people within society who were more
7 their mental health was more adverselyaffected than
8 others as a result of the pandemic? If you can't answer
9 the question, I don't want to pressyou on something
10 that
11 A. Yeah, what information I can give you is that I know in
12 those patients who were already known to the mental
13 health services, large groups of them completely had
14 their follow up stopped, so the existing people with
15 mental health problems no longer had any ongoing contact
16 with the service, and I think that was becausea lot of
17 the psychiatrists were redeployed.
18 Q. As a GP, if someonecame to you with mental health
19 issues prior to March 2020 and somebodycame to you
20 in April 2020, was there a difference in the services
21 that would have been available to somebody?
22 A. Yes, and the main difference would be that the patients
23 were getting seenremotely by secondarycare. But
24 I have to say that during the pandemic itself , we or
25 I certainly did not seea lot of patients presenting

1 with mental health problems. It's later on, as the
2 pandemic progressed,that people came in and now that
3 they're coming in. So I think the mental health
4 problems stayed at home, as it were, and were hidden,
5 and those patients weren't accessingthe Health Service
6 like they would have done in the past.
7 Q. And with mental health obviously certain diseasesare
8 degenerativeand get worse over time if not treated. Is
9 that the samewith mental health?
10 A. Yes, that's definitely the samewith mental health. You
11 know, the longer a mental health condition goes
12 untreated, the more difficult it is to treat and the
13 longer is the recovery. In fact we're seeing patients
14 that haven't yet recovered.
15 Q. You deal with you've already spokenabout this. At
16 paragraph 47 you identify that the pandemic had
17 a disproportionate affect on ethnic minorities ,
18 including doctors, and that those minorities felt they
19 were less able to raise concernsabout issuesat work.
20 Do you know why that is, the reasoningbehind it, the
21 background to why they felt less able to raise concerns?
22 A. Yes. So certainly the groups that told us they found it
23 more difficult to raise concernswere black Africans,
24 South East Asians, Filipinos, those that were most at
25 risk and those with disabilities and those with in

1 the shielding groups, clinically extremely vulnerable.
2 Now, I think it's fair to say that these problems
3 existed pre pandemic so would have been exacerbatedby
4 the pandemic. These members always tell us that it is
5 far more difficult for them to speak up and they are
6 more likely to be dealt with unfavourably.
7 Q. Is there something that can be done about that that
8 you're aware of?
9 A. There is. You know, for example, the BMA in Scotland
10 has a the Scottish Race Equality Forum, where we meet
11 and we share concernsfrom our ethnic minority groups
12 and we feed that information to both within the BMA
13 and to Government. So certainly our organisation is
14 much more diverse than it's ever been before and issues
15 around discrimination are commonly spoken about and
16 we're trying to do our best to improve the working
17 environment for those groups.
18 Q. Moving on to paragraph 52, you say in paragraph 52 that
19 there were significant shortcomings in relation to
20 healthcare settings, including infection control,
21 guidance and PPE. And at paragraph 53 you go on to say
22 that the Government and agenciesrefused to take on
23 board what the BMA was saying. Again, you've told us
24 about the daily contact, but is it the same points that
25 are being made on a daily basis in terms of infection

1 control?
2 A. Yes, I go back to what I said about droplet dogma and
3 this lack of acceptancethat COVID was an airborne
4 diseaseand therefore fundamentally the infection
5 protection control guidancewas wrong and remains wrong.
6 Specifically there's an onus still within the IPC
7 infection protection control guidance for employees
8 to raise concernsand to request the proper respiratory
9 protective equipment, FFP3 masksor similar, whereaswe
10 believe that guidance should be changedand it should
11 follow the Health and Safety at Work Act 1974, where the
12 onus is on the employer to risk assessand provide the
13 proper respiratory protective equipment.
14 As I've said repeatedly, the fluid resistant
15 surgical masks are completely inadequate for protecting
16 healthcare workers from COVID and we should have all
17 been provided with FFP3 or similar. So we were not
18 protected from what is an occupational diseaseand the
19 BMA believesthat COVID should be classifiedas an
20 occupational disease.
21 THE CHAIR: Can I interject there
22 MR DUNLOP: Yes, of course, my Lord.
23 THE CHAIR: Dr Kennedy, you usedthe word at the beginning
24 of that answer or the words of "droplet dogma"; quite
25 strong language actually. This may seemrather an

1 obvious point, but you are the representatives of the
2 medical profession, put in its most broad sense, in
3 Scotland and you tell us in your evidence that you were
4 giving guidance essentially from the outset of the
5 pandemic and on a very regular basis which and I'm
6 cutting it short but basically advised the Government
7 that their view in relation to the method of
8 transmission of COVID and, as a consequence, the
9 provision of appropriate PPE was incorrect again very
10 strong language, not nuanced at all just telling them
11 it's wrong.
12 Given the strength of both the language you've used
13 in your answer today and indeed the advice you
14 apparently gave to the Government, can you tell me was
15 there any and this went on for a long time, as
16 I understand it. Indeed persists to this day have
17 you been given a reasoned explanation why something you
18 were asserting was your view was correct and their view
19 was incorrect have you been given a reasoned
20 explanation of why their view was correct and you were
21 incorrect by inference?
22 A. So, Lord Brailsford, the people that I've spoken to
23 within the BMA and the experts within the BMA advised me
24 that the fundamental problem was that the Government was
25 taking Public Health advice rather than occupational

1 medicine advice. So the experts in PPE are not
2 Public Health doctors, they are occupational physicians,
3 and our most eminent expert in occupational medicine at
4 UK level was excluded from the necessary advisory group.
5 I forget its name. But had we followed Health and
6 Safety at Work Act 1974 guidance and occupational
7 medicine guidance rather than Public Health guidance,
8 I believe the Government or governments would have come
9 to a different conclusion.
10 THE CHAIR: Very helpful answer. Thank you very much
11 indeed.
12 MR DUNLOP: Thank you, my Lord. Just one further question
13 that follows on from that: was the BMA providing advice,
14 whether that be scientific papers or guidance was it
15 providing data to the Scottish Government to demonstrate
16 your point?
17 A. On the specific area
18 Q. On the specific point that it was an airborne disease.
19 I think what you said is you're saying that your
20 position or the BMA's position was that it was an
21 airborne disease. I'm wondering whether that simply was
22 an email saying "We think it's an airborne disease" or
23 whether you were providing the Scottish Government with
24 documentary submissions that supported what you were
25 saying.

1 A. Yeah, so I've read a number of papers recently where,
2 you know, data has been provided since, but I'm not sure
3 at the time if data was being provided or whether it was
4 opinion. I'm not sure about that.
5 Q. If it was opinion, was there professional opinion being
6 given and the reasons for that professional opinion?
7 A. Yes, at the highest level, yeah, within the BMA, our
8 experts.
9 Q. You state in paragraph 53 and you're dealing with the
10 point that the IPC guidance did not reflect the reality
11 of how COVID was transmitted the IPC guidance that
12 was being issued, was that from the Scottish Government?
13 A. I think that's at UK level and I think the
14 Scottish Government followed the UK guidance.
15 Q. I can appreciate the difficulty with the masks, but in
16 paragraph I think you say in you talk about the
17 compliance with health and safety legislation. Would it
18 be fair to say that a health board could impose
19 irrespective of what the guidance said, putting aside
20 PPE but could a GP practice or a health board
21 essentially impose upon itself a higher standard than
22 the guidance required?
23 A. So I was sitting in bronze command in NHS Highland at
24 the time and I was there in my capacity as professional
25 secretary of the GP sub committee. My experience of

1 that bronze command was, in the initial weeks, it was
2 very positive. We pulled together and changed the way
3 we delivered healthcare services very effectively.
4 As the weeks and months went by, I would say we got
5 into more command and control structure and there was
6 a huge reluctance to do anything at all that went away
7 from central Government advice, so I certainly saw no
8 evidence of any health board demonstrating flexibility
9 or a willingness to do anything that wasn't a "Once for
10 Scotland approach." I would say that the culture in
11 Scotland is very much to follow central Government
12 advice.
13 Q. Just for our benefit, you talk about bronze control.
14 I think we've heard talk about gold, I'm not sure if
15 I've seen silver yet, but can you explain to us what
16 bronze control is?
17 A. Yeah, so I think it was called "bronze command".
18 Q. Sorry, bronze command.
19 A. So I think in bronze so in that group it was primary
20 care predominantly, so there would have been maybe
21 two GPs, dentists, nurses, community nurses, pharmacists
22 and primary care managers, and then and the deputy
23 medical director, who was a GP, led that group, and then
24 he reported into silver command, where there was another
25 deputy medical director, and I think gold command would

1 be the chief executive of the board and the medical
2 director .
3 Q. And above that was there a silver
4 A. So there's bronze, silver , sort of associate medical
5 director level , and gold, chief executive medical
6 director , yeah.
7 Q. We've discussed PPE, but the organisational statement
8 comes onto it at paragraph 59 and I just want to ask
9 a couple of questions about using PPE that was out of
10 date. It may be explained by others who are giving
11 evidence that PPE has an expiry date but it was tested
12 to see if that expiry date essentially was premature.
13 Did the BMA have a view on the testing of PPE which had,
14 on the face of it , expired?
15 A. Yes. I think I can give you sort of two facets of
16 that part of the pandemic. So I remember, you know,
17 seeing the pictures, particularly on social media, of
18 date labels being stuck on to packages of PPE which
19 could be peeled off and showed the previous date. That
20 certainly caused a lot of alarm to our members. It made
21 them feel that they were using outdated PPE. It also
22 made them feel in some way that they were expendable.
23 So there was a lot of anxiety at the time and anger from
24 our members at the time.
25 However, I've heard more recently from some of my

1 senior colleagues in the BMA at UK level that they were
2 actually involved in that decision. So they became
3 aware that there was stockpiles of PPE that was about to
4 go out of date, so the advice given, including from my
5 BMA colleagues in London, was to test 10% of the PPE
6 and, if it was meeting standards, then it was okay to
7 redate them. So the BMA actually had a role in leading
8 to that outcome.
9 Q. Were there any regional differences in the availability
10 or suitability of PPE? I'm just wondering if it was
11 concentrated in the central belt or if there was
12 a greater shortage in the central belt. Were there any
13 differences regionally within Scotland?
14 A. I'm not aware of any regional differences, but I do
15 recall the GP committee making representation about
16 a somewhat haphazard supply of PPE. It was a bit
17 mysterious about when PPE was going to arrive and the
18 PPE was often changing and we often saw a reduction in
19 quality of the PPE, particularly around aprons, and, you
20 know, sometimes we would be using eye protection, other
21 times we'd be using visors. So there were quite a lot
22 of changes, particularly at the start , and supplies
23 would suddenly arrive and big boxes would suddenly
24 appear in my practice. So it was all a bit mysterious.
25 Q. You say big boxes arrived. How would the supplier of

1 that PPE know what was required within a particular
2 practice?
3 A. So I don't know, but my assumption was that it was all
4 done centrally through primary care managers and the
5 practice managers.
6 Q. Okay. You also discuss poor training in the use of PPE.
7 Whose responsibility would it be to train the wearers of
8 PPE?
9 A. So drawing on my own experience, there's two places
10 where I was taught to use PPE: one, in my medical
11 practice, our lead doctor would make sure that he was
12 abreast of all the advice and we had group tutorials and
13 they were videoed and shared with people who weren't in
14 during the day. So we did our in house training; and
15 when I worked at the COVID assessment centre in
16 Inverness, I was trained to don and doff, put on and
17 take off , my PPE by a senior nurse.
18 Q. Moving away from PPE, at paragraph 69 you start to
19 discuss the reporting of COVID infections of medical
20 staff . You say at paragraph 69:
21 "Alongside deficiencies with risk assessment and
22 other protections in the workplace, many employers also
23 failed to report Covid 19 ... of staff via RIDDOR ...
24 despite it being a legal requirement."
25 When you talk about "workplace", are you simply

1 talking about medical or are you talking about the
2 population as a whole?
3 A. I think, from my memory of reading that paragraph
4 before, we were talking about healthcare settings
5 because I think RIDDOR is about occupational diseases,
6 so COVID being an occupational disease.
7 Q. Did the BMA then do anything about that that you're
8 aware of?
9 A. Yeah, I don't recall what we did then. I know that we
10 still call for COVID 19 to be classified as an
11 occupational disease.
12 Q. And is it an occupational disease now?
13 A. I think at the moment it's not.
14 Q. It's not. And you say that that reporting may also
15 assist staff , with long COVID developed as a result of
16 an infection acquired at work, seeking compensation.
17 A. Yeah, I think
18 Q. Sorry, the question I was going to ask is: do you know
19 that where COVID is identified on a sickness absence, is
20 there a distinction drawn, to your knowledge, between
21 long COVID and COVID?
22 A. I don't know because I don't work with anyone that has
23 long COVID so I've not seen a sickness absence record
24 with long COVID, so I don't know.
25 Q. At paragraph 70 you identify that risk assessments were

1 not being carried out in relation to whether medical
2 staff were at increased risk of contracting COVID or,
3 where risk assessments would be carried out, the
4 mitigation measures were not being implemented and that
5 the BMA raised this with the director general of Health
6 and Social Care. I think you mentioned you discussed
7 that earlier in your evidence. Do you know if there was
8 anything done as a result of raising that?
9 A. I don't know.
10 Q. You may not be able to answer my next question, then,
11 but you also identify and I appreciate other people
12 have contributed to the organisational statement but
13 the organisational statement also identifies that the
14 capacity of regular testing in Scotland or the lack
15 of I think is probably the better way to put it
16 was also raised with the director general. I'm just
17 wondering if you're aware of the outcome of that.
18 A. Again, I'm not aware of the outcome, but testing has
19 been a significant concern for us.
20 Q. In what respect?
21 A. The complete inadequacy of testing at the start of the
22 pandemic. So I wasn't being tested for COVID,
23 healthcare workers weren't being tested regularly for
24 COVID, so therefore we did not know, when we were going
25 into work, whether we were carriers we know now that

1 a lot of what we call "COVID spreaders" were
2 asymptomatic. So doctors and other healthcare workers
3 could have been going into work, inadvertently taking
4 COVID in with them, and we just didn't know and we
5 weren't therefore able to keep people away from the
6 workplace who were potentially COVID positive.
7 The same applies to patients as well. So in terms
8 of control measures, that source control, being able to
9 keep patients away from healthcare settings who were
10 COVID positive and being able to keep the workforce away
11 from healthcare settings who were COVID positive, was
12 hampered by the fact that we were not testing people,
13 and I assume that that was because of a lack of testing
14 kits.
15 Q. Okay. I suppose two questions. Was that raised with
16 anyone senior within the Scottish Government or another
17 agency?
18 A. I believe it was repeatedly.
19 Q. Okay, and what were the BMA asking for?
20 A. Well, they were certainly asking for regular testing of
21 healthcare workers.
22 Q. And to put that into practical terms, what would that
23 require? Testing kids to be provided?
24 A. Yes, that's right, so that people could test before they
25 went into work.

1 Q. And do you know the reason why testing kits weren't
2 being provided to healthcare staff?
3 A. I think it was simply to do with lack of availability,
4 lack of supply. They were being reserved for
5 positive or patients with symptoms.
6 Q. Is that at a particular dealing with the lack of
7 testing kits, is that concentrated at a particular
8 moment? The Inquiry is concerned with the period from
9 2020 to the end of 2022, the lack of testing. Is that
10 concentrated to a particular period of time during that
11 period?
12 A. I think the biggest concern would have been around about
13 the March 2020 to April/May period. That's when we
14 would have most concern about the lack of testing.
15 Q. I'll ask you to move forward to paragraph 120, please,
16 of the statement. You identify that the pandemic
17 increased staff shortages due to various factors,
18 including illness and medical staff being deployed to
19 high need services. Has this led to a backlog or has
20 this contributed to the backlog that we read about in
21 the papers almost daily?
22 A. Yeah, absolutely. Pre pandemic we had staff shortages.
23 We know that, in our hospitals, at least one in twelve
24 hospital consultant posts were vacant and we know that
25 between 2013 and 2019 GP numbers in Scotland flatlined.

1 There was a promise in around 2018 that there would be
2 800 more GPs produced and we know that that hasn't
3 happened. So we started from a very under resourced NHS
4 with staff shortages and also a shortage of beds and
5 inadequate facilities, and then so it was the worst
6 time to have the pandemic. And when the pandemic came,
7 yes, it had a huge impact on the workforce. First of
8 all we identified clinically extremely vulnerable people
9 within our workforce and, for example, in my own
10 practice, one doctor and one nurse then could not see
11 patients face to face at all and largely worked from
12 home, so they were largely removed from the workplace,
13 and, similarly, that would have happened across the
14 hospitals.
15 And, of course, every time somebody caught COVID in
16 the workplace and became COVID positive, they would
17 automatically be off work for at least a week. So that
18 of course put huge pressure on the remaining doctors.
19 So, for example, in my own group of practices we now
20 have four practices. I think we had three at the
21 time that would mean that at short notice people
22 would have to be redeployed elsewhere. So we were
23 already way under resourced in terms of staff in
24 Scotland and it got much worse during the pandemic and
25 it has got worse since.

1 Q. Can I ask, in terms of the we've heard evidence about
2 the health professionals being under resourced prior to
3 the pandemic. I'm wondering if you can assist me. Is
4 there anything putting aside simply recruiting more
5 people, is there anything that, in your opinion, could
6 have been done to enable patients more patients to
7 have been seen during the pandemic other than recruiting
8 more healthcare staff? Is there anything that could
9 have been done differently?
10 A. Well, retrospectively we perhaps could have divided
11 patients into and this would have depended upon
12 proper testing on those who were COVID positive, who
13 had COVID, and those who were not. If we had the
14 adequate facilities and the adequate staff, we could
15 then perhaps have continued to deliver long term
16 condition management, chronic disease management, in
17 general practice and also perhaps we could have
18 continued to deliver elective, planned hospital care if
19 we had separate systems. But I think in reality we did
20 not have the staff to be able to do that. But in future
21 that would, I think, be a better way of doing things and
22 then we wouldn't have this massive backlog that we have.
23 We know that, prior to the pandemic well,
24 March 2020 there were 335,000 people on waiting lists
25 in Scotland, both for hospital, inpatient and

1 outpatient, and December 2023, that figure has risen to
2 680,000 on waiting lists.
3 Q. Not just the increased waiting lists. Are there people
4 who, had they received treatment earlier for whatever
5 condition they were suffering from, wouldn't have
6 deteriorated? Is that a fair comment?
7 A. Yeah, and that's a common finding amongst general
8 practitioners, that patients' conditions have worsened,
9 and I'm thinking particularly of orthopaedic conditions,
10 people's hips and knees. But also the population has
11 become generally deconditioned, staying at home more,
12 gained weight, and some long term conditions haven't
13 been managed as well as they might have been had the
14 ongoing long term condition management continued.
15 Q. It may be an obvious question, but if a condition has
16 deteriorated, does that mean that more extensive
17 treatment will be required normally?
18 A. It does, but one of the bigger concerns is sometimes the
19 anaesthetist will not regard the patient fit for
20 surgery. So people who might have had surgery
21 pre pandemic are no longer fit enough to have their
22 surgery.
23 Q. I'll come on to screening later this morning or later
24 this afternoon perhaps. In terms of screening for
25 cancer, in your opinion, during the pandemic period

1 from, say, March 2020 to the end of December 2022 and
2 it may be different throughout that period was the
3 cancer screening available for people adequate?
4 A. So, from memory, I believe we stopped cervical screening
5 for I may get this wrong, but I think from memory it
6 was about six months. It may have been a year. So in
7 an ideal world, of course, we would want to have
8 continued to do that screening, so it wasn't adequate
9 because screening works and obviously we'd like to have
10 continued to do it, but it was stopped.
11 I think all healthcare professionals would have
12 agreed with that decision, that screening should be
13 stopped so that we could concentrate our resources on
14 the sick, but for those individuals who would be
15 receiving cervical screening, for example, or
16 mammograms, I'm sure that that would have been a huge
17 concern and an understandable concern for them.
18 Q. As a GP you deal with this in your statement at
19 paragraph 131 you talk about the demand on general
20 practice and so forth. I just wonder I suppose this
21 is more your evidence as a GP rather than your position
22 within the BMA but can you assist us: in terms of
23 other than cancer, what screenings would have normally
24 been available during the early stages of the pandemic
25 which weren't available and what were the consequences

1 of that or tests? Maybe I'll not just say
2 screenings; tests medical testing.
3 A. So we do tests obviously when we're looking for
4 particular diseases or patients come in with symptoms
5 and we're trying to drill down and find out what the
6 root of those symptoms are. So these tests would have
7 continued. You know, we moved very rapidly to mainly
8 telephone consultations and doctors and other healthcare
9 professionals are very comfortable with telephone
10 consultations. We've been doing them for 20 years or
11 more and it's quite easy for us to pick up when we need
12 to see a patient face to face and when we need to
13 investigate. So my practice, in terms of investigating
14 and doing tests, didn't change, and I would imagine that
15 would be similar for most doctors across the country.
16 Q. What about the impact on any maternity services,
17 antenatal fertility treatment? Was there an impact on
18 that in GP practices? I'm particularly interested in
19 GP practices.
20 A. So maternity services have moved out of general practice
21 in Scotland for many years. I no longer see pregnant
22 women for their pregnancy. That's all dealt with by
23 midwives. So I don't know the answer. I would assume
24 a lot more was done by telephone and by video.
25 Q. And fertility treatment, is that anything that GPs would

1 ever get involved in, even at the early I don't know
2 if there's testing and so forth at the early stages?
3 A. Yes, we get very involved at the start and I would
4 imagine that most of that would have stopped. I think
5 that would have been one of the areas that we would have
6 advised patients, "We cannot deal with that at the
7 moment".
8 Q. What about addiction services?
9 A. Again, I see a lot of patients with addictions. My
10 impression is that people with addictions stayed away.
11 In fact I believe that the pandemic will have inevitably
12 worsened many addictions because people working from
13 home it's much easier to conceal an addiction and for
14 an addiction to exacerbate if you don't have to turn up
15 and be seen by colleagues. So I think I could say
16 anecdotally that I saw less people presenting with
17 addictions and, again, the addiction services, I would
18 imagine, dealt with many more people remotely rather
19 than face to face, and it's so important to see people
20 with addictions face to face because you learn a lot
21 from the body language.
22 Q. Just dealing with the movement from in person to remote
23 consultation and you deal with this at I think
24 paragraph 132 of the organisational statement, and
25 within your organisational statement there's a useful

1 discussion on I suppose the shortcomings in the
2 IT equipment and the infrastructure in GP practices.
3 But I just wonder if you can help us, were there
4 particular groups of patients who were perhaps more at
5 a disadvantage when there was a move to remote
6 consultations, perhaps people that didn't have the
7 equipment or didn't know how to use the equipment? Did
8 you identify that there were particular groups of people
9 who were disadvantaged by that new method of working?
10 A. Yes. It's quite interesting when we talk about remote
11 consultations because I think the public thinks that
12 means a huge variety of modes of remote consultation.
13 In reality, 99% are done by telephone.
14 But we did, including myself, start doing video
15 consultations, but we very quickly found out that video
16 consultations were time consuming, difficult for the
17 patients to set up, difficult for the doctors to set up,
18 and often you would see a patient and bring them in
19 anyway because even a rash is difficult to diagnose over
20 video. So I think video consultations, although pushed
21 by the Government, are not really found by many
22 healthcare professionals, particularly GPs, as not [sic]
23 being that useful. Although in the Highlands, for
24 remote patients, there is a role.
25 [Redacted], who is a researcher at

1 Oxford University, has done a lot of research in this
2 area and she did a presentation to the annual
3 representative meeting of the BMA, and what she showed
4 was that remote consultations, particularly video
5 consultations, widens inequalities. So particularly for
6 people with disabilities and immediately autism
7 springs to mind video consultation is not
8 particularly good for dealing with people with that sort
9 of disability, but also the elderly and, again, ethnic
10 minority groups, those who need translators. So video
11 consultations definitely widen inequalities. And
12 I remember dealing with a patient who had a background
13 in IT and she couldn't even sort her video consultation
14 with me. It was quite amusing at the time and we
15 I think I ended up speaking to her on the phone.
16 Q. I think we've all been there at some point over the last
17 few years.
18 At paragraph 141 of your statement you then touch on
19 the health of children and I wonder if I could ask
20 you and I suppose these questions are also geared or
21 principally geared towards you, with your experience,
22 having been a practising GP for so long. Can you tell
23 me, in terms of the pandemic, did that, that you're
24 aware of, have any impact on the safeguarding of
25 children? Is that something that, as a GP, you would be

1 involved in or medical say, for instance, medical
2 appointments in relation to potential foster care
3 placements, is that something that as a GP you've
4 experienced?
5 A. So I have experience of safeguarding as a GP and of
6 doing fostering medicals and I'm trying to think of
7 those experiences during the pandemic. I know for sure
8 that fostering medicals stopped during the pandemic and,
9 in terms of safeguarding, I certainly was aware of
10 widespread acknowledgement that there was an increase in
11 domestic violence which would inevitably impact on
12 children. So, you know, with parents being in the home,
13 I think relationships certainly suffered for some
14 families during the pandemic. I can't remember anything
15 specifically said about safeguarding but I think it
16 would be reasonable to make the assumption that there
17 would have been a worsening of safeguarding incidents.
18 Q. Thank you. We'll hear from social work departments in
19 due course in evidence in any event, which they may
20 have more with respect, they may deal with it more on
21 a daily basis.
22 In terms of looked after children and young people,
23 my understanding is that they normally have an annual
24 medical arranged through the local authority with
25 a general practitioner. I don't know if that's

1 something you've ever dealt with.
2 A. No, that's something that definitely doesn't happen.
3 There definitely isn't an annual medical with GPs done.
4 I've been a GP in my practice for 23 years. I think
5 I can maybe remember doing one medical. So if those
6 medicals are done, they're done elsewhere and I'm not
7 sure who does them.
8 Q. Thank you. Moving forward to paragraph 156, you tell us
9 that the BMA published guidance "in the absence of clear
10 and adequate guidance" from the Government. Can you
11 assist me, when you're talking about inadequate
12 guidance, is that from the UK Government, the
13 Scottish Government or is it both?
14 A. It would be both, and I think it's fair to say that
15 generally the Scottish Government would have followed
16 the UK guidance.
17 Q. Okay. Was this guidance published throughout the
18 pandemic period that we're interested in, from 2020 to
19 2022, or was it a one off publication on a particular
20 topic or was it updated as matters developed?
21 A. So the BMA was regularly producing guidance in various
22 areas where they felt that the guidance was inadequate
23 or where the Government had chosen not to put out
24 guidance.
25 Q. I just have a few more questions for you, Doctor. At

1 paragraph 160 you discuss the engagement with the
2 Scottish Government throughout the pandemic and I think
3 you use words like "regular" and "supportive". I'm just
4 wondering if there was over the past hour we've heard
5 evidence that the Scottish Government, particularly in
6 relation to whether it was an airborne disease, haven't
7 always agreed. I'm just wondering, is that when you
8 say that the Scottish Government were that the
9 meetings were regular and supportive, in what respect?
10 A. So I know that the relationship between our national
11 director, who is not a doctor, and the Government was
12 very good. I've seen a list of about six different
13 regular meetings that she attended. So I know that the
14 relationship was good and the lines of communication
15 were kept open. And also I know that my predecessor was
16 involved probably in the majority of those meetings and
17 there would be no problem with the chair of the BMA
18 speaking, for example, with the Chief Medical Officer.
19 And certainly at the start of the pandemic, I think
20 relationships were good.
21 Q. I don't want to put words in your mouth, but it strikes
22 me from some of the things I'm reading I appreciate
23 that what you're saying is the lines of communication
24 were good, but I'm just wondering whether you're saying,
25 ultimately, that things were being done

1 notwithstanding that there was somebody that you could
2 speak to in the Scottish Government, were things being
3 done to the satisfaction of BMA Scotland at least?
4 A. So it's quite common for the BMA not to be happy with
5 Government decisions and it's quite common for us to
6 disagree. I think it's fair to say there were a number
7 of issues throughout the pandemic that the BMA in
8 Scotland disagreed with the Scottish Government on and
9 with the Chief Medical Officer on, and my understanding
10 is that the four chief medical officers across the four
11 nations kept to a single line of advice, and it might be
12 that Scotland was following the advice of the other
13 three nations at a pan UK level and that we, the BMA in
14 Scotland, were not able to influence that
15 decision making in a way that we would have liked to
16 have done.
17 Q. Finally, in the last two pages of the organisational
18 statement you detail BMA Scotland's recommendations and
19 we have those in evidence. I'm just wondering if
20 there's anything which I either haven't mentioned today
21 or have mentioned that you would like to clarify, if
22 there's anything this is an opportunity essentially
23 if there's anything further you would like to add in
24 your evidence today.
25 A. So I think the key thing to emphasise is that we need

1 a better resourced NHS. If we started from a bad
2 position, and I'm particularly thinking about workforce
3 and also about estates, and that affected ventilation
4 and our ability to see patients. I think I've
5 emphasised that healthcare workers were inadequately
6 protected. We didn't have the right control measures in
7 place at source, you know, with ventilation through the
8 pathways and with the receptors, us, the healthcare
9 workers. We didn't focus enough on inequalities and
10 vulnerable people and we didn't get safeguarding right.
11 We didn't safeguard the mental health of the workforce
12 nor did we protect doctors from long COVID and nor did
13 we protect the training I haven't spoken much about
14 the impact on junior doctors but their training
15 certainly suffered.
16 I'd also like to say a little bit about the culture.
17 We do have a cultural problem in the NHS in Scotland
18 still, where doctors and other healthcare workers don't
19 feel confident about speaking up and raising concerns.
20 We still have a blame culture. We still have a rather
21 command and control culture in the NHS in Scotland, and
22 that's not good for patients because we don't feel able
23 to speak up so much about patient safety.
24 And, finally, my final point would be we didn't
25 focus enough on recovery. Right now the NHS in Scotland

1 is in the worst position that I can remember it in terms
2 of staffing and in terms of our estates. We started the
3 pandemic 1 million £1 billion behind in maintenance
4 and we've now got a complete cessation on capital
5 projects, so we needed to have kept money aside or to
6 have put resources into the recovery phase of the
7 pandemic.
8 MR DUNLOP: Thank you, Doctor. May I just take this
9 opportunity also to thank you for participating in the
10 Inquiry and preparing such a comprehensive
11 organisational statement on behalf of your organisation.
12 It's very much appreciated and the Inquiry requires
13 bodies like yours to participate to work.
14 My Lord, I have no further questions and there are
15 no further witnesses this afternoon.
16 THE CHAIR: No. I was aware of that. Thank you. No, all
17 that remains for me to do is to thank Dr Kennedy as well
18 and thank the BMA for their full assistance in this very
19 large statement which you've prepared. So thank you.
20 A. Thank you, my Lord.
21 THE CHAIR: I think all I have to say therefore is that it's
22 slightly unusual tomorrow I'm just checking my
23 timetable because I think we're starting at now, I'm
24 told on my I don't know if you know the answer to
25 this, Mr Dunlop, but I've got as usual tomorrow starting

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1 at 9.45. My recollection is that, because of trying to
2 condense work into a shorter period tomorrow, we're
3 starting at 9.30. Can you confirm that?
4 MR DUNLOP: That's my understanding as well. My Lord, I'll
5 certainly check with those that certainly will know
6 without any doubt, but my understanding was there was to
7 be an earlier start to accommodate Mr Macaskill and
8 thereafter Ms Hedge.
9 THE CHAIR: That's what I thought as well. So I think,
10 ladies and gentlemen, we're starting at 9.30 tomorrow
11 morning, but until then, thank you all.
12 MR DUNLOP: Thank you, my Lord.
13 (12.27 pm)
14 (The hearing adjourned until
15 Friday, 22 March 2024 at 9.30 am)
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