OPUS 2

Scottish Covid-19 Inquiry

Day 36

April 19, 2024

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Friday, 19 April 2024
(9.30 am)
(Proceedings delayed)
(9.43 am)
THE CHAIR: Good morning, Ms Trainer.
MS TRAINER: Good morning, my Lord.
MS DALJEET DAGON (called)
THE CHAIR: Good morning, Ms Dagon.
Right. When you're ready, Ms Trainer.
MS TRAINER: Thank you, my Lord.
Questions by MS TRAINER
MS TRAINER: I wonder if you can start by telling us your name.
A. My name is Daljeet Dagon.
Q. And you I think, as per your statement, are a programme manager at Barnardo's Scotland; is that right?
A. I am, yes.
Q. You have provided a statement to the Inquiry and, for our benefit and the benefit of the recording, that bears the reference SCI-WT0485-000001. You should understand that all of that information will form part of the evidence that the Inquiry is able to consider.
Your statement first of all goes through your professional background and tells us I think that you began working at Barnardo's some 26 years ago.

A. Yes, I did.
Q. And you tell us, I think, that you've had various roles, but I wonder if you could maybe summarise the services that you were running in 2020.
A. Yeah. So I manage kind of two portfolio services, one specifically in relation to child exploitation, which is both sexual and criminal exploitation, and that was primarily in the west of Scotland but also in Dundee and Fife at the time, and also in terms of family support services, which straddled two different authorities which was Glasgow City and East Dunbartonshire.
Q. So we have family support services where -- do you support the whole family as opposed to individual children?
A. Yeah, so we have kind of two services. One is about trying to keep children at home where it's safe to do so and, if not, obviously looking at alternative options. It's very much about providing support to all the individual children as well as the parents and carers that kind of support that child, and also, in terms of our Parent Capacity Assessment service, that's about supporting children who have already been removed from the home but it's very much about assessing the parents' and carers' ability to have long-term care of those children. So it's about helping the local authority

make decisions in terms of permanence and long-term planning for those children.
Q. At paragraph 17 of your statement, you describe the children that you work with and you say essentially that they vary and the families vary but in a sense they all come under the category of vulnerable.
A. Yes.
Q. I wondered if you could explain that further.
A. So basically -- it's quite funny because, thinking back, our service was known as the "last chance saloon", so like the families that we worked with were families who had been through every other service possible, and it was about working with children who were primarily on the Child Protection Register. That was -- so if you can think about all the issues that go with that in terms of children being on the register due to physical neglect, physical injury, emotional abuse, sexual abuse. So that's primarily that kind of group of children that we worked with. Obviously, in terms of our child exploitation services, we were working with children who were directly experiencing exploitation at the time.
Q. In terms of where the referrals to your service come from, do those come directly from the local authority, from social work departments?
A. Yeah, so in terms of our family support services,

because we were commissioned, they all came from local authority social workers. In terms of our exploitation services, because Barnardo's puts a lot of its own funding into that, we have referrals from local authority, police, education, health, but also sometimes from children and family themselves and primarily families that we've worked with, so like -- I remember we had -- we've had referrals from parents that I used to work with when I was a practitioner, and they were children and they've actually made referrals for their own children because they've been so worried and concerned.
Q. First of all, turning to the family support service that you described, you in your statement tell us about various impacts that the pandemic had on that service, but the first thing you mentioned at paragraph 26 is that part of the service is based in a local authority building and that posed its own logistical difficulties for you because that building immediately was closed.
A. Yeah, so in terms of East Dunbartonshire, our Parent Capacity Assessment service had to go online straightaway because we weren't allowed in the building and it wasn't a COVID-secure building and none of the tenants were allowed in the building, and that was quite challenging because you already had parents who were

struggling to engage with the service because of the very nature of it. So those processes in terms of making decisions —— making decisions that would affect children's long—term kind of well—being were delayed even longer because parents were enabled not to engage with the service, and then getting online wasn't easy because, actually, ourselves as an organisation —— as a large children's charity, we didn't actually have the capacity —— because we weren't used to engaging with people, and then there were certain platforms that we couldn't use —— we weren't allowed to use because they weren't secure —— and then obviously, even if we could access platforms, our families didn't have devices, didn't have wifi, so it was about trying to organise and arrange all that, so that took a wee bit of time.

So that group of staff actually supported our wider family support services so that they were still engaged, so that did take a bit of support. But we actually then took the service out to families' homes and we tried to actually —— because normally with our Parent Capacity Assessment service, people would come into our place. We had it set up like a home. You had a kitchen, you had a bathroom, we had like a two—way mirror, so we weren't in the same room as families as they were trying to, I suppose, engage in normal family kind of

practices. So actually, where we could, we'd go into families' homes, but we were also met with quite a lot of reticence in terms of, "We've got COVID" or "We don't want to let people in because we're scared about germs coming into the house", and there was no consequences for those families. I don't mean that in a bad way, but it's like, at the end of the day, we were trying to make decisions or help local authority make long—term decisions for children and we weren't being enabled to do that because families were allowed to kind of delay things.

But in terms of our intensive family support service, we basically —— you know, we did doorstep visits, we did —— if it was a case of shouting up to the window, that's what we did. The families didn't —— because it was about trying to see children as much as possible. So even if it was getting a wee wave at the window or a conversation through the letter—box or at the door, we made every effort to kind of try and see children.

Also there was lots of children who didn't have access to gardens, for instance, so in terms of our prioritisation, it was about thinking about which children weren't getting out at all and which children were getting fresh air and exercise, so trying to work

out like —— it was about trying to persuade families or children to go out for a walk or go for a cycle or whatever.

So we kind of got —— I mean, we tried everything we could —— do you know what I mean? —— just to make sure that we were setting eyes and physical eyes on children and young people rather than online. Although it was good having the opportunity to go online, we tried to do it face to face as much as possible.

Q. It's maybe tempting for us to assume that everyone during that time tried to move things online, but I think at paragraph 29 of your statement you say you consciously tried not to do that.

A. Yeah.

Q. I wonder if you can maybe explain the reasons why you didn't think that that was appropriate all the time.

A. Yeah. So I mean, obviously, we're working with children and families where —— the kind of reason that they've been referred to our services is because there's a lot of often harm within the home as well as outside of the home, so we deliberately didn't do a lot of online stuff because we didn't know who else was in the room. There was no privacy. And what we didn't want was children being coached by others in terms of letting us know that everything was okay. So it was very much about wanting

to see children physically and also wanting to make sure that they were not being coerced into working with us or seeing us or saying certain things.

It was very much about trying to get to see children and families and parents where there was —— because we were actually working with families where there was domestic abuse, where there was sexual abuse and exploitation, so we just didn't know who else was actually around and whether what they were saying was —— like I said, whether they were being coerced and manipulated. So that's why we deliberately didn't try to do things online.

Q. You also, later on in your statement, I think touch on a matter you mentioned before, where sometimes families who are referred to your service maybe are families who typically don't really want to engage to start off with and maybe COVID and the lockdown being quite a good excuse for that to happen.

A. Yeah.

Q. Can you tell me more about how you managed to reach those families?

A. I mean, I think —— from our perspective, I suppose what we were was persistent and we persevered. Even when families weren't letting us in, we kept going and we would say, "Right, we're coming back tomorrow or Friday

or next week", do you know what I mean, and we'd put notes through the door; we'd leave activity packs, like word puzzles or fidget toys, anything we could think of —— do you know what I mean? I think certainly —— I suppose one of the things I've always done as a practitioner is try to think of the practical things people need.

And it's not about, you know, coercing or manipulating families into working with you, but it's about, you know, really simple things about actually what is it that this family needs because there would be a whole raft of reasons why families have been referred to our services, but people often don't think about, "Well, how are they going to get from A to B? What's going to assist them?". So it was things like doing food parcels and recognising that, although children weren't able to go to school, it wasn't just school education they missed out on, it was a breakfast, it was a lunch, and a lot of families couldn't afford that. So it was simple things like organising cereal, organising milk, and it sounds really basic, but for a lot of these families they didn't have that. So we got into a routine where every week we made sure we were buying breakfast stuff and lunch stuff specifically for families.

We were doing word puzzles, like I said, colouring books, fidget toys, things like chocolate, making sure that they were remembering people's birthdays. If it was a celebration, if it was Christmas or Divali or Eid or whatever, we were making sure that we were making a fuss of people and just keeping people in mind all the time. Whether that door was open or not, we were persevering, shouting up to the window, like I said. People always chapped the door —— and we would try different workers as well because obviously a lot of the families that we work with, we would have more than one worker, so we just persevered all the time and tried what we could.

Q. In your statement at paragraph 32, you really go on to talk about the observations that you think —— the impact the pandemic had on children and young people accessing the service. The first thing you say is that it caused stress and tension which was above normal levels and that was something you were seeing. How were you seeing that?

A. So we often work with families where there's large sibling groups and I suppose, in terms of like referrals, for instance —— you asked me right at the beginning, "Do you work with the whole family or do you work with individual children?". Often what we would

find is, when a referral is made to our service, it will be the child that sticks out for the family or the local authority, so often people pay a lot of attention to that particular child. And what we've always done is said, "Look, actually what we're going to do is work with the whole family, work with all the children", but you will always have an emphasis on one or two so that can cause additional stress and tension.

But you've also got children who have multiple support needs, so we had children with neurodiversity and sometimes children would be going to different schools and obviously accessing different levels of support and weren't used to being with each other 24/7. You also had families where parents might be working from home or they only had one parent in the home, so often what we'd have is there would be shared care arrangements. And initially what you would have is everybody in the one home and there was no respite either for the mum or the dad, who was the main carer, or for the other brothers and sisters.

So there was a lot of competitiveness, but also there was a lot of harm as well, and I'm sure you'll probably ask me about this later on, but some of that harm also led to sibling sexual abuse as well because children are cooped up, they were in environments that

they weren't used to being together 24/7 and there was —— there was a lack of supervision and guidance. And also in terms of education, although children had access to education, they found it repetitive and it wasn't —— it didn't motivate them. It wasn't interesting. And also children have very different learning styles and not all the children that we were working with were able to engage with that type of learning either.

You also had parents and carers who had very poor or no literacy skills and numeracy skills so they didn't have the ability to support their child, so actually, because there was no respite in terms of and because —— and if children didn't have a garden, they were stuck in a, you know, multi—storey building and they couldn't get out and there was nobody to take them out. You often had parents who were suffering from mental health issues or addiction issues or had mobility issues so they weren't taking children out either.

So, for us, they became our priorities in terms of who we invested in in terms of, "Right, okay, we need to get you out, we need to see you, we need to bring you to our office", in terms of —— and sometimes it was about actually different workers taking different children out and doing different things so that they were separated

because that —— which was the opposite of what we'd done in the past because in the past it was about trying to work with children so that they were, I suppose, adopting skills around negotiation, around compromise, around —— you know, looking at the socialisation, whereas this time round it was about that separation because it was about giving children that opportunity to just talk about their own individual stresses and worries without necessarily worrying their younger brothers and sisters —— do you know what I mean? —— or it was about, "They're doing my head in and I want time away from them". So it was about thinking about what would be in their best interests and trying to be able to support that as much as possible.

Q. As well as the stress and the tension and maybe a difficult environment at home, you also talk about your experience of seeing more young people presenting with sexually transmitted infections.

A. Yes.

Q. You say that's due to more children being unsupervised and having sexual contact. Is that something that the service experienced anecdotally from staff feeding that back?

A. Yes. So we had that direct information from children and young people but we also had feedback from the local

authority and also health workers, who were seeing a rise in infections such as gonorrhoea, for instance, that hadn't existed for a long time. They were also had young people who were unknown to them presenting with —— talking about unprotected sex because they didn't have access to contraception, but also children being coerced and manipulated into having sex when they didn't want to have sex.

I suppose, you know, just in terms of erring on —— we spoke about mental health and stress and tension, and I suppose it was about children trying to offer each other comfort and support but that becoming exploitative and abusive as well. So that was direct information that we had from children and young people, but, like I said, also from colleagues in health and social work. That was particularly noticeable in one particular local authority and we had conversations —— and also in terms of starting to look at registrations and some of the reasons —— and some of the reasons for children starting to come to the attention to services that they hadn't previously been known to.

Q. When you say "registrations" ——

A. Child protection registrations. So I'm talking about under 16—year—olds, I'm not talking about children over the age of 16 here.

Q. Another thing you mentioned again anecdotally is that you saw what you perceived to be an increase in the use of alcohol amongst young people.

A. Yes. So certainly —— I mean, obviously, in terms of the work that we've done for years and years around exploitation —— alcohol and exploitation pretty much go hand in hand in terms of, you know, children being coerced into taking alcohol and drugs as a way of, you know, I suppose manipulating them into engaging in activities that they wouldn't ordinarily engage in. And certainly what children were saying to us was access to alcohol was very easy because there was more alcohol in homes, because families were doing a lot more online shopping, so, rather than buying one bottle of wine, they might buy three bottles of wine or whatever —— do you know what I mean? —— because it was about bulk buying. I suppose everybody, myself included, got involved in bulk buying, whether it was toilet rolls or whatever it was that people were buying. So, because of the increased alcohol in the home, families weren't really missing —— if something went missing —— do you know what I mean? —— if it was a bottle of vodka or a bottle of wine or whatever, it wasn't as noticeable as it would have been in the past.

So there was access to alcohol, but also young

people were reporting that their own parents were drinking more but also drinking longer in the day because they were working from home. So rather than like getting up at, I don't know, 6 or 7 o'clock at the morning to get dressed, showered and out of the house, you were maybe rolling out your bed at 8, half 8, sticking on a hoody or smart top and sitting in front of a screen so —— and you weren't driving to work or whatever, so people didn't have those same restrictions, but there was a lot more alcohol in the home. And that's certainly what children had reported to us as well having access to alcohol as well. And —— sorry —— I think just going back to what I said earlier on about children having —— more likely to be coerced into having sex, that was also as a result of having consumed alcohol as well.

Q. At paragraph 34 you say that there was an assumption that children and young people were breaching lockdown rules all the time by going out, but you were being told the opposite as some of the children and young people you worked with said that it was beneficial for them to stay in their house because that would avoid them being exposed to external harms.

A. Yeah.

Q. What type of harms are you discussing there?

A. So we had numerous examples of young people —— and young women in particular, less so boys —— but certainly young women in particular who were kind of proudly saying to us, "You know, it's been brilliant being at home because it means I've got an excuse. I can say to so—and—so that I can't get out, I can't see you, because I'm not allowed because Nicola Sturgeon has said we've got to be at home, we can't stay —— we can't go out". And for a lot of young people it was a relief because previously, when they'd been out and about, they would be —— as I said, be manipulated into engaging in activities that they didn't want to engage in. And by that I'm talking about rape and sexual assault.

And that's what was happening to our children and young people on a daily basis prior to COVID because they weren't in control of what was happening and what was going on, whereas actually this was one way that they could take back control and say, actually, "I need to be at home. I can't get out. I'm not allowed out", because before —— what a lot of people don't understand about exploitation and grooming in particular is it's not only the child that gets groomed. Often families are groomed as well and parents and carers. So actually —— you know, offenders are very skilled in terms of the tactics that they use, so actually this

way, you know, children and families were able to say, "No, no, so—and—so has to stay at home and they're not allowed out", which was, for a lot of children, you know, one, beneficial, but also a sense of relief in terms of, actually, "I'm not going to be forced into doing something I don't want to do because actually I've got a really good reason to stay at home".

Q. You go on I think to caveat that by saying:

"The unfortunate thing is offenders are always able to adapt to unusual circumstances."

A. Yeah.

Q. What ways did you see that manifest?

A. Yeah, so very specifically young people spoke to us about how offenders were saying to them, "But you're allowed out for an hour's exercise every day, so you can get out, so see that hour's exercise that you're getting out for, that's when you come and meet me". Also parents and carers were —— obviously they were keen for their child to get out and get exercise, get fresh air, so they were also kind of pushing the child to get out for that hour's exercise as well. And, unfortunately, for a lot of children, they felt exposed, and if you remember in the early days of COVID —— or maybe it's just me looking at it through rose—tinted glasses —— but the weather seemed much better and it seemed warmer and

everybody was out and about and you had a spring in your step and people were going to parks and these kind of public environments. And basically that's where a lot of offenders were kind of coercing children into meeting them and sex would take place and harms would take place, whether that child wanted to or not.

So it was very specifically around that hour's exercise time where children felt, I suppose, that they were coerced into being harmed. But also I think, certainly —— I mean, when I think back, there was some children who had spoken about domestic abuse and tension in the home and lots of family arguments, so they would kind of sneak out the window —— do you know what I mean? —— and obviously we were all encouraged to provide devices for children, so access to social media, you know, increased exponentially. So people would actually contact —— make contact with anyone that they saw as being able to kind of support them in their hour of need. So there was times both during the day and also covertly that children got out and were exposed to harm.

Q. The types of harm that you describe and you talk about in terms of exploitation and sexual abuse, you talk about those in your statement really anecdotally and in generality. Do you know if statistics exist in relation

to that?

A. Not as far as I'm aware. I don't think so. I think one of the challenges was we weren't having —— we weren't routinely having those multi—agency meetings that you would have where information would be shared across agencies. So we weren't able to kind of join the dots in terms of, "This is the information that we've got, this is the information that police has got", in the way that we map all the time. Both pre COVID and post COVID, that just simply didn't happen.

It was interesting because, when I was thinking back and I was chatting to staff yesterday, we actually —— it's funny how you kind of forget things and you shouldn't forget things —— but actually we very vividly remember a young woman that we worked with, who was aged 16 at the time, and she'd been raped and she wasn't able to tell anybody. She wasn't able to give a statement because she felt she wasn't able to leave the house. She believed that all police stations were shut, so she couldn't go into a police station even during that hour's exercise.

So when you think back and you think how horrific was that —— do you know what I mean? —— that a child ... and it's hard enough for somebody who has been exposed to harm like that to actually tell, but even when you

want to tell, thinking, "Actually there's no one to tell because there's nowhere or no place I can go to tell". So I think for that —— I suppose when you think back, you think it maybe wasn't the right thing to do in terms of saying to people, "You can't go out" or "All these places need to be shut". But simply in terms of statistics, there was nobody who was recording.

Even in hindsight —— you know, we would normally record themes and trends and patterns and, you know, unmet need, but because we were having to, you know, kind of respond to so many different returns for local authorities and also our own organisation and the Care Inspectorate, plus we were also having to risk—assess and those risk assessments would change every three weeks and we were told by Scottish Government about what we could do, what we couldn't do and what was increasing, we didn't actually routinely record some of those anecdotes to see whether there was trends or patterns, and in hindsight that's probably not the right thing to have done. But we were all living in the here and now —— do you know what I mean? —— and just focusing with what was happening right now and what could be happening next week, in a fortnight, so we just didn't. And there was nobody who was kind of —— I suppose kind of cross—correlating

that information with other organisations in the way that we did before and continue to do now.

Q. So you're now at a stage, I suppose, when you're able to discuss matters with staff and able to reflect and maybe identify some of the themes that at the time were kind of overtaken by a lot of what was going on?

A. Yeah. Yeah, totally, because it was just —— because there was so much reporting to be done —— there was so much about like, you know, whether you could go into somebody's house, how many people could be there, you know, this just —— all those different things about where you could go, where you couldn't go —— I suppose that energy was just on all of that and, from my perspective, my energy was also around supporting our staff team. And we had two staff teams. You had one that was working and you had one that was shielding. And it was about trying to make sure that everybody's needs were being met and it was about trying to make sure that those staff who were shielding still felt part of a team, still felt part of a service, and they tried to support the colleagues who were working as much as possible from their homes by doing simple things like —— so see, for instance, we were putting nurture bags together or getting fidget toys and whatever —— it was them that were like on Amazon, identifying what to buy,

getting things delivered, all that kind of stuff —— do you know what I mean? So for me it was very much about meeting the needs of our staff team and especially those who are living on their own in particular —— because the first thing I did was find out who was living on their own and I had them in the office as quickly as possible, so I was seeing them and making sure that they were, you know —— I suppose in terms of their emotional well—being.

And it's in a sense really daft, but every Wednesday, for instance, we used to, as a staff team —— that was our day when we got —— we had —— I play hockey, and through my hockey club we organised food being delivered to our office so that we could then put together food parcels for all the families. So we had a group of staff who would pull all that together and then we had another group of staff who would then pick that up and deliver it. And funnily enough, because my boyfriend —— he would make a pot of soup every week, and every week I would take that pot of soup into work on a Wednesday. So every week, once people had packed all the stuff, we would all have a bowl of soup together —— do you know what I mean? And it was just simple things like that that made such a difference in terms of supporting people, keeping an eye on people, but also

that camaraderie in terms of working together and supporting families.

And particularly —— and, yes, people were getting support from Government in terms of —— you know, like additional food vouchers to schools and stuff, but I don't think people appreciated what it's like having children —— well, I'm not a parent, but having children in the house 24/7 because children need —— it's not just breakfast, lunch and dinner. It's all the snacks. Children just constantly eat if they can't get out, do you know what I mean?, so it was just making sure that things were topped up and families were supported. So, yeah, it was full on.

Q. You go on at paragraph 36 to talk about how perhaps safeguarding concerns weren't able to be picked up and you say that protective environments such as school just simply didn't exist so there were less people to set eyes on children and for them to talk to and maybe report concerns. Does that mean, from your perspective, that the organisation saw an increase in your own safeguarding concerns coming to light because nobody else really had eyes on these children?

A. Yeah, definitely, but I think one of the biggest challenges for us was where to take it because, in the past —— working for the voluntary sector sometimes ——

I mean, like power dynamics always play a part when it comes to multi—agency meetings, and often when you —— well, when I've been in meetings and my staff have gone into meetings in the past, often you would seek support from other agencies in terms of, "Yes, I've seen that change of behaviour. Yes, I've also seen that change in appearance", or whatever. But because we were the only agency that was actually seeing children and young people, it became harder to amplify the voices of children but also amplify our own voice so that other organisations were hearing what we were saying and recognising the concerns and thinking about whether we needed to escalate.

Also there was a reluctance to challenge those families where parents were reluctant in terms of letting you in the home. It was a case of, "Yeah, I can understand because they've got underlying health conditions or they've had COVID or they've had COVID three times. I can understand why they don't want to let anyone in", whereas in the past it would have been, "The reason we have got the PACe service involved is because actually we're concerned about the vulnerability of these children and, if you don't let, you know, PACe in, then we'll look at a joint visit with social work or we'll look at X, Y and Z". None of that was happening

and we were kind of left on our own to not just persevere but also raise those concerns and keep on raising them but not have that same ability in terms of influencing decisions because we didn't have the same support from school in particular.

And also, from children's perspective, a lot of children —— you know, going to school isn't just about education, it's about seeing their pals, it's about seeing their favourite teacher, it's about being able to get a bit of respite from what's going on at home —— do you know what I mean? —— in terms of feeling unsafe or feeling overwhelmed, so we just didn't have that ability to actually engage. And also trying to get hold of workers was really difficult because a lot of social workers in particular were working from home but they hadn't been provided with work phones, for instance, so it was quite difficult, and they didn't have laptops, so it was quite hard trying to make contact with them. So, yeah, it wasn't easy. Certainly in the first kind of three to six months it was quite hard.

Q. You talk at paragraph 45 about new referrals to your service and you say that that's one area which you think didn't work well.

A. No.

Q. Did you continue to get new referrals throughout the time of the pandemic?

A. Yeah, all the time. So we got new referrals in terms of exploitation work as well as in terms of family support work, and the difficulty we had was we had no relationship with those families at all because ordinarily what we would have done is —— so when we get a referral, we would also —— we would always have a joint visit with a social worker and we would —— kind of explain to the family about why we were involved, what people's worries and concerns were and what our intentions were, and it was very much a kind of collaborative approach. So straight off there was no joint visits because social work weren't working in the same way that we were. So we were having to cold—call, and obviously cold—call —— because it was a family that we didn't know, we would always have two workers —— do you know what I mean? —— so straightaway people's backs were up, people didn't know who we were, it hadn't been explained to them about why they had been referred to our service. There was a lot of kind of mistrust so families weren't letting us in. And we kept persevering but one of the things that we found was families just didn't let —— just didn't want us to have access to their children unsupervised. They were reluctant for us

to have their children on their own.

A lot of that is because —— a lot of the families that we've traditionally worked with don't trust agencies or don't trust adults and we didn't have that ability to get alongside parents and work with them —— because in the past what we would have done is children would have been at school, so we would have met parents on their own. We would have either been in the home or we would invite them into our office or we would take them for a coffee or whatever, whatever kind of best suited their needs. But because children were in the house, there was no privacy, there was no ability to have conversations about what that parent was required to do in terms of being able to have the capacity or the ability to safeguard their children.

So we just weren't able to get alongside and sometimes, unfortunately, we were able to —— we had to say to social workers, "We actually can't engage this family, we can't work with this family, we haven't been able to see the child". And that happened with some of our exploitation cases, where those children hadn't been known to us prior to the pandemic. So sometimes, unfortunately, we had children who were left in harmful situations both in the home but also outwith the home because we simply weren't able —— and like we tried

whatever we could —— you name it, we tried it —— but sometimes we had to just say, "We can't do this". But we would always make sure that we were communicating with all the relevant organisations and looking at alternative means because, if there was, for instance, somebody else that that child had had a better relationship with, whether it had been a teacher or whether it had been a social worker or a youth worker, we would try to engage them to see if we could, through them, try to engage that young person.

So the difficulty for us was that other organisations weren't as agile as we tried to make ourselves, so there was a kind of reluctance to try and get alongside us to try and support those young people, unfortunately.

Q. I think in particular one of the elements that you say maybe wasn't agile or wasn't as thought through was that there existed these education hubs —— sorry, this is at paragraph 50 of your statement —— there existed these education hubs specifically for vulnerable young people and some people did access them, but you say the vast —— first of all, the vast majority in your experience didn't, but also education departments wouldn't engage with you to let you go into schools and also help.

A. Yeah. So in terms of some of the children that we've

worked with —— so it was clear pre—pandemic that a lot of the young people actually needed support to be in school and to stay in school. Some of the children that we worked with wouldn't get past the first bell, so you're talking —— they didn't. They weren't able to stay in school beyond half past 10, which might seem bizarre for a lot of people, but for a lot of children that we worked with, that was their daily life.

So some of the work that we did pre—pandemic was being with them during playtime to kind of support those social interactions, to support them into that class after lunch, to maybe stay with them in that class or to do something different so that they were still in the school environment but they weren't necessarily in the classroom.

When the hubs were set up, they were quite specific. So it was a case of —— there was school staff deployed and there was children and no other agencies were allowed in, so those children that we would have supported to engage and interact with other children or simply to be able to have the confidence to stay within the school environment wasn't supported.

Also a lot of children go to school not just to be educated but to see their pals and, when they were going to these education hubs —— you'll know yourself, you'll

remember, that those hubs weren't for every child. Children were selected depending on vulnerabilities. So a lot of time when they went to school, their friends weren't there, so it was like, "There's no point in me going because —— my best pal's not there so I'm not going", so children just didn't go and they weren't supported.

Sometimes it was a case of —— again, like I said, we worked with larger groups, sibling groups, so some children were going to school to the education hubs and some weren't, so again that became quite divisive in families. I don't think people were thinking through actually the impact that would have on families, where some children could go to school and some couldn't. So it was difficult for parents to actually get them to school because —— in terms of being able to leave children unsupervised at home whilst taking other children to school, so it just didn't happen. It just didn't happen at all.

Q. You also go on to say at paragraph 52 that, from your experience, there was little attempt made to get children to engage in online education. I wondered what you think was lacking and what could have been done better in order to get them to engage.

A. I don't think people understood the fact that, as we all

do, children have different learning styles in terms of how they take in information, how they process information. Lots of the children that we worked with had one device between five —— do you know what I mean? —— so they couldn't actually access education individually. And I know —— and that was a challenge for everybody. It wasn't —— so I'm not having a go at education or anything like that, but also children —— if you think about our intensive family support services, some of the reasons we got involved was because there was no structure in the family home, there was no routines, there was no boundaries. So what I'm talking about, there was no kind of strict bedtime routines, there was no one supporting with homework, there was no one making sure that you got up in time to be able to go to school —— do you know what I mean? —— so children routinely weren't prepared and weren't engaged and ready to engage in education.

So it wasn't some —— it wasn't a simple thing like, "Okay, we'll give you a laptop or we'll give you an iPad and you can just switch it on and access, go and —— here we go". There was a lack of understanding about all the processes that come before you can actually switch that laptop on in terms of are you ready emotionally and physically and actually what's your attention span like

to be able to engage. Actually what children were saying to us was the information they got was boring, it was repetitive, it was the same stuff and it was of no interest to them and they just stopped engaging.

Q. You talk about a particular category of the young people you supported, it being very difficult for, and those are the children that were transitioning between primary and secondary school, and you felt, I think, like you weren't able to support them adequately into that transition. Again I wondered what you think could have been done better in relation to that particular group of young people.

A. I mean, I think for me one of the challenges was that we saw children as a homogenous group and actually, in terms of the children that we worked -- children and young people we worked with, actually they had a whole range of needs, both emotional, behavioural, practical needs. I always remember, like, working with a child who -- she had a really good experience in primary school and, when she got to secondary school, she stopped going. It wasn't until our staff got involved that we understood why she stopped going. The reason she stopped going was she couldn't tell the time -- right? -- and, because she couldn't tell the time, she didn't know what time she had to be from one class to

another class; right?

Now, so if you think about primary school, you're in one class, you've got one teacher, you've got one set of classmates, it feels quite secure, it feels quite stable, and you've got children who are then going into a high school environment. So children didn't have that support to prepare in terms of what it's like to go to a school where it's bigger, it's larger, you've got to be -- you've got to navigate from one school -- from one class to another class that could be at the other end of the building, "How do I get there? How am I going to get there? Who is going to support me?".

So, in terms of the work that we do, that's some of the things we would do with the families that we work with. We would support them to get to school, sometimes we would hang around, like I said, until the playtime bell and then help support them navigate to the next class -- do you know what I mean? That wasn't happening. So suddenly children missed a whole year of education and then they were expected to know their way around the school, they were expected to understand, you know, how to get to different classes and be able to form relationships and behave -- by "behave", I mean like, you know, be able to stay silent almost for like 35 minutes in terms of that specific class when they

weren't used to doing that because actually, at home, they'd go and get a glass of water, they can go to the toilet. You know yourself -- I mean, like, if there's something else that you can do rather than focus on what you're supposed to, you'll go away and do it. So they weren't used to sitting in one place for like even 35 minutes, for us which seems -- it's probably been 35 minutes or longer that I've been sitting here and I can do it, but if you've not been used to that and suddenly that's outwith your comfort zone, it becomes quite difficult.

I suppose also the other thing when I was reflecting, some of our older young people -- you know, that transition from secondary school to adulthood has been quite difficult because they've missed out on work experience -- do you know what I mean? -- and careers advice and careers guidance, so they left school without having any support. I mean, I'm thinking like -- when I left school, I had, you know -- did I really know what I wanted to do? Yes, I did, but that's because I was supported. Do you know what I mean? A lot of our young people left school and it was like that, it came to an end and they got no support ongoing.

We've got -- one of our staff yesterday was talking about just her younger brother, how he's starting his

apprenticeship. He's aged 20 and he's just starting his apprenticeship now because he's missed out, and he's really struggling with engaging with his peers and that whole adult environment where he has to make decisions for himself rather than being guided and supported. So I think those two groups are young people I think have had very difficult experiences.

The other thing that we've really noticed is in terms of people who experience university, particularly in terms of social work students, we would routinely take social work students and we've had social work students who spent their course online, so when we expected them to have their placements with us and have the work face to face, it was a massive shock for them. It was like, "Oh, no, but I thought I could do my placement online", and you're thinking, "No, you need to be in front of a child, you need to be in front of a family. You can't do that from being online". But that was their experience because, for them, their placements had been online. Very few universities had insisted on face-to-face placements. So I think there's been multiple challenges in terms of education and training.

Q. I think, in particular, you mention that aspect of there being an expectation to not maybe do practical work as

much as a problem in recruiting your own staff.
A. Yes, definitely. It's been really challenging because -- like, I don't think we've had a single interview where people don't ask how much time they can spend working from home, and that's been a real challenge because actually you can't do the work that we do -- do you know what I mean?
Online has some huge benefits. However, in terms of working with children and families, that engagement has got to be face to face every single time. But even in terms of working with your peers and other practitioners -- I mean, like, for me, a lot of online working worked really well because I already had relationships with those practitioners, those managers -- do you know what I mean? -- but trying to build a kind of relationship with somebody you don't know -- because a lot -- because, when you have an online meeting, you log on and you have that meeting and it's done. There's none of that chit-chat before the meeting, during the meeting, you know, over a cup of tea afterwards, none of that. So in terms of recruitment it's been challenging because -- and also the other thing I've found is -- and if you think about that hour's exercise, a lot of people got dogs, for instance, and particularly those people living on their own. And

they've now got dogs and those dogs need to be tended to and supported, so people have got other pressures on them in terms of priorities. So folk are like, "Oh, but I need to be at home because ..." or "I need to do the pick up and drop off from school", and you just can't -- it's really difficult in terms of what people's expectations are of work because we need to be able to see children. We need to be able to see them after school hours, during school hours, in the evening, at the weekend. That's how we work and that's the support that our commissioners expect. So that's been really challenging in terms of workers' expectations of what they can do.
THE CHAIR: Can I ask you, are you managing to break down -- I understand exactly how it's come to pass and perhaps I've got some sympathy for the people that ask these questions if they've never had to meet people face to face and so on.
A. Yeah, definitely.
THE CHAIR: But when you explain to them, as I'm sure you do, at interview that it is necessary for social workers to meet people face to face, do they accept that or are you actually finding this an obstacle that prevents you recruiting the number of people you want?
A. It's an interesting question. My organisation probably

won't thank me for this, but you know in that way we try to be too flexible with people, we try to be too kind, rather than saying, "Actually, this is your job and this is what we need you to do". So I found myself, as a manager, saying, "This is my expectations and this is what I expect you to do and I expect 80% of your time to be out there" -- do you know what I mean? -- because actually pre-pandemic 80% of people's work was expected to be in front of families or in meetings and stuff, so you always have 20% in terms of admin tasks. Do you know what I mean?
THE CHAIR: Yes, of course.
A. So, for instance, we continued to have our team meetings online, and that was okay and that still feels okay because we see each other quite a lot. So like, for instance, we recently took on a social work student last year and we insisted that she had to be in the office and she had to be in and around her colleagues because her learning was very much about actually observing a colleague, you know, maybe on a phone call to a social worker or shadowing home visits or whatever, and we said, "We want you to do that for the first four weeks". And some of that was about trust as well because we don't know these people -- do you know what I mean? -- and then it was about actually saying, "Actually we do

trust you to go home and do your recordings" -- do you know what I mean? We did. But we were saying, "For the first four weeks we want you in here 100% of the time", but we do have this kind of 80/20 split and that's our expectation.
And as a manager I have had some people say, "Oh, but so-and-so down the road isn't doing that and they're allowed", and I'm like that, "In here, this is our expectations. We're commissioned to do this and actually this is -- if we want to build relationships with children and families, this is how we build relationships", and there's no flexibility in that. Do you know what I mean? Obviously, I am flexible and adaptable -- do you know what I mean? -- but at the same time I'm dead clear with what the expectations are.
THE CHAIR: Do people accept that or do some of them simply refuse to take the work, the job?
A. We have challenges. We have people who will push boundaries, absolutely, and that's managed through supervision and team meeting structures. I've never had to escalate that to a senior manager because, actually, eventually people see what their colleagues are doing -- do you know what I mean? -- and also understand the benefits. But, yeah, you have people who will -- yeah, like I said, push boundaries. Some people have left --

and there's no denial —— some people have left because they're not able to manage our expectations and that's unfortunate, but, for me, it's —— what I'd rather have is somebody with less experience but actually somebody who is willing to learn and somebody who is prepared to do the work that's required rather than somebody who thinks they can do it from home.

THE CHAIR: Thank you.

Ms Trainer.

MS TRAINER: I think you say at paragraph 65 of your statement that you did lose some staff and the problem that you found is that none of them have been replaced like for like ——

A. Yeah.

Q. —— so it's been difficult to find people who have the same skill set as who have left.

A. Yeah, so —— if you think about the number of people that were shielding, for instance, a lot of those people —— I'm saying "a lot" —— some of the staff that I had that were shielding didn't really recover, really struggled to come into work, were dead fearful, really scared, spent far too much time watching those news reels over and over and getting really worried. Some of those staff have gone on to jobs where they can have a better work/life balance, they can spend more time working from

home, for instance, and they were very experienced staff, very committed staff pre—pandemic. I'm not saying that they weren't committed during the pandemic —— do you know what I mean? —— but they had a different experience.

What I've found is —— and, to be honest, pre—pandemic, recruitment was hard, but it's even harder now because lots of people have made different choices in their life in terms of what they want, in terms of how much contact they want to have with people who are vulnerable but also in terms of funding. We didn't have a cost of living rise and, even when we did, we offered our staff 1%. We had a one—off payment for staff which was taxed so it wasn't actually what people were anticipating. If you compare that to the public sector, rises of 9%/10% —— in real life, you know, if you think about cost of living, it's huge in terms of the challenges.

I've got staff who go to food banks. Do you know what I mean? It's not about our families going to food banks, our staff are going to food banks. And these are qualified social workers who have chosen to work in the voluntary sector, but we cannot match the pay of the public sector and we are not getting the cost of living rises that people had in the past.

So in terms of recruitment it's become quite challenging in terms of what people's expectations are. Obviously, when you advertise a post, you advertise it full scale, people have expectations. I mean, just to kind of explain, during this whole process some of our services had been retendered and, when you put in a tender, the local authority expects you to submit salaries that are mid—scale, mid—point. Now, we've got staff who are already at the top of their scale, so already —— when we are going for tenders, we are already taking a hit because we know that the local authority are not going to pay us what we're currently paying our staff because we're only allowed to put in mid—point scales in the actual tender. So that becomes quite hard for an organisation to manage, if you think about the size of an organisation.

And also, as an organisation, we also lost quite a lot of funding if you think about —— we get quite a lot of revenue from our shops. Our shops were closed during the pandemic so we lost a lot of revenue as well, so that's had a massive impact in terms of how —— in terms of the level of voluntary funds that we have and therefore we have had to prioritise where we spend our voluntary funds.

Q. You also I think, within your statement, talk about

there being a distinction for some of your staff as being key workers and then some of them not and that having a financial implication.

A. Yeah, that was horrendous. So one of my services is registered with the Care Inspectorate, and one of the advantages of that actually was we got access to PPE and we got access to PPE very early and we also got access to vaccinations, which was fantastic, and we had this routine where we phoned in for a PPE order and picked it up. It worked like clockwork. But one of the disadvantages was that the only workers that were recognised officially by Scottish Government as being key workers were those that were registered with the Care Inspectorate and local authority workers. Bearing in mind the local authority workers —— a lot of them work from home, whereas my staff didn't, so a small group of my staff were given a £500 bonus for being key workers and for doing the work that they did. That included my manager incidentally —— do you know what I mean? —— and I had a whole heap of staff who aren't —— whose services aren't registered with the Care Inspectorate who got nothing.

And my manager at the time, to be fair, tried to find a way of being able to give his £500 to —— you know, being able to —— because, like me, myself,

I didn't want the £500, I wanted staff who were doing that front—line work but who weren't working in a service that was registered —— but there was no physical way of doing that and we weren't actually allowed to do that. But there was this discrepancy in terms of —— and it felt means—tested, for want of a better phrase, in terms of who got and who didn't get. And actually a lot of workers who got that money weren't front—line workers actually in terms of actually what they were doing. But something like two—thirds of my staff didn't get that.

And £500 doesn't seem like a lot of money and for staff it wasn't about money, it was about being valued —— do you know what I mean? —— and actually being respected in terms of what they were doing and actually the danger that they faced, because at that time we didn't know what was going on but they were still prepared to take some of those risks and it just wasn't recognised, which was, I think —— I think it was a real shame and a really poor decision actually.

Q. You talk a bit about local authorities and social workers who are employed by local authorities and your contact with them. At paragraph 77 you say you were able to communicate with local authorities but you never saw them.

A. Yeah.

Q. You go on to explain that things like child protection conferences, children's hearings, things that were traditionally very important meetings in person completely changed.

A. Yeah.

Q. How do you think that had an impact on the people that you were serving?

A. I think we forgot about why we were there in the first place and, if you think about children's hearings in particular, it's a child's meeting and it's the child that's —— we say this all the time. Children are at the centre. The child is at the core. It's their meeting. They determine who is at the meeting and they can also have —— they've also got the ability to speak to panel members, for instance, on their own. Children's hearings just didn't happen. They just did not happen. And some of that was about not having the technology. Some of that, I think, was about the fact that schools were closed and people weren't working in the same way. So statutory workers weren't seeing workers so there was delays in children's hearings because there was no ability —— well, there was less ability for those workers to compile reports and to be able to share assessments. So actually children simply weren't seen

and their needs weren't recognised. It was a real struggle to try and get children's hearings and, even when they did start, for children to be present.

There was no recognition about how we got children there. There was no recognition —— like, again, because there was no schools, schools weren't open, it was quite difficult for parents to leave some children at home and bring other children, so it just didn't happen. From a very practical perspective, they didn't have somebody to look after, like, a baby, so they couldn't bring the baby along because we were quite strict about how many people could be in the room.

I myself have been in children's hearings where there's like two rows, there's that many people in the hearing, but the numbers were restricted and there was no recognition about who the child wanted in the room. You know, there was other adults who were making some of those decisions.

We were having child protection case conferences on the telephone. That was before even things went online. And even when things went online, people would have their cameras off. That was both professionals and family members. Now, I think all of us have had technical issues but sometimes that felt quite deliberate in terms of not being on screen. It felt ——

particularly when you're on the phone or you were online, you didn't know who else was in the room.

I remember myself like going to a child protection case conference, which wasn't unusual actually, pre—pandemic, where I hadn't met the child, I hadn't met the family, because sometimes, when we had referrals, we might use that environment as our referral meeting, so it was more an information—gathering setting —— rather than, you know, meeting a family and speaking about their issues, it was more about information—gathering. But I remember like —— it was a particular case, it was a child, she was 16, she was pregnant, she'd been the victim of sexual exploitation, she'd been raped and her pregnancy was as a result of that rape, so quite a difficult experience. She herself had addiction issues. She was living at home and, although home was a safe environment or safer environment, her mum, although supportive, had an abusive ex—partner, so this child had been exposed to domestic abuse.

So there I was, on the phone with a child and her mum, who I had never met, with no awareness of who else was in that home, whether that violent ex—partner was in the home, trying to have very difficult conversations about her vulnerability and about how she was going to keep her child safe, how she was going to take

responsibility for keeping this child away from the offender, who was also the father of the child and had parental rights. So quite a difficult experience.

And also I was very wary about not asking inappropriate questions. And you know that way in a meeting before, if you're in a face—to—face meeting, you could kick somebody under the table or you could scowl at them in terms of, "Don't be silly asking that question", we couldn't do any of that. So I found that whole experience very uncomfortable because I found people in the meeting asking questions that I didn't think that were appropriate because we had no way of knowing who was in the room. But also it wasn't —— we weren't able to see that person's reaction. You know —— because you know that way sometimes you think that this person is very uncomfortable with what you've just asked, so you know to stop or to take a break, "Let's give the person five minutes, ten minutes". We weren't able to do that and we weren't actually doing that. We weren't thinking about "Let's take a break"; do you know what I mean?

Actually I think one of our biggest failures is that we continued to have some of those meetings online because I've heard colleagues in the statutory sector say, "They're efficient, they're effective". But

they're efficient and effective for them. They're not efficient and effective for the child or for the family —— do you know what I mean? —— because we can get a meeting done and dusted in an hour or half an hour. Do you know what I mean? We're not taking that child's needs and I think we've lost all sense of why we're there.

And we just soldier on because —— and I'm sure everyone sitting here, your diaries have got back—to—back meetings —— do you know what I mean? —— so everyone is really struggling for time. So for us it's efficient and effective but for the child absolutely not, and I do think we need to rethink that. And I think certainly during that time we lost sense, I think, of what was important and who was important and meeting those children's individual needs.

THE CHAIR: That's a pretty important statement, if I may say so.

A. Sorry?

THE CHAIR: It's a pretty important statement, if I may say so.

A. Thank you. But I think —— for me I think it's —— for me that's really basic —— really, really basic. But we lost all sense of what was important.

THE CHAIR: Maybe that's why it is important.

A. Thank you.

MS TRAINER: One of the general trends that you talk about as a result of the pandemic and the people that you work with is that you say that generally there was a distinct period of time that you could identify that you were working with families and children, and I think you say from this statistic you see that to be around ten months or so prior to the pandemic. At paragraph 87 you go on to say that this is now far, far greater.

A. Yeah.

Q. I wondered why you think that is and why you're working with families much longer than you were previously.

A. Yeah. It's interesting and I'll give an example. I had a member of staff who was recruited and started during the pandemic, so she started in October 2020, and her caseload —— 60% of her caseload currently —— and she works in our exploitation services —— about 60% of her caseload is young people that she started working with in October 2020. We're nearly four years on. And those young people were aged 12 at that time, so 15/16 now. The reason I think it's a lot longer is because we weren't actually able to do the work that we would ordinarily do in terms of therapeutic work and also talking about the harm that they had been exposed to, were being exposed to, because it was just about trying

to build a relationship and it was about dealing with that huge uncertainty which was the pandemic, and that's what everybody focused on —— do you know what I mean? So we actually didn't get into the detail of why we were involved, and some of that was also because we didn't have a private space to be able to have that conversation.

Sometimes it was about recognising that where they were living wasn't home —— sorry, wasn't a safe environment so we didn't want to be having those conversations and then placing that young person in a kind of unsafe environment again —— do you know what I mean? So a lot of that initial work for the first two years was about holding them. Some of that was about helping them with education actually, so children who weren't going to school. So we were helping them with their reading and writing, which I know seems really basic, but actually we were trying to, you know, support those young people. Some of it was about socialisation because they weren't used to being around their peers. Some of it was about managing living at home with —— and, you know, being around their brothers and sisters and their family members. So it wasn't the work that we would ordinarily do —— do you know what I mean?

Then it takes a bit of time to break that pattern

because they've got —— young people have got used to —— you know, you take them out for a coffee or take them for lunch, and it was like, "What do you mean I've got to do something else?" —— do you know what I mean? So it's been much slower. Also during that period young people's emotional well—being has deteriorated so the work that we do do is in smaller chunks. So before you would spend an hour, now you spend 20 minutes doing that piece of work and then you build on it. So it's taking much longer to do that.

The downside to that is we've been bombarded with lots of referrals and referrals that we're not able to take. And obviously, when we see the work that we're doing and who we're doing it with and we see the referrals, that gives us —— that puts extra pressure on us because we're like that, "Actually those children that we're not supporting really need our support", but I'm also —— and I work with an organisation where we deliberately don't have a waiting list. And that's very, very deliberate because, when you have a waiting list, there's a sense that something is going to happen and there's a sense that we don't need to do something because something is going to happen soon.

The reason we don't have a waiting list is because I'm saying, "I can't tell you if something is going to

happen, when it's going to happen, so therefore you need to find something else for this child", rather than thinking, "I can stop worrying about this child because Barnardo's are going to do something. I'm not quite sure when, but they're going to do something". And what we're clearly saying is, "No, we're not going to do something. You need to go and find something else to do".

But our staff —— and my team manager yesterday was talking about her worry —— we were putting together an annual report and she was talking about that worry in terms of the length of time it's taken us to pick up support for a family because they've had to wait because we've not had capacity, and I'm like that, "That's not your worry", because actually, up until the point we engage with that family, they're not our service users —— do you know what I mean —— and somebody else needs to make those decisions. And it sounds really harsh, but actually somebody else needs to take responsibility for ensuring —— because we don't have a statutory responsibility for those families, somebody else does, and they've got resources that we don't have so it's their responsibility and we need to be really clear on that.

THE CHAIR: I'm afraid you've got less than ten minutes,

Ms Trainer.

MS TRAINER: I'm grateful, my Lord.

I think you go on to say at paragraph 101 that at the point now you're busier than ever and you're effectively at capacity. I wondered if you attributed any of that to the pandemic.

A. Oh, definitely. Without a doubt. I mean, I think what we've got is workers in the local authority who are now working with families, now working with children and young people whose needs have gone through the roof, and that's because there weren't other people who were setting eyes and ears —— there's no eyes and ears on those children. The harms that they have been exposed to, were exposed to pre—pandemic, during the pandemic —— we are now seeing that there's children who should have been on the Child Protection Register and actually who are now being accommodated because their needs are so great, but we're now seeing families where we weren't able to intervene earlier.

So we've got so many more referrals. We've also got —— I mean, like yesterday, we had a meeting with police and social work, where their demands from both are like, "But we need you to see these children. We've got these children who have gone missing and we need someone to do those return discussions"; we've got

a local authority saying, "We've got children who are being exploited here and now. We need that support". We're saying actually this is the funding you give us, and they're like that, but there's no throughput in terms of service. And I was like that, "But actually we can't just close cases because we've got these other referrals coming in because otherwise we're doing more harm than good in terms of those young people that we're currently supporting".

So, yeah, our referrals have gone through the roof, our funding has reduced in real terms. It's taken —— for all the reasons I've said, in terms of not having staff who have got the same experience, we're having to do a lot more hand—holding in terms of supporting staff with some very difficult issues that children are presenting with and that —— navigating that multi—agency system network has been quite challenging as well. But, yeah, it's really —— it's hard because, like I said, we are working with children and families a lot longer than we used to for all the reasons I've said.

Q. In terms of rounding off your statement, one of the more general things you say at paragraph 113 is that one of the lessons that you hope can be learned is that we recognise, of course, the risk of COVID and the risk that the pandemic had, but that shouldn't override

everything else and particularly that shouldn't override potential harms to children. I wonder if all of the issues that you've spoken about perhaps being left you feel have really caused perhaps a longer-term harm.
A. Sorry, can you say that again?
Q. So you speak about that at the time we didn't deal with the harms to children and that perhaps the pandemic was more important than that. I wondered if you feel that's had a long-term effect on children.
A. Oh, definitely, because actually I think we probably aren't very good at having conversations with children about what their experiences were like during that period, so I think what you've got is a whole raft of workers who are dealing with the here and now and it's all about what children are doing or not doing. So I'll give an example, a very basic example, where you've got -- we see lots of headlines about how schools are at breaking point, the levels of violence in school, for instance, children's behaviour in school. It's all about what children are doing. But what we're not thinking about is actually we had a whole group of young people who weren't supported through transitions, in terms of primary/secondary, secondary/adulthood, we had children who were exposed to harm while -- during that pandemic, who didn't have a protective structure around

them and the home environment wasn't protective. We don't understand that sometimes children need to act out and, by acting out, that's their way of telling us that they are distressed, that they are traumatised, and that's particularly relevant for boys. So we see that acting out behaviour as a problem and we see children as being aggressive and violent rather than seeing children trying to tell us something.

Pre-pandemic, I remember lots of boys that I've worked with over the years who have said to me, "My way of telling you something's wrong is by getting into a fight", "My way of telling you I'm upset and distressed is by getting into a fight, and that's my way of self-harming". We need to understand that behaviour is about children trying to tell us something. It's not poor behaviour, it's not -- and what we've got is saying, "Our schools can't cope. We need to exclude these children". We need to understand where is this behaviour coming from -- do you know what I mean? -- and that's about the harms children have been exposed to and continue to be exposed to and that's not what we're talking to them about.
Q. Those I think are all the questions I had for you. We're now quite close to running out of time but I wondered if there was anything else that we haven't

covered that you thought it was important to raise today.
A. Okay. So just two very quick things, so, one, for me -- I know obviously none of us had ever experienced this before, but I think -- if ever we have something like this again, I think we really need to consciously think about is staying at home the best thing because, for some children, staying at home was very damaging because home was not a safe place; right? We can't assume that a home environment is safe.

And the second thing for me is we had a whole group of workers who were out there -- like my staff were -- out there working and we had a whole group of staff who were at home, and one of the challenges for workers today is that actually some of that group of staff who were at home have been churning out guidance, policies, legislation -- right? -- and we've got a workforce who is overwhelmed with The Promise, UNCRC, all the raft. And whilst we all embrace all of that, a lot of workers are just like that, "I'm overwhelmed. I don't understand it. I don't know what's going on". So I think we need to strike a balance where we support people to do their job, which is fundamentally keeping a child at the heart, at the centre, making sure that child's voice is included, and next time let's include

children's voices and ask children and young people about what they think we should be doing rather than, "This is what we need to do and this is how we need to do it". So that's me. Hopefully I've not gone over time.
MS TRAINER: Thank you.
THE CHAIR: Thank you very much for your very helpful evidence.
A. Okay. Thank you.
THE CHAIR: Good. Quarter past 11.
(11.00 am)
(A short break)
(11.15 am)
THE CHAIR: Good morning.
Ms Trainer, when you're ready.
MS TRAINER: Thank you, my Lord.
MS CAROL-ANN CROSSAN GURUGE (called)
Questions by MS TRAINER
MS TRAINER: Good morning. I wonder if you could start by saying your full name.
A. Yes, it's Carol-Ann Crossan Guruge.
Q. You are a children's services manager at Barnardo's Scotland; is that right?
A. That's correct, yes.
Q. And I think you tell us that you cover the Highlands and

Islands region particularly .
A. Yeah, Highlands.
Q. I presume from that that there are other children's service managers for lots of other regions in Scotland?
A. Yeah, yeah, a few of us around.
Q. You have provided a statement to the Inquiry that should be appearing on screen and, for our benefit, the reference for that is SCI—WT0314—000001. That is information which the Inquiry will have and be able to use as evidence to consider.
Your statement tells us I think that you have been in your current role since summer of 2021; is that right?
A. Yeah, that's about right.
Q. Paragraph 7, I think you cover some of the services which you now have responsibility for. I wonder if you're able to just briefly take us through those.
A. Yeah —— so, yeah, I've got kind of local responsibility for a residential children's home, a through—care and after—care service, our RISE Highland service, our new kind of Anchor Service, which is attached to youth work, and we've also got a partnership service supporting unaccompanied asylum seekers.
Q. That's a role which you started in 2021?
A. Yes.

Q. Prior to that, you tell us I think that, when the pandemic started in March of 2020, you were the registered manager of one of those discrete services, which is Northern Lights, the residential ——
A. That's correct, yeah.
Q. When you were in that role in Northern Lights, working in the residential service, what were your responsibilities ?
A. So I was the team manager at the time, registered manager for the service, so it was really everything to do with running the home effectively. I was based within the residential home at the time. I had previously been in the home as a senior practitioner and as a project worker, so I was very familiar with the home. Generally I reported to the assistant director at the time, and it was anything that would equate to running the home and engaging with the commissioners.
Q. In terms of Northern Lights as a service, are you able to give us a general view as to what it is ——
A. Yeah.
Q. —— who lives there and why they're there?
A. So it's a children's home for five young people. We take our referrals regularly from the local authority and we work very closely with them. So we look after them —— we tend to look after —— it's long—term

placements, so they tend to come to us with a view of staying for a long time, may that be a few years until they're ready, and then we support them —— once they move on from Northern Lights, it tends to be in the community and in their own homes. So it's a very kind of safe, secure home for them.
Q. You say five young people or a place for five young people within the home.
A. Yeah.
Q. How many staff work there?
A. We have ten core staff and, in addition to that we have —— at the moment we have a registered team manager and a senior practitioner .
Q. You mention, I think, that the funding for that service comes entirely from Highland Council; is that right?
A. Yes.
Q. In terms of the people that live within Northern Lights, is there a particular profile that you can maybe describe?
A. No, I wouldn't say there was a particular profile . It tends to be young people who can't stay at home. We have —— it tends to be from 14 upwards that we've accommodated —— more recently that's what we have.
Q. Are there kind of typical examples of reasons why they're not able to stay at home?

A. It could vary. So it depends on what —— their individual plan they need, but it could be that they couldn't stay at home for, you know, parental breakdowns. Some of our young people don't have parents and have been accommodated because the local authority have got parental rights and responsibilities for them. It just depends on the individual needs. We do have a matching process, so we try to match our young people —— because it's long—term placements, where there's a process before we would take a young person into the home, to make sure that it's right for them, first and foremost, but also that it would be right for the other young people as well.
Q. When you say that it's a long—term placement, what kind of timescale are we talking about?
A. So it would vary for every young person, but we would aim to keep them up until they wanted to move on, so 18—plus. We've had young people stay until they're 21 and opted for continued care, but that option is always open to our young people. I think the benefit from our service is that, because we have the through—care and after—care service that works across Highland, when they come to our Northern Lights service, they're supported up until they're 26 through Barnardo's, so it's that kind of wrap—around support.

Q. At the time of lockdown in 2020, you were working within Northern Lights?
A. That's right.
Q. And in your statement you tell us at -- I think starting from paragraph 19 about the working patterns and routines that existed before that period.
A. Yeah.
Q. I take it from what you're saying that, as soon as the lockdown happened, that all required some quite radical change?
A. Yeah, absolutely radical.
Q. Can you tell us what happened and the course that it then followed?
A. Yeah, so previously -- before lockdown happened, the staff kind of worked on a rota. It tended to be 12-hour shifts. We've kind of changed that in the duration of the time that we've had it to meet the needs of the service and to meet the staff -- we are always constantly reviewing that.

Just before lockdown actually, when there was discussions about kind of socially distancing and potential lockdowns happening, quite a lot of our young people were kind of struggling with that and not really understanding it. We also didn't understand it. We'd never experienced anything like that before. We looked

at what might happen and we decided as a team -- actually it was a group of us who were having discussions about this, and I suppose back then none of us knew what this was, none of us knew what was going to happen -- and we decided that, if there was a lockdown, that the safest option for our young people and for us to protect the workforce but to protect the young people as well and give them that stability -- that we felt that we should lock down with them as families were, and obviously that is quite a radical thing to do.

So we had actually initially discussed that as a team, a few of us -- our colleagues, we talked -- there were three of us at the time -- and before we even discussed it with Barnardo's or the local authority, we agreed that we wanted to put this option on the table. We spoke to our families first to check that they would be okay with it. Our families all were supportive of it. And then we took it to kind of Barnardo's and discussed it and then we took it to the young people to discuss it with them, to check they were happy with it.

What we did was -- there was a team of six of us and we did a week each basically. So we moved into the house on the Wednesday -- before we moved in, we were testing and we were obviously following guidance -- and we moved in on the Wednesday and then moved out on the

Wednesday -- the following Wednesday and then alternated teams.
Q. So would you have a week on and a week off?
A. A week on, yes. So we literally packed a suitcase for a week and moved in, and before we moved out we did our PCR testing and things and moved out, and then went back for a week.
Q. That I can imagine -- and I think you talk about it in paragraph 21 of your statement -- obviously there was space for all of the residents to stay there. You had to make space for you to stay there?
A. Yeah, so we were very lucky because the home that we have is a beautiful home. It's on the outskirts of Inverness and it's on its own. It's got a lot of grounds in it and it's a big house, so we had already had space for two sleepover rooms, which is part of the house anyway. But we moved -- so the downstairs office, which was my office at the time, we just moved it around a little bit and put a kind of sofabed in it and we used that. So we did have the space, but we were very lucky to have the space because of the building that we have.
Q. When you're talking about this week-on/week-off pattern, at the time I would imagine you didn't know how long it was going to go on for.
A. No, we didn't know.

Q. How long did it go on for?
A. So that pattern went on for about four and a half months, I think, from memory, and then we phased it out a little bit, so we didn't drastically go back to our old pattern. What we found was that the staff actually really liked that pattern and the young people responded really well to that pattern but it wasn't really sustainable. So we phased it out and we cut our days down and sort of went to four, I think, first and then cut it down to three and just phased it out. So we did do long-term -- and we still do actually. So the staff still do kind of double shifts and they'll sleep over for two night and are there for three days, and that works really well.
Q. I think you say at paragraph 28 there was -- so there was the first period of lockdown and then there was a second period of lockdown, and you recognised that there was some benefits to the previous arrangement but it needed to be tweaked.
A. Yeah.
Q. Is that what you're talking about --
A. Yeah, yeah, that's it. So we cut it down. That was just because it was a lot to expect, we were also phasing other staff back in and trying to manage that kind of week on -- we had too many staff to do that with

as well.
Q. You describe I think there being a lot of willingness from staff to take part in this ——
A. Yeah.
Q. —— and you wouldn't have been able to do it if there wasn't that. I hope you don't mind me asking, but you do mention your own personal circumstances in this statement.
A. Yeah.
Q. You say, I think, that at home you had a very young child who you had to leave for a long period of time.
A. Yeah.
Q. How was that for you?
A. So at the time it was —— I think at the time —— when I reflect back, I often wonder, if I knew what I knew now, would have happened, but at the time I was living with my husband and my daughter and my grandmother, who was older, and we really didn't know what this virus was. We didn't have a lot of information. And there was —— my husband at the time was furloughed, so he was off. He works in the construction industry so him going to work wasn't happening. And I guess I was really worried about —— I was trying to put my job and my family —— and trying to work out how I do that, and, for me, managing a children's home, you can't do that from

a distance. You need to be in there with the staff, especially during something that is very unknown and quite scary for people, so you almost need to roll up your sleeves and do that with them.
But I was also very aware that every time I was going into work, I could potentially be bringing back something into my family and what that impact would be. So that was part of the discussions —— when me and my colleagues were discussing, you know, "What do we do with this and what's our action plan?", we had that discussion with my husband and we agreed that actually it would be safer to do that, and then we obviously had the discussion with Barnardo's and the local authority.
It was really difficult. I remember at the time I thought, you know, "It's okay, I'll keep in touch", and FaceTime and things like that, but that was really hard for my daughter, so we had to stop that and I would just have to sort of get a video from my husband sent to me —— I'd speak to my husband regularly but I wasn't able to actually speak to her because when she saw me she would be upset and obviously the return home was quite difficult.
I think it was the right thing to do for our young people as well. I remember at the time, you know, a lot of young people —— when you work in residential care,

you are trying to create a safe space, you are trying to show young people that you care for them and that you're there for them and almost that family environment, and a lot of young people in the past, you know, had almost said, "You're kind of paid to work here. This is why you're here. You don't care about us", and things, and I remember quite clearly the young people saying, "You must care about us because you're doing this". So for them it was a very physical response that, "You do care about us because you wouldn't do this if you didn't", and that was quite evident from how the lockdown went. So it was hard and it wasn't easy but I do think it was the right thing to do.
Q. At paragraph 25 of your statement you say:
"... when I look back I recognise that we might have been a bit mad to suggest the lockdown plan and that it was a [really] big ask from staff ..."
A. Yeah. So we had the discussion —— there was three of us that had the discussion and we just put it out there on the table, and there was no pressure for anyone to do it, you know. It was, "This is an idea. What do people think?". And actually there were six of us that kind of opted in and thought, "No, we want to do this", for our own different reasons. I guess I was a bit conscious about what —— you know, like maybe what Barnardo's

thought about at the time, but they were so supportive of it and made sure that we were supported to do it, so we made sure there was enough of us that we could all get breaks and we had contingency plans and things like that in place, that people could come in and swap in and swap out and stuff. But the organisation very much supported us and it was up to us —— you know, if we wanted to stop that, we could at any point.
Q. There's no need to answer this. If you don't know, just let me know. But do you know if that is a model which happened in other residential settings?
A. From my knowledge, I think there was other services that did do a similar —— have a similar approach. I don't think they did the long approach but I think that they —— from what I know is they did a couple of days each. I'm not —— I don't recall anyone doing a week at a time.
Q. You go on to discuss within your statement about the guidance in place about those residential care settings.
A. Yes.
Q. At paragraph 15 you say:
"I do not believe the guidance provided by the Scottish Government was specific enough. I believe it focused more on care homes for adults rather than care homes for children. There was not enough guidance on

care homes for children."

I wondered if you could maybe explain a bit further why you think it should have been tailored to the settings that you were working in.

A. Yeah. So I think it was -- it's really difficult when you, you know, categorise a care home because they are very different and actually every children's home is very different. They're managed differently. There will be, you know, the same sort of scrutiny and the work of the Care Inspectorate and guidance, but they do operate differently. So I think from when I -- when we were looking at the guidance, we had to follow the guidance from Scottish Government but we also had to follow Barnardo's guidance, and they aligned, but it was trying to manage it all. And actually it was actually easier for us to go into lockdown as a family than it was to try and manage all that guidance because we just locked down. I think for other services it would have been really difficult because you had a staff team who were also trying to manage what was going on and then come into work, so I think it didn't capture enough for looked-after children.

Q. You then go on to say at paragraph 16 that you thought some of the guidance was quite unrealistic.

A. Yeah.

Q. I wondered if you could explain that further.

A. So I recall there being guidance about, you know, having areas in the house that were red zones and green zones and things like that and, you know, walkways and stuff. When you think about children's homes, what we're trying to do, it's their homes, so this is the children's home. So if I was going into my home and putting that guidance in for my child, they are not -- teenagers are not going to abide by that. "This is my home. Why would I have a red zone and a green zone and one-way systems round the house?". So it was just things like that then -- we were trying really, really hard to make these as homes for children and not institutions, so having a lot of this felt like an institution for young people.

And, you know, we were lucky that -- we followed the guidance, but because we were locking down with the young people, we lived as a family, so we didn't have to have one-way systems in place.

Q. You also say at paragraph 31 that another difficulty that you faced was that that guidance was just constantly changing --

A. Yeah.

Q. -- and that meant that people were really getting burnt out by how much work they had to do in order to keep up

with those changes. Can you think of any examples of that or tell us more about it?

A. I can't think of any examples, but just trying to navigate it all at the time while for us our priority was keeping our young children safe -- that was the priority and making sure that they found what was coming out, because they were watching the news regularly and they were seeing -- and it was quite scary, it was quite scary for all of us, so we were trying to protect them as well. So having to do that and spend time with young people and then having to constantly update your risk assessments and -- which we have to do anyway, but it was changing so quickly, trying to keep up was really difficult, I guess while you were trying to process everything that was going on.

Q. Were you able to explain what was going on to the young people that you were living with? How did they find it?

A. Yes, we were, but again there was lots of questions and we couldn't answer all those questions, so we were in it together really. We were kind of learning it together. And I do remember one of our young people before lockdown had happened had said, "Why do I have to socially distance? Youse come into work all the time so it's not that bad", but the minute we locked down, that was -- they got it. They were like, "This is really

serious", so it was -- again for them it really helped because they were like, "This is actually really serious".

Q. As part of the experiences that you had within the residential setting, I think you mention that some of the young people were on court orders, compulsory supervision orders, effectively were legally regulated that they were staying there, and that I think as a consequence is that they have to have children's hearings.

A. Yes.

Q. You discuss children's hearings within your statement at paragraph 44 and you say:

"Interaction with the Children's Hearings System during COVID was [just] not great I would say."

A. Yeah.

Q. Tell us more about that.

A. So we didn't have that many hearings that took place, but the ones that we did, you know, they were online, so, again, it's that young person's safe space. When hearings -- if hearings are particularly difficult for young people, they're happening in their safe space, which is their home, and that wasn't easy for them and then they had nowhere to go from there. So, in my experience, where hearings have happened face to face,

not all young people like that and don't always like to attend, but they can go back to a safe space, so —— and the workers that are there with them will be able to support them with that and almost help them manage what's going on. But when they were happening in their home, that was really difficult for young people because where did they go when they wanted to have space.

Q. I think you also say young people should have been given a choice but the choice was taken away from them, they weren't given one.

A. Yeah. At the beginning I think I recall that just all hearings were done virtually and then it kind of phased out, but at the time they were all virtually, from my experience.

Q. You also mention that that practice, the practice of them being online, continued even after lockdowns had ended and some meetings were able to go back to face to face, but some children's hearings didn't do that.

A. Yeah.

Q. How did that have an impact?

A. Yeah, so there was a few hearings that definitely didn't —— could probably have been face to face. I think there were still restrictions in place but the world was kind of opening up again. I think that happened —— I think there was only one that we were

part of that happened virtually and it didn't go well. Again it's because the young people should be given a choice if they can —— if it's virtual or face to face. And, like I say, they might not want to do it face to face, but if they've got the choice, then they're making that choice and they're empowered to do that.

Q. What are some of the reasons you think they might opt for a face—to—face children's hearing?

A. For young people?

Q. Yes.

A. I think it depends on the young person, but I think it is a process for them. So it's like "I'm going to somewhere" rather than "I'm having to join on a computer screen". The other example might be because the people that are joining the hearing, who may be their parents or family members, might not have access to online or might not understand how to use online, so the young people may feel, if it's face to face, then they'll come, whereas if it's online, they might not come or they might not —— and they might find accessing it really difficult.

Q. People who are important to them might be missing?

A. Yeah, absolutely.

Q. You go on to discuss generally the impact on young people that you experienced within the service and you

say at paragraph 49 that:

"Initially the young people just didn't understand what was going on."

Do you have any particular view on whether messaging and guidance was or should have been geared towards young people?

A. Yeah, I think we probably could have done a bit more with that. We all had the information that was coming out. I mean, the news was constant, you know, there were notifications and things, but I think at the time everybody —— it was so unknown for everybody that people were just scared as well. So if we knew what we knew now, we would be able to adapt that and make it really young—person friendly. I don't think we did that as good as we could have.

Q. How do you think it could be adapted?

A. Even using sort of social media and things like that, sending them messages that —— it would be hard to say exactly what could have been done because back then we didn't actually know what this looked like so the response was to safeguard everyone, which was the right response, but the information coming out was just changing so rapidly that it was hard to reassure young people that this was going to be okay when we actually didn't know if it was going to be okay.

Q. I wondered if you thought that there is a difference between just generally young people who are getting messages and reading the media about the pandemic and the young people who are being looked after by the local authority, whether it's in your residential care settings or whether it's in foster care or something like that. Do those two groups of people have different needs and what are they?

A. Yeah. Well, I think young people that are in residential care —— there will be a number of reasons why they're in care, so they've suffered trauma, so they might be more scared, they might not understand what's going on, they don't have the safety net of a family around them. That would be difficult for them when something really scary is happening in the world, that they don't have the security of their family around them.

Q. You go on to discuss families and the birth families that were around the children who were residing within Northern Lights and you say at paragraph 56 that you had mixed communications regarding contact and you remember that being a very —— a particularly difficult issue at the time.

A. Yeah.

Q. You go on to say that firstly some children had

a generic letter which essentially said no contact should take place.
A. Yeah.
Q. Can you tell me more about that happening and who did the letter come from?
A. I can't recall that -- I can't recall it coming directly to me but I recall there being discussions around it and there was a lot of -- it felt at the time that young people that were in care -- it was like just shut off, that they just have to either stay in care or go back to their families. Then obviously contact would generally take place -- depending on the young person's needs and what the arrangements were with the family -- it varies with every child -- but they may have contact in their homes, they may live in a residential care home but might spend a lot of their time with their family, their home family, and then return to the residential home, but that obviously couldn't take place.
So that -- for some children that would mean that there might be other children in the family like siblings living at home, but they lived in a children's home. That just stopped because they couldn't go into another household, which was really difficult.
And at the time -- again, we were very lucky because of where our house is. So where we lived, we've got

a lot of land round the house. So we were very lucky, again, that we had good weather, that we were able to put a number of gazebos up and distance them from the house, where we could have family visits in the gardens and have kind of socially distanced contact. It wasn't the same as going to your family home and spending time as a family, but that was a solution that we did have that maybe others didn't. We could create spaces within the grounds.
Q. When you say that the children couldn't or weren't allowed to go to the homes of their birth families for the contact that they perhaps typically had, who told them that they couldn't and where did that come from, do you know?
A. So following the guidance, entering different households. So if we were one household and one bubble, so they couldn't go into another household or another bubble.
Q. And were you told that by either -- you took that from the guidance or was it from the local authority or was it you as an organisation yourself decided that?
A. No, it was from the guidance from -- we were all following the guidance, so -- the local authority at the time were following the guidance. We were all managing the situation safely. When things did relax a bit

better and the households became more -- we were able to opt into that, but at the beginning contact with -- going into other homes, we couldn't do.
Q. Is it your understanding that social workers and the local authority prevented contact from happening as well between birth families and ...
A. I don't think they prevented it. I think they were trying to do everything they could to keep it happening but safely.
THE CHAIR: Can I ask a question? This is a rather technical question. Ms Trainer will keep me right if I get this wrong as a matter of law. But paragraph 56, the first two sentences:
"We had mixed communications regarding contact and I remember it being really difficult at the time. Initially I remember some young people had received a generic letter stating that there would be no contact which was really hard."
A. Yeah.
THE CHAIR: Now, I was reading that as that letter came from the Social Work Department, the local authority.
A. Yeah, I think it did come from the Social Work Department at the beginning. I'm not sure -- I can't recall the letter itself. I just remember there was a clear -- that they couldn't have contact at that time.

THE CHAIR: You say there "some young people" and I had read that or interpreted it as meaning that that would be young people who were looked-after children, who there was a responsibility resting with the Social Work Department and the local authority --
A. Yeah.
THE CHAIR: -- but I think you also said earlier in your evidence that not all children that resided with you fell into that category so they might have been the ones that didn't receive that letter. Would that be --
A. Yeah, that would be correct.
THE CHAIR: I think I understand that. Thank you.
MS TRAINER: You also mention there being a communication and a discussion at the time about whether children living in residential accommodation could just go home --
A. Yeah.
Q. -- to their birth families and live there during the lockdown period.
A. Yeah.
Q. You say:
"I am sure this was asked by social work. To me this was a crazy idea."
A. So, yeah, there was young people -- and that would be very individualised as well. So especially where young

people may have a lot of contact with their family, which is quite positive, but still reside within a care home -- and this wasn't specific to our service as well -- there was discussions, and this was about people trying to plan, "What can we do? What should we do? How do we do it safely?". So young people who maybe specifically did spend periods of time on home contact, as they would say it, you know, weekends, maybe, there was a discussion around, "Could they go home and stay at home?".

Personally I didn't think that was the right call. I think, if it was possible to do that, we should be taking young people home full-time, and that is my experience, is that where young people should live at home, they should always live at home. So that again was a bit confusing. I'm not clear whether young people specifically were asked that or if it was a generic discussion between professionals, but, yeah, I think, where we can keep young people at home, we should always have them at home.

Q. You presumably became aware of that because that was something in which Barnardo's were involved in discussing with Highland Council?

A. No, it was just general across residential care, so it wasn't specifically around Barnardo's and it didn't

actually impact our young people within our home.

Q. You obviously say to me this was a crazy idea and you say that you didn't agree with it.

A. Yeah.

Q. Why do you say that?

A. Because if young people can be at home full-time, they should always be at home full-time. I think that where young people can have -- and this is again my opinion -- where there's young people that may need respite, that's different, but if you can live with your family at home, you should always be at home with family, with support if needed.

Q. You go on to talk about how this parental contact but also the general situation has impacted on young people's mental health and you describe your organisation particularly or your work, close work, with CAMHS.

A. Yeah.

Q. You say at paragraph 65 that in general terms you understand the risk to children and young people's mental health to have increased due to COVID. What makes you say that and can you tell us maybe a little bit more about what you saw?

A. I think I can probably only speak from the experience I had with the young people we worked with, but in terms

of isolation and not having that -- you know, young people that were in school and that just going or people that were going to college, their experiences, that just went for them, so they didn't -- everything was online. That was really difficult. Peers -- a lot of teenagers rely heavily on their peer relationships, which is really positive for them in terms of their growth. That went. They were communicating just digitally, which isn't the same as going and seeing your friend and having time with your friend.

So, in terms of their mental health, I think that was really difficult and I think that would apply to all children and young people, not just children and young people that are care-experienced.

Q. You give a particular example at paragraph 66. You say:

"We had a young person who did struggle with their mental health and had on a number of occasions needed to go ... to A&E."

And what was difficult for you was that you couldn't go in with them and support them in a normal way?

A. Yeah.

Q. Is there perhaps a distinction in those circumstances between somebody who is actually a parent, in a parent role, and can go in with them perhaps and you, as a worker, who maybe isn't allowed?

A. I'm not sure. The young person was over 16 at the time so that could have been a factor, but it did make it difficult. You would kind of go in the front doors and you would have to leave just because of the restrictions in those hospitals. I don't know what it would have looked like for children with their parents and if they were younger as well, but for us that young person was over 16 so ...

Q. Did you see any other impacts or examples of mental health or health generally being a difficulty for the children that you were caring for?

A. Attending appointments with GPs was difficult as well -- not specifically in relation to the residential home, but young people that need some support to go to GP appointments, that was difficult as well because we couldn't go into GP appointments with them.

Q. Did you ask?

A. Yeah. So I personally was supporting a young person after the lockdown and was unable to go in to an appointment and had to wait in the car. That was particularly difficult because of how the young person was feeling. And then, when they returned to the car and I asked, "How did it go?", they said, "I don't even know. I just ..." -- it didn't work. He just didn't know what had happened so his words didn't come out and

he didn't feel that he'd got anywhere, whereas, if I'd been there, that support would have been there for him, whether to advocate for him or guide him or just be present with him, whatever he needed.

Q. You go on to talk about generally there being changes to the services as a result of the pandemic. One of them you've already mentioned, I think, which is that now there is a change to working hours because of the arrangement you had in place. I wondered if you could tell us a bit more about how that has had a longer-term impact.

A. I think that's actually impacted really positively actually for our young people. So when we kind of decided to do the lockdown rota, as it was, for a week on, when we were phasing out of that we looked at how we best do that so that the young people had that consistency and that -- we just managed to transition it. Then, when we spoke to the wider team about what they felt -- when we do these things, we speak to the staff and we speak to the young people and we take everyone's voices into consideration -- and then people were quite happy with the idea of doing more hours, but -- you know, not as many as a week but having a kind of block.

The young people liked the week on, we had really

a lot of positive feedback about that, so then we moved to the sort of two and three model, which was sort of two sleepovers and then three days, and that does work really well. I think for the young people it does give them that consistency. They have a kind of idea of who is on. There's less people coming in and out as well. So if you have people that are on back shifts and day shifts, you have more people coming in. So there's less people. You just have three people a day and it's just consistency for the young people.

Q. I suppose that might feel more like a home environment --

A. Yeah.

Q. -- rather than a kind of work shift pattern.

A. Yeah, definitely.

Q. Is that something that is in place now?

A. Yeah, absolutely. Yeah.

Q. From 2021 I think you say that you were in charge of what's called the "Springboard Service".

A. Yeah, that's the after-care service.

Q. I wondered if that service has seen any longer-term impact.

A. I can't say from my experience the impact of COVID. I wasn't -- I was involved with Springboard at the time but I wasn't directly managing the service at the time,

and the service is growing and developing naturally anyway. So I wouldn't be able to say -- I wouldn't be able to give an example of any impact on that service.

Q. In general terms, you make the comment within your statement that we've already discussed, that the guidance wasn't young-person-friendly. At paragraph 80 I think you conclude by saying specifically that there should have been a more considerate response for different demographics of people. One of those demographics is looked-after children and young people. I wondered, do you feel as if that's a demographic that was perhaps forgotten about?

A. From my experience, yes. I think I recall the guidance being social care guidance and there would have been a reference to looked-after children but I don't know that it was specific enough, not from what I had saw anyway.

Q. And what would have helped you, if you're able to say? It's difficult looking back now, I can appreciate that, but can you think of any examples of things that we could do differently?

A. I can't think of any examples, but I think at the time we were launching with The Promise, The Promise has been really heavily in the news and things, which is fantastic, so it would have been a good time to think

about The Promise in terms of lockdown and what that looked like for young people.

I think we can't forget that it was a really difficult time for people and people were just trying to do the safest thing possible. We were very lucky with our service because we had a really good support team around us, we had a good senior management team, we were supported to do what we needed to do for our young people and we were able to respond to the needs of the young people. So I wouldn't be able -- if I was to say I would go back and do something differently, I probably wouldn't do anything differently because I think what we did at the time was the right thing to do and it worked really well. But we were also very lucky to do that and that was because of the support that we had from the organisation, the support we had from the local authority, and also where we were located. That was a big part of our decision in terms of the layout of the house and what we had there. That wouldn't have been possible for all children's homes to do that, because of the size of the building for example.

So I don't think there would be anything specific that I would go back and say we would do differently.

Q. You mentioned there The Promise and that perhaps we maybe should have thought a bit more about the

principles to do with that. For those of us who don't know what The Promise is and what the ethos of that is, can you tell us a bit about it?
A. Yeah. So The Promise is a new —— it's not new now but it came from the Care Review and it's about —— it's about making Scotland the best place for children regardless of whether you're care—experienced or not and making sure that the right scaffolding and support is there for young people and their families and for the workforce.
Q. And when you say, "We could have been a bit more mindful of that", what do you mean?
A. I think just that —— The Promise is a really good —— there's a lot of work been done for The Promise and it's a really good piece of guidance I would say. I think if we were thinking about it now, we would think differently in terms of what it looked like for families and the support that we're offering and for the workforce as well. But we weren't there back then and that was because we didn't know what this virus was; we didn't know what was going on. We didn't know what it looked like. Things that we were seeing in the news was really scary so the thought of getting COVID was scary for people. What we saw was, when people did get COVID, some of them were okay with that and that was easier.

So I think back then we just didn't know what we were dealing with.
Q. You mentioned there the workforce. You obviously were a manager and continue to be a manager in charge of a workforce, first of all in Northern Lights, but now more spread across a wider variety of services. Can you tell us about any general trends or difficulties that you might have experienced because of the pandemic period?
A. I think we were —— in this service that we had, we were quite specific in what we were doing and obviously, in terms of numbers, we were specific in how many numbers of staff we needed. What we did is we made sure that the staff that weren't able to do lockdown for whatever reason were supported as well. So we didn't just forget about them, so they took on different roles as well. So we had a lot of support that we were distributing on behalf of the Scottish Government, from Barnardo's, that —— and some of those staff members took part in doing that role. And it was different. They were more out there and food parcels and things like that. But we made sure that we all connected so that was really important.
One of the things that —— so we had obviously our kind of core support and we had a lot of support in

terms of well—being meetings and discussions and things like that, but we also made sure that we would have, again, similar to what other families did, that we would have our kind of quiz nights as well. So all the team would join in, and the young people, when we were doing it from the residential home and we would have the kind of big screen up and we would have quiz nights and the young people would take part and things like that, so we did all that as well. That was about making sure that the staff that weren't part of what we were doing still felt part of it as well, and obviously the young people could continue the relationships with the staff that weren't living with them at that time. So that was obviously really good too.
But I think overall, in terms of impact, it actually was a really good experience for our team and we didn't actually have any negative impact from it.
Q. And thinking about there being, I suppose, two separate workforces, one who is involved in the caring and is effectively living within the residential setting and one who is not able to do that for whatever reason, after the pandemic how has it been re—integrating those two groups of people?
A. Fine, yeah. It's been all —— yeah. So when we started to phase into the kind of different shift pattern, we

phased other staff back and things. I don't think that it was a really difficult thing to do because we kept the relationships there with the young people. So although they weren't living with them, we kept the communication, we used our digital platforms to do that. So we used Teams and Google Meet and things to connect up, facilitated by the staff, you know, and where other staff felt comfortable to do that.
Then as things relaxed, where we were able to kind of have contact and meet, we would meet some of the staff, they would come out and we'd maybe go for a walk and things like that, so it wasn't really difficult to integrate them back in. We've been very lucky because we've got a really good workforce, we managed to retain staff really well. So it was all about the young people and what they felt they needed at the time and making sure that people were available, telephone calls and things too.
Q. Those are all of the matters which I wanted to raise with you but I wondered if there's anything that we haven't covered that you thought it was important to raise today.
A. No, I don't think so.
MS TRAINER: Well, thank you very much for your time.
A. Thank you very much.

THE CHAIR: Yes, thank you very much for your evidence.
A. Thank you.
THE CHAIR: I appreciate that.
Now, we've finished sharp. Normally, I'd see if we can get the next witness in earlier. I suspect that's not going to be possible for the next witness who has some special needs, so I think it has to be 1.30. I'm sorry about that, but thank you.
(11.59 am)
(The short adjournment)
(1.28 pm)
THE CHAIR: Mr Gale.
MX CASS MACDONALD (called)
MR GALE: Thank you, my Lord. The next witness is Cass MacDonald. They represent the Scottish Healthcare Workers' Coalition. The reference to their statement is SCI-WT0465-000001.
THE CHAIR: Yes.
MR GALE: It's been agreed for the purposes of today that I will refer to the witness as "Cass".
Questions by MR GALE
MR GALE: So, Cass, you provided us with a statement on behalf of the Scottish Healthcare Workers' Coalition and you are, as I understand, agreeable that that statement will be the evidence on behalf of the Coalition together

with the evidence that you give in amplification of that statement today?
A. Yes, that's correct.
Q. And you're agreeable that your statement is published and that the evidence that you give today is recorded and broadcast?
A. Yes.
Q. Can I make just two preliminary observations? You've provided us, as is apparent from your statement, with a lot of very carefully researched footnotes. For those of us who don't particularly like working from a screen, that's volume 1 of your footnotes (Indicates) and that's volume 2 of your footnotes (Indicates). So these footnotes largely relate to issues surrounding long COVID.
A. They're quite broad-based. Some of them relate to pieces of work that have been done, some of it is national guidance, so it's quite broad -- I believe some of it is actual scientific research that's been done as well, so it's quite broad, but a lot of it does refer to long COVID, that's correct.
Q. I think, from our perspective, we would like to thank you very much for putting that repository together because that does indeed help --
A. Yeah.

Q. -- with the work that the Inquiry is doing, particularly in relation to long COVID.
A. Yeah, I think it's a great deal of work by our legal team and also the wider group as opposed to myself specifically, so thanks really need to go to everybody I think who put time in.
Q. Well, thank you very much. The other observation I'd like to make is that, in connection with your statement, we find at several of the introductions to each section that you quote from individuals generally who have been affected with long COVID and, again, those quotations -- having gone through some of your footnotes, I found those quotations within the material within the footnotes. So could you just indicate how you chose the various quotations and what was their purpose?
A. We chose the quotations because we felt that they were very -- they really spoke to what we were trying to say within those sections. They were real-life examples. They were, for the most part, given anonymously, through work that the Scottish Healthcare Workers' Coalition has done and they also came from the report that the Key Worker Petition Campaign did last March 2023, which of course I'm also involved with.
So most of them are anonymous. I think some comments came from one individual who I know personally,

but they -- and they gave their consent for them to be included within the work that we were doing because of the importance, but they've asked to remain anonymous and I wish to respect that.
Q. Yes, indeed. Thank you.
Can I ask you a little about your own background and in particular we can see that you're here in a wheelchair. Could you indicate how you've come to be in that situation and in particular the origins of your health condition insofar as it relates I think principally to long COVID?
A. It's fair to say that I had some underlying but well-controlled chronic conditions like asthma prior to having COVID. I contracted COVID in April 2020. I believe I contracted it at work. Unfortunately it -- it's got to know me in a long and personal way. I was largely healthy prior to COVID. I had some mental health issues, I did have -- I have hypermobile Ehlers-Danlos syndrome, so I have chronic pain syndrome, but they were very well controlled. But since I've had COVID, I've developed a cardiac arrhythmia, I've developed a condition called postural orthostatic tachycardia syndrome, I was diagnosed with moderate sleep apnoea last week, which they believe is secondary to dysautonomia, of which POTS is a version. I have

been diagnosed with myalgic encephalomyelitis, ME —— chronic fatigue syndrome —— in addition to long COVID. I have been in daily severe pain since June 2020 as a result of my COVID infection and I've been diagnosed with functional neurological disorder. I have problems with my short—term memory. I have to —— I've had to rest aggressively to be able to appear today because I'm very prone to what people like to call "brain fog" but I refer to as "cognitive dysfunction" because it's like my brain is trying to wade through treacle. I sometimes have problems with my speech, with concentration, with understanding.

I'm no longer able to speak foreign languages and I have been speaking foreign languages since I was —— over 40 years, since I was a child, and that's probably not the entire extent. It feels like every day something new crops up. And I have an allergic condition called "mast cell activation syndrome" as well, which has even affected my diet and I have a lot of medication I am now on.

Q. I think I should point out that, should you feel that you would like a break at any point in time as you're giving your evidence, please tell us ——

A. I will. Thank you.

Q. —— and arrangements will be made. You said you were

working prior to the pandemic. I'll use that as a point in time, so prior to 2020. What were you doing?

A. I was a band 5 nurse. I worked for my employer since 2012, NHS Lothian, and started in theatres, went to sterilisation, decontamination, and I was working within the wider infection prevention control team as an audit and surveillance nurse, gathering data for national surveillance programmes.

Q. When was it that you found you were unable to continue with work?

A. I —— the last day I worked was 8 August 2021. I tried several times to go back to work after my infection in April 2020 and I —— my contract was terminated in August last year, two years to the day since I'd last worked, and I'm now medically retired.

Q. Right. Okay. Thank you. There are one or two things you've already mentioned that I'd like to look at in a little bit more detail, but a consistent theme through your statement is long COVID and the implications that that has had for you personally but for many within the group that you represent; is that correct?

A. Yes.

Q. Now, one of the points you make really at the beginning of your statement is that long COVID is not or should not be taken as synonymous with an extended or delayed

recovery from COVID. Can you explain why you say that?

A. That is possibly best explained by medical experts, for example, Claire Taylor. However, the way I understood it is this is the chronic condition that has arisen as a result of post—viral implications, be they obvious or not obvious at the start, that is currently not able to be treated. I believe it is a disease in the same family as ME, chronic fatigue service [sic], which therefore means that this is potentially a life—long condition.

I know some people —— I believe it's a relapsing remitting condition. I have good days and I have bad days, I have good periods and I have bad periods. And I know that people are —— believe they've made a full recovery. Others believe, while they've got a lot of function back, that they have not. So I believe this is potentially life—long, as currently it —— we cannot treat it.

Q. I was perhaps pointing to something perhaps more simple in this. Perhaps —— and it may be the way I took the expression —— that the suggestion of —— which we've I think in the general public and one does here —— that, "Oh, it's just your recovery has been delayed a bit", it perhaps lessens the significance of it; is that something you would agree with?

A. I know people think we're just a little bit tired. I've now been ill for four years —— four years, two weeks —— and there is no sign that I'm improving. In fact I believe —— I'm hoping I don't get any worse. I don't think that's a long recovery and I don't think the general public realise the full extent of the issues and symptoms that many of us are having to deal with.

Q. One of the points that we've come across really from the outset of our hearings into the pandemic and in particular into long COVID is a widespread scepticism, particularly in the public domain, as to the genuineness, if I can put it that way, of long COVID. Is that something you and your colleagues have come across?

A. Very much so. I think we would say that we've experienced this from fellow healthcare professionals. Some of us have experienced abuse online. A big factor of some of the abuse that we get is that people insist that this is a vaccine injury, it's our own fault or it's related to —— you know, perhaps we were overweight and we clearly must have had something wrong with us. So it's a lot of ableist victim—blaming, but the vaccine injury thing is quite a big thing, even for those of us who were infected before there were vaccines.

Q. One of the things we do occasionally hear is that you're

lazy.
A. Yes, lazy and not trying hard enough.
Q. Yes. A good bit of exercise will do you the world of good?
A. In my case, that would make me extremely unwell because, when I stand up, my heart rate hits the hundreds, which is —— and I can pass out. And I can't really walk very far anyway, which is why I'm in a wheelchair.
Q. Can you tell us about the Key Worker Petition Campaign?
A. I can. I formed that campaign in 2022 with a midwife friend of mine from Wales and a fellow nurse from Devon. It's a grass roots campaign that is seeking a compensation and pension scheme along the lines of the Armed Forces Compensation Scheme for all key workers irregardless of whether they were in healthcare or even stacking shelves in supermarkets who have occupational long COVID.
Q. I think this is a campaign that is UK—wide.
A. It is UK—wide and last year we handed in a 125000—strong petition to Downing Street.
Q. Where is that campaign at the moment? How is it progressing?
A. There's not —— we're not a big campaign team. We obviously are engaging in work and my role at the moment is I'm working with the Scottish Healthcare Workers'

Coalition on behalf of healthcare workers in Scotland and this is kind of part of our more broad remit. We're not very well peopled so, unfortunately, sometimes we have to fight which battle we can.
Q. I'd also like to ask you about the Scottish Parliamentary Inquiry into long COVID. How has that been progressing?
A. So that was the COVID—19 Recovery Committee. It was a specific committee that decided to open an inquiry into long COVID because of concerns that they had. The Inquiry closed and a report was published. There were an awful lot of people who gave evidence from around —— within Scotland and also around the United Kingdom about the experience of individuals with long COVID, their access to health and social care services, amongst other things, and a big feature that came out of that was the lack of information and data that existed on the scale of long COVID.
Q. We'll come back to some of the data in due course, but has that improved?
A. No, I don't believe so. As far as I know, the UK Government has stopped counting even COVID cases. Data is essentially based on a lot of people self—reporting their symptoms and we, as a group, have been engaged in trying to gather information, using

freedom of information, and we have found it extremely difficult to get information back from employers about COVID infections, the scale of long COVID and so on and so forth.
Q. Thank you. At paragraph 7 of your statement you say that the Coalition —— I'll abbreviate it to "the Coalition —— "contends that the consequences of the handling of the pandemic have been borne, unfairly and disproportionately, by Scotland's healthcare workers". Could you explain that in a little more detail for us?
A. From some of the information we've been able to gather from the Office of National Statistics and the limited data that they have gathered, key workers, healthcare workers and social care workers in particular have had a much higher incidence rate of long COVID. I also remember from the BBC Panorama programme, "Forgotten heroes of the front line", someone who sits on the Industrial Injuries Advisory Council —— I think it's "Council" —— said that, when they actually looked into information, healthcare workers had double the risk of contracting COVID and double the risk of dying from COVID.
Obviously, as a population group, our exposure to COVID being higher has meant that we have a higher incidence of long COVID and that is backed up by limited

data within the ONS. I think the average population —— I think it's —— of everybody who has had COVID, I think it's something like 3.4% have long COVID but the rate is above 5% for healthcare workers.
Q. Yes, I've seen those figures.
You juxtapose, I suppose, the work that healthcare workers carried out prior to and during the pandemic and you say that that work was carried out, as you put it, "at exceptional risk to ourselves". Then you go on to say that:
"The Scottish Government and the NHS Health Boards failed to properly manage and support healthcare workers, placing them in harm's way, and at unreasonable, unconscionable, and frequently avoidable risk of serious harm to their health."
I realise that is a summation of what you go on to develop, but those are very, very striking criticisms, and in fact you do go on to level a charge of negligence against the Scottish Government and the NHS health boards. Now, can you just give us a little more flavour as to why you were so critical of both the Government and the health boards?
A. My feeling is that they were completely unprepared for the pandemic. I believe that guidance that was handed down, that was being passed on to us, was flawed and it

was not based on emerging science. I know of incidences where staff within health and social care who had underlying health conditions —— there were huge delays in their being assessed by occupational health. My understanding is that, in some areas, it was only specific —— for example, it was only if somebody was pregnant or had diabetes that their own manager was required to do any assessment of them. Everything else was expected to be done by occupational health. In my own case it wasn't until six weeks after I had my COVID infection that I finally had my occupational health risk assessment, my COVID age assessment.

I believe that, as a result of being so underprepared, there was a lack of availability of both PPE and respiratory protective equipment and I believe decisions made to only use surgical masks in certain situations when caring for COVID patients was very much flawed. I mean, we could spend probably all day on this.

But also it was —— at a time when asthmatics in Scotland were all being told to shield, I was being told that NHS Scotland had done a risk assessment and it was perfectly safe for me to attend work but, oh, I just shouldn't —— even though I was a non—driver, I just shouldn't use public transport because that

wasn't safe. And I've never been given those pieces of guidance which I was told came from NHS Scotland.

Q. You've said that the guidance was flawed and again you put that in general terms. Can you provide us with some specifics in your view as to how the guidance was flawed?

A. It was based on an assumption that COVID is spread by droplets and that guidance does not appear to adequately take into account, well, the —— what we believe and what the emerging science says about COVID, which is that it's airborne —— and you have people like —— I think his name is Julian Tang. He's a consultant virologist. He was warning that this appeared to be airborne in April 2020 —— and it didn't seem to take into account any issues around ventilation —— I mean, we don't have HEPA filtration —— or the numbers of people who would be in a room. If you have a lot of people coughing in a room, there's going to be an awful lot of droplets in the air even if you assume that it's just droplet spread. But we think it was —— we think it's airborne.

Q. So one of your particular criticisms, therefore, is in relation to what appears to be a presumption underlying guidance, which was that the means of transmission of COVID in the early days of the pandemic was by droplets rather than airborne transmission?

A. Yeah, initially they were using RPE, if you were looking after COVID patients, and that changed quite suddenly. We think that decision may have been taken by individuals in Scotland but we are not sure. I know that we have submitted evidence —— there have been individuals like [redacted] —— there's an individual I know ——

Q. Can I ask you not to mention names, if you don't mind.

A. Oh, the restriction —— who has done quite a bit of digging. That appears to perhaps have had its source in Scotland, the change in —— this push to change it to, "Oh, it must just be droplets. We'll just wear surgical masks". That appears to have originated in Scotland and then was subsequently picked up by the four nations infection control advisory bodies because it all became —— it became an issue that all four nations were using the same guidance.

Q. I think we've heard evidence, Cass, I think from particularly representatives of the RCN, that they were campaigning, if that's the correct word for it, or advocating for the fact that the principal means of transmission was airborne rather than by droplets, but they were doing that really from the outset of the pandemic ——

A. Yeah.

Q. —— so from March 2020 onwards.

A. Yeah.

Q. Were you aware of that?

A. I was certainly aware that a number of individuals were looking at pre—existing information that existed on similar viruses, similar coronaviruses, for example SARS and also MERS, Middle Eastern Respiratory Syndrome. I was actually asked to look into —— if I would look up articles by my manager, which I did, and I came to the same conclusion that the RCN later came to with their literature review of all of this, which was that respiratory protective equipment, so your FFP3 masks and so on and so forth, gave —— well, there seemed to be a less —— if you look at the —— compare them to the individuals who just wore a surgical mask, they weren't getting infected. And then a study was done at Addenbrooke's Hospital. They had a standard COVID ward, they gave all of the staff FFP3 masks and none of their staff contracted COVID from their work. And I know that the RCN have referred to that study, whereas with surgical masks there seemed to be a higher risk of infection.

I suppose in that case it has come down to interpretation —— it's come down to interpretation of pre—existing science and the science that has

obviously —— emerging science since COVID.
Q. Yes, I think that's one of the other points I was going to ask you about because you did say that you level the charge against the Government and against the health boards on the basis that there was insufficient regards paid by them to the emergence of developing science. Now, is that all in connection with this idea of airborne as opposed to droplet transmission?
A. Yes, so I think also it's partly to do with they at all points seem to have failed to consider that what turned into the pandemic would leave a significant number permanently disabled. That has happened with SARS. There were people speaking out about that at the start of the pandemic, particularly in Canada in March 2020. There was evidence from SARS studies taken I think in 2010, so a significant time afterwards we knew that people were suffering from long-term effects, at that point seven years after the SARS epidemic. They knew healthcare staff had been disabled by Swine flu back in —— I think it was 2008 or thereabouts in the UK. There didn't appear to be any consideration paid that that could be a possibility and therefore, with a novel and unknown virus that they simply did not know what the long-term effects would be, I don't think they paid enough attention to that, no.

Q. All right. Thank you. We heard a little bit the other day from Mr McKirdy of the Royal College of Physicians and Surgeons in Glasgow, talking about AGPs, which you also mention in your statement. There there was obviously an implication for both the mask-wearing and the wearing of particular types of masks, so can you explain why and in what circumstances there would be a justification for wearing different types of mask?
A. Well, I'm not the person who made the decision about what was an aerosol-generating procedure. For some reason somebody deciding that coughing and speaking were not and, at the early point of the pandemic, we know that choirs, for example, were banned because of outbreaks of COVID. Essentially there is a list of procedures, so, for example, intubation, suctioning and so on and so forth. Some were not on that list. There was quite a bit of debate —— I recall people arguing with my colleagues over it —— of what should and should not be included, and that was not something we had any —— or the IP —— the infection prevention control nurses had any control over. We were working under guidance that was changing all the time.
But, yes, so if you were dealing with an arrest situation or you were intubating and suctioning, you were supposed to wear an FFP3 mask or similar. But for

everything else, even if the patient or patients were coughing, talking, et cetera, you wore a surgical mask.
Q. Another point you make is about fit-testing masks.
A. Yes.
Q. Now, in the more general sense we've heard evidence in the Inquiry about one of the deficiencies, I suppose, in the provision of PPE, that it was designed for your average male. A lot of it was not designed for or to fit the average female face. Is that one of the difficulties that we've had?
A. I'm not a manufact —— I've never been involved in the manufacture.
Q. No, I appreciate that.
A. I have been involved in fit-testing and I do happen to know that it would be a procurement issue as to why the wider Scottish procurement services pick particular kinds of mask, and they tend to pick the ones that will fit most people. I believe 3M Aura and also Alpha Solway were two companies that provided quite a broad range of masks, although at some point some were discontinued during the period that you're talking about and they had to find substitutes.
I think the bigger problem is actually around fit-testing itself. In my experience from a different scenario, back when I was working in theatres, when

people were concerned that Ebola would make its way to the United Kingdom after a Scottish nurse was infected, they realised that a huge number of staff had never been tested within the organisation as a whole. Many of them had never been retested. I would imagine that that was the case —— certainly when I joined the organisation in 2012, I was not fit-tested. Some of this could be down to time; some of this could be down to having the skill set to do that. So I believe a huge part of the problem would have been that staff simply had never been fit-tested or had never been retested, and I don't know if they've ever solved that particular issue.
Q. Again, looking at the generality of what you say at the beginning of your statement at paragraph 8 —— this is perhaps a reflection on what you've said earlier —— you say that you and your colleagues "did our job but now we have been ... disabled, we feel abandoned and forgotten by the government and the healthcare systems we worked for". I know you go into more detail, but could you just explain the effect of that feeling that you have upon you?
A. I know people who are lucky enough to still be employed and who are having significant problems in trying to access reasonable adjustments at work. They are experiencing ableism and unconscious bias, and I would

argue that that is institutional. It is a longstanding problem, certainly within the NHS and probably within other sectors as well. And for those of us that were struggling to keep up, assuming we managed to get reasonable adjustments -- some of us were told, "Oh, this was short term, we wouldn't get this for the long term" -- we had to deal with attendance policy being used against us. If we have chronic conditions we're going to be off sick more, however, we're expected to keep up with those who don't have those conditions. I know people experienced bullying and, for those of us who simply haven't been well enough, our contracts have been terminated. I do believe in some cases it was because simply they were being told, "You can't keep up with the terms of your original contract".

I discussed with my union rep many times about how organisations did not seem to be evolving with the pandemic, they did not seem to be looking at roles, changing things up so that they could attempt to retain experienced staff. However, it seems to be, "If you can't keep up, there's the door". And I've been very lucky in that I've managed to get certain benefits, I've been able to medically retire at tier 2, but I know a lot of people who are having their applications for ill health retirement turned down, they're having

applications for benefits turned down, there's a lot of delay and they are experiencing financial distress -- something I know extremely well from the whole of 2023, my own personal experience -- up to the point that many are at risk of losing their homes, some have lost their homes, they've lost their income, we've lost our careers, and particularly in the case of some of them, like nursing, that's a vocation, that's a huge part of who we are, you know. And we've lost our health, I've lost my mobility. It's very difficult to come to terms with. And we don't know how long this will last.

Q. In your own personal case, have you been given any indication as to the long-term prognosis?

A. Poor. I'm not expected to ever work again. I came off the register last year, I could not reregister with the NMC, Nursing and Midwifery Council, and I'm not -- there is apparently nowhere to refer me to and I have now been waiting for a year to see a social worker to get additional support. It's -- I'm waiting for research basically.

Q. It's not something I normally do, Cass, with witnesses but I am going to, with your leave, make an exception. How old are you?

A. 48.

Q. You were expecting to work for at least another

12 years?

A. I probably wouldn't have left for another 20 years actually. I fully expected to work until I was 67, perhaps beyond.

Q. Okay. You make a point in your statement about clean air and it's something that you have referred us to. Obviously this is something that the Inquiry will be considering in some detail at an appropriate point, but taking the matter briefly, it's your contention I think that the Scottish Government should match the CDC standard, which is the American standard, in relation to clean air; is that right?

A. Our contention is that current ventilation standards need to be improved because it's been some time since they were last reviewed, and that clean air measures need to be brought in, particularly to health and social care. They are slightly separate but very closely allied issues.

Q. Okay, thank you. Can I also ask you a little about the occupational health and workplace support that you refer to in your statement. I should say -- and I should have said this at the outset. I apologise for not doing -- there are parts of your statement that we will take as read simply because we need to concentrate on certain aspects of your statement so please be assured that

everything within your statement will be taken account of, but I would like to look at some specific areas.

You note, in paragraph 22, that occupational health support has been variable across health boards, with common themes suggesting under-resourcing and underfunding, with many experiencing long waits to be seen. Can you give us a little flavour of that, please?

A. Occupational health has obviously always existed. At the start of the pandemic, occupational health took on a role for obviously testing staff at a time when testing within the wider community was not available and, all of a sudden, occupational health departments had to deal with an influx of staff members who were unwell. And each employer, I believe, would have taken a different approach, depending on their resources. I know that Greater Glasgow and Clyde NHS chose to set up a lifestyle management course for their staff members affected by long COVID, but that was not nationally rolled out. I actually wrote to Scottish Government about this. They told me it was an employer issue. I wrote to my own employer about this course and they told me that they did not have the resources to do this and they pointed me to what they did have, which was counselling and physiotherapy.

I do also know that I believe they were having --

it's my belief they were having —— that my own trust were certainly having to ration support. Prior to the pandemic, if you had a chronic condition and you were off work, you might have seen occupational health more than once to see how you were. That was different. At this point you really would only have access to appointments if you were ready to go back to work and to discuss reasonable adjustments or if they were making a decision about whether or not you would be able to work again in the future and whether your contract should be terminated. That's my belief.

Q. Support within the workplace, obviously from a managerial level downwards, I take it that that was also, in your experience and in the experience of your group, variable?

A. Very.

Q. And was that level of support affected by the level of scepticism about your condition?

A. I think there's probably multiple factors. It probably would have been related to what the organisation was able to offer. However, although the Equality Act does provide that reasonable adjustments should be made available where they are reasonable, it can be the case that a manager refuses to put them in or they are time—limited. You can also —— a lot of people have been

dealing with ableism and so on and so forth. You know, this can range from somebody saying, "I really need a specific schedule at work, a specific rota", and being told, "Well, that's not fair to everybody else", which is a bit tricky —— you know, even accessing perhaps equipment that may have been bought for you, for example. You can have some limited equipment bought for you like chairs and so on and so forth. But I know that some people have really struggled with their —— and continue to struggle with their managers, having to involve their union. And I know that in some cases they've attempted to remove reasonable adjustments, like working from home, without the best of reasoning. And, obviously, if you're trying to go through this and fighting for this to try and stay working, this causes stress and, unfortunately, that's emotional exertion and that can impact on and bring on symptoms.

Q. You did give us an example —— I think you alluded to it earlier —— again in your own circumstances, you're asthmatic.

A. Yes.

Q. You were in your job not, as I understand it, given the opportunity to shield ——

A. No.

Q. —— and effectively were asked to come in ——

A. Yes.

Q. —— as an asthmatic ——

A. Yes.

Q. —— presumably on public transport ——

A. Yes.

Q. —— and to not have the same degree of protection that a general member of the public would have?

A. I'd say that's fair. We can obviously discuss that more when I return to give my individual testimony.

Q. Yes. Okay. Now, could I ask you a little about the access to social care —— the access to health and social care section of your statement. It begins at the numbered paragraph 32, but you give one of your quotes before that. You refer to some of the data that we have or that you have and you give the figure of an estimate of 91,000 Scots currently suffering from long COVID. I think you give the source of that data. I think we've also heard a more rounded—up figure of 175,000, which I think comes from the general —— simply taking the figure which is thought to be for the whole of the rest of the UK and simply applying that to Scotland.

There is similarly an importance of the prevalence of long COVID amongst women and also the importance of the prevalence of long COVID on those of working age. These are factors that you point to in your statement as

emerging from the data; is that correct?

A. That's correct.

Q. I think one of the things we have heard from certain witnesses about long COVID is that the idea that one had to have some pre—existing health condition which rendered you susceptible to long COVID or, alternatively, that you weren't somebody who was particularly active —— the examples or many of the examples we've heard of are people who were very active in their life prior to the emergence of long COVID in their condition. You're nodding.

A. Yeah, that's —— I would say so. When it came down to shielding, it was exceptionally prescriptive. You had to have one specific condition. It did not seem to give points if you had a range of conditions, for example. And when you talk about the data and you talk about the numbers, the studies —— obviously it's an estimate. Nobody seems to be accurately counting the numbers and a study will only look at the specifics of those they are including in the study.

So, for example, in some cases it was, "Did you have a positive test?". Well, that excludes an awful lot of us in the very early days of the pandemic because we could not access testing. And, again, we talk about the self—reported, but this is an issue that has been

identified with the long COVID report that was done by the COVID-19 Recovery Committee, which is data is lacking. And again we've tried to find out information about reporting and so on and so forth and we've hit a brick wall.

Q. Okay. Can I just -- it's perhaps something that I'll return to on a number of occasions. At the bottom of paragraph 33 of your statement you talk about that "people living with Long Covid frequently experience stigma [you say], including gaslighting and psychologising from medical professionals".

A. Oh, yes.

Q. Tell us about that, please.

A. I know of individuals who have been flat out told by healthcare professionals that long COVID does not exist -- more widely in the community, but also involving members of our group. I know that people have had referrals to services turned down because it mentions post COVID or long COVID. I had a registrar tell me to my face that my condition was entirely -- well, basically it was psychological despite -- and related to -- I believe the words she used were "childhood trauma", which is kind of interesting because it never affected me to this degree and certainly not like this and it all seemed to come on since COVID.

I know many people have experienced issues with certain specialties like cardiology and postural -- well, we're not getting support for a condition called "postural orthostatic tachycardia syndrome". The only clinic in Scotland has now -- well, they've stopped funding it. It's been -- I know doctors and nurses who have faced being told that this is all in their heads, that they just need to exercise their way out of it, by fellow healthcare professionals. And I think while those of us who were disabled before the pandemic have faced a little bit of this, I think it's been a rude awakening to a lot of people who have never been in this position before.

Q. I think, if one reads the newspapers, listens or watches the news, rarely a week goes by without something being said about long COVID in terms of further research being done. I've got something here, "Large scale phenotyping of patients with long COVID post hospitalisation", which somebody very kindly gave me the other day and asked me to read, and I will. But that came out very recently. With this continuing publicising of long COVID, has that affected the scepticism and the stigma attached to long COVID in your experience?

A. In my experience, I'm fairly belligerent and I tell people how it is, you know, and I explain what's

happened to me, but it's really difficult to say. I know that people are still experiencing problems with their GPs. I know people are still experiencing problems trying to access healthcare. It's -- the funding that the Scottish Government has given is inadequate and most of us are not seeing that as change in our day-to-day lives. I know people would rather we stop talking about long COVID. However, there is millions of us around the world who have this condition and many of us are unable to work and, as many of us are key workers, that's having a massive effect on public services and, as a result, the wider economy.

Q. You've just mentioned the -- this was the gatekeepers to treatment of long COVID as GPs. Are GPs, in your view, sufficiently or adequately aware of long COVID?

A. I feel for a lot of GPs. I do believe, because I know of individual experience, that there are some GPs who don't believe long COVID exists or agree it exists but are unwilling or unable to refer on. I know from the experience of others that GPs are very frustrated because the pathways for referral to try and get us assessed or any kind of support simply aren't there. Some of us, if we qualify to access certain services, like, for example, ME/CFS services, which again are a postcode lottery, find that the support is very much

short term. And a big problem I think for a lot of healthcare professionals is that, even though we do have training for long COVID, varying quality and so on and so forth, we have GPs who are massively oversubscribed, under-resourced and underfunded. They don't necessarily have the time to stop and do training.

If you ask any healthcare worker about, you know, if they're able to get their protected time for study to further their own knowledge and obviously for their own development and for their registration, they'll tell you that most of them are doing it on their own time because they're not able to access the protected time because of the pressures they are under. So I believe it's multifaceted. Having the training there is all well and good, but if you cannot -- if you don't have the time to access it, then you're not going to be able to learn from it.

Q. I suppose also taking the matter on from the level of the initial consultation with the GP, if one is then looking to specialist -level treatment, I think one of the points you've made is that that can be piecemeal. I take from that that, if you present with a particular problem in the context of long COVID, you could end up being sent to a specialist who is a specialist in one area rather than a specialist who has a more holistic

approach to it; would that be correct?
A. That's correct. Many in the long COVID community in Scotland have been advocating for clinics where there is a multi-disciplinary team approach in terms of assessment because, at the moment, GPs have to refer into individual services. So this is multiple referrals, multiple pathways. That's exhausting for the individual to deal with, you know, a lot of appointments, answering the same questions, undergoing tests, but then that assumes that the GP can actually -- that there is a service for one of your particular problems. And that obviously takes up a lot of GPs' time because they have to do all of these referrals. You'll have to go in and talk to them. It's taking up unnecessary time when it could be much more streamlined.
Q. Perhaps inherent in what you've just said, delays --
A. Yeah.
Q. -- in -- I suppose if you are referred to one specialist and then to another and then to another, there will be an inherent delay in that, but also there are presumably just delays in the whole service?
A. There are. There were a significant number of vacancies before the pandemic. As a result of the ongoing pandemic, we have lost staff due to COVID and long COVID and some people have left the service because of the

psychological toll that the experience took on them. So there were long waiting lists beforehand and now you have an awful lot more people who are being added to existing waiting lists, waiting to be seen. But I don't believe that funding has been -- enough funding has been given to existing services, let alone creating new services to take into account all these people who, for example, now have cardiovascular issues and so on and so forth.
Q. Can I take you on to the psychological impact? You begin this -- after a lengthy quote, from one of your members, I think, you take this up at paragraph 37. If one goes back to the quote, the person who has provided that quote observes that the suspected route of transmission or observes the suspected route of transmission and the speaker says that he or she considers lack of information to have been -- I use the quote -- "irresponsible and dangerous".
A. Yeah.
Q. Now, is that something that one finds in many of your colleagues within the group, that they feel that there was a lack of relevant information?
A. It was an extremely difficult time. I know from sitting in an office and checking that the guidance was changing almost -- sometimes it could be changing twice a day,

even if it was minor changes. You perhaps also would have policies making decisions about where they were sending patients, and this is something that I am aware happened, that even -- you know, not just between health boards -- that it was a case of information perhaps was not being passed along about a patient, when a patient was being transferred. I do know that one such situation led to a huge outbreak in which 26 healthcare staff were infected as a result. I wasn't on the wards myself, my job was very different, but I do know from what friends who both have COVID and didn't have COVID have spoken of. And for some of them, what they saw and experienced, it still sits with them today and mental health services are -- have a very long wait for people to be assessed and seen.
Q. That leads me on to one other thing I'd like to ask you about, and that's counselling. What is your view on the availability of counselling for long COVID sufferers?
A. If you are a member of a union, you can probably access short-term counselling. You may be lucky enough to have an occupational health service that can refer you, again, for short-term counselling. However, short-term counselling is like putting a -- you know, it's like putting a sticking plaster over a major veinous bleed. Short-term counselling -- I am now on a waiting list to

be assessed for complex post-traumatic stress disorder, some of it related to my COVID experience. I suspect a lot of my colleagues also may be suffering from PTSD as a result of their pandemic experiences. And the waiting lists to be assessed by community mental health teams for this and obviously wait then for treatment, they're very long. We've known this for a very long time, that there are issues accessing timely support.
Short-term can be helpful for issues that are ongoing in the moment, but when trying to deal with things that require long-term treatment, it is -- it's a sticking plaster. It's not a solution. And if you have an awful lot of people who need to access those resources, you're going to have to wait for them.
Q. I suppose one of the other issues is the availability of counsellors.
A. Indeed.
Q. Can I also ask you about pressure that members of your group have experienced in being -- using your expression -- pushed back into work? Can you explain what information you have about that and why it was occurring?
A. I know of individuals who have been pushed back into work, forced to use up their annual leave for sick leave. You know, they're pressurised -- you know,

they're told, "Well, we'll start attendance procedures if you don't come back to work; "We will ...", you know, "If you're off sick again, we're going to sack you because you've been off too much"; "We need you. We don't have enough people in".

You feel -- I was never in that position myself but I do know that some people would have been -- when they were having the management contact would have felt pressure to go back because the team was under so much pressure, but that's due to staffing problems, not the fault of the individual who has contracted COVID, and, unfortunately, we now know that going back to work too early may have contributed to our developing long COVID because we pushed ourselves too far too soon.

Q. One of the other obvious impacts on people with long COVID is one you've touched on both personally and in your statement, and that's the economic impact on people. Can you, if you're prepared to, tell us a little about your own experience or perhaps just more anecdotally, tell us a little bit about what your members have experienced?

A. I mean, personally, I had to reduce my hours at work, which meant an immediate loss of 20% of my salary, and obviously for those people who -- once particularly COVID special leave ended and people went back on to

normal sickness, you know, after six months -- that's the maximum you can get -- you know, after a certain period you drop down to half pay and then you drop down to no pay. Trying to access benefits can be difficult. You can be turned down for them. There can be long waits.

My own personal experience, I waited pretty much most of 2023 to actually get adult disability change of circumstances reviewed and awarded. I'm still waiting -- I've been waiting now since July last year for industrial illness disablement benefit. A lot of people have benefits turned down and they're obviously not getting any income from work and I know of people who are applying for their pensions, medical retirement, and they're not being awarded them. So they are losing significant parts of their income and, obviously, if you are potentially working in the private sector, you may not have that same timeframe because COVID special leave of course didn't apply to primary care or whatever.

If we don't have money, we're not paying tax into the system. We also don't have the same spending power and obviously spending drives the economy. And as well as that, the economy depends on people being fit and healthy and working and so on, but if you have a lot of people who have had to leave public service jobs, like

the NHS, then that means that lists get cancelled -- you know, operating lists get cancelled, there are delays in being seen, and that impacts on the rest of society. And we do know from -- certainly there was a study in Germany and they now believe from their data that long COVID is having an impact on the economy and it's a negative impact on the economy.

Q. Right. You've given us your views on -- in the last paragraphs of your statement -- on human rights. Again, as you're probably aware, the Inquiry has a human-rights-based approach to its proceedings but also clearly has consideration of matters of inequality inherent in -- well, indeed explicit in our terms of reference, so all you've said in relation to human rights will be taken into account and we are very grateful to you for your views on that.

Cass, that's really all that I'd like to ask you at this stage. I know you're going to come back and give us some views on your own personal experience. Like all witnesses, we offer you an opportunity -- if there's something that you would like to say to us at this point that you haven't said or you've felt perhaps has not come across in the amount of detail or perhaps with the strength that you would like it to come across, so this is your opportunity to do so.

A. I would like to thank the Inquiry for giving a voice to Scottish health and social care workers who are impacted by long COVID. Many are too unwell to participate. And we offer our sincere condolences to those who lost loved ones, colleagues and friends and we extend our solidarity to all our fellow key workers as well as everybody else in the long COVID community.

Many of us have lost absolutely everything, our health, our jobs, our careers and our homes. We've gone from being called "heroes" to being treated like zeros. We may have to live with COVID for the rest of our lives and I know many who are dealing with inflexible employers and ways of working, inadequate health and social care, and they struggle, as we've talked about, to access any kind of meaningful financial support, and I believe that's injustice.

We really do hope that everybody and particularly you, sir, do listen to our concerns. We do feel that there are issues that need to be looked into further regarding risk assessment, PPE, RPE. We do feel questions need to be asked about data collection, both previously and ongoing, and information-gathering, why people aren't answering questions.

This can't happen again on this scale. None of us understand why lessons were never learned from previous

incidents like the Swine flu epidemic. We don't understand why they didn't take pandemic exercises like Cygnus and Alice into consideration. How could we have been so underprepared and who was responsible for that? We would like answers. It revealed how marginalised and vulnerable individuals were being treated. Many of us have now joined them and, for some who had pre-existing protective characteristics like race or disability, that's now multiplied.

We hope that you will act on our concerns and we hope you will gather information on them and we hope, if possible -- we know the remit of the Inquiry -- we hope that you will hold these people accountable because we need you to, because anything else would be a betrayal of those of us that have to live with this. Thank you.

Q. Cass, one thing I remember noticing in your statement and I didn't ask you about, but I think you've actually made this point: you say at paragraph 40 that you are "all grieving for the loss of our health". Does it feel like a grief?

A. It is grieving.

Q. A loss?

A. It is a loss. We've lost a huge part of our identities and we've lost our health. It is grieving and sometimes -- you know, there's five stages of it, you

know, anger, acceptance, denial, bargaining -- I forget the last one. It's an ongoing process. Many people are starting from scratch. They don't want to accept this is happening to them, but -- you know, our careers are, particularly in healthcare, a huge part of who we are and a lot of people only regard individuals by their economic value and, if we can't work anymore, they don't see us as having any value, which I think is flawed.

But, that is how people see themselves. You know, they can't be -- I can't be the aunt that I once was. I know people that they can't be the parents that they used to be. You know, they can't socialise like they used to. It's impacting every single part of their lives.

MR GALE: Cass, thank you very much for giving us the benefit of your evidence, we are very grateful. Thank you, my Lord.

THE CHAIR: Thank you very much indeed. 3.15, possibly a few minutes earlier.

MR GALE: A few minutes earlier.

THE CHAIR: Very good. Thank you.

(2.38 pm)

(A short break)

(2.57 pm)

MR DONALD MACASKILL (recalled)

THE CHAIR: Welcome back, Mr Macaskill. Thank you for

coming I suppose I should say.

Yes, Mr Gale, when you're ready.

MR GALE: Thank you.

Questions by MR GALE (continued)

MR GALE: Dr Macaskill, thank you very much for coming back and assisting us. We have obviously the transcript of your evidence that you've already given, so we're adding that to your statement from the UKI, the transcript of your evidence from the UKI, and we also now have the transcript of part of your evidence from 22 March of this year.

I think I ended your evidence with talking about some of the impacts on ongoing treatment of people within care homes and I think you've given us some information on that, but I wondered if I could go back to some of the -- to get a little bit more detail in relation to guidance visiting and also the general approach that one should take to these matters.

I think it was you who had used the expression "gatekeepers" as referencing people who were having to determine whether or not somebody should get into a care home and see their relatives or not. You do mention that in one of the first communications that Scottish Care issued was an acceptance of the importance of family members being present at the end of life.

Now, that probably seems very obvious, but could you explain why you felt it was necessary to reiterate that in the context of the pandemic?

A. I think it was very necessary and together with, if I can remember, Marie Curie and the Royal College of Physicians and Surgeons of Edinburgh and the Royal College of General Practitioners, we issued a statement to encourage essential visiting, to delineate that essential visiting was not just in the latter days of the end of life -- it's always very difficult pastorally in a palliative situation to know when somebody is reaching their last days, as they are termed -- but to try to encourage people to be aware of the significance of being present, not least when somebody is cognitive and hasn't perhaps slipped to that stage of not being able to recognise and not being able to know that there are people present.

The care sector has always, both in care homes and in the community, been aware of the significance of people being present at the point and the moments of somebody dying, and that guidance was -- and the stress on essential visiting was re-articulated because I think we had experience of people being uncertain -- with all the emphasis on not letting anybody into the care home, of being protective as to what that meant.

I had written myself of a scenario where a widow, as she then became, had written to me about what it felt like to hold her husband's hands as he died, as she was wearing a set of gloves, and she pointed out how invaluable that moment was even though —— and how she, in her words, felt his heart through her hands. So we were —— and that statement was primarily about encouraging people to have confidence and assurance that this was really important.

Q. Who was that communication intended to be received by?

A. So it was intended to be received by all involved, families, staff, providers of care, Public Health, health protection teams, just to underline the significance of a broader understanding of end of life and essential visiting.

Q. In your view, would it have been of use if that qualification could have been included in the guidance that was emanating from Government at the time?

A. I think either that or something equivalent to it would have been useful at the start of the publication of numerous sets of guidance to explain why it was important and what was meant by "essential visiting", because I think many providers deemed essential visiting to be literally the last hours and moments whereas practitioners in a palliative context know that that's

not really —— it is critically important but it is by no means all that is important.

Q. Thank you. Now, at paragraph 29 of your statement you tell us that as early as April 2020 you were making recommendations that a complete restriction on visiting to care homes was —— I'm using your words —— "increasingly disproportionate and [was] failing to meet the pastoral and care needs of individuals". Now, did you make that apparent both to your members and also to the Government who were issuing guidance at that time?

A. Yes. It was contained in a blog which I published and which was picked up by the media, so it was very widely known. I didn't probably need to make it aware to our members —— not that I'm suggesting they read everything I write —— but it was they who were telling me. It was they who were saying, "Okay, we agreed that it was proportionate, reasonable, to achieve the legitimate aim of keeping people safe at the start of the pandemic, to close down and lock the doors, literally" —— because that's what our practice had been —— but four/six weeks in, the effect of not having family contact, the depression psychologically, the deterioration physiologically, of residents was palpable to those who were there at the front line. So I didn't need to tell

members about the urgency of trying to do something different. They were telling me. I certainly made the issue very clear to colleagues at Government.

Q. When you say that you made this clear to members and perhaps in response to what members were saying to you, were members, in the sense of organisations that were running care homes as opposed to individuals and individual managers of care homes —— were the organisations as receptive to that advice as perhaps individual members would be?

A. I might not necessarily make that distinction because, as I think I've said elsewhere in both my statement and in evidence, the majority of Scotland's care homes are made up of small family—run entities or charities and anybody running an organisation which is larger than that recognises, not least during a pandemic, that your knowledge comes from front—line managers and staff and, if you fail to listen to what they're saying to you, then you're failing to run that organisation effectively.

Undoubtedly there might be different demands on senior managers in an organisation, but I think they were more than sensitive to the reality that closing care homes was having, in April and thereafter, a really significant impact. And what I wrote in April was that

there has to be more to life than simply the existence of —— the ability to breathe in and out. There has to be more. And that includes the benefit of having purpose and meaning in your life and a sense of contribution to family and others.

Q. You mention that you made this view that you expressed apparent through a blog that you'd issued. Do you know if this was communicated, either directly or indirectly, to the Scottish Government, who were the originators of advice?

A. I am very aware that Scottish Government knew particularly my thoughts and the thoughts of the sector, not just because I wrote a blog but because I was saying the same things on television and radio whenever I had opportunity at that particular time and was communicating it in meetings that I was able to hold with the Cabinet Secretary and on the multiple occasions when we had contact. And it wasn't just me. It was numerous individuals saying, "Listen, this is having an impact. We need to think really speedily about different ways of keeping people safe".

So I don't want to give the impression there was a cohort of us saying "Fling the doors open" and there was a resistance to any contact, but the nuance and the risk aversion at the heart of those making decisions at

Government I think outweighed the pastoral care and concern of those at the ground level. And I've said elsewhere in the statement that I think one of the reasons for that is the structural inability to listen to the care sector and, to some extent, respect the professionalism of those on the ground.

Q. One of the points you've made earlier in your statement is that you come to your role with a human-rights-based approach and you've said that you had a desire to bring that into your role as the CEO of Scottish Care. Do you feel that there was -- with that background, was there any resistance or kick-back from your members to the emphasis of the human-rights-based approach that you were advocating?

A. In all honesty, no, I don't think there was. Now, when I say and talk about a human-rights-based approach, I'm not talking about creating legal experts in every care home or in every home-care organisation. But people who were sensitive, I think I said previously, to the relational dynamic involved, I think if there -- there certainly wasn't resistance. There maybe was a lack of knowledge about what did that actually mean, and by that I mean that people may not have been aware of how you can use human rights models to help in decision-making and particularly in decisions where there are

conflicting views because human rights for me, in a non-legal perspective, aren't about black and white application of decision but about using frameworks to deal with situations where there may be multiple views. And from that perspective, I think the care sector still, every much as the National Health Service, lacks a full understanding of how you embed human rights in practice. I've often said that I would make it a mandatory requirement for anybody working in health and social care to have a basic grasp of what human rights in practice means because it helps as a tool in situations where there is potential disagreement and conflict.

Q. Clearly with some of your members there was perhaps an inability to understand what you were saying in regard to the human-rights-based approach. Do you feel that there may have been on your part, in your role, any deficiency in trying to get that point across to your members?

A. I think it's fair to say, Mr Gale, that numerous times, and certainly in listening to the evidence of those most impacted, family, staff and others, as I have, I am continuously asking myself, "Could I have done more, spoken more, shouted louder, given confidence to both members and front-line staff and challenged more

effectively?". I will leave that for others to decide whether I could have done a better job, but I was certainly very aware of the importance of trying to embed a human-rights-based approach and I was aware that often I was speaking in contexts where people were giving a vocal tick-box to what I was saying without necessarily thinking about what the application of a rights-based approach meant for, for instance, visiting guidance.

Q. Do you think it would have been advantageous, either then or now, to have this human-rights-based approach embedded in a document that would have been available to all your staff -- all your members?

A. Ultimately there is no shortage of documentation guidance which mentions human rights and it's a much beloved phrase of political leadership, but it is the application of human rights in practice. It's the working out of scenarios where there are conflicting views, which doesn't happen in a document or even in a training course but happens in practice. That's where I think the real gap is, both in the provision and the delivery of care, both in the NHS and in social care.

So knowledge about human rights is one thing; embedding a human rights empathy is I think quite another. And that, at a time of challenge, was probably

never likely to happen by people reading from a booklet because the practitioners that I know and came across frequently were embedding a human-rights-based approach all the time in the struggles of delivering care.

Q. I take your point, but do you feel that having a referable document that members of your organisation could look at and have, as it were, reinforced by perhaps being a separate document with that heading -- would that have been an advantage?

A. It might have been. Such documentation already existed. I think reference has already been made to the Care About Rights programme, which had been developed by the Scottish Human Rights Commission and which had been rolled out in the care sector. So there were many managers and front-line workers who had begun to think about the conversation of practical human rights implementation.

Would a separate document have made a difference in the context of multiple documents? It might have, but what would have really made the difference is the ability to develop relationships of trust amongst local teams between commissioners, contractors, HPT teams, Public Health Scotland, the Inspectorate and local staff. And the deficit of trust and the deficit of professional due regard was probably more of an issue

rather than the absence of a human-rights-based document.

Q. Thank you. Again, we've heard from a number of witnesses that many care home managers did resort to the constant refrain of "We are only following the guidance" when they restricted or denied visiting. At paragraph 34 of your statement, you say that:

"At a local level ... staff were consistently having to balance the demands of those [who were] wanting [greater] access ... and those who [were wanting] to limit (it) ..."

I think in brackets you also say "out of a sense of fear. Can I understand what the reference to the "sense of fear" is, please?

A. I suspect the Inquiry has already heard something of this from front-line staff in the evidence and managers a couple of weeks ago, having watched that. So in that context what I meant was that, particularly at the start of the pandemic, particularly in April and then later on with the Omicron virus, there was a real debate amongst families and individuals, who said, you know, "We don't know what we're dealing with. Please don't make our family any more vulnerable than they already are", and there was understandably a different perspective of people who were desperate to see their relatives.

Now, that changed during the course of the pandemic, and into 2021 and 2022 it was very few people who were resistant to opening up. But at different points and certainly at the start there was resistance, and the denial of the anxiety expressed by these people I think is inappropriate because they were genuinely worried about this unknown virus coming into the home. It wasn't because they didn't love their relatives or they didn't want to have contact -- and sometimes that has been communicated -- it was because they loved their relatives and they feared the consequence of an unknown virus that they were worried about access being given. And front-line staff were continually balancing that dynamic, more dramatically at some times than at others.

Q. Yes, I think you've made the point that -- while we've obviously heard a great deal about the campaigns by various groups, but particularly by Care Home Relatives, about relaxing or facilitating the visiting of essential visitors, you have made the point that there existed also a cohort of people who were very much, for good reason in their own mind, refusing or supporting the refusal of access of them to their relatives so as to protect those relatives.

A. Yeah, and the truth of that statement should not lead us to create a situation of conflict. Both were

desperately concerned about the health and well-being of their loved ones, both were equally struggling with restrictions and both groups of people and individuals within these groups were unsure about what was best.

That changed obviously as time went by and I think more and more people were sensitive to the damaging impact of exclusion, but even when I wrote that in April, I was very sensitive to the fact that not everybody would agree with what I had written because we didn't know about the virus impact and indeed we had just come through April, through the worst period of deaths.

Q. One of the problems I suppose that we've heard about is that there could be conflicting approaches to the guidance within the same geographic area, so that within Fife one particular care home could be allowing a more liberal approach to visiting than another. Obviously for people trying to ascertain whether they could and should be visiting their relatives, that was a problem. Do you see any way that that could have been avoided or resolved?

A. It was a problem. It was equally a problem for staff in those care homes where, for instance, advice by health protection teams in one part of an area, because of a particular approach by a particular individual, who

ultimately for instance signed off a document allowing -- a risk assessment allowing visiting was different from the approach of another professional in another part of, say, Fife as an example. So staff struggled with the degree of inconsistency and uncertainty, and I think the only way in which that then and potentially in the future can be addressed is if there is real collaborative working and mutual respect and if the care sector was less done to and more enabled by the whole process of collaborative trust-based working. In the absence of that, that's what creates inconsistency.

THE CHAIR: I can see that. That's a perfectly well-reasoned argument. But at a time as existed in April 2020, where there is no irrefutable body of information or evidence to give an answer, that may well be the situation in any future pandemic until a time comes when the scientific knowledge has been unequivocally developed. Then, even applying the approach which I think you quite rightly advocate, the collaborative, trusting approach, there may well be -- there probably will not be any definitive "Yes" or "No".

A. I agree, your Lordship, and I suppose my comment was more related to those periods of the pandemic, for instance later in the year of 2020 and during the

Omicron outbreaks in the early part of 2021 and when visiting a risk assessment was being exercised at local level, where the lack of consistency at local level was not helped by the lack of relationship.

I agree that at core times, with little knowledge of the impact of the virus, as we had in the early stage, there was of necessity more likely to be a greater degree of uniformity. But I suppose that comes to the heart of the issue about the application of human rights later on, but also at this time, as to whether or not blanket assessments and judgments were most appropriate or was there a possibility or should there be a possibility for flexibility to take account of local circumstance, the nature and specificity of a care home and its residents and the particular needs of those residents. And certainly —— we may go on to talk about Anne's Law, but certainly the hope and aspiration of that law, when it is eventually enacted, would be to ensure continuity of contact even with one individual and one resident.

MR GALE: Thank you. I suppose one —— and I'm not suggesting it as one that one should necessarily follow —— but I suppose one approach would be to turn guidance from guidance into something more prescriptive in relation to the instruction that was being given to

give less element of discretion?

A. That is certainly an approach which I think some in the care sector would have valued because it would have removed any dubiety. But that sort of approach I think is only valid if there is consistency in terms of the ability to implement that instruction. So when you have, in the care sector, as we had in 2020, a situation where one care home was able to be insured and that allowing —— and their insurer allowed you to allow visitors and then, in another part of the sector, insurance could hardly be gained —— I came across an email in preparation for today, last night, which was dated early April, in which the provider was saying that, on request from the insurance company that he had dealt with for many years, the insurance quoted in early April was 850% more than it had been the previous year.

So we may talk about insurance later, but the impact of diverse circumstance I think goes to the heart of whether or not you could have a blanket instruction. I think that only works if there is equality in terms of different care homes at different levels.

Q. A blanket instruction in —— let's talk about visiting and that, irrespective of the circumstance, there is an absolute restriction on visiting, would that fit, in

your view —— and I ask you with your human rights background —— would that fit with the human rights approach?

A. In a theoretical sense, no. I mean by that that I think the uniqueness and the —— I might even say the glory of the human rights approach is that it is not the empty application of a rule into a particular circumstance but, rather, it's the creation of a relationship in a particular context. I mean by that that —— you know, I had been used to working with staff in situations where there had been a dispute between a resident, another resident, a staff member, a family member, and, you know, the human rights frameworks and models enable you to use human rights almost in a mediatorial manner. In that context, that's about not a black and white application; it's about, for each context, analysing the situation, seeing those who are most impacted, identifying which rights might be impinged or impacted and what can be done to enable an individual to achieve and fulfil their human rights as much as possible. That's, dare I say, much more flexible and loose than simply an instructional approach, which gives no room for flexibility or the creation of relationship.

THE CHAIR: We're getting into a rather philosophical debate here but ——

A. On a Friday afternoon, my Lord, I know.

THE CHAIR: On a Friday afternoon! To use another synonym, a human rights approach is more nuanced and should be more nuanced, and I think we could probably all readily agree on that. The problem is, of course, that legislation, if properly drafted, does not readily allow for much nuance once it is promulgated and we're back to the situation: when there is no precise degree of knowledge, then nuance is very valuable because it allows, if discretion is granted or mediation —— I liked the use of the word "mediation" in the sentence you used there —— it's a mediative process. It's a frightfully difficult ground —— I'm sure all three of us could agree on that —— isn't it?

A. Yes, and that's why it changes so —— I think I said this the last time —— that I had no difficulty in March with there being a very definitive decision to lock down care homes because the legitimate aim was literally to keep people alive. As the time and the passage of time changed, then I think there were other human rights, the right to privacy, the right to family life, the right to association, and our knowledge of psychological harm, of the impact of restricting people to their own room and space, was growing. So other human rights became equally significant and that's where I think that

your Lordship's phrase, "nuance", became really important. My concern then and now is that too often the application of the visiting guidance was too didactic and open to little flexibility rather than it being open to flexibility .

THE CHAIR: In fact it could be argued it was rather dangerous because it turned its blind eye to nuance and yet at the same time purported to be flexible ——

A. Yeah.

THE CHAIR: —— and it was neither in reality ——

A. Yeah.

THE CHAIR: —— or at least that's an argument.

A. Yeah, and I would agree with that.

MR GALE: Can we move on perhaps a little from the philosophy ——

THE CHAIR: Sorry.

MR GALE: I enjoyed it —— to a particular situation.

I think you're aware that there was a meeting in September —— it was 18 September 2020 —— between members of the Care Home Relatives group, key members, and they met with the Cabinet Secretary, Jeane Freeman, to argue their case for essential care—giver status. You're obviously aware of that campaign. I think you had had meetings with them in relation to it.

A. [Nods]

Q. Essential to that was the suggestion that a family member or family members should be regarded as part of the care team. Bearing in mind that probably many of those members —— many of those relatives had probably been care—givers up until the point when a relative went into a care home, were you supportive of that?

A. Yes. I would go further and I think many of those individuals —— not all, but many of those individuals continued to be care—givers when the person entered into the care home. And I think you've already heard, but I certainly recognise from staff comments that family is not an irritation , a hindrance, a challenge. They are an essential component of the relationship you want to form in a congregated or shared living environment. It enables —— and sadly, unfortunately, there are a significant number of residents in a care home who don't have family or anybody to visit them, and the ability of others to care for , to be present, to contribute to the care and support of their relative , frees staff up to spend more time with those who would otherwise have nobody and to focus more.

So, as an organisation, we were always supportive of the role of family. Now, you know, we might have had disagreements —— and I had conversations with Care Home Relatives Scotland about some terminology, like

"a member of the care team", because that immediately might have got us into challenge with regulators around, well , is this a voluntary role or somebody to be registered —— but I think the principle of allowing —— and that's why I think Anne's Law is so significant and why it needs to be implemented sooner rather than later —— the principle of having, in an emergency situation or any situation , the right of an individual to choose a family member to be their additional support to the professional carers and to be present and to be their advocate is undeniable.

Q. You've mentioned a couple of interesting points which are in my mind. First of all , we all know —— I'm sure those of us who have been in the situation of being a relative to somebody who is in a care home, we know that there are very frequently other residents within that care home who never see anybody and their level of loneliness can only be guessed at, I suppose. So there is that situation . You also mentioned in one of your answers that that might —— if one had a relative as a dedicated or as an appointed member of the care team, however one phrases that —— I'm sure we could argue about that —— but however one phrases that, you could see that as an advantage in freeing up other members of the in—house care team, if I can put it , to spend time

with people who are on their own.

A. Absolutely, yes, and my experience is also the fact that, if you have a relative who becomes part of the community of care in a care home, they don't just spend time with their own relatives, they get to know other residents . And in particular I think we're all aware of those residents in a care home who have no family left because literally there is no family, but also , and maybe more challenging, those individuals who do have family but that family chooses not to visit or is unable to visit . And I think all visitors to a care home, particularly over the longer period of time, get to know everybody, not just their own particular relative .

Q. Can I take you to something that you were asked about in your evidence to the UKI? My Lord, the reference is to the transcript of 18 January of this year and it's page 164, line 21, to 165, line 15. If I could just quote for the benefit of everyone —— you were being asked by Mr Tariq, Counsel to the —— sorry, Mr Dawson, I think it was.

A. No, it was Mr ...

Q. You were being asked certain questions and you were asked this question:

"We know that visitors' restrictions were eased in autumn 2020, but the guidance on outbreaks meant that

many residents still faced severe restrictions for many weeks. Do you consider that the Scottish Government's approach on this issue in late 2020, going into 2021 and 2022 —— did it move towards considering properly the human rights of the residents and their families? [as read]"

Your answer was unqualified:

"No, it did not."

Do you remain of that view?

A. Absolutely.

Q. Can you explain to us a little of why you are of that view or why you remain of that view and were of that view at the time?

A. So at the time we were in a situation where the rest of the country was opened by —— to an extent that we hadn't seen for some considerable period and yet those in care homes, who were by that stage one of the most protected population groups —— so we had had vaccination, we had rigorous PPE, we had infection prevention and control measures and so on —— and yet there was developed additional restrictions that, should there be an outbreak, even with one person, then all visiting would have to stop.

And that extent of lack of flexibility, I argued at the time, was a denial of the individual human rights of

those residents because it was treating the residents of a care home as an amorphous group without there being flexibility. And without getting into our previous philosophical debate, I argued at the time that it should be perfectly possible to bestow professional flexibility on the part of care home managers to manage an outbreak in a manner which would continue to allow visiting to happen for those individuals.

Now, clearly if a significant percentage of residents were infected during an outbreak, that's going to lead to a different decision compared to a handful of residents who could be appropriately supported and looked after, bearing in mind that we're talking late into the Omicron strain and evidence by that stage had shown significant lessening of impact, even on the care home population, as shown by the thankfully diminishing death rate.

Q. Just to complete that reference to your evidence in the UKI, you went on to be asked:

"Why would you say that the Scottish Government didn't move to a human—rights—based approach later on in the pandemic? [as read]"

Again, you give an answer in these terms:

"I think that the fear of repeating the trauma of the spring and of there being a resultant increase in

death as a result of not tightly managing a care environment was an overriding concern and, ultimately, as people kept saying to me, can we live our lives rather than exist in an improved environment, which was a sentiment expressed by staff as much as it was by family residents and carers [as read]."

A. And I would still hold to that statement and sentiment. We had, by that stage, a population that had been through hell and the least they deserved was a flexible approach to enable them to spend their last few months —— people I think forget that the life expectancy of somebody in a care home today is between 14 months and 18 months. Care homes are essentially hospices, increasingly, in our communities. And I don't know about many people, but if I was faced with the prospect and knowledge that I possibly had three to six months to live of my stay in a care home, I would be less concerned about getting COVID than I would be concerned about never seeing my family and being able to hold a grandchild or being able to spend time with my spouse. And those were the sort of things that people were saying to us. Those were the things that staff were saying to us, that our colleagues and Care Home Relatives organisation were saying. It was felt to many of us that care home residents had been forgotten as the

rest of society returned to what was increasingly called the "new normal". It was because of fear.

THE CHAIR: Dr Macaskill, might I suggest to you that, having regard to the factors that you identified in the answers to the question, both in the UKI and a moment or two ago to Mr Gale, and having regard to the other factors at that period of time, whilst I acknowledge the merits in the human rights approach argument you've been advancing, one could come to the same conclusion as you are using the human rights approach to advance and advocate —— you could come to the same conclusion simply by an application of common sense, that the stage had been reached when it was sensible to proceed as you suggested. Would you agree with that?

A. I would, and I would —— and further —— and certainly said at the time that there is no other context where I think we would make clinical decisions around the well—being and health of an individual which were based on everybody in that environment but, rather, we would —— you know, if I became ill, I would hope that I was attended to and that my particular needs were addressed according to my clinical needs at the time.

But that's not what we did with care home residents. We assumed and we presumed by blanket implementation of guidance, at this stage in particular —— which is why

I said it was a denial of the human-rights-based approach because a human-rights-based approach treats an individual not as part of a mass but an individual in their own right -- and that's not what we did throughout a significant part of the pandemic. And moving forward, if we were ever to be in this circumstance again, we cannot have blanket rules on guidance which fail to appreciate the individuality and the uniqueness of each person and the fact that, "I may have a year to live but you might only have a few days".

MR GALE: Bearing in mind what you've just said and the passages from the UKI evidence that we've looked at, can I take you back because the context in which you were being asked those questions was autumn 2020 and thereafter really through to the end of -- certainly to the end of the period of our terms of reference in this Inquiry. I suppose there's two aspects of what I'd like to ask you. First of all, in the early days of the pandemic, so back into March/April of 2020, and in your dealings with Scottish Government in particular, did you see any indication of a human-rights-based approach featuring in the way in which guidance was being drafted?

A. No.

Q. No. Do you feel that it should have done at that

earlier stage?

A. Absolutely, but that would have involved different people being at the table. I think the first time that human rights were explicitly mentioned by Government in terms of the pandemic was when, as is referred to in my evidence and I think others', some of us, including myself, reacted negatively to the then Chief Medical Officer's outline plan for what would happen were resources to be restricted and the way in which age and frailty was used as a proxy for clinical decision-making. And that was the first real piece of work which was undertaken which included bodies like the Equality and Human Rights Commission, the Scottish Human Rights Commission and others. And I was part of that process to try to come up with a framework if we got to a situation of having to make a clinical decision about whether one person was treated and another was not. I think the output of that eventually is something which we can be justly settled on were those circumstances to arise in the future because it was human-rights-based, but apart from that piece of work, human rights were absent from the COVID response in the early stages.

THE CHAIR: For the avoidance of doubt, in the second part of the answer to Mr Gale's question, you mentioned the first time the human rights approach was expressly

mentioned. In the first part you answered the question with a very definite "No", but -- I think I know the answer to this question -- I think you would agree that you don't actually need to mention the words "human rights approach" to display or apply a human rights approach. Your answer still remains "No"?

A. Yeah, my answer was I suppose primarily addressing the situation about the care sector, the pandemic and visiting. The CMO guidance was not explicitly about the care sector; it was about the NHS having to make challenging decisions potentially. So I still hold to the line that human rights was singularly absent, both in terms of the literal application but also in terms of the behaviours, and most especially I remember -- and I think Ms Hedge in her evidence recorded this -- remember explicitly asking on a number of occasions, "Has a human rights assessment been undertaken?". And I had the honour previously of working in developing a human-rights-based framework for assessing decision-making by public authorities, and there was -- so it was something, very rarely, I knew a little bit about -- it was singularly lacking because it does mean you can't just say, "This is a human-rights-based approach". You've got to evidence, "Have you gone through a process in making this decision, in writing

this guidance and developing this practice which is properly human-rights-based assessed?", and that was not evident at all.

Q. Thank you. Just one further matter at this stage. We will hear from a considerable number of witnesses who represent workers in the care sector. Some of them are union representatives, others are individuals. But one of the points that is made is that they felt that the guidance issued by the Scottish Government regarding visiting and isolation within care settings was drafted without having proper consideration of the circumstances that exist within a care home. Would you agree with that?

A. Totally.

Q. I think we can all imagine the situation, those who wander, those who perhaps do not understand the need to keep things clean.

Right. Can I move on again to something else that you've already mentioned, and that's Anne's Law. You're aware of the proposal that was initiated by the petition in name of Anne, and that's a petition to the Parliament. As the representative of those organisations that would have to implement it, what's your view on what is presently before Parliament in the form of clause 40 of the bill?

A. Personally I fully support it, my organisation does the same and I have spoken to no care provider who has difficulty with the implementation of Anne's Law. I personally think it's reprehensible that here we are in 2024, in the spring, and we still haven't had that law or something equivalent to it enacted. It suggests a lack of political focus and leadership.
Q. Right. Do you consider that it should be enacted in the form that it presently is or do you feel that there should be changes to that?
A. I think broadly the current form —— and both myself and colleagues have been involved in the group that has helped to develop and shape it —— I think it's broadly in the right territory and is acceptable. I think, in reflection to everything I've said earlier, what matters here is not the letter of the law but how it's implemented and the support that's given to implementation and how we deal with any challenges which may exist because the implementation of any new guidance or legislation will bring challenge. So I hope there is an adequacy of resource and there's support for all those engaged, whether family, relatives or front—line staff. But in terms of a piece of legislation, as worded I have no difficulty with it.
Q. Okay, thank you. Can I turn to a matter again you've

touched on a little today and referred us to last time you gave evidence, and that's the question of indemnity and insurance. Now, we're aware that the care home sector did not have the indemnity that was available from the Government in respect of the NHS and we've talked about that, but you explain how care homes require to obtain insurance and what risks they are insured against. You've told us about that. In view of the difficulties that you've already indicated, are you aware of any pressure from the care home —— I use the word "industry" not in a pejorative way —— but the care home industry to have a similar indemnity as the NHS has?
A. Insurance became a real issue very, very quickly and what we saw was a huge number of insurance organisations, providers, exiting the market, making a decision that they weren't going to offer premiums. That lasted —— in fact I came across research which we did in the summer of —— sorry —— in the spring of 2022 and, of 16 insurance —— large insurance organisations, 13 of them were not prepared to offer insurance to a care home.
Later on in that year, I encountered an email where a provider was informed by their insurance organisation that they should not admit somebody who was

COVID—positive otherwise they wouldn't get insurance. And what happened was, because insurance happens and premiums occur at different points of the year, throughout the year we saw a flux and very quickly, however —— I mentioned in the case of a provider in April, an 850% increase in premiums —— very quickly we began to see a huge spike in premiums. That settled a little bit. Then, when Omicron came, it went up through the roof to an average of 500% across the board. That presented a massive challenge, particularly for smaller providers. And it wasn't just a fiscal challenge, it was the fact that insurance for any communicable disease was withdrawn. The impact of —— had there been deaths in the care home, that impacted on insurance and the ability to find insurance. Whether or not there had been an inspection using IPC also impacted. So insurance, which had previously never been a major issue or concern for providers, became a very dominant one, including around some of the issues that we've talked about, which related to a risk aversion on the part of some providers.
THE CHAIR: This is not for Dr Macaskill but you, Mr Gale. When this issue raised its head —— and I don't actually think I'm thinking particularly of your evidence, Dr Macaskill —— I was interested in it. I think it is

important. I received —— not advice because it wasn't fully formulated, but it may actually be a reserved matter and therefore falls outwith my remit to examine it. Do you have any answer to that question as of the moment?
MR GALE: My Lord, the reason that I'm looking at it is that it does seem to me that the question we are looking at at the moment are impacts. We are looking at the impact on not merely those who were in receipt of care but the givers of care, and those include persons such as the companies, individuals, that Mr Macaskill represents. And also I think the approach that I was taking to this is that —— it's perhaps incorporated in the next question that I had for Dr Macaskill, which is what effect this had on the providers, particularly the smaller providers of care homes —— what effect that had in creating a level of uncertainty about their continuation.
THE CHAIR: Well, I'm perfectly happy that Dr Macaskill should answer that. I'm interested in it as well. But I think it's only fair to say publicly that, whilst I'll consider the matter and I may say something about it as a matter of impact, it may —— I haven't had a definitive answer yet —— it may be that —— if insurance is a reserved matter, I may be very constrained in any

recommendations I make in relation to that.
MR GALE: Thank you, my Lord.
THE CHAIR: Subject to that caveat, go ahead.
A. Okay, so not being a lawyer and an expert on what is reserved or not, nevertheless the impact of insurance, which is predominantly —— and the vast majority of insurance companies are outwith Scotland —— the impact of insurance was really significant. And I raised it on numerous meetings and, to the credit of Scottish Government, both the Cabinet Secretary and ministers, they sought to bring these matters up with colleagues at Westminster. And on one occasion I was invited to a meeting to explain the challenges and circumstances to the then UK Government minister, Gillian Keegan at that time, and expressed just how significant an impact the insurance issue was. So regardless of jurisdiction or influence, it had a huge impact on front—line ability and flexibility.
Q. Thank you. I think that's probably as far as I was intending to take it, my Lord.
THE CHAIR: No, I have no difficulty with that, subject to the caveat I made, of course.
MR GALE: Yes.
Right. Can I touch on the impact on the mental health and mental well—being of staff and staff morale?

Now, you've provided us with quite a lot of information at paragraphs 95 to 103 and 114 to 116 of your statement. Two areas I'd like to ask you about and, again, with the information you have from your members, I'd like to ask you about abuse of staff and, in particular, first of all, the abuse of staff in altercations with those who are wanting to access care homes. Is that something that cropped up often?
A. It did, but only in a very minimal way and I'm even uncomfortable with the term "abuse" in the context. I think people were massively frustrated, emotional, angry, hurt, lost, because they didn't know what to do. And often —— because especially in those times, when the rest of society was getting about doing their ordinary business, going to the pub, going —— you know, socialising, and yet they couldn't see their loved one, that frustrated understandably and sometimes people's frustration just poured over and words were said or actions were undertaken which, in all the instances I've known, were very quickly regretted.
And staff understood that frustration and were —— many —— I think we often forget that many care staff have relatives themselves in care situations and they probably felt the same frustrations in different contexts. So I wouldn't necessarily call that "abuse"

but there was and —— you know, there were behaviours which were unfortunate.
Q. Perhaps if I can put it better, expressions of annoyance?
A. Yes.
Q. The other area I'm interested in emerges out of what you say at paragraph 114, where members of staff were accused of letting in the virus. We obviously live in an age of social media. What effect did that have on members of staff? Was that uncomfortable?
A. Yeah, it was awful because nobody goes to work with an intent to harm another and staff were putting themselves often in situations of vulnerability and at very real risk themselves and their families. And there were instances where people were name—called; people were treated aggressively when it was discovered that they were a member of the staff in a care home where publicly it was known that there was a significant number of deaths. And I think that is a question to those who engaged in those behaviours because all those staff were doing was a job of compassionate care. There was nothing more.
What I have particular frustration and anger about were those instances I discovered during the course of the pandemic, where members of the media and particular

members of the media behaved in a manner which followed staff home —— one journalist jumping out on a staff member from a hedge literally as that staff member left a care home where there had been multiple deaths.
So I think there were those who were frustrated in terms of visiting, there were those who engaged in behaviour which is really unacceptable in the community, but what is wholly reprehensible was the treatment of some journalists, who don't deserve the name, against some staff members, and what that resulted in was a real sense of vulnerability in those locations and for those individual staff members, which caused considerable mental health distress.
Q. Thank you. Can I ask you very briefly about the effect that the pandemic had on recruitment into the sector? We obviously are constrained by our terms of reference to the end of 2022, so perhaps bearing that restriction on us in mind, are you able to make an observation of how the sector was impacted post the pandemic?
A. So I suppose it depends what you mean by "post the pandemic". I'd want to say during the real key period of the pandemic, in the year 2020/early 2021, the stability index, as it's called —— that's how many people are still in their job a year after the index is assessed —— had never been as high because women and men

in the care sector, whether in the community or in care homes, stood up. They were present, they were sacrificial, they were —— and I don't like the word "heroic" because it suggests as if they were super—human, but they were humanity at our best, and so stability was evidence of that level of commitment.

But, inevitably, as exhaustion took over, as energy was depleted, people began to reassess and singularly, without revisiting old ground, the impact of Operation Koper resulted in a significant number of people leaving their posts. And so into 2022, into 2023, that stability index decreased significantly, down from the high 80s, if not the 90s —— down to just around about 70%, where it sits now. So today nearly a third of the people working in our care homes were not working during the pandemic. And so it's —— and we have the highest level of staff shortage, particularly of nursing, than we have had. That's been addressed in part by the decision at the start of 2022 to introduce a social care visa, but without going beyond the scope of the Inquiry's timeframe, that is now being impacted by more recent decisions.

Q. Thank you. Could I ask you briefly again about testing? You talk about this in paragraph 71 and following of your statement. I'm interested in what you say at

paragraph 73. One of the issues you mention there is a lack of trust between the organisations or the bodies that were making the transfer and those into whom the transfer was going. Could you explain that a little bit?

A. I think this was particularly in reference to the decision to discharge a significant number of people in the early stage of the pandemic from hospitals, many of whom were returning to care homes, many of whom could only be supported in care homes, so if care homes hadn't taken them, they would have had no place. What that was referring to was, pre—pandemic, the nature of the relationship between receiving care homes and clinical colleagues in care homes and professionals and those in discharge teams, and that relationship was brilliant in some parts of the country and absolutely atrocious in others. And it was atrocious because of a lack of professional regard, mutual understanding of roles and in some instances a priority in the needs of the person, so discharging people on a Friday night with less than full detail of clinical case notes, with insufficient pharmaceutical support, was commonplace, and I'm using that word "commonplace" before the pandemic.

So in that context —— and I remember referencing this to parliamentary committees before —— in that

context there was a lack of trust when the time came in March in particular and into April, which is why we encouraged all our members that, if they were receiving somebody at point of discharge, to assume that that person was COVID—positive because the quote, "clinical assurance", in some instances wasn't worth the listening to.

Q. You go on to talk about a trust deficit in paragraph 75. Then at 76 you say:

"It took some time for the Scottish Government to make a policy decision that stricter measures should be adopted and for this to be reflected in the guidance from [Public Health Scotland]. Scottish Care was still addressing instances of poor discharge practices with CPAG, with Professor Graham Ellis and with Hugh Masters in May and June 2020 ..."

You're critical obviously of the time that it took the Scottish Government to make a policy decision on stricter measures. Can you give a little more context to that, please?

A. I've stated elsewhere that the —— we, from the get—go, literally the get—go, said to the Cabinet Secretary and clinicians at Government that we wanted those discharged from hospitals into care homes but also into the community to be tested and perceived that this

population, older individuals with multiple comorbidities, were deserving of equal treatment, even in a scarce resource situation, as those who were perhaps being admitted into hospital where tests were being used.

Now, as I said, even —— and I grant that there was a restricted number of tests —— I considered that the prioritisation of the NHS at the expense of care homes in particular was not balanced and acceptable, that different prioritisation could and should have been used. I think what we were equally despairing about was the length of time it took between folks like me raising these concerns and a decision being taken eventually that anybody being discharged from hospital should be tested twice. And the comment there highlights that, even when that was made explicit and the Cabinet Secretary very supportively was standing in Parliament, making it clear that this was a requirement, we were finding instances which we brought to clinical colleagues at Government of discharge occurring with no testing or less than accurate description of testing.

Q. Thank you. Just a couple of other matters, Dr Macaskill. Paragraph 51 of your statement, we're going back to PPE and we dealt with PPE when you were last here, but one of the points you make there at

paragraph 51 is what you call the "unnecessary politicisation" of the use of PPE or failure to use PPE and "unmerited criticism of the sector". You say:

"By way of example, statements were made by trade unions suggesting that some independent social care providers were not allocating the appropriate PPE to their staff."

Now, before I go any further with that, Dr Macaskill, we have some considerable information from several union representatives, affiliates of the STUC, which do suggest that that was actually happening. Is that contrary to your understanding?

A. So I'd want to say that we worked during the pandemic and since very closely with some of our trade union colleagues so that, you know -- because nine times out of ten we're saying the same thing, maybe with a different dialect. But it was our experience and the experience of our members at local level that there were instances where local trade unions were acting in a manner to suggest that providers at specific times were preventing staff from getting access to PPE. Now, I personally know of no such instances. What I do know was that the nature of the PPE required in guidance at specific times in the care home sector was not the same as the nature of PPE required of our colleagues in the

NHS, so it would appear, to all intents and purposes, that you could look at a care-home worker who was not wearing appropriate PPE if your assessment of appropriateness was what an NHS worker should wear. My colleague, Karen Hedge, gave a description of how, particularly in the community, there were instances where a nurse or a carer -- a nurse appeared wearing almost the equivalent of a hazmat and yet the care worker went in just wearing an apron.

So we are very aware and we've presented evidence to the Inquiry of the different stages of PPE requirement, and then in some instances, when it was not required to use particular PPE, we had to -- and were in dialogue with unions who were saying that providers were withdrawing PPE or withholding PPE, and that was not the case because it wasn't necessary. I don't know of any instance where any provider, deliberately knowing that you should use PPE of a particular nature and who had that PPE, withheld that PPE because why would they do that? I would be interested to see the evidence of the trade unions.

Q. Okay, well, you will hear it in due course.

Dr Macaskill, I'd like to, given the time, just go briefly to your lessons to be learned. You provided us, in paragraphs 117 onwards, with your views on the

lessons that you feel should be learned. A lot of these we have touched on in your evidence, but I wonder if I could ask you, sir, to read paragraphs 121 to 123 inclusive, so that we just get that in your own words.

A. "The keeping of provider bodies at arm's length during the pandemic was a critical error and meant that opportunities to benefit from the knowledge and experience of the sector were repeatedly missed.

"This resulted in an inadequacy of guidance, lack of contextual awareness around clinical needs for example residents who had dementia and the operational realities of delivering care home and homecare services. The application of practice appropriate in one area (typically an NHS acute setting) to another area was assumed. The felt presumption of Scottish Government in its guidance was that the social care sector is an extension of a clinical NHS environment and it is not. It is still the case that the group overseeing pandemic preparedness does not have anyone on it from a direct social care delivery perspective. There is also no equivalent role to the Chief Medical Officer for social care within the Scottish Government.

"Had it been invited to participate at an earlier stage, I believe that Scottish Care could have helped the Scottish Government to foresee some of the

challenges that arose in the care sector which would have helped to mitigate the subsequent impacts.

I consider that it is essential that representatives from the social care sector are involved in future pandemic planning exercises."

Q. Thank you. Dr Macaskill, as with all witnesses, we invite, at the conclusion of evidence, to address us on any matters that you feel require to be taken into account or that we haven't dealt with, so I'll offer you that opportunity now, if I may.

A. I want to thank the Inquiry for giving me the opportunity twice now to describe the impact, and there is no substantial matter to raise other than maybe to recall a conversation I had last week with a front-line nurse at an event that I was -- two weeks ago -- at an event that I was attending, who came up to me and said, "The pandemic is not over for me. Every night I go to bed, I see the faces of those residents who are no longer here and every night I ask myself could I have done better". I think she's reflective of the vast majority of providers of care and front-line staff. We are always remembering those who are no longer here and asking ourselves, "Could we have done better?", and we leave it for others to decide that.

MR GALE: Dr Macaskill, on that point, the Inquiry is very

grateful to you for coming back a second time and for the care that you've given to the presentation of your evidence. Thank you very much.
A. Thank you.
THE CHAIR: Yes, thank you, Dr Macaskill. I'm sorry you had to come twice.
A. Thank you.
THE CHAIR: Very good. That's fine.
MR GALE: Thank you, my Lord. That's it for today.
THE CHAIR: I think we're sitting on Tuesday. I'm getting a bit muddled because next week is a bit muddled, I'm afraid.
MR GALE: We are here on Tuesday.
THE CHAIR: There are a couple of days when we're not sitting, but I think we're here on Tuesday.
MR GALE: At least I am, my Lord. I hope you will be as well.
THE CHAIR: Well, actually I'm not going to be here but I'll be on the screen on Tuesday. Is it 9.45 or is it 9.30 on Tuesday in fact? It's 9.30. I was right. Thank you.
MR GALE: Thank you, my Lord.
(4.17 pm)
(The hearing adjourned until Tuesday, 23 April 2024 at 9.30 am)

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