

OPUS2

Scottish Covid-19 Inquiry

Day 36

April 19, 2024

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Phone: 020 4518 8448

Email: transcripts@opus2.com

Website: <https://www.opus2.com>

1 Friday, 19 April 2024
2 (9.30 am)
3 (Proceedings delayed)
4 (9.43 am)
5 THE CHAIR: Good morning, Ms Trainer.
6 MS TRAINER: Good morning, my Lord.
7 MS DALJEET DAGON (called)
8 THE CHAIR: Good morning, Ms Dagon.
9 Right. When you're ready, Ms Trainer.
10 MS TRAINER: Thank you, my Lord.
11 Questions by MS TRAINER
12 MS TRAINER: I wonder if you can start by telling us your
13 name.
14 A. My name is Daljeet Dagon.
15 Q. And you I think, as per your statement, are a programme
16 manager at Barnardo's Scotland; is that right?
17 A. I am, yes.
18 Q. You have provided a statement to the Inquiry and, for
19 our benefit and the benefit of the recording, that bears
20 the reference SCI-WT0485-000001. You should understand
21 that all of that information will form part of the
22 evidence that the Inquiry is able to consider.
23 Your statement first of all goes through your
24 professional background and tells us I think that you
25 began working at Barnardo's some 26 years ago.

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

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

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

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

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

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

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

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

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1 out like -- it was about trying to persuade families or
 2 children to go out for a walk or go for a cycle or
 3 whatever.

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

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

14 A. Yeah.

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

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

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

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

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

19 A. Yeah.

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

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

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1 or next week", do you know what I mean, and we'd put
 2 notes through the door; we'd leave activity packs, like
 3 word puzzles or fidget toys, anything we could think
 4 of — do you know what I mean? I think certainly —
 5 I suppose one of the things I've always done as
 6 a practitioner is try to think of the practical things
 7 people need.
 8 And it's not about, you know, coercing or
 9 manipulating families into working with you, but it's
 10 about, you know, really simple things about actually
 11 what is it that this family needs because there would be
 12 a whole raft of reasons why families have been referred
 13 to our services, but people often don't think about,
 14 "Well, how are they going to get from A to B? What's
 15 going to assist them?". So it was things like doing
 16 food parcels and recognising that, although children
 17 weren't able to go to school, it wasn't just school
 18 education they missed out on, it was a breakfast, it was
 19 a lunch, and a lot of families couldn't afford that. So
 20 it was simple things like organising cereal, organising
 21 milk, and it sounds really basic, but for a lot of these
 22 families they didn't have that. So we got into
 23 a routine where every week we made sure we were buying
 24 breakfast stuff and lunch stuff specifically for
 25 families.

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1 We were doing word puzzles, like I said, colouring
 2 books, fidget toys, things like chocolate, making sure
 3 that they were remembering people's birthdays. If it
 4 was a celebration, if it was Christmas or Divali or Eid
 5 or whatever, we were making sure that we were making
 6 a fuss of people and just keeping people in mind all the
 7 time. Whether that door was open or not, we were
 8 persevering, shouting up to the window, like I said.
 9 People always chapped the door — and we would try
 10 different workers as well because obviously a lot of the
 11 families that we work with, we would have more than one
 12 worker, so we just persevered all the time and tried
 13 what we could.
 14 Q. In your statement at paragraph 32, you really go on to
 15 talk about the observations that you think — the impact
 16 the pandemic had on children and young people accessing
 17 the service. The first thing you say is that it caused
 18 stress and tension which was above normal levels and
 19 that was something you were seeing. How were you seeing
 20 that?
 21 A. So we often work with families where there's large
 22 sibling groups and I suppose, in terms of like
 23 referrals, for instance — you asked me right at the
 24 beginning, "Do you work with the whole family or do you
 25 work with individual children?". Often what we would

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1 find is, when a referral is made to our service, it will
 2 be the child that sticks out for the family or the local
 3 authority, so often people pay a lot of attention to
 4 that particular child. And what we've always done is
 5 said, "Look, actually what we're going to do is work
 6 with the whole family, work with all the children", but
 7 you will always have an emphasis on one or two so that
 8 can cause additional stress and tension.
 9 But you've also got children who have multiple
 10 support needs, so we had children with neurodiversity
 11 and sometimes children would be going to different
 12 schools and obviously accessing different levels of
 13 support and weren't used to being with each other 24/7.
 14 You also had families where parents might be working
 15 from home or they only had one parent in the home, so
 16 often what we'd have is there would be shared care
 17 arrangements. And initially what you would have is
 18 everybody in the one home and there was no respite
 19 either for the mum or the dad, who was the main carer,
 20 or for the other brothers and sisters.
 21 So there was a lot of competitiveness, but also
 22 there was a lot of harm as well, and I'm sure you'll
 23 probably ask me about this later on, but some of that
 24 harm also led to sibling sexual abuse as well because
 25 children are cooped up, they were in environments that

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1 they weren't used to being together 24/7 and there
 2 was — there was a lack of supervision and guidance.
 3 And also in terms of education, although children had
 4 access to education, they found it repetitive and it
 5 wasn't — it didn't motivate them. It wasn't
 6 interesting. And also children have very different
 7 learning styles and not all the children that we were
 8 working with were able to engage with that type of
 9 learning either.
 10 You also had parents and carers who had very poor or
 11 no literacy skills and numeracy skills so they didn't
 12 have the ability to support their child, so actually,
 13 because there was no respite in terms of and because —
 14 and if children didn't have a garden, they were stuck in
 15 a, you know, multi-storey building and they couldn't get
 16 out and there was nobody to take them out. You often
 17 had parents who were suffering from mental health issues
 18 or addiction issues or had mobility issues so they
 19 weren't taking children out either.
 20 So, for us, they became our priorities in terms of
 21 who we invested in in terms of, "Right, okay, we need to
 22 get you out, we need to see you, we need to bring you to
 23 our office", in terms of — and sometimes it was about
 24 actually different workers taking different children out
 25 and doing different things so that they were separated

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1 because that — which was the opposite of what we'd done
 2 in the past because in the past it was about trying to
 3 work with children so that they were, I suppose,
 4 adopting skills around negotiation, around compromise,
 5 around — you know, looking at the socialisation,
 6 whereas this time round it was about that separation
 7 because it was about giving children that opportunity to
 8 just talk about their own individual stresses and
 9 worries without necessarily worrying their younger
 10 brothers and sisters — do you know what I mean? — or
 11 it was about, "They're doing my head in and I want time
 12 away from them". So it was about thinking about what
 13 would be in their best interests and trying to be able
 14 to support that as much as possible.
 15 Q. As well as the stress and the tension and maybe
 16 a difficult environment at home, you also talk about
 17 your experience of seeing more young people presenting
 18 with sexually transmitted infections.
 19 A. Yes.
 20 Q. You say that's due to more children being unsupervised
 21 and having sexual contact. Is that something that the
 22 service experienced anecdotally from staff feeding that
 23 back?
 24 A. Yes. So we had that direct information from children
 25 and young people but we also had feedback from the local

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1 authority and also health workers, who were seeing
 2 a rise in infections such as gonorrhoea, for instance,
 3 that hadn't existed for a long time. They were also had
 4 young people who were unknown to them presenting with —
 5 talking about unprotected sex because they didn't have
 6 access to contraception, but also children being coerced
 7 and manipulated into having sex when they didn't want to
 8 have sex.
 9 I suppose, you know, just in terms of erring on —
 10 we spoke about mental health and stress and tension, and
 11 I suppose it was about children trying to offer each
 12 other comfort and support but that becoming exploitative
 13 and abusive as well. So that was direct information
 14 that we had from children and young people, but, like
 15 I said, also from colleagues in health and social work.
 16 That was particularly noticeable in one particular local
 17 authority and we had conversations — and also in terms
 18 of starting to look at registrations and some of the
 19 reasons — and some of the reasons for children starting
 20 to come to the attention to services that they hadn't
 21 previously been known to.
 22 Q. When you say "registrations" —
 23 A. Child protection registrations. So I'm talking about
 24 under 16-year-olds, I'm not talking about children over
 25 the age of 16 here.

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1 Q. Another thing you mentioned again anecdotally is that
 2 you saw what you perceived to be an increase in the use
 3 of alcohol amongst young people.
 4 A. Yes. So certainly — I mean, obviously, in terms of the
 5 work that we've done for years and years around
 6 exploitation — alcohol and exploitation pretty much go
 7 hand in hand in terms of, you know, children being
 8 coerced into taking alcohol and drugs as a way of, you
 9 know, I suppose manipulating them into engaging in
 10 activities that they wouldn't ordinarily engage in. And
 11 certainly what children were saying to us was access to
 12 alcohol was very easy because there was more alcohol in
 13 homes, because families were doing a lot more online
 14 shopping, so, rather than buying one bottle of wine,
 15 they might buy three bottles of wine or whatever —
 16 do you know what I mean? — because it was about bulk
 17 buying. I suppose everybody, myself included, got
 18 involved in bulk buying, whether it was toilet rolls or
 19 whatever it was that people were buying. So, because of
 20 the increased alcohol in the home, families weren't
 21 really missing — if something went missing — do you
 22 know what I mean? — if it was a bottle of vodka or
 23 a bottle of wine or whatever, it wasn't as noticeable as
 24 it would have been in the past.
 25 So there was access to alcohol, but also young

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1 people were reporting that their own parents were
 2 drinking more but also drinking longer in the day
 3 because they were working from home. So rather than
 4 like getting up at, I don't know, 6 or 7 o'clock at the
 5 morning to get dressed, showered and out of the house,
 6 you were maybe rolling out your bed at 8, half 8,
 7 sticking on a hoody or smart top and sitting in front of
 8 a screen so — and you weren't driving to work or
 9 whatever, so people didn't have those same restrictions,
 10 but there was a lot more alcohol in the home. And
 11 that's certainly what children had reported to us as
 12 well having access to alcohol as well. And — sorry —
 13 I think just going back to what I said earlier on about
 14 children having — more likely to be coerced into having
 15 sex, that was also as a result of having consumed
 16 alcohol as well.
 17 Q. At paragraph 34 you say that there was an assumption
 18 that children and young people were breaching lockdown
 19 rules all the time by going out, but you were being told
 20 the opposite as some of the children and young people
 21 you worked with said that it was beneficial for them to
 22 stay in their house because that would avoid them being
 23 exposed to external harms.
 24 A. Yeah.
 25 Q. What type of harms are you discussing there?

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1 A. So we had numerous examples of young people — and young
 2 women in particular, less so boys — but certainly young
 3 women in particular who were kind of proudly saying to
 4 us, "You know, it's been brilliant being at home because
 5 it means I've got an excuse. I can say to so—and—so
 6 that I can't get out, I can't see you, because I'm not
 7 allowed because Nicola Sturgeon has said we've got to be
 8 at home, we can't stay — we can't go out". And for
 9 a lot of young people it was a relief because
 10 previously, when they'd been out and about, they would
 11 be — as I said, be manipulated into engaging in
 12 activities that they didn't want to engage in. And by
 13 that I'm talking about rape and sexual assault.
 14 And that's what was happening to our children and
 15 young people on a daily basis prior to COVID because
 16 they weren't in control of what was happening and what
 17 was going on, whereas actually this was one way that
 18 they could take back control and say, actually, "I need
 19 to be at home. I can't get out. I'm not allowed out",
 20 because before — what a lot of people don't understand
 21 about exploitation and grooming in particular is it's
 22 not only the child that gets groomed. Often families
 23 are groomed as well and parents and carers. So
 24 actually — you know, offenders are very skilled in
 25 terms of the tactics that they use, so actually this

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1 way, you know, children and families were able to say,
 2 "No, no, so—and—so has to stay at home and they're not
 3 allowed out", which was, for a lot of children, you
 4 know, one, beneficial, but also a sense of relief in
 5 terms of, actually, "I'm not going to be forced into
 6 doing something I don't want to do because actually I've
 7 got a really good reason to stay at home".
 8 Q. You go on I think to caveat that by saying:
 9 "The unfortunate thing is offenders are always able
 10 to adapt to unusual circumstances."
 11 A. Yeah.
 12 Q. What ways did you see that manifest?
 13 A. Yeah, so very specifically young people spoke to us
 14 about how offenders were saying to them, "But you're
 15 allowed out for an hour's exercise every day, so you can
 16 get out, so see that hour's exercise that you're getting
 17 out for, that's when you come and meet me". Also
 18 parents and carers were — obviously they were keen for
 19 their child to get out and get exercise, get fresh air,
 20 so they were also kind of pushing the child to get out
 21 for that hour's exercise as well. And, unfortunately,
 22 for a lot of children, they felt exposed, and if you
 23 remember in the early days of COVID — or maybe it's
 24 just me looking at it through rose-tinted glasses — but
 25 the weather seemed much better and it seemed warmer and

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1 everybody was out and about and you had a spring in your
 2 step and people were going to parks and these kind of
 3 public environments. And basically that's where a lot
 4 of offenders were kind of coercing children into meeting
 5 them and sex would take place and harms would take
 6 place, whether that child wanted to or not.
 7 So it was very specifically around that hour's
 8 exercise time where children felt, I suppose, that they
 9 were coerced into being harmed. But also I think,
 10 certainly — I mean, when I think back, there was some
 11 children who had spoken about domestic abuse and tension
 12 in the home and lots of family arguments, so they would
 13 kind of sneak out the window — do you know what
 14 I mean? — and obviously we were all encouraged to
 15 provide devices for children, so access to social media,
 16 you know, increased exponentially. So people would
 17 actually contact — make contact with anyone that they
 18 saw as being able to kind of support them in their hour
 19 of need. So there was times both during the day and
 20 also covertly that children got out and were exposed to
 21 harm.
 22 Q. The types of harm that you describe and you talk about
 23 in terms of exploitation and sexual abuse, you talk
 24 about those in your statement really anecdotally and in
 25 generality. Do you know if statistics exist in relation

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1 to that?
 2 A. Not as far as I'm aware. I don't think so. I think one
 3 of the challenges was we weren't having — we weren't
 4 routinely having those multi-agency meetings that you
 5 would have where information would be shared across
 6 agencies. So we weren't able to kind of join the dots
 7 in terms of, "This is the information that we've got,
 8 this is the information that police has got", in the way
 9 that we map all the time. Both pre COVID and post
 10 COVID, that just simply didn't happen.
 11 It was interesting because, when I was thinking back
 12 and I was chatting to staff yesterday, we actually —
 13 it's funny how you kind of forget things and you
 14 shouldn't forget things — but actually we very vividly
 15 remember a young woman that we worked with, who was aged
 16 16 at the time, and she'd been raped and she wasn't able
 17 to tell anybody. She wasn't able to give a statement
 18 because she felt she wasn't able to leave the house.
 19 She believed that all police stations were shut, so she
 20 couldn't go into a police station even during that
 21 hour's exercise.
 22 So when you think back and you think how horrific
 23 was that — do you know what I mean? — that a child ...
 24 and it's hard enough for somebody who has been exposed
 25 to harm like that to actually tell, but even when you

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1 want to tell, thinking, "Actually there's no one to tell
2 because there's nowhere or no place I can go to tell".
3 So I think for that — I suppose when you think back,
4 you think it maybe wasn't the right thing to do in terms
5 of saying to people, "You can't go out" or "All these
6 places need to be shut". But simply in terms of
7 statistics, there was nobody who was recording.
8 Even in hindsight — you know, we would normally
9 record themes and trends and patterns and, you know,
10 unmet need, but because we were having to, you know,
11 kind of respond to so many different returns for local
12 authorities and also our own organisation and the
13 Care Inspectorate, plus we were also having to
14 risk-assess and those risk assessments would change
15 every three weeks and we were told by
16 Scottish Government about what we could do, what we
17 couldn't do and what was increasing, we didn't actually
18 routinely record some of those anecdotes to see whether
19 there was trends or patterns, and in hindsight that's
20 probably not the right thing to have done. But we were
21 all living in the here and now — do you know what
22 I mean? — and just focusing with what was happening
23 right now and what could be happening next week, in
24 a fortnight, so we just didn't. And there was nobody
25 who was kind of — I suppose kind of cross-correlating

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1 that information with other organisations in the way
2 that we did before and continue to do now.
3 Q. So you're now at a stage, I suppose, when you're able to
4 discuss matters with staff and able to reflect and maybe
5 identify some of the themes that at the time were kind
6 of overtaken by a lot of what was going on?
7 A. Yeah. Yeah, totally, because it was just — because
8 there was so much reporting to be done — there was so
9 much about like, you know, whether you could go into
10 somebody's house, how many people could be there, you
11 know, this just — all those different things about
12 where you could go, where you couldn't go — I suppose
13 that energy was just on all of that and, from my
14 perspective, my energy was also around supporting our
15 staff team. And we had two staff teams. You had one
16 that was working and you had one that was shielding.
17 And it was about trying to make sure that everybody's
18 needs were being met and it was about trying to make
19 sure that those staff who were shielding still felt part
20 of a team, still felt part of a service, and they tried
21 to support the colleagues who were working as much as
22 possible from their homes by doing simple things like —
23 so see, for instance, we were putting nurture bags
24 together or getting fidget toys and whatever — it was
25 them that were like on Amazon, identifying what to buy,

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

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

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1 that camaraderie in terms of working together and
2 supporting families.

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

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

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

24

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

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

25

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

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

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

25 A. No.

26

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

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

27

1 to have their children on their own.

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

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

28

1 whatever we could — you name it, we tried it — but
 2 sometimes we had to just say, "We can't do this". But
 3 we would always make sure that we were communicating
 4 with all the relevant organisations and looking at
 5 alternative means because, if there was, for instance,
 6 somebody else that that child had had a better
 7 relationship with, whether it had been a teacher or
 8 whether it had been a social worker or a youth worker,
 9 we would try to engage them to see if we could, through
 10 them, try to engage that young person.
 11 So the difficulty for us was that other
 12 organisations weren't as agile as we tried to make
 13 ourselves, so there was a kind of reluctance to try and
 14 get alongside us to try and support those young people,
 15 unfortunately.
 16 Q. I think in particular one of the elements that you say
 17 maybe wasn't agile or wasn't as thought through was that
 18 there existed these education hubs — sorry, this is at
 19 paragraph 50 of your statement — there existed these
 20 education hubs specifically for vulnerable young people
 21 and some people did access them, but you say the vast —
 22 first of all, the vast majority in your experience
 23 didn't, but also education departments wouldn't engage
 24 with you to let you go into schools and also help.
 25 A. Yeah. So in terms of some of the children that we've

1 worked with — so it was clear pre-pandemic that a lot
 2 of the young people actually needed support to be in
 3 school and to stay in school. Some of the children that
 4 we worked with wouldn't get past the first bell, so
 5 you're talking — they didn't. They weren't able to
 6 stay in school beyond half past 10, which might seem
 7 bizarre for a lot of people, but for a lot of children
 8 that we worked with, that was their daily life.
 9 So some of the work that we did pre-pandemic was
 10 being with them during playtime to kind of support those
 11 social interactions, to support them into that class
 12 after lunch, to maybe stay with them in that class or to
 13 do something different so that they were still in the
 14 school environment but they weren't necessarily in the
 15 classroom.
 16 When the hubs were set up, they were quite specific.
 17 So it was a case of — there was school staff deployed
 18 and there was children and no other agencies were
 19 allowed in, so those children that we would have
 20 supported to engage and interact with other children or
 21 simply to be able to have the confidence to stay within
 22 the school environment wasn't supported.
 23 Also a lot of children go to school not just to be
 24 educated but to see their pals and, when they were going
 25 to these education hubs — you'll know yourself, you'll

1 remember, that those hubs weren't for every child.
 2 Children were selected depending on vulnerabilities. So
 3 a lot of time when they went to school, their friends
 4 weren't there, so it was like, "There's no point in me
 5 going because — my best pal's not there so I'm not
 6 going", so children just didn't go and they weren't
 7 supported.
 8 Sometimes it was a case of — again, like I said, we
 9 worked with larger groups, sibling groups, so some
 10 children were going to school to the education hubs and
 11 some weren't, so again that became quite divisive in
 12 families. I don't think people were thinking through
 13 actually the impact that would have on families, where
 14 some children could go to school and some couldn't. So
 15 it was difficult for parents to actually get them to
 16 school because — in terms of being able to leave
 17 children unsupervised at home whilst taking other
 18 children to school, so it just didn't happen. It just
 19 didn't happen at all.
 20 Q. You also go on to say at paragraph 52 that, from your
 21 experience, there was little attempt made to get
 22 children to engage in online education. I wondered what
 23 you think was lacking and what could have been done
 24 better in order to get them to engage.
 25 A. I don't think people understood the fact that, as we all

1 do, children have different learning styles in terms of
 2 how they take in information, how they process
 3 information. Lots of the children that we worked with
 4 had one device between five — do you know what
 5 I mean? — so they couldn't actually access education
 6 individually. And I know — and that was a challenge
 7 for everybody. It wasn't — so I'm not having a go at
 8 education or anything like that, but also children — if
 9 you think about our intensive family support services,
 10 some of the reasons we got involved was because there
 11 was no structure in the family home, there was no
 12 routines, there was no boundaries. So what I'm talking
 13 about, there was no kind of strict bedtime routines,
 14 there was no one supporting with homework, there was
 15 no one making sure that you got up in time to be able to
 16 go to school — do you know what I mean? — so children
 17 routinely weren't prepared and weren't engaged and ready
 18 to engage in education.
 19 So it wasn't some — it wasn't a simple thing like,
 20 "Okay, we'll give you a laptop or we'll give you an iPad
 21 and you can just switch it on and access, go and — here
 22 we go". There was a lack of understanding about all the
 23 processes that come before you can actually switch that
 24 laptop on in terms of are you ready emotionally and
 25 physically and actually what's your attention span like

1 to be able to engage. Actually what children were
 2 saying to us was the information they got was boring, it
 3 was repetitive, it was the same stuff and it was of no
 4 interest to them and they just stopped engaging.
 5 Q. You talk about a particular category of the young people
 6 you supported, it being very difficult for, and those
 7 are the children that were transitioning between primary
 8 and secondary school, and you felt, I think, like you
 9 weren't able to support them adequately into that
 10 transition. Again I wondered what you think could have
 11 been done better in relation to that particular group of
 12 young people.
 13 A. I mean, I think for me one of the challenges was that we
 14 saw children as a homogenous group and actually, in
 15 terms of the children that we worked — children and
 16 young people we worked with, actually they had a whole
 17 range of needs, both emotional, behavioural, practical
 18 needs. I always remember, like, working with a child
 19 who — she had a really good experience in primary
 20 school and, when she got to secondary school, she
 21 stopped going. It wasn't until our staff got involved
 22 that we understood why she stopped going. The reason
 23 she stopped going was she couldn't tell the time —
 24 right? — and, because she couldn't tell the time, she
 25 didn't know what time she had to be from one class to

33

1 another class; right?
 2 Now, so if you think about primary school, you're in
 3 one class, you've got one teacher, you've got one set of
 4 classmates, it feels quite secure, it feels quite
 5 stable, and you've got children who are then going into
 6 a high school environment. So children didn't have that
 7 support to prepare in terms of what it's like to go to
 8 a school where it's bigger, it's larger, you've got to
 9 be — you've got to navigate from one school — from one
 10 class to another class that could be at the other end of
 11 the building, "How do I get there? How am I going to
 12 get there? Who is going to support me?".
 13 So, in terms of the work that we do, that's some of
 14 the things we would do with the families that we work
 15 with. We would support them to get to school, sometimes
 16 we would hang around, like I said, until the playtime
 17 bell and then help support them navigate to the next
 18 class — do you know what I mean? That wasn't
 19 happening. So suddenly children missed a whole year of
 20 education and then they were expected to know their way
 21 around the school, they were expected to understand, you
 22 know, how to get to different classes and be able to
 23 form relationships and behave — by "behave", I mean
 24 like, you know, be able to stay silent almost for like
 25 35 minutes in terms of that specific class when they

34

1 weren't used to doing that because actually, at home,
 2 they'd go and get a glass of water, they can go to the
 3 toilet. You know yourself — I mean, like, if there's
 4 something else that you can do rather than focus on what
 5 you're supposed to, you'll go away and do it. So they
 6 weren't used to sitting in one place for like even
 7 35 minutes, for us which seems — it's probably been
 8 35 minutes or longer that I've been sitting here and
 9 I can do it, but if you've not been used to that and
 10 suddenly that's outwith your comfort zone, it becomes
 11 quite difficult.

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

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

35

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

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

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

36

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

37

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

38

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

39

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

40

1 and there's no denial --- some people have left because
 2 they're not able to manage our expectations and that's
 3 unfortunate, but, for me, it's --- what I'd rather have
 4 is somebody with less experience but actually somebody
 5 who is willing to learn and somebody who is prepared to
 6 do the work that's required rather than somebody who
 7 thinks they can do it from home.
 8 THE CHAIR: Thank you.
 9 Ms Trainer.
 10 MS TRAINER: I think you say at paragraph 65 of your
 11 statement that you did lose some staff and the problem
 12 that you found is that none of them have been replaced
 13 like for like ---
 14 A. Yeah.
 15 Q. --- so it's been difficult to find people who have the
 16 same skill set as who have left.
 17 A. Yeah, so --- if you think about the number of people that
 18 were shielding, for instance, a lot of those people ---
 19 I'm saying "a lot" --- some of the staff that I had that
 20 were shielding didn't really recover, really struggled
 21 to come into work, were dead fearful, really scared,
 22 spent far too much time watching those news reels over
 23 and over and getting really worried. Some of those
 24 staff have gone on to jobs where they can have a better
 25 work/life balance, they can spend more time working from

41

1 home, for instance, and they were very experienced
 2 staff, very committed staff pre-pandemic. I'm not
 3 saying that they weren't committed during the
 4 pandemic --- do you know what I mean? --- but they had
 5 a different experience.
 6 What I've found is --- and, to be honest,
 7 pre-pandemic, recruitment was hard, but it's even harder
 8 now because lots of people have made different choices
 9 in their life in terms of what they want, in terms of
 10 how much contact they want to have with people who are
 11 vulnerable but also in terms of funding. We didn't have
 12 a cost of living rise and, even when we did, we offered
 13 our staff 1%. We had a one-off payment for staff which
 14 was taxed so it wasn't actually what people were
 15 anticipating. If you compare that to the public sector,
 16 rises of 9%/10% --- in real life, you know, if you think
 17 about cost of living, it's huge in terms of the
 18 challenges.
 19 I've got staff who go to food banks. Do you know
 20 what I mean? It's not about our families going to food
 21 banks, our staff are going to food banks. And these are
 22 qualified social workers who have chosen to work in the
 23 voluntary sector, but we cannot match the pay of the
 24 public sector and we are not getting the cost of living
 25 rises that people had in the past.

42

1 So in terms of recruitment it's become quite
 2 challenging in terms of what people's expectations are.
 3 Obviously, when you advertise a post, you advertise it
 4 full scale, people have expectations. I mean, just to
 5 kind of explain, during this whole process some of our
 6 services had been retendered and, when you put in
 7 a tender, the local authority expects you to submit
 8 salaries that are mid-scale, mid-point. Now, we've got
 9 staff who are already at the top of their scale, so
 10 already --- when we are going for tenders, we are already
 11 taking a hit because we know that the local authority
 12 are not going to pay us what we're currently paying our
 13 staff because we're only allowed to put in mid-point
 14 scales in the actual tender. So that becomes quite hard
 15 for an organisation to manage, if you think about the
 16 size of an organisation.
 17 And also, as an organisation, we also lost quite
 18 a lot of funding if you think about --- we get quite
 19 a lot of revenue from our shops. Our shops were closed
 20 during the pandemic so we lost a lot of revenue as well,
 21 so that's had a massive impact in terms of how --- in
 22 terms of the level of voluntary funds that we have and
 23 therefore we have had to prioritise where we spend our
 24 voluntary funds.
 25 Q. You also I think, within your statement, talk about

43

1 there being a distinction for some of your staff as
 2 being key workers and then some of them not and that
 3 having a financial implication.
 4 A. Yeah, that was horrendous. So one of my services is
 5 registered with the Care Inspectorate, and one of the
 6 advantages of that actually was we got access to PPE and
 7 we got access to PPE very early and we also got access
 8 to vaccinations, which was fantastic, and we had this
 9 routine where we phoned in for a PPE order and picked it
 10 up. It worked like clockwork. But one of the
 11 disadvantages was that the only workers that were
 12 recognised officially by Scottish Government as being
 13 key workers were those that were registered with the
 14 Care Inspectorate and local authority workers. Bearing
 15 in mind the local authority workers --- a lot of them
 16 work from home, whereas my staff didn't, so a small
 17 group of my staff were given a £500 bonus for being
 18 key workers and for doing the work that they did. That
 19 included my manager incidentally --- do you know what
 20 I mean? --- and I had a whole heap of staff who aren't ---
 21 whose services aren't registered with the
 22 Care Inspectorate who got nothing.
 23 And my manager at the time, to be fair, tried to
 24 find a way of being able to give his £500 to --- you
 25 know, being able to --- because, like me, myself,

44

1 I didn't want the £500, I wanted staff who were doing
 2 that front-line work but who weren't working in
 3 a service that was registered -- but there was no
 4 physical way of doing that and we weren't actually
 5 allowed to do that. But there was this discrepancy in
 6 terms of -- and it felt means--tested, for want of
 7 a better phrase, in terms of who got and who didn't get.
 8 And actually a lot of workers who got that money weren't
 9 front-line workers actually in terms of actually what
 10 they were doing. But something like two-thirds of my
 11 staff didn't get that.
 12 And £500 doesn't seem like a lot of money and for
 13 staff it wasn't about money, it was about being
 14 valued -- do you know what I mean? -- and actually being
 15 respected in terms of what they were doing and actually
 16 the danger that they faced, because at that time we
 17 didn't know what was going on but they were still
 18 prepared to take some of those risks and it just wasn't
 19 recognised, which was, I think -- I think it was a real
 20 shame and a really poor decision actually.
 21 Q. You talk a bit about local authorities and
 22 social workers who are employed by local authorities and
 23 your contact with them. At paragraph 77 you say you
 24 were able to communicate with local authorities but you
 25 never saw them.

1 A. Yeah.
 2 Q. You go on to explain that things like child protection
 3 conferences, children's hearings, things that were
 4 traditionally very important meetings in person
 5 completely changed.
 6 A. Yeah.
 7 Q. How do you think that had an impact on the people that
 8 you were serving?
 9 A. I think we forgot about why we were there in the first
 10 place and, if you think about children's hearings in
 11 particular, it's a child's meeting and it's the child
 12 that's -- we say this all the time. Children are at the
 13 centre. The child is at the core. It's their meeting.
 14 They determine who is at the meeting and they can also
 15 have -- they've also got the ability to speak to panel
 16 members, for instance, on their own. Children's
 17 hearings just didn't happen. They just did not happen.
 18 And some of that was about not having the technology.
 19 Some of that, I think, was about the fact that schools
 20 were closed and people weren't working in the same way.
 21 So statutory workers weren't seeing workers so there was
 22 delays in children's hearings because there was no
 23 ability -- well, there was less ability for those
 24 workers to compile reports and to be able to share
 25 assessments. So actually children simply weren't seen

1 and their needs weren't recognised. It was a real
 2 struggle to try and get children's hearings and, even
 3 when they did start, for children to be present.
 4 There was no recognition about how we got children
 5 there. There was no recognition -- like, again, because
 6 there was no schools, schools weren't open, it was quite
 7 difficult for parents to leave some children at home and
 8 bring other children, so it just didn't happen. From
 9 a very practical perspective, they didn't have somebody
 10 to look after, like, a baby, so they couldn't bring the
 11 baby along because we were quite strict about how many
 12 people could be in the room.
 13 I myself have been in children's hearings where
 14 there's like two rows, there's that many people in the
 15 hearing, but the numbers were restricted and there was
 16 no recognition about who the child wanted in the room.
 17 You know, there was other adults who were making some of
 18 those decisions.
 19 We were having child protection case conferences on
 20 the telephone. That was before even things went online.
 21 And even when things went online, people would have
 22 their cameras off. That was both professionals and
 23 family members. Now, I think all of us have had
 24 technical issues but sometimes that felt quite
 25 deliberate in terms of not being on screen. It felt --

1 particularly when you're on the phone or you were
 2 online, you didn't know who else was in the room.
 3 I remember myself like going to a child protection
 4 case conference, which wasn't unusual actually,
 5 pre-pandemic, where I hadn't met the child, I hadn't met
 6 the family, because sometimes, when we had referrals, we
 7 might use that environment as our referral meeting, so
 8 it was more an information-gathering setting -- rather
 9 than, you know, meeting a family and speaking about
 10 their issues, it was more about information-gathering.
 11 But I remember like -- it was a particular case, it was
 12 a child, she was 16, she was pregnant, she'd been the
 13 victim of sexual exploitation, she'd been raped and her
 14 pregnancy was as a result of that rape, so quite
 15 a difficult experience. She herself had addiction
 16 issues. She was living at home and, although home was
 17 a safe environment or safer environment, her mum,
 18 although supportive, had an abusive ex-partner, so this
 19 child had been exposed to domestic abuse.
 20 So there I was, on the phone with a child and her
 21 mum, who I had never met, with no awareness of who else
 22 was in that home, whether that violent ex-partner was in
 23 the home, trying to have very difficult conversations
 24 about her vulnerability and about how she was going to
 25 keep her child safe, how she was going to take

1 responsibility for keeping this child away from the
 2 offender, who was also the father of the child and had
 3 parental rights. So quite a difficult experience.
 4 And also I was very wary about not asking
 5 inappropriate questions. And you know that way in
 6 a meeting before, if you're in a face-to-face meeting,
 7 you could kick somebody under the table or you could
 8 scowl at them in terms of, "Don't be silly asking that
 9 question", we couldn't do any of that. So I found that
 10 whole experience very uncomfortable because I found
 11 people in the meeting asking questions that I didn't
 12 think that were appropriate because we had no way of
 13 knowing who was in the room. But also it wasn't -- we
 14 weren't able to see that person's reaction. You know --
 15 because you know that way sometimes you think that this
 16 person is very uncomfortable with what you've just
 17 asked, so you know to stop or to take a break, "Let's
 18 give the person five minutes, ten minutes". We weren't
 19 able to do that and we weren't actually doing that. We
 20 weren't thinking about "Let's take a break"; do you know
 21 what I mean?
 22 Actually I think one of our biggest failures is that
 23 we continued to have some of those meetings online
 24 because I've heard colleagues in the statutory sector
 25 say, "They're efficient, they're effective". But

49

1 they're efficient and effective for them. They're not
 2 efficient and effective for the child or for the
 3 family -- do you know what I mean? -- because we can get
 4 a meeting done and dusted in an hour or half an hour.
 5 Do you know what I mean? We're not taking that child's
 6 needs and I think we've lost all sense of why we're
 7 there.
 8 And we just soldier on because -- and I'm sure
 9 everyone sitting here, your diaries have got
 10 back-to-back meetings -- do you know what I mean? -- so
 11 everyone is really struggling for time. So for us it's
 12 efficient and effective but for the child absolutely
 13 not, and I do think we need to rethink that. And
 14 I think certainly during that time we lost sense,
 15 I think, of what was important and who was important and
 16 meeting those children's individual needs.
 17 THE CHAIR: That's a pretty important statement, if I may
 18 say so.
 19 A. Sorry?
 20 THE CHAIR: It's a pretty important statement, if I may say
 21 so.
 22 A. Thank you. But I think -- for me I think it's -- for me
 23 that's really basic -- really, really basic. But we
 24 lost all sense of what was important.
 25 THE CHAIR: Maybe that's why it is important.

50

1 A. Thank you.
 2 MS TRAINER: One of the general trends that you talk about
 3 as a result of the pandemic and the people that you work
 4 with is that you say that generally there was a distinct
 5 period of time that you could identify that you were
 6 working with families and children, and I think you say
 7 from this statistic you see that to be around ten months
 8 or so prior to the pandemic. At paragraph 87 you go on
 9 to say that this is now far, far greater.
 10 A. Yeah.
 11 Q. I wondered why you think that is and why you're working
 12 with families much longer than you were previously.
 13 A. Yeah. It's interesting and I'll give an example. I had
 14 a member of staff who was recruited and started during
 15 the pandemic, so she started in October 2020, and her
 16 caseload -- 60% of her caseload currently -- and she
 17 works in our exploitation services -- about 60% of her
 18 caseload is young people that she started working with
 19 in October 2020. We're nearly four years on. And those
 20 young people were aged 12 at that time, so 15/16 now.
 21 The reason I think it's a lot longer is because we
 22 weren't actually able to do the work that we would
 23 ordinarily do in terms of therapeutic work and also
 24 talking about the harm that they had been exposed to,
 25 were being exposed to, because it was just about trying

51

1 to build a relationship and it was about dealing with
 2 that huge uncertainty which was the pandemic, and that's
 3 what everybody focused on -- do you know what I mean?
 4 So we actually didn't get into the detail of why we were
 5 involved, and some of that was also because we didn't
 6 have a private space to be able to have that
 7 conversation.
 8 Sometimes it was about recognising that where they
 9 were living wasn't home -- sorry, wasn't a safe
 10 environment so we didn't want to be having those
 11 conversations and then placing that young person in
 12 a kind of unsafe environment again -- do you know what
 13 I mean? So a lot of that initial work for the first two
 14 years was about holding them. Some of that was about
 15 helping them with education actually, so children who
 16 weren't going to school. So we were helping them with
 17 their reading and writing, which I know seems really
 18 basic, but actually we were trying to, you know, support
 19 those young people. Some of it was about socialisation
 20 because they weren't used to being around their peers.
 21 Some of it was about managing living at home with --
 22 and, you know, being around their brothers and sisters
 23 and their family members. So it wasn't the work that we
 24 would ordinarily do -- do you know what I mean?
 25 Then it takes a bit of time to break that pattern

52

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

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

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

1 happen, when it's going to happen, so therefore you need
 2 to find something else for this child", rather than
 3 thinking, "I can stop worrying about this child because
 4 Barnardo's are going to do something. I'm not quite
 5 sure when, but they're going to do something". And what
 6 we're clearly saying is, "No, we're not going to do
 7 something. You need to go and find something else to
 8 do".
 9 But our staff --- and my team manager yesterday was
 10 talking about her worry --- we were putting together an
 11 annual report and she was talking about that worry in
 12 terms of the length of time it's taken us to pick up
 13 support for a family because they've had to wait because
 14 we've not had capacity, and I'm like that, "That's not
 15 your worry", because actually, up until the point we
 16 engage with that family, they're not our
 17 service users --- do you know what I mean --- and somebody
 18 else needs to make those decisions. And it sounds
 19 really harsh, but actually somebody else needs to take
 20 responsibility for ensuring --- because we don't have
 21 a statutory responsibility for those families, somebody
 22 else does, and they've got resources that we don't have
 23 so it's their responsibility and we need to be really
 24 clear on that.

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

1 Ms Trainer.

2 MS TRAINER: I'm grateful, my Lord.

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

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

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

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

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

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

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

57

1 them and the home environment wasn't protective. We
2 don't understand that sometimes children need to act out
3 and, by acting out, that's their way of telling us that
4 they are distressed, that they are traumatised, and
5 that's particularly relevant for boys. So we see that
6 acting out behaviour as a problem and we see children as
7 being aggressive and violent rather than seeing children
8 trying to tell us something.
9 Pre-pandemic, I remember lots of boys that I've
10 worked with over the years who have said to me, "My way
11 of telling you something's wrong is by getting into
12 a fight", "My way of telling you I'm upset and
13 distressed is by getting into a fight, and that's my way
14 of self-harming". We need to understand that behaviour
15 is about children trying to tell us something. It's not
16 poor behaviour, it's not — and what we've got is
17 saying, "Our schools can't cope. We need to exclude
18 these children". We need to understand where is this
19 behaviour coming from — do you know what I mean? — and
20 that's about the harms children have been exposed to and
21 continue to be exposed to and that's not what we're
22 talking to them about.
23 Q. Those I think are all the questions I had for you.
24 We're now quite close to running out of time but
25 I wondered if there was anything else that we haven't

58

1 covered that you thought it was important to raise
2 today.
3 A. Okay. So just two very quick things, so, one, for me —
4 I know obviously none of us had ever experienced this
5 before, but I think — if ever we have something like
6 this again, I think we really need to consciously think
7 about is staying at home the best thing because, for
8 some children, staying at home was very damaging because
9 home was not a safe place; right? We can't assume that
10 a home environment is safe.
11 And the second thing for me is we had a whole group
12 of workers who were out there — like my staff were —
13 out there working and we had a whole group of staff who
14 were at home, and one of the challenges for workers
15 today is that actually some of that group of staff who
16 were at home have been churning out guidance, policies,
17 legislation — right? — and we've got a workforce who
18 is overwhelmed with The Promise, UNCRC, all the raft.
19 And whilst we all embrace all of that, a lot of workers
20 are just like that, "I'm overwhelmed. I don't
21 understand it. I don't know what's going on". So
22 I think we need to strike a balance where we support
23 people to do their job, which is fundamentally keeping
24 a child at the heart, at the centre, making sure that
25 child's voice is included, and next time let's include

59

1 children's voices and ask children and young people
2 about what they think we should be doing rather than,
3 "This is what we need to do and this is how we need to
4 do it". So that's me. Hopefully I've not gone over
5 time.
6 MS TRAINER: Thank you.
7 THE CHAIR: Thank you very much for your very helpful
8 evidence.
9 A. Okay. Thank you.
10 THE CHAIR: Good. Quarter past 11.
11 (11.00 am)
12 (A short break)
13 (11.15 am)
14 THE CHAIR: Good morning.
15 Ms Trainer, when you're ready.
16 MS TRAINER: Thank you, my Lord.
17 MS CAROL—ANN CROSSAN GURUGE (called)
18 Questions by MS TRAINER
19 MS TRAINER: Good morning. I wonder if you could start by
20 saying your full name.
21 A. Yes, it's Carol—Ann Crossan Guruge.
22 Q. You are a children's services manager at Barnardo's
23 Scotland; is that right?
24 A. That's correct, yes.
25 Q. And I think you tell us that you cover the Highlands and

60

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

61

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

62

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

63

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

64

1 Q. At the time of lockdown in 2020, you were working within
2 Northern Lights?
3 A. That's right.
4 Q. And in your statement you tell us at --- I think starting
5 from paragraph 19 about the working patterns and
6 routines that existed before that period.
7 A. Yeah.
8 Q. I take it from what you're saying that, as soon as the
9 lockdown happened, that all required some quite radical
10 change?
11 A. Yeah, absolutely radical.
12 Q. Can you tell us what happened and the course that it
13 then followed?
14 A. Yeah, so previously --- before lockdown happened, the
15 staff kind of worked on a rota. It tended to be 12-hour
16 shifts. We've kind of changed that in the duration of
17 the time that we've had it to meet the needs of the
18 service and to meet the staff --- we are always
19 constantly reviewing that.
20 Just before lockdown actually, when there was
21 discussions about kind of socially distancing and
22 potential lockdowns happening, quite a lot of our young
23 people were kind of struggling with that and not really
24 understanding it. We also didn't understand it. We'd
25 never experienced anything like that before. We looked

65

1 at what might happen and we decided as a team ---
2 actually it was a group of us who were having
3 discussions about this, and I suppose back then none of
4 us knew what this was, none of us knew what was going to
5 happen --- and we decided that, if there was a lockdown,
6 that the safest option for our young people and for us
7 to protect the workforce but to protect the young people
8 as well and give them that stability --- that we felt
9 that we should lock down with them as families were, and
10 obviously that is quite a radical thing to do.
11 So we had actually initially discussed that as
12 a team, a few of us --- our colleagues, we talked ---
13 there were three of us at the time --- and before we even
14 discussed it with Barnardo's or the local authority, we
15 agreed that we wanted to put this option on the table.
16 We spoke to our families first to check that they would
17 be okay with it. Our families all were supportive of
18 it. And then we took it to kind of Barnardo's and
19 discussed it and then we took it to the young people to
20 discuss it with them, to check they were happy with it.
21 What we did was --- there was a team of six of us and
22 we did a week each basically. So we moved into the
23 house on the Wednesday --- before we moved in, we were
24 testing and we were obviously following guidance --- and
25 we moved in on the Wednesday and then moved out on the

66

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

67

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

68

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

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

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

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

1 care homes for children.”

2 I wondered if you could maybe explain a bit further
3 why you think it should have been tailored to the
4 settings that you were working in.
5 A. Yeah. So I think it was — it’s really difficult when
6 you, you know, categorise a care home because they are
7 very different and actually every children’s home is
8 very different. They’re managed differently. There
9 will be, you know, the same sort of scrutiny and the
10 work of the Care Inspectorate and guidance, but they do
11 operate differently. So I think from when I — when we
12 were looking at the guidance, we had to follow the
13 guidance from Scottish Government but we also had to
14 follow Barnardo’s guidance, and they aligned, but it was
15 trying to manage it all. And actually it was actually
16 easier for us to go into lockdown as a family than it
17 was to try and manage all that guidance because we just
18 locked down. I think for other services it would have
19 been really difficult because you had a staff team who
20 were also trying to manage what was going on and then
21 come into work, so I think it didn’t capture enough for
22 looked-after children.
23 Q. You then go on to say at paragraph 16 that you thought
24 some of the guidance was quite unrealistic.
25 A. Yeah.

73

1 Q. I wondered if you could explain that further.
2 A. So I recall there being guidance about, you know, having
3 areas in the house that were red zones and green zones
4 and things like that and, you know, walkways and stuff.
5 When you think about children’s homes, what we’re trying
6 to do, it’s their homes, so this is the children’s home.
7 So if I was going into my home and putting that
8 guidance in for my child, they are not — teenagers are
9 not going to abide by that. “This is my home. Why
10 would I have a red zone and a green zone and one-way
11 systems round the house?”. So it was just things like
12 that then — we were trying really, really hard to make
13 these as homes for children and not institutions, so
14 having a lot of this felt like an institution for young
15 people.
16 And, you know, we were lucky that — we followed the
17 guidance, but because we were locking down with the
18 young people, we lived as a family, so we didn’t have to
19 have one-way systems in place.
20 Q. You also say at paragraph 31 that another difficulty
21 that you faced was that that guidance was just
22 constantly changing —
23 A. Yeah.
24 Q. — and that meant that people were really getting burnt
25 out by how much work they had to do in order to keep up

74

1 with those changes. Can you think of any examples of
2 that or tell us more about it?
3 A. I can’t think of any examples, but just trying to
4 navigate it all at the time while for us our priority
5 was keeping our young children safe — that was the
6 priority and making sure that they found what was coming
7 out, because they were watching the news regularly and
8 they were seeing — and it was quite scary, it was quite
9 scary for all of us, so we were trying to protect them
10 as well. So having to do that and spend time with young
11 people and then having to constantly update your risk
12 assessments and — which we have to do anyway, but it
13 was changing so quickly, trying to keep up was really
14 difficult, I guess while you were trying to process
15 everything that was going on.
16 Q. Were you able to explain what was going on to the young
17 people that you were living with? How did they find it?
18 A. Yes, we were, but again there was lots of questions and
19 we couldn’t answer all those questions, so we were in it
20 together really. We were kind of learning it together.
21 And I do remember one of our young people before
22 lockdown had happened had said, “Why do I have to
23 socially distance? Youse come into work all the time so
24 it’s not that bad”, but the minute we locked down, that
25 was — they got it. They were like, “This is really

75

1 serious”, so it was — again for them it really helped
2 because they were like, “This is actually really
3 serious”.
4 Q. As part of the experiences that you had within the
5 residential setting, I think you mention that some of
6 the young people were on court orders, compulsory
7 supervision orders, effectively were legally regulated
8 that they were staying there, and that I think as
9 a consequence is that they have to have children’s
10 hearings.
11 A. Yes.
12 Q. You discuss children’s hearings within your statement at
13 paragraph 44 and you say:
14 “Interaction with the Children’s Hearings System
15 during COVID was [just] not great I would say.”
16 A. Yeah.
17 Q. Tell us more about that.
18 A. So we didn’t have that many hearings that took place,
19 but the ones that we did, you know, they were online,
20 so, again, it’s that young person’s safe space. When
21 hearings — if hearings are particularly difficult for
22 young people, they’re happening in their safe space,
23 which is their home, and that wasn’t easy for them and
24 then they had nowhere to go from there. So, in my
25 experience, where hearings have happened face to face,

76

1 not all young people like that and don't always like to
 2 attend, but they can go back to a safe space, so --- and
 3 the workers that are there with them will be able to
 4 support them with that and almost help them manage
 5 what's going on. But when they were happening in their
 6 home, that was really difficult for young people because
 7 where did they go when they wanted to have space.
 8 Q. I think you also say young people should have been given
 9 a choice but the choice was taken away from them, they
 10 weren't given one.
 11 A. Yeah. At the beginning I think I recall that just all
 12 hearings were done virtually and then it kind of phased
 13 out, but at the time they were all virtually, from my
 14 experience.
 15 Q. You also mention that that practice, the practice of
 16 them being online, continued even after lockdowns had
 17 ended and some meetings were able to go back to face to
 18 face, but some children's hearings didn't do that.
 19 A. Yeah.
 20 Q. How did that have an impact?
 21 A. Yeah, so there was a few hearings that definitely
 22 didn't --- could probably have been face to face.
 23 I think there were still restrictions in place but the
 24 world was kind of opening up again. I think
 25 that happened --- I think there was only one that we were

77

1 part of that happened virtually and it didn't go well.
 2 Again it's because the young people should be given
 3 a choice if they can --- if it's virtual or face to face.
 4 And, like I say, they might not want to do it face to
 5 face, but if they've got the choice, then they're making
 6 that choice and they're empowered to do that.
 7 Q. What are some of the reasons you think they might opt
 8 for a face-to-face children's hearing?
 9 A. For young people?
 10 Q. Yes.
 11 A. I think it depends on the young person, but I think it
 12 is a process for them. So it's like "I'm going to
 13 somewhere" rather than "I'm having to join on a computer
 14 screen". The other example might be because the people
 15 that are joining the hearing, who may be their parents
 16 or family members, might not have access to online or
 17 might not understand how to use online, so the young
 18 people may feel, if it's face to face, then they'll
 19 come, whereas if it's online, they might not come or
 20 they might not --- and they might find accessing it
 21 really difficult.
 22 Q. People who are important to them might be missing?
 23 A. Yeah, absolutely.
 24 Q. You go on to discuss generally the impact on young
 25 people that you experienced within the service and you

78

1 say at paragraph 49 that:
 2 "Initially the young people just didn't understand
 3 what was going on."
 4 Do you have any particular view on whether messaging
 5 and guidance was or should have been geared towards
 6 young people?
 7 A. Yeah, I think we probably could have done a bit more
 8 with that. We all had the information that was coming
 9 out. I mean, the news was constant, you know, there
 10 were notifications and things, but I think at the time
 11 everybody --- it was so unknown for everybody that people
 12 were just scared as well. So if we knew what we knew
 13 now, we would be able to adapt that and make it really
 14 young-person friendly. I don't think we did that as
 15 good as we could have.
 16 Q. How do you think it could be adapted?
 17 A. Even using sort of social media and things like that,
 18 sending them messages that --- it would be hard to say
 19 exactly what could have been done because back then we
 20 didn't actually know what this looked like so the
 21 response was to safeguard everyone, which was the right
 22 response, but the information coming out was just
 23 changing so rapidly that it was hard to reassure young
 24 people that this was going to be okay when we actually
 25 didn't know if it was going to be okay.

79

1 Q. I wondered if you thought that there is a difference
 2 between just generally young people who are getting
 3 messages and reading the media about the pandemic and
 4 the young people who are being looked after by the local
 5 authority, whether it's in your residential care
 6 settings or whether it's in foster care or something
 7 like that. Do those two groups of people have different
 8 needs and what are they?
 9 A. Yeah. Well, I think young people that are in
 10 residential care --- there will be a number of reasons
 11 why they're in care, so they've suffered trauma, so they
 12 might be more scared, they might not understand what's
 13 going on, they don't have the safety net of a family
 14 around them. That would be difficult for them when
 15 something really scary is happening in the world, that
 16 they don't have the security of their family around
 17 them.
 18 Q. You go on to discuss families and the birth families
 19 that were around the children who were residing within
 20 Northern Lights and you say at paragraph 56 that you had
 21 mixed communications regarding contact and you remember
 22 that being a very --- a particularly difficult issue at
 23 the time.
 24 A. Yeah.
 25 Q. You go on to say that firstly some children had

80

1 a generic letter which essentially said no contact
2 should take place.

3 A. Yeah.

4 Q. Can you tell me more about that happening and who did
5 the letter come from?

6 A. I can't recall that -- I can't recall it coming directly
7 to me but I recall there being discussions around it and
8 there was a lot of -- it felt at the time that young
9 people that were in care -- it was like just shut off,
10 that they just have to either stay in care or go back to
11 their families. Then obviously contact would generally
12 take place -- depending on the young person's needs and
13 what the arrangements were with the family -- it varies
14 with every child -- but they may have contact in their
15 homes, they may live in a residential care home but
16 might spend a lot of their time with their family, their
17 home family, and then return to the residential home,
18 but that obviously couldn't take place.

19 So that -- for some children that would mean that
20 there might be other children in the family like
21 siblings living at home, but they lived in a children's
22 home. That just stopped because they couldn't go into
23 another household, which was really difficult.

24 And at the time -- again, we were very lucky because
25 of where our house is. So where we lived, we've got

81

1 a lot of land round the house. So we were very lucky,
2 again, that we had good weather, that we were able to
3 put a number of gazebos up and distance them from the
4 house, where we could have family visits in the gardens
5 and have kind of socially distanced contact. It wasn't
6 the same as going to your family home and spending time
7 as a family, but that was a solution that we did have
8 that maybe others didn't. We could create spaces within
9 the grounds.

10 Q. When you say that the children couldn't or weren't
11 allowed to go to the homes of their birth families for
12 the contact that they perhaps typically had, who told
13 them that they couldn't and where did that come from,
14 do you know?

15 A. So following the guidance, entering different
16 households. So if we were one household and one bubble,
17 so they couldn't go into another household or another
18 bubble.

19 Q. And were you told that by either -- you took that from
20 the guidance or was it from the local authority or was
21 it you as an organisation yourself decided that?

22 A. No, it was from the guidance from -- we were all
23 following the guidance, so -- the local authority at the
24 time were following the guidance. We were all managing
25 the situation safely. When things did relax a bit

82

1 better and the households became more -- we were able to
2 opt into that, but at the beginning contact with --
3 going into other homes, we couldn't do.

4 Q. Is it your understanding that social workers and the
5 local authority prevented contact from happening as well
6 between birth families and ...

7 A. I don't think they prevented it. I think they were
8 trying to do everything they could to keep it happening
9 but safely.

10 THE CHAIR: Can I ask a question? This is a rather
11 technical question. Ms Trainer will keep me right if
12 I get this wrong as a matter of law. But paragraph 56,
13 the first two sentences:

14 "We had mixed communications regarding contact and
15 I remember it being really difficult at the time.
16 Initially I remember some young people had received
17 a generic letter stating that there would be no contact
18 which was really hard."

19 A. Yeah.

20 THE CHAIR: Now, I was reading that as that letter came from
21 the Social Work Department, the local authority.

22 A. Yeah, I think it did come from the Social Work
23 Department at the beginning. I'm not sure -- I can't
24 recall the letter itself. I just remember there was
25 a clear -- that they couldn't have contact at that time.

83

1 THE CHAIR: You say there "some young people" and I had read
2 that or interpreted it as meaning that that would be
3 young people who were looked--after children, who there
4 was a responsibility resting with the Social Work
5 Department and the local authority --

6 A. Yeah.

7 THE CHAIR: -- but I think you also said earlier in your
8 evidence that not all children that resided with you
9 fell into that category so they might have been the ones
10 that didn't receive that letter. Would that be --

11 A. Yeah, that would be correct.

12 THE CHAIR: I think I understand that. Thank you.

13 MS TRAINER: You also mention there being a communication
14 and a discussion at the time about whether children
15 living in residential accommodation could just go
16 home --

17 A. Yeah.

18 Q. -- to their birth families and live there during the
19 lockdown period.

20 A. Yeah.

21 Q. You say:

22 "I am sure this was asked by social work. To me
23 this was a crazy idea."

24 A. So, yeah, there was young people -- and that would be
25 very individualised as well. So especially where young

84

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

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

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

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

85

1 actually impact our young people within our home.
2 Q. You obviously say to me this was a crazy idea and you
3 say that you didn't agree with it.
4 A. Yeah.
5 Q. Why do you say that?
6 A. Because if young people can be at home full-time, they
7 should always be at home full-time. I think that where
8 young people can have — and this is again my opinion —
9 where there's young people that may need respite, that's
10 different, but if you can live with your family at home,
11 you should always be at home with family, with support
12 if needed.

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

18 A. Yeah.

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

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

86

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

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

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

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

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

21 A. Yeah.

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

87

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

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

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

17 Q. Did you ask?

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

88

1 he didn't feel that he'd got anywhere, whereas, if I'd
 2 been there, that support would have been there for him,
 3 whether to advocate for him or guide him or just be
 4 present with him, whatever he needed.
 5 Q. You go on to talk about generally there being changes to
 6 the services as a result of the pandemic. One of them
 7 you've already mentioned, I think, which is that now
 8 there is a change to working hours because of the
 9 arrangement you had in place. I wondered if you could
 10 tell us a bit more about how that has had a longer-term
 11 impact.
 12 A. I think that's actually impacted really positively
 13 actually for our young people. So when we kind of
 14 decided to do the lockdown rota, as it was, for a week
 15 on, when we were phasing out of that we looked at how we
 16 best do that so that the young people had that
 17 consistency and that — we just managed to transition
 18 it. Then, when we spoke to the wider team about what
 19 they felt — when we do these things, we speak to the
 20 staff and we speak to the young people and we take
 21 everyone's voices into consideration — and then people
 22 were quite happy with the idea of doing more hours,
 23 but — you know, not as many as a week but having a kind
 24 of block.
 25 The young people liked the week on, we had really

89

1 a lot of positive feedback about that, so then we moved
 2 to the sort of two and three model, which was sort of
 3 two sleepovers and then three days, and that does work
 4 really well. I think for the young people it does give
 5 them that consistency. They have a kind of idea of who
 6 is on. There's less people coming in and out as well.
 7 So if you have people that are on back shifts and day
 8 shifts, you have more people coming in. So there's less
 9 people. You just have three people a day and it's just
 10 consistency for the young people.
 11 Q. I suppose that might feel more like a home
 12 environment —
 13 A. Yeah.
 14 Q. — rather than a kind of work shift pattern.
 15 A. Yeah, definitely.
 16 Q. Is that something that is in place now?
 17 A. Yeah, absolutely. Yeah.
 18 Q. From 2021 I think you say that you were in charge of
 19 what's called the "Springboard Service".
 20 A. Yeah, that's the after-care service.
 21 Q. I wondered if that service has seen any longer-term
 22 impact.
 23 A. I can't say from my experience the impact of COVID.
 24 I wasn't — I was involved with Springboard at the time
 25 but I wasn't directly managing the service at the time,

90

1 and the service is growing and developing naturally
 2 anyway. So I wouldn't be able to say — I wouldn't be
 3 able to give an example of any impact on that service.
 4 Q. In general terms, you make the comment within your
 5 statement that we've already discussed, that the
 6 guidance wasn't young-person-friendly. At paragraph 80
 7 I think you conclude by saying specifically that there
 8 should have been a more considerate response for
 9 different demographics of people. One of those
 10 demographics is looked-after children and young people.
 11 I wondered, do you feel as if that's a demographic that
 12 was perhaps forgotten about?
 13 A. From my experience, yes. I think I recall the guidance
 14 being social care guidance and there would have been
 15 a reference to looked-after children but I don't know
 16 that it was specific enough, not from what I had saw
 17 anyway.
 18 Q. And what would have helped you, if you're able to say?
 19 It's difficult looking back now, I can appreciate that,
 20 but can you think of any examples of things that we
 21 could do differently?
 22 A. I can't think of any examples, but I think at the time
 23 we were launching with The Promise, The Promise has been
 24 really heavily in the news and things, which is
 25 fantastic, so it would have been a good time to think

91

1 about The Promise in terms of lockdown and what that
 2 looked like for young people.
 3 I think we can't forget that it was a really
 4 difficult time for people and people were just trying to
 5 do the safest thing possible. We were very lucky with
 6 our service because we had a really good support team
 7 around us, we had a good senior management team, we were
 8 supported to do what we needed to do for our young
 9 people and we were able to respond to the needs of the
 10 young people. So I wouldn't be able — if I was to say
 11 I would go back and do something differently, I probably
 12 wouldn't do anything differently because I think what we
 13 did at the time was the right thing to do and it worked
 14 really well. But we were also very lucky to do that and
 15 that was because of the support that we had from the
 16 organisation, the support we had from the local
 17 authority, and also where we were located. That was
 18 a big part of our decision in terms of the layout of the
 19 house and what we had there. That wouldn't have been
 20 possible for all children's homes to do that, because of
 21 the size of the building for example.
 22 So I don't think there would be anything specific
 23 that I would go back and say we would do differently.
 24 Q. You mentioned there The Promise and that perhaps we
 25 maybe should have thought a bit more about the

92

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

93

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

94

1 terms of well-being meetings and discussions and things
 2 like that, but we also made sure that we would have,
 3 again, similar to what other families did, that we would
 4 have our kind of quiz nights as well. So all the team
 5 would join in, and the young people, when we were doing
 6 it from the residential home and we would have the kind
 7 of big screen up and we would have quiz nights and the
 8 young people would take part and things like that, so we
 9 did all that as well. That was about making sure that
 10 the staff that weren't part of what we were doing still
 11 felt part of it as well, and obviously the young people
 12 could continue the relationships with the staff that
 13 weren't living with them at that time. So that was
 14 obviously really good too.

15 But I think overall, in terms of impact, it actually
 16 was a really good experience for our team and we didn't
 17 actually have any negative impact from it.
 18 Q. And thinking about there being, I suppose, two separate
 19 workforces, one who is involved in the caring and is
 20 effectively living within the residential setting and
 21 one who is not able to do that for whatever reason,
 22 after the pandemic how has it been re-integrating those
 23 two groups of people?
 24 A. Fine, yeah. It's been all — yeah. So when we started
 25 to phase into the kind of different shift pattern, we

95

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

96

1 THE CHAIR: Yes, thank you very much for your evidence.
 2 A. Thank you.
 3 THE CHAIR: I appreciate that.
 4 Now, we've finished sharp. Normally, I'd see if we
 5 can get the next witness in earlier. I suspect that's
 6 not going to be possible for the next witness who has
 7 some special needs, so I think it has to be 1.30. I'm
 8 sorry about that, but thank you.
 9 (11.59 am)
 10 (The short adjournment)
 11 (1.28 pm)
 12 THE CHAIR: Mr Gale.
 13 MX CASS MACDONALD (called)
 14 MR GALE: Thank you, my Lord. The next witness is Cass
 15 MacDonald. They represent the Scottish Healthcare
 16 Workers' Coalition. The reference to their statement is
 17 SCI-WT0465-000001.
 18 THE CHAIR: Yes.
 19 MR GALE: It's been agreed for the purposes of today that
 20 I will refer to the witness as "Cass".
 21 Questions by MR GALE
 22 MR GALE: So, Cass, you provided us with a statement on
 23 behalf of the Scottish Healthcare Workers' Coalition and
 24 you are, as I understand, agreeable that that statement
 25 will be the evidence on behalf of the Coalition together

97

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

98

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

99

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

100

1 been diagnosed with myalgic encephalomyelitis, ME ---
 2 chronic fatigue syndrome --- in addition to long COVID.
 3 I have been in daily severe pain since June 2020 as
 4 a result of my COVID infection and I've been diagnosed
 5 with functional neurological disorder. I have problems
 6 with my short-term memory. I have to --- I've had to
 7 rest aggressively to be able to appear today because I'm
 8 very prone to what people like to call "brain fog" but
 9 I refer to as "cognitive dysfunction" because it's like
 10 my brain is trying to wade through treacle. I sometimes
 11 have problems with my speech, with concentration, with
 12 understanding.
 13 I'm no longer able to speak foreign languages and
 14 I have been speaking foreign languages since I was ---
 15 over 40 years, since I was a child, and that's probably
 16 not the entire extent. It feels like every day
 17 something new crops up. And I have an allergic
 18 condition called "mast cell activation syndrome" as
 19 well, which has even affected my diet and I have a lot
 20 of medication I am now on.
 21 Q. I think I should point out that, should you feel that
 22 you would like a break at any point in time as you're
 23 giving your evidence, please tell us ---
 24 A. I will. Thank you.
 25 Q. --- and arrangements will be made. You said you were

101

1 working prior to the pandemic. I'll use that as a point
 2 in time, so prior to 2020. What were you doing?
 3 A. I was a band 5 nurse. I worked for my employer since
 4 2012, NHS Lothian, and started in theatres, went to
 5 sterilisation, decontamination, and I was working within
 6 the wider infection prevention control team as an audit
 7 and surveillance nurse, gathering data for national
 8 surveillance programmes.
 9 Q. When was it that you found you were unable to continue
 10 with work?
 11 A. I --- the last day I worked was 8 August 2021. I tried
 12 several times to go back to work after my infection
 13 in April 2020 and I --- my contract was terminated
 14 in August last year, two years to the day since I'd last
 15 worked, and I'm now medically retired.
 16 Q. Right. Okay. Thank you. There are one or two things
 17 you've already mentioned that I'd like to look at in
 18 a little bit more detail, but a consistent theme through
 19 your statement is long COVID and the implications that
 20 that has had for you personally but for many within the
 21 group that you represent; is that correct?
 22 A. Yes.
 23 Q. Now, one of the points you make really at the beginning
 24 of your statement is that long COVID is not or should
 25 not be taken as synonymous with an extended or delayed

102

1 recovery from COVID. Can you explain why you say that?
 2 A. That is possibly best explained by medical experts, for
 3 example, Claire Taylor. However, the way I understood
 4 it is this is the chronic condition that has arisen as
 5 a result of post-viral implications, be they obvious or
 6 not obvious at the start, that is currently not able to
 7 be treated. I believe it is a disease in the same
 8 family as ME, chronic fatigue service [sic], which
 9 therefore means that this is potentially a life-long
 10 condition.
 11 I know some people --- I believe it's a relapsing
 12 remitting condition. I have good days and I have bad
 13 days, I have good periods and I have bad periods. And
 14 I know that people are --- believe they've made a full
 15 recovery. Others believe, while they've got a lot of
 16 function back, that they have not. So I believe this is
 17 potentially life-long, as currently it --- we cannot
 18 treat it.
 19 Q. I was perhaps pointing to something perhaps more simple
 20 in this. Perhaps --- and it may be the way I took the
 21 expression --- that the suggestion of --- which we've
 22 I think in the general public and one does here --- that,
 23 "Oh, it's just your recovery has been delayed a bit", it
 24 perhaps lessens the significance of it; is that
 25 something you would agree with?

103

1 A. I know people think we're just a little bit tired. I've
 2 now been ill for four years --- four years, two weeks ---
 3 and there is no sign that I'm improving. In fact
 4 I believe --- I'm hoping I don't get any worse. I don't
 5 think that's a long recovery and I don't think the
 6 general public realise the full extent of the issues and
 7 symptoms that many of us are having to deal with.
 8 Q. One of the points that we've come across really from the
 9 outset of our hearings into the pandemic and in
 10 particular into long COVID is a widespread scepticism,
 11 particularly in the public domain, as to the
 12 genuineness, if I can put it that way, of long COVID.
 13 Is that something you and your colleagues have come
 14 across?
 15 A. Very much so. I think we would say that we've
 16 experienced this from fellow healthcare professionals.
 17 Some of us have experienced abuse online. A big factor
 18 of some of the abuse that we get is that people insist
 19 that this is a vaccine injury, it's our own fault or
 20 it's related to --- you know, perhaps we were overweight
 21 and we clearly must have had something wrong with us.
 22 So it's a lot of ableist victim-blaming, but the vaccine
 23 injury thing is quite a big thing, even for those of us
 24 who were infected before there were vaccines.
 25 Q. One of the things we do occasionally hear is that you're

104

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

105

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

106

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

107

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

108

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

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

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

109

1 wasn't safe. And I've never been given those pieces of
2 guidance which I was told came from NHS Scotland.
3 Q. You've said that the guidance was flawed and again you
4 put that in general terms. Can you provide us with some
5 specifics in your view as to how the guidance was
6 flawed?
7 A. It was based on an assumption that COVID is spread by
8 droplets and that guidance does not appear to adequately
9 take into account, well, the — what we believe and what
10 the emerging science says about COVID, which is that
11 it's airborne — and you have people like — I think his
12 name is Julian Tang. He's a consultant virologist. He
13 was warning that this appeared to be airborne
14 in April 2020 — and it didn't seem to take into account
15 any issues around ventilation — I mean, we don't have
16 HEPA filtration — or the numbers of people who would be
17 in a room. If you have a lot of people coughing in
18 a room, there's going to be an awful lot of droplets in
19 the air even if you assume that it's just droplet
20 spread. But we think it was — we think it's airborne.
21 Q. So one of your particular criticisms, therefore, is in
22 relation to what appears to be a presumption underlying
23 guidance, which was that the means of transmission of
24 COVID in the early days of the pandemic was by droplets
25 rather than airborne transmission?

110

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

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

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

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

25 A. Yeah.

111

1 Q. — so from March 2020 onwards.

2 A. Yeah.

3 Q. Were you aware of that?

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

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

112

1 obviously — emerging science since COVID.
 2 Q. Yes, I think that's one of the other points I was going
 3 to ask you about because you did say that you level the
 4 charge against the Government and against the health
 5 boards on the basis that there was insufficient regards
 6 paid by them to the emergence of developing science.
 7 Now, is that all in connection with this idea of
 8 airborne as opposed to droplet transmission?
 9 A. Yes, so I think also it's partly to do with they at all
 10 points seem to have failed to consider that what turned
 11 into the pandemic would leave a significant number
 12 permanently disabled. That has happened with SARS.
 13 There were people speaking out about that at the start
 14 of the pandemic, particularly in Canada in March 2020.
 15 There was evidence from SARS studies taken I think in
 16 2010, so a significant time afterwards we knew that
 17 people were suffering from long-term effects, at that
 18 point seven years after the SARS epidemic. They knew
 19 healthcare staff had been disabled by Swine flu back
 20 in — I think it was 2008 or thereabouts in the UK.
 21 There didn't appear to be any consideration paid that
 22 that could be a possibility and therefore, with a novel
 23 and unknown virus that they simply did not know what the
 24 long-term effects would be, I don't think they paid
 25 enough attention to that, no.

113

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

114

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

115

1 people were concerned that Ebola would make its way to
 2 the United Kingdom after a Scottish nurse was infected,
 3 they realised that a huge number of staff had never been
 4 tested within the organisation as a whole. Many of them
 5 had never been retested. I would imagine that that was
 6 the case — certainly when I joined the organisation in
 7 2012, I was not fit-tested. Some of this could be down
 8 to time; some of this could be down to having the skill
 9 set to do that. So I believe a huge part of the problem
 10 would have been that staff simply had never been
 11 fit-tested or had never been retested, and I don't know
 12 if they've ever solved that particular issue.
 13 Q. Again, looking at the generality of what you say at the
 14 beginning of your statement at paragraph 8 — this is
 15 perhaps a reflection on what you've said earlier — you
 16 say that you and your colleagues "did our job but now we
 17 have been ... disabled, we feel abandoned and forgotten
 18 by the government and the healthcare systems we worked
 19 for". I know you go into more detail, but could you
 20 just explain the effect of that feeling that you have
 21 upon you?
 22 A. I know people who are lucky enough to still be employed
 23 and who are having significant problems in trying to
 24 access reasonable adjustments at work. They are
 25 experiencing ableism and unconscious bias, and I would

116

1 argue that that is institutional . It is a longstanding
 2 problem, certainly within the NHS and probably within
 3 other sectors as well . And for those of us that were
 4 struggling to keep up, assuming we managed to get
 5 reasonable adjustments --- some of us were told, "Oh,
 6 this was short term, we wouldn't get this for the long
 7 term" --- we had to deal with attendance policy being
 8 used against us . If we have chronic conditions we're
 9 going to be off sick more, however, we're expected to
 10 keep up with those who don't have those conditions.
 11 I know people experienced bullying and, for those of us
 12 who simply haven't been well enough, our contracts have
 13 been terminated. I do believe in some cases it was
 14 because simply they were being told, "You can't keep up
 15 with the terms of your original contract".
 16 I discussed with my union rep many times about how
 17 organisations did not seem to be evolving with the
 18 pandemic, they did not seem to be looking at roles,
 19 changing things up so that they could attempt to retain
 20 experienced staff . However, it seems to be, "If you
 21 can't keep up, there's the door". And I've been very
 22 lucky in that I've managed to get certain benefits, I've
 23 been able to medically retire at tier 2, but I know
 24 a lot of people who are having their applications for
 25 ill health retirement turned down, they're having

117

1 applications for benefits turned down, there's a lot of
 2 delay and they are experiencing financial distress ---
 3 something I know extremely well from the whole of 2023,
 4 my own personal experience --- up to the point that many
 5 are at risk of losing their homes, some have lost their
 6 homes, they've lost their income, we've lost our
 7 careers, and particularly in the case of some of them,
 8 like nursing, that's a vocation, that's a huge part of
 9 who we are, you know. And we've lost our health, I've
 10 lost my mobility. It's very difficult to come to terms
 11 with. And we don't know how long this will last.
 12 Q. In your own personal case, have you been given any
 13 indication as to the long-term prognosis?
 14 A. Poor. I'm not expected to ever work again. I came off
 15 the register last year, I could not reregister with the
 16 NMC, Nursing and Midwifery Council, and I'm not --- there
 17 is apparently nowhere to refer me to and I have now been
 18 waiting for a year to see a social worker to get
 19 additional support. It's --- I'm waiting for research
 20 basically .
 21 Q. It's not something I normally do, Cass, with witnesses
 22 but I am going to, with your leave, make an exception.
 23 How old are you?
 24 A. 48.
 25 Q. You were expecting to work for at least another

118

1 12 years?
 2 A. I probably wouldn't have left for another 20 years
 3 actually. I fully expected to work until I was 67,
 4 perhaps beyond.
 5 Q. Okay. You make a point in your statement about clean
 6 air and it's something that you have referred us to.
 7 Obviously this is something that the Inquiry will be
 8 considering in some detail at an appropriate point, but
 9 taking the matter briefly, it's your contention I think
 10 that the Scottish Government should match the CDC
 11 standard, which is the American standard, in relation to
 12 clean air; is that right?
 13 A. Our contention is that current ventilation standards
 14 need to be improved because it's been some time since
 15 they were last reviewed, and that clean air measures
 16 need to be brought in, particularly to health and social
 17 care. They are slightly separate but very closely
 18 allied issues .
 19 Q. Okay, thank you. Can I also ask you a little about the
 20 occupational health and workplace support that you refer
 21 to in your statement. I should say --- and I should have
 22 said this at the outset. I apologise for not doing ---
 23 there are parts of your statement that we will take as
 24 read simply because we need to concentrate on certain
 25 aspects of your statement so please be assured that

119

1 everything within your statement will be taken account
 2 of, but I would like to look at some specific areas.
 3 You note, in paragraph 22, that occupational health
 4 support has been variable across health boards, with
 5 common themes suggesting under-resourcing and
 6 underfunding, with many experiencing long waits to be
 7 seen. Can you give us a little flavour of that, please?
 8 A. Occupational health has obviously always existed. At
 9 the start of the pandemic, occupational health took on
 10 a role for obviously testing staff at a time when
 11 testing within the wider community was not available
 12 and, all of a sudden, occupational health departments
 13 had to deal with an influx of staff members who were
 14 unwell. And each employer, I believe, would have taken
 15 a different approach, depending on their resources.
 16 I know that Greater Glasgow and Clyde NHS chose to set
 17 up a lifestyle management course for their staff members
 18 affected by long COVID, but that was not nationally
 19 rolled out. I actually wrote to Scottish Government
 20 about this. They told me it was an employer issue.
 21 I wrote to my own employer about this course and they
 22 told me that they did not have the resources to do this
 23 and they pointed me to what they did have, which was
 24 counselling and physiotherapy.
 25 I do also know that I believe they were having ---

120

1 it's my belief they were having --- that my own trust
 2 were certainly having to ration support. Prior to the
 3 pandemic, if you had a chronic condition and you were
 4 off work, you might have seen occupational health more
 5 than once to see how you were. That was different. At
 6 this point you really would only have access to
 7 appointments if you were ready to go back to work and to
 8 discuss reasonable adjustments or if they were making
 9 a decision about whether or not you would be able to
 10 work again in the future and whether your contract
 11 should be terminated. That's my belief.
 12 Q. Support within the workplace, obviously from
 13 a managerial level downwards, I take it that that was
 14 also, in your experience and in the experience of your
 15 group, variable?
 16 A. Very.
 17 Q. And was that level of support affected by the level of
 18 scepticism about your condition?
 19 A. I think there's probably multiple factors. It probably
 20 would have been related to what the organisation was
 21 able to offer. However, although the Equality Act does
 22 provide that reasonable adjustments should be made
 23 available where they are reasonable, it can be the case
 24 that a manager refuses to put them in or they are
 25 time-limited. You can also --- a lot of people have been

121

1 dealing with ableism and so on and so forth. You know,
 2 this can range from somebody saying, "I really need
 3 a specific schedule at work, a specific rota", and being
 4 told, "Well, that's not fair to everybody else", which
 5 is a bit tricky --- you know, even accessing perhaps
 6 equipment that may have been bought for you, for
 7 example. You can have some limited equipment bought for
 8 you like chairs and so on and so forth. But I know that
 9 some people have really struggled with their --- and
 10 continue to struggle with their managers, having to
 11 involve their union. And I know that in some cases
 12 they've attempted to remove reasonable adjustments, like
 13 working from home, without the best of reasoning. And,
 14 obviously, if you're trying to go through this and
 15 fighting for this to try and stay working, this causes
 16 stress and, unfortunately, that's emotional exertion and
 17 that can impact on and bring on symptoms.
 18 Q. You did give us an example --- I think you alluded to it
 19 earlier --- again in your own circumstances, you're
 20 asthmatic.
 21 A. Yes.
 22 Q. You were in your job not, as I understand it, given the
 23 opportunity to shield ---
 24 A. No.
 25 Q. --- and effectively were asked to come in ---

122

1 A. Yes.
 2 Q. --- as an asthmatic ---
 3 A. Yes.
 4 Q. --- presumably on public transport ---
 5 A. Yes.
 6 Q. --- and to not have the same degree of protection that
 7 a general member of the public would have?
 8 A. I'd say that's fair. We can obviously discuss that more
 9 when I return to give my individual testimony.
 10 Q. Yes. Okay. Now, could I ask you a little about the
 11 access to social care --- the access to health and social
 12 care section of your statement. It begins at the
 13 numbered paragraph 32, but you give one of your quotes
 14 before that. You refer to some of the data that we have
 15 or that you have and you give the figure of an estimate
 16 of 91,000 Scots currently suffering from long COVID.
 17 I think you give the source of that data. I think we've
 18 also heard a more rounded-up figure of 175,000, which
 19 I think comes from the general --- simply taking the
 20 figure which is thought to be for the whole of the rest
 21 of the UK and simply applying that to Scotland.
 22 There is similarly an importance of the prevalence
 23 of long COVID amongst women and also the importance of
 24 the prevalence of long COVID on those of working age.
 25 These are factors that you point to in your statement as

123

1 emerging from the data; is that correct?
 2 A. That's correct.
 3 Q. I think one of the things we have heard from certain
 4 witnesses about long COVID is that the idea that one had
 5 to have some pre-existing health condition which
 6 rendered you susceptible to long COVID or,
 7 alternatively, that you weren't somebody who was
 8 particularly active --- the examples or many of the
 9 examples we've heard of are people who were very active
 10 in their life prior to the emergence of long COVID in
 11 their condition. You're nodding.
 12 A. Yeah, that's --- I would say so. When it came down to
 13 shielding, it was exceptionally prescriptive. You had
 14 to have one specific condition. It did not seem to give
 15 points if you had a range of conditions, for example.
 16 And when you talk about the data and you talk about the
 17 numbers, the studies --- obviously it's an estimate.
 18 Nobody seems to be accurately counting the numbers and
 19 a study will only look at the specifics of those they
 20 are including in the study.
 21 So, for example, in some cases it was, "Did you have
 22 a positive test?". Well, that excludes an awful lot of
 23 us in the very early days of the pandemic because we
 24 could not access testing. And, again, we talk about the
 25 self-reported, but this is an issue that has been

124

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

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

12 A. Oh, yes.

13 Q. Tell us about that, please.

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

125

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

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

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

126

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

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

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

127

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

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

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

128

1 approach to it; would that be correct?

2 A. That's correct. Many in the long COVID community in
3 Scotland have been advocating for clinics where there is
4 a multi-disciplinary team approach in terms of
5 assessment because, at the moment, GPs have to refer
6 into individual services. So this is multiple
7 referrals, multiple pathways. That's exhausting for the
8 individual to deal with, you know, a lot of
9 appointments, answering the same questions, undergoing
10 tests, but then that assumes that the GP can actually --
11 that there is a service for one of your particular
12 problems. And that obviously takes up a lot of GPs'
13 time because they have to do all of these referrals.
14 You'll have to go in and talk to them. It's taking up
15 unnecessary time when it could be much more streamlined.

16 Q. Perhaps inherent in what you've just said, delays --
17 A. Yeah.

18 Q. -- in -- I suppose if you are referred to one specialist
19 and then to another and then to another, there will be
20 an inherent delay in that, but also there are presumably
21 just delays in the whole service?

22 A. There are. There were a significant number of vacancies
23 before the pandemic. As a result of the ongoing
24 pandemic, we have lost staff due to COVID and long COVID
25 and some people have left the service because of the

129

1 psychological toll that the experience took on them. So
2 there were long waiting lists beforehand and now you
3 have an awful lot more people who are being added to
4 existing waiting lists, waiting to be seen. But I don't
5 believe that funding has been -- enough funding has been
6 given to existing services, let alone creating new
7 services to take into account all these people who, for
8 example, now have cardiovascular issues and so on and so
9 forth.

10 Q. Can I take you on to the psychological impact? You
11 begin this -- after a lengthy quote, from one of your
12 members, I think, you take this up at paragraph 37. If
13 one goes back to the quote, the person who has provided
14 that quote observes that the suspected route of
15 transmission or observes the suspected route of
16 transmission and the speaker says that he or she
17 considers lack of information to have been -- I use the
18 quote -- "irresponsible and dangerous".

19 A. Yeah.

20 Q. Now, is that something that one finds in many of your
21 colleagues within the group, that they feel that there
22 was a lack of relevant information?

23 A. It was an extremely difficult time. I know from sitting
24 in an office and checking that the guidance was changing
25 almost -- sometimes it could be changing twice a day,

130

1 even if it was minor changes. You perhaps also would
2 have policies making decisions about where they were
3 sending patients, and this is something that I am aware
4 happened, that even -- you know, not just between health
5 boards -- that it was a case of information perhaps was
6 not being passed along about a patient, when a patient
7 was being transferred. I do know that one such
8 situation led to a huge outbreak in which 26 healthcare
9 staff were infected as a result. I wasn't on the wards
10 myself, my job was very different, but I do know from
11 what friends who both have COVID and didn't have COVID
12 have spoken of. And for some of them, what they saw and
13 experienced, it still sits with them today and mental
14 health services are -- have a very long wait for people
15 to be assessed and seen.

16 Q. That leads me on to one other thing I'd like to ask you
17 about, and that's counselling. What is your view on the
18 availability of counselling for long COVID sufferers?

19 A. If you are a member of a union, you can probably access
20 short-term counselling. You may be lucky enough to have
21 an occupational health service that can refer you,
22 again, for short-term counselling. However, short-term
23 counselling is like putting a -- you know, it's like
24 putting a sticking plaster over a major venous bleed.
25 Short-term counselling -- I am now on a waiting list to

131

1 be assessed for complex post-traumatic stress disorder,
2 some of it related to my COVID experience. I suspect
3 a lot of my colleagues also may be suffering from PTSD
4 as a result of their pandemic experiences. And the
5 waiting lists to be assessed by community mental health
6 teams for this and obviously wait then for treatment,
7 they're very long. We've known this for a very long
8 time, that there are issues accessing timely support.

9 Short-term can be helpful for issues that are
10 ongoing in the moment, but when trying to deal with
11 things that require long-term treatment, it is -- it's
12 a sticking plaster. It's not a solution. And if you
13 have an awful lot of people who need to access those
14 resources, you're going to have to wait for them.

15 Q. I suppose one of the other issues is the availability of
16 counsellors.

17 A. Indeed.

18 Q. Can I also ask you about pressure that members of your
19 group have experienced in being -- using your
20 expression -- pushed back into work? Can you explain
21 what information you have about that and why it was
22 occurring?

23 A. I know of individuals who have been pushed back into
24 work, forced to use up their annual leave for sick
25 leave. You know, they're pressurised -- you know,

132

1 they're told, "Well, we'll start attendance procedures
 2 if you don't come back to work; "We will ...", you know,
 3 "If you're off sick again, we're going to sack you
 4 because you've been off too much"; "We need you. We
 5 don't have enough people in".
 6 You feel -- I was never in that position myself but
 7 I do know that some people would have been -- when they
 8 were having the management contact would have felt
 9 pressure to go back because the team was under so much
 10 pressure, but that's due to staffing problems, not the
 11 fault of the individual who has contracted COVID, and,
 12 unfortunately, we now know that going back to work too
 13 early may have contributed to our developing long COVID
 14 because we pushed ourselves too far too soon.
 15 Q. One of the other obvious impacts on people with
 16 long COVID is one you've touched on both personally and
 17 in your statement, and that's the economic impact on
 18 people. Can you, if you're prepared to, tell us
 19 a little about your own experience or perhaps just more
 20 anecdotally, tell us a little bit about what your
 21 members have experienced?
 22 A. I mean, personally, I had to reduce my hours at work,
 23 which meant an immediate loss of 20% of my salary, and
 24 obviously for those people who -- once particularly
 25 COVID special leave ended and people went back on to

133

1 normal sickness, you know, after six months -- that's
 2 the maximum you can get -- you know, after a certain
 3 period you drop down to half pay and then you drop down
 4 to no pay. Trying to access benefits can be difficult .
 5 You can be turned down for them. There can be long
 6 waits.
 7 My own personal experience, I waited pretty much
 8 most of 2023 to actually get adult disability change of
 9 circumstances reviewed and awarded. I'm still
 10 waiting -- I've been waiting now since July last year
 11 for industrial illness disablement benefit. A lot of
 12 people have benefits turned down and they're obviously
 13 not getting any income from work and I know of people
 14 who are applying for their pensions, medical retirement,
 15 and they're not being awarded them. So they are losing
 16 significant parts of their income and, obviously, if you
 17 are potentially working in the private sector, you may
 18 not have that same timeframe because COVID special leave
 19 of course didn't apply to primary care or whatever.
 20 If we don't have money, we're not paying tax into
 21 the system. We also don't have the same spending power
 22 and obviously spending drives the economy. And as well
 23 as that, the economy depends on people being fit and
 24 healthy and working and so on, but if you have a lot of
 25 people who have had to leave public service jobs, like

134

1 the NHS, then that means that lists get cancelled -- you
 2 know, operating lists get cancelled, there are delays in
 3 being seen, and that impacts on the rest of society.
 4 And we do know from -- certainly there was a study in
 5 Germany and they now believe from their data that
 6 long COVID is having an impact on the economy and it's
 7 a negative impact on the economy.
 8 Q. Right. You've given us your views on -- in the last
 9 paragraphs of your statement -- on human rights. Again,
 10 as you're probably aware, the Inquiry has
 11 a human-rights-based approach to its proceedings but
 12 also clearly has consideration of matters of inequality
 13 inherent in -- well, indeed explicit in our terms of
 14 reference, so all you've said in relation to human
 15 rights will be taken into account and we are very
 16 grateful to you for your views on that.
 17 Cass, that's really all that I'd like to ask you at
 18 this stage. I know you're going to come back and give
 19 us some views on your own personal experience. Like all
 20 witnesses, we offer you an opportunity -- if there's
 21 something that you would like to say to us at this point
 22 that you haven't said or you've felt perhaps has not
 23 come across in the amount of detail or perhaps with the
 24 strength that you would like it to come across, so this
 25 is your opportunity to do so.

135

1 A. I would like to thank the Inquiry for giving a voice to
 2 Scottish health and social care workers who are impacted
 3 by long COVID. Many are too unwell to participate. And
 4 we offer our sincere condolences to those who lost loved
 5 ones, colleagues and friends and we extend our
 6 solidarity to all our fellow key workers as well as
 7 everybody else in the long COVID community.
 8 Many of us have lost absolutely everything, our
 9 health, our jobs, our careers and our homes. We've gone
 10 from being called "heroes" to being treated like zeros.
 11 We may have to live with COVID for the rest of our lives
 12 and I know many who are dealing with inflexible
 13 employers and ways of working, inadequate health and
 14 social care, and they struggle, as we've talked about,
 15 to access any kind of meaningful financial support, and
 16 I believe that's unjust.
 17 We really do hope that everybody and particularly
 18 you, sir, do listen to our concerns. We do feel that
 19 there are issues that need to be looked into further
 20 regarding risk assessment, PPE, RPE. We do feel
 21 questions need to be asked about data collection, both
 22 previously and ongoing, and information-gathering, why
 23 people aren't answering questions.
 24 This can't happen again on this scale. None of us
 25 understand why lessons were never learned from previous

136

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

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

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

21 A. It is grieving.

22 Q. A loss?

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

137

1 know, anger, acceptance, denial, bargaining — I forget
 2 the last one. It's an ongoing process. Many people are
 3 starting from scratch. They don't want to accept this
 4 is happening to them, but — you know, our careers are,
 5 particularly in healthcare, a huge part of who we are
 6 and a lot of people only regard individuals by their
 7 economic value and, if we can't work anymore, they don't
 8 see us as having any value, which I think is flawed.
 9 But, that is how people see themselves. You know, they
 10 can't be — I can't be the aunt that I once was. I know
 11 people that they can't be the parents that they used to
 12 be. You know, they can't socialise like they used to.
 13 It's impacting every single part of their lives .

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

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

19 MR GALE: A few minutes earlier.

20 THE CHAIR: Very good. Thank you.
 21 (2.38 pm)

22 (A short break)

23 (2.57 pm)

24 MR DONALD MACASKILL (recalled)

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

138

1 coming I suppose I should say.
 2 Yes, Mr Gale, when you're ready.

3 MR GALE: Thank you.

4 Questions by MR GALE (continued)

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

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

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

139

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

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

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

140

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

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

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

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

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

141

1 not really --- it is critically important but it is by no
 2 means all that is important.

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

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

142

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

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

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

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

143

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

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

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

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

144

1 Government I think outweighed the pastoral care and
 2 concern of those at the ground level. And I've said
 3 elsewhere in the statement that I think one of the
 4 reasons for that is the structural inability to listen
 5 to the care sector and, to some extent, respect the
 6 professionalism of those on the ground.
 7 Q. One of the points you've made earlier in your statement
 8 is that you come to your role with a human-rights-based
 9 approach and you've said that you had a desire to bring
 10 that into your role as the CEO of Scottish Care. Do you
 11 feel that there was -- with that background, was there
 12 any resistance or kick-back from your members to the
 13 emphasis of the human-rights-based approach that you
 14 were advocating?
 15 A. In all honesty, no, I don't think there was. Now, when
 16 I say and talk about a human-rights-based approach, I'm
 17 not talking about creating legal experts in every care
 18 home or in every home-care organisation. But people who
 19 were sensitive, I think I said previously, to the
 20 relational dynamic involved, I think if there -- there
 21 certainly wasn't resistance. There maybe was a lack of
 22 knowledge about what did that actually mean, and by that
 23 I mean that people may not have been aware of how you
 24 can use human rights models to help in decision-making
 25 and particularly in decisions where there are

145

1 conflicting views because human rights for me, in
 2 a non-legal perspective, aren't about black and white
 3 application of decision but about using frameworks to
 4 deal with situations where there may be multiple views.
 5 And from that perspective, I think the care sector
 6 still, every much as the National Health Service, lacks
 7 a full understanding of how you embed human rights in
 8 practice. I've often said that I would make it
 9 a mandatory requirement for anybody working in health
 10 and social care to have a basic grasp of what human
 11 rights in practice means because it helps as a tool in
 12 situations where there is potential disagreement and
 13 conflict.
 14 Q. Clearly with some of your members there was perhaps an
 15 inability to understand what you were saying in regard
 16 to the human-rights-based approach. Do you feel that
 17 there may have been on your part, in your role, any
 18 deficiency in trying to get that point across to your
 19 members?
 20 A. I think it's fair to say, Mr Gale, that numerous times,
 21 and certainly in listening to the evidence of those most
 22 impacted, family, staff and others, as I have, I am
 23 continuously asking myself, "Could I have done more,
 24 spoken more, shouted louder, given confidence to both
 25 members and front-line staff and challenged more

146

1 effectively?". I will leave that for others to decide
 2 whether I could have done a better job, but I was
 3 certainly very aware of the importance of trying to
 4 embed a human-rights-based approach and I was aware that
 5 often I was speaking in contexts where people were
 6 giving a vocal tick-box to what I was saying without
 7 necessarily thinking about what the application of
 8 a rights-based approach meant for, for instance,
 9 visiting guidance.
 10 Q. Do you think it would have been advantageous, either
 11 then or now, to have this human-rights-based approach
 12 embedded in a document that would have been available to
 13 all your staff -- all your members?
 14 A. Ultimately there is no shortage of documentation
 15 guidance which mentions human rights and it's a much
 16 beloved phrase of political leadership, but it is the
 17 application of human rights in practice. It's the
 18 working out of scenarios where there are conflicting
 19 views, which doesn't happen in a document or even in
 20 a training course but happens in practice. That's where
 21 I think the real gap is, both in the provision and the
 22 delivery of care, both in the NHS and in social care.
 23 So knowledge about human rights is one thing;
 24 embedding a human rights empathy is I think quite
 25 another. And that, at a time of challenge, was probably

147

1 never likely to happen by people reading from a booklet
 2 because the practitioners that I know and came across
 3 frequently were embedding a human-rights-based approach
 4 all the time in the struggles of delivering care.
 5 Q. I take your point, but do you feel that having
 6 a referable document that members of your organisation
 7 could look at and have, as it were, reinforced by
 8 perhaps being a separate document with that heading --
 9 would that have been an advantage?
 10 A. It might have been. Such documentation already existed.
 11 I think reference has already been made to the Care
 12 About Rights programme, which had been developed by the
 13 Scottish Human Rights Commission and which had been
 14 rolled out in the care sector. So there were many
 15 managers and front-line workers who had begun to think
 16 about the conversation of practical human rights
 17 implementation.
 18 Would a separate document have made a difference in
 19 the context of multiple documents? It might have, but
 20 what would have really made the difference is the
 21 ability to develop relationships of trust amongst local
 22 teams between commissioners, contractors, HPT teams,
 23 Public Health Scotland, the Inspectorate and local
 24 staff. And the deficit of trust and the deficit of
 25 professional due regard was probably more of an issue

148

1 rather than the absence of a human—rights—based
 2 document.
 3 Q. Thank you. Again, we've heard from a number of
 4 witnesses that many care home managers did resort to the
 5 constant refrain of "We are only following the guidance"
 6 when they restricted or denied visiting. At
 7 paragraph 34 of your statement, you say that:
 8 "At a local level ... staff were consistently having
 9 to balance the demands of those [who were] wanting
 10 [greater] access ... and those who [were wanting] to
 11 limit (it) ..."
 12 I think in brackets you also say "out of a sense of
 13 fear. Can I understand what the reference to the "sense
 14 of fear" is, please?
 15 A. I suspect the Inquiry has already heard something of
 16 this from front—line staff in the evidence and managers
 17 a couple of weeks ago, having watched that. So in that
 18 context what I meant was that, particularly at the start
 19 of the pandemic, particularly in April and then later on
 20 with the Omicron virus, there was a real debate amongst
 21 families and individuals, who said, you know, "We don't
 22 know what we're dealing with. Please don't make our
 23 family any more vulnerable than they already are", and
 24 there was understandably a different perspective of
 25 people who were desperate to see their relatives .

149

1 Now, that changed during the course of the pandemic,
 2 and into 2021 and 2022 it was very few people who were
 3 resistant to opening up. But at different points and
 4 certainly at the start there was resistance, and the
 5 denial of the anxiety expressed by these people I think
 6 is inappropriate because they were genuinely worried
 7 about this unknown virus coming into the home. It
 8 wasn't because they didn't love their relatives or they
 9 didn't want to have contact — and sometimes that has
 10 been communicated — it was because they loved their
 11 relatives and they feared the consequence of an unknown
 12 virus that they were worried about access being given.
 13 And front—line staff were continually balancing that
 14 dynamic, more dramatically at some times than at others.
 15 Q. Yes, I think you've made the point that — while we've
 16 obviously heard a great deal about the campaigns by
 17 various groups, but particularly by Care Home Relatives,
 18 about relaxing or facilitating the visiting of essential
 19 visitors, you have made the point that there existed
 20 also a cohort of people who were very much, for good
 21 reason in their own mind, refusing or supporting the
 22 refusal of access of them to their relatives so as to
 23 protect those relatives .
 24 A. Yeah, and the truth of that statement should not lead us
 25 to create a situation of conflict. Both were

150

1 desperately concerned about the health and well—being of
 2 their loved ones, both were equally struggling with
 3 restrictions and both groups of people and individuals
 4 within these groups were unsure about what was best.
 5 That changed obviously as time went by and I think
 6 more and more people were sensitive to the damaging
 7 impact of exclusion, but even when I wrote that
 8 in April, I was very sensitive to the fact that not
 9 everybody would agree with what I had written because we
 10 didn't know about the virus impact and indeed we had
 11 just come through April, through the worst period of
 12 deaths.
 13 Q. One of the problems I suppose that we've heard about is
 14 that there could be conflicting approaches to the
 15 guidance within the same geographic area, so that within
 16 Fife one particular care home could be allowing a more
 17 liberal approach to visiting than another. Obviously
 18 for people trying to ascertain whether they could and
 19 should be visiting their relatives, that was a problem.
 20 Do you see any way that that could have been avoided or
 21 resolved?
 22 A. It was a problem. It was equally a problem for staff in
 23 those care homes where, for instance, advice by health
 24 protection teams in one part of an area, because of
 25 a particular approach by a particular individual, who

151

1 ultimately for instance signed off a document
 2 allowing — a risk assessment allowing visiting was
 3 different from the approach of another professional in
 4 another part of, say, Fife as an example. So staff
 5 struggled with the degree of inconsistency and
 6 uncertainty, and I think the only way in which that then
 7 and potentially in the future can be addressed is if
 8 there is real collaborative working and mutual respect
 9 and if the care sector was less done to and more enabled
 10 by the whole process of collaborative trust—based
 11 working. In the absence of that, that's what creates
 12 inconsistency.
 13 THE CHAIR: I can see that. That's a perfectly
 14 well—reasoned argument. But at a time as existed
 15 in April 2020, where there is no irrefutable body of
 16 information or evidence to give an answer, that may well
 17 be the situation in any future pandemic until a time
 18 comes when the scientific knowledge has been
 19 unequivocally developed. Then, even applying the
 20 approach which I think you quite rightly advocate, the
 21 collaborative, trusting approach, there may well be —
 22 there probably will not be any definitive "Yes" or "No".
 23 A. I agree, your Lordship, and I suppose my comment was
 24 more related to those periods of the pandemic, for
 25 instance later in the year of 2020 and during the

152

1 Omicron outbreaks in the early part of 2021 and when
 2 visiting a risk assessment was being exercised at local
 3 level, where the lack of consistency at local level was
 4 not helped by the lack of relationship.
 5 I agree that at core times, with little knowledge of
 6 the impact of the virus, as we had in the early stage,
 7 there was of necessity more likely to be a greater
 8 degree of uniformity. But I suppose that comes to the
 9 heart of the issue about the application of human rights
 10 later on, but also at this time, as to whether or not
 11 blanket assessments and judgments were most appropriate
 12 or was there a possibility or should there be
 13 a possibility for flexibility to take account of local
 14 circumstance, the nature and specificity of a care home
 15 and its residents and the particular needs of those
 16 residents. And certainly — we may go on to talk about
 17 Anne’s Law, but certainly the hope and aspiration of
 18 that law, when it is eventually enacted, would be to
 19 ensure continuity of contact even with one individual
 20 and one resident.
 21 MR GALE: Thank you. I suppose one — and I’m not
 22 suggesting it as one that one should necessarily
 23 follow — but I suppose one approach would be to turn
 24 guidance from guidance into something more prescriptive
 25 in relation to the instruction that was being given to

153

1 give less element of discretion?
 2 A. That is certainly an approach which I think some in the
 3 care sector would have valued because it would have
 4 removed any dubiety. But that sort of approach I think
 5 is only valid if there is consistency in terms of the
 6 ability to implement that instruction. So when you
 7 have, in the care sector, as we had in 2020, a situation
 8 where one care home was able to be insured and that
 9 allowing — and their insurer allowed you to allow
 10 visitors and then, in another part of the sector,
 11 insurance could hardly be gained — I came across an
 12 email in preparation for today, last night, which was
 13 dated early April, in which the provider was saying
 14 that, on request from the insurance company that he had
 15 dealt with for many years, the insurance quoted in
 16 early April was 850% more than it had been the previous
 17 year.
 18 So we may talk about insurance later, but the impact
 19 of diverse circumstance I think goes to the heart of
 20 whether or not you could have a blanket instruction.
 21 I think that only works if there is equality in terms of
 22 different care homes at different levels.
 23 Q. A blanket instruction in — let’s talk about visiting
 24 and that, irrespective of the circumstance, there is an
 25 absolute restriction on visiting, would that fit, in

154

1 your view — and I ask you with your human rights
 2 background — would that fit with the human rights
 3 approach?
 4 A. In a theoretical sense, no. I mean by that that I think
 5 the uniqueness and the — I might even say the glory of
 6 the human rights approach is that it is not the empty
 7 application of a rule into a particular circumstance
 8 but, rather, it’s the creation of a relationship in
 9 a particular context. I mean by that that — you know,
 10 I had been used to working with staff in situations
 11 where there had been a dispute between a resident,
 12 another resident, a staff member, a family member, and,
 13 you know, the human rights frameworks and models enable
 14 you to use human rights almost in a mediatorial manner.
 15 In that context, that’s about not a black and white
 16 application; it’s about, for each context, analysing the
 17 situation, seeing those who are most impacted,
 18 identifying which rights might be impinged or impacted
 19 and what can be done to enable an individual to achieve
 20 and fulfil their human rights as much as possible.
 21 That’s, dare I say, much more flexible and loose than
 22 simply an instructional approach, which gives no room
 23 for flexibility or the creation of relationship.
 24 THE CHAIR: We’re getting into a rather philosophical debate
 25 here but —

155

1 A. On a Friday afternoon, my Lord, I know.
 2 THE CHAIR: On a Friday afternoon! To use another synonym,
 3 a human rights approach is more nuanced and should be
 4 more nuanced, and I think we could probably all readily
 5 agree on that. The problem is, of course, that
 6 legislation, if properly drafted, does not readily allow
 7 for much nuance once it is promulgated and we’re back to
 8 the situation: when there is no precise degree of
 9 knowledge, then nuance is very valuable because it
 10 allows, if discretion is granted or mediation — I liked
 11 the use of the word “mediation” in the sentence you used
 12 there — it’s a mediative process. It’s a frightfully
 13 difficult ground — I’m sure all three of us could agree
 14 on that — isn’t it?
 15 A. Yes, and that’s why it changes so — I think I said this
 16 the last time — that I had no difficulty in March with
 17 there being a very definitive decision to lock down care
 18 homes because the legitimate aim was literally to keep
 19 people alive. As the time and the passage of time
 20 changed, then I think there were other human rights, the
 21 right to privacy, the right to family life, the right to
 22 association, and our knowledge of psychological harm, of
 23 the impact of restricting people to their own room and
 24 space, was growing. So other human rights became
 25 equally significant and that’s where I think that

156

1 your Lordship's phrase, "nuance", became really
 2 important. My concern then and now is that too often
 3 the application of the visiting guidance was too
 4 didactic and open to little flexibility rather than it
 5 being open to flexibility .
 6 THE CHAIR: In fact it could be argued it was rather
 7 dangerous because it turned its blind eye to nuance and
 8 yet at the same time purported to be flexible ---
 9 A. Yeah.
 10 THE CHAIR: --- and it was neither in reality ---
 11 A. Yeah.
 12 THE CHAIR: --- or at least that's an argument.
 13 A. Yeah, and I would agree with that.
 14 MR GALE: Can we move on perhaps a little from the
 15 philosophy ---
 16 THE CHAIR: Sorry.
 17 MR GALE: I enjoyed it --- to a particular situation.
 18 I think you're aware that there was a meeting
 19 in September --- it was 18 September 2020 --- between
 20 members of the Care Home Relatives group, key members,
 21 and they met with the Cabinet Secretary, Jeane Freeman,
 22 to argue their case for essential care-giver status.
 23 You're obviously aware of that campaign. I think you
 24 had had meetings with them in relation to it.
 25 A. [Nods]

157

1 Q. Essential to that was the suggestion that a family
 2 member or family members should be regarded as part of
 3 the care team. Bearing in mind that probably many of
 4 those members --- many of those relatives had probably
 5 been care-givers up until the point when a relative went
 6 into a care home, were you supportive of that?
 7 A. Yes. I would go further and I think many of those
 8 individuals --- not all, but many of those individuals
 9 continued to be care-givers when the person entered into
 10 the care home. And I think you've already heard, but
 11 I certainly recognise from staff comments that family is
 12 not an irritation, a hindrance, a challenge. They are
 13 an essential component of the relationship you want to
 14 form in a congregated or shared living environment. It
 15 enables --- and sadly, unfortunately, there are
 16 a significant number of residents in a care home who
 17 don't have family or anybody to visit them, and the
 18 ability of others to care for, to be present, to
 19 contribute to the care and support of their relative,
 20 frees staff up to spend more time with those who would
 21 otherwise have nobody and to focus more.
 22 So, as an organisation, we were always supportive of
 23 the role of family. Now, you know, we might have had
 24 disagreements --- and I had conversations with Care Home
 25 Relatives Scotland about some terminology, like

158

1 "a member of the care team", because that immediately
 2 might have got us into challenge with regulators around,
 3 well, is this a voluntary role or somebody to be
 4 registered --- but I think the principle of allowing ---
 5 and that's why I think Anne's Law is so significant and
 6 why it needs to be implemented sooner rather than
 7 later --- the principle of having, in an emergency
 8 situation or any situation, the right of an individual
 9 to choose a family member to be their additional support
 10 to the professional carers and to be present and to be
 11 their advocate is undeniable.
 12 Q. You've mentioned a couple of interesting points which
 13 are in my mind. First of all, we all know --- I'm sure
 14 those of us who have been in the situation of being
 15 a relative to somebody who is in a care home, we know
 16 that there are very frequently other residents within
 17 that care home who never see anybody and their level of
 18 loneliness can only be guessed at, I suppose. So there
 19 is that situation. You also mentioned in one of your
 20 answers that that might --- if one had a relative as
 21 a dedicated or as an appointed member of the care team,
 22 however one phrases that --- I'm sure we could argue
 23 about that --- but however one phrases that, you could
 24 see that as an advantage in freeing up other members of
 25 the in-house care team, if I can put it, to spend time

159

1 with people who are on their own.
 2 A. Absolutely, yes, and my experience is also the fact
 3 that, if you have a relative who becomes part of the
 4 community of care in a care home, they don't just spend
 5 time with their own relatives, they get to know other
 6 residents. And in particular I think we're all aware of
 7 those residents in a care home who have no family left
 8 because literally there is no family, but also, and
 9 maybe more challenging, those individuals who do have
 10 family but that family chooses not to visit or is unable
 11 to visit. And I think all visitors to a care home,
 12 particularly over the longer period of time, get to know
 13 everybody, not just their own particular relative.
 14 Q. Can I take you to something that you were asked about in
 15 your evidence to the UKI? My Lord, the reference is to
 16 the transcript of 18 January of this year and it's
 17 page 164, line 21, to 165, line 15. If I could just
 18 quote for the benefit of everyone --- you were being
 19 asked by Mr Tariq, Counsel to the --- sorry, Mr Dawson,
 20 I think it was.
 21 A. No, it was Mr ...
 22 Q. You were being asked certain questions and you were
 23 asked this question:
 24 "We know that visitors' restrictions were eased in
 25 autumn 2020, but the guidance on outbreaks meant that

160

1 many residents still faced severe restrictions for many
 2 weeks. Do you consider that the Scottish Government's
 3 approach on this issue in late 2020, going into 2021 and
 4 2022 — did it move towards considering properly the
 5 human rights of the residents and their families? [as
 6 read]"
 7 Your answer was unqualified:
 8 "No, it did not."
 9 Do you remain of that view?
 10 A. Absolutely.
 11 Q. Can you explain to us a little of why you are of that
 12 view or why you remain of that view and were of that
 13 view at the time?
 14 A. So at the time we were in a situation where the rest of
 15 the country was opened by — to an extent that we hadn't
 16 seen for some considerable period and yet those in care
 17 homes, who were by that stage one of the most protected
 18 population groups — so we had had vaccination, we had
 19 rigorous PPE, we had infection prevention and control
 20 measures and so on — and yet there was developed
 21 additional restrictions that, should there be an
 22 outbreak, even with one person, then all visiting would
 23 have to stop.
 24 And that extent of lack of flexibility, I argued at
 25 the time, was a denial of the individual human rights of

161

1 those residents because it was treating the residents of
 2 a care home as an amorphous group without there being
 3 flexibility. And without getting into our previous
 4 philosophical debate, I argued at the time that it
 5 should be perfectly possible to bestow professional
 6 flexibility on the part of care home managers to manage
 7 an outbreak in a manner which would continue to allow
 8 visiting to happen for those individuals.
 9 Now, clearly if a significant percentage of
 10 residents were infected during an outbreak, that's going
 11 to lead to a different decision compared to a handful of
 12 residents who could be appropriately supported and
 13 looked after, bearing in mind that we're talking late
 14 into the Omicron strain and evidence by that stage had
 15 shown significant lessening of impact, even on the care
 16 home population, as shown by the thankfully diminishing
 17 death rate.
 18 Q. Just to complete that reference to your evidence in the
 19 UKI, you went on to be asked:
 20 "Why would you say that the Scottish Government
 21 didn't move to a human-rights-based approach later on in
 22 the pandemic? [as read]"
 23 Again, you give an answer in these terms:
 24 "I think that the fear of repeating the trauma of
 25 the spring and of there being a resultant increase in

162

1 death as a result of not tightly managing a care
 2 environment was an overriding concern and, ultimately,
 3 as people kept saying to me, can we live our lives
 4 rather than exist in an improved environment, which was
 5 a sentiment expressed by staff as much as it was by
 6 family residents and carers [as read]."
 7 A. And I would still hold to that statement and sentiment.
 8 We had, by that stage, a population that had been
 9 through hell and the least they deserved was a flexible
 10 approach to enable them to spend their last few
 11 months — people I think forget that the life expectancy
 12 of somebody in a care home today is between 14 months
 13 and 18 months. Care homes are essentially hospices,
 14 increasingly, in our communities. And I don't know
 15 about many people, but if I was faced with the prospect
 16 and knowledge that I possibly had three to six months to
 17 live of my stay in a care home, I would be less
 18 concerned about getting COVID than I would be concerned
 19 about never seeing my family and being able to hold
 20 a grandchild or being able to spend time with my spouse.
 21 And those were the sort of things that people were
 22 saying to us. Those were the things that staff were
 23 saying to us, that our colleagues and Care Home
 24 Relatives organisation were saying. It was felt to many
 25 of us that care home residents had been forgotten as the

163

1 rest of society returned to what was increasingly called
 2 the "new normal". It was because of fear.
 3 THE CHAIR: Dr Macaskill, might I suggest to you that,
 4 having regard to the factors that you identified in the
 5 answers to the question, both in the UKI and a moment or
 6 two ago to Mr Gale, and having regard to the other
 7 factors at that period of time, whilst I acknowledge the
 8 merits in the human rights approach argument you've been
 9 advancing, one could come to the same conclusion as you
 10 are using the human rights approach to advance and
 11 advocate — you could come to the same conclusion simply
 12 by an application of common sense, that the stage had
 13 been reached when it was sensible to proceed as you
 14 suggested. Would you agree with that?
 15 A. I would, and I would — and further — and certainly
 16 said at the time that there is no other context where
 17 I think we would make clinical decisions around the
 18 well-being and health of an individual which were based
 19 on everybody in that environment but, rather, we
 20 would — you know, if I became ill, I would hope that
 21 I was attended to and that my particular needs were
 22 addressed according to my clinical needs at the time.
 23 But that's not what we did with care home residents.
 24 We assumed and we presumed by blanket implementation of
 25 guidance, at this stage in particular — which is why

164

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

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

24 A. No.

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

165

1 earlier stage?

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

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

166

1 mentioned. In the first part you answered the question
 2 with a very definite “No”, but — I think I know the
 3 answer to this question — I think you would agree that
 4 you don’t actually need to mention the words “human
 5 rights approach” to display or apply a human rights
 6 approach. Your answer still remains “No”?

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

167

1 this guidance and developing this practice which is
 2 properly human—rights—based assessed?”, and that was not
 3 evident at all.

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

14 A. Totally.

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

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

168

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

169

1 touched on a little today and referred us to last time
 2 you gave evidence, and that's the question of indemnity
 3 and insurance. Now, we're aware that the care home
 4 sector did not have the indemnity that was available
 5 from the Government in respect of the NHS and we've
 6 talked about that, but you explain how care homes
 7 require to obtain insurance and what risks they are
 8 insured against. You've told us about that. In view of
 9 the difficulties that you've already indicated, are you
 10 aware of any pressure from the care home --- I use the
 11 word "industry" not in a pejorative way --- but the care
 12 home industry to have a similar indemnity as the NHS
 13 has?
 14 A. Insurance became a real issue very, very quickly and
 15 what we saw was a huge number of insurance
 16 organisations, providers, exiting the market, making
 17 a decision that they weren't going to offer premiums.
 18 That lasted --- in fact I came across research which we
 19 did in the summer of --- sorry --- in the spring of 2022
 20 and, of 16 insurance --- large insurance organisations,
 21 13 of them were not prepared to offer insurance to
 22 a care home.
 23 Later on in that year, I encountered an email where
 24 a provider was informed by their insurance organisation
 25 that they should not admit somebody who was

170

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

171

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

172

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

173

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

174

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

175

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

176

1 in the care sector, whether in the community or in care
 2 homes, stood up. They were present, they were
 3 sacrificial, they were — and I don't like the word
 4 "heroic" because it suggests as if they were
 5 super-human, but they were humanity at our best, and so
 6 stability was evidence of that level of commitment.
 7 But, inevitably, as exhaustion took over, as energy
 8 was depleted, people began to reassess and singularly,
 9 without revisiting old ground, the impact of
 10 Operation Koper resulted in a significant number of
 11 people leaving their posts. And so into 2022, into
 12 2023, that stability index decreased significantly, down
 13 from the high 80s, if not the 90s — down to just around
 14 about 70%, where it sits now. So today nearly a third
 15 of the people working in our care homes were not working
 16 during the pandemic. And so it's — and we have the
 17 highest level of staff shortage, particularly of
 18 nursing, than we have had. That's been addressed in
 19 part by the decision at the start of 2022 to introduce
 20 a social care visa, but without going beyond the scope
 21 of the Inquiry's timeframe, that is now being impacted
 22 by more recent decisions.
 23 Q. Thank you. Could I ask you briefly again about testing?
 24 You talk about this in paragraph 71 and following of
 25 your statement. I'm interested in what you say at

177

1 paragraph 73. One of the issues you mention there is
 2 a lack of trust between the organisations or the bodies
 3 that were making the transfer and those into whom the
 4 transfer was going. Could you explain that a little
 5 bit?
 6 A. I think this was particularly in reference to the
 7 decision to discharge a significant number of people in
 8 the early stage of the pandemic from hospitals, many of
 9 whom were returning to care homes, many of whom could
 10 only be supported in care homes, so if care homes hadn't
 11 taken them, they would have had no place. What that was
 12 referring to was, pre-pandemic, the nature of the
 13 relationship between receiving care homes and clinical
 14 colleagues in care homes and professionals and those in
 15 discharge teams, and that relationship was brilliant in
 16 some parts of the country and absolutely atrocious in
 17 others. And it was atrocious because of a lack of
 18 professional regard, mutual understanding of roles and
 19 in some instances a priority in the needs of the person,
 20 so discharging people on a Friday night with less than
 21 full detail of clinical case notes, with insufficient
 22 pharmaceutical support, was commonplace, and I'm using
 23 that word "commonplace" before the pandemic.
 24 So in that context — and I remember referencing
 25 this to parliamentary committees before — in that

178

1 context there was a lack of trust when the time came
 2 in March in particular and into April, which is why we
 3 encouraged all our members that, if they were receiving
 4 somebody at point of discharge, to assume that that
 5 person was COVID-positive because the quote, "clinical
 6 assurance", in some instances wasn't worth the listening
 7 to.
 8 Q. You go on to talk about a trust deficit in paragraph 75.
 9 Then at 76 you say:
 10 "It took some time for the Scottish Government to
 11 make a policy decision that stricter measures should be
 12 adopted and for this to be reflected in the guidance
 13 from [Public Health Scotland]. Scottish Care was still
 14 addressing instances of poor discharge practices with
 15 CPAG, with Professor Graham Ellis and with Hugh Masters
 16 in May and June 2020 ..."
 17 You're critical obviously of the time that it took
 18 the Scottish Government to make a policy decision on
 19 stricter measures. Can you give a little more context
 20 to that, please?
 21 A. I've stated elsewhere that the — we, from the get-go,
 22 literally the get-go, said to the Cabinet Secretary and
 23 clinicians at Government that we wanted those discharged
 24 from hospitals into care homes but also into the
 25 community to be tested and perceived that this

179

1 population, older individuals with multiple
 2 comorbidities, were deserving of equal treatment, even
 3 in a scarce resource situation, as those who were
 4 perhaps being admitted into hospital where tests were
 5 being used.
 6 Now, as I said, even — and I grant that there was
 7 a restricted number of tests — I considered that the
 8 prioritisation of the NHS at the expense of care homes
 9 in particular was not balanced and acceptable, that
 10 different prioritisation could and should have been
 11 used. I think what we were equally despairing about was
 12 the length of time it took between folks like me raising
 13 these concerns and a decision being taken eventually
 14 that anybody being discharged from hospital should be
 15 tested twice. And the comment there highlights that,
 16 even when that was made explicit and the
 17 Cabinet Secretary very supportively was standing in
 18 Parliament, making it clear that this was a requirement,
 19 we were finding instances which we brought to clinical
 20 colleagues at Government of discharge occurring with no
 21 testing or less than accurate description of testing.
 22 Q. Thank you. Just a couple of other matters,
 23 Dr Macaskill. Paragraph 51 of your statement, we're
 24 going back to PPE and we dealt with PPE when you were
 25 last here, but one of the points you make there at

180

1 paragraph 51 is what you call the "unnecessary
 2 politicisation" of the use of PPE or failure to use PPE
 3 and "unmerited criticism of the sector". You say:
 4 "By way of example, statements were made by trade
 5 unions suggesting that some independent social care
 6 providers were not allocating the appropriate PPE to
 7 their staff."
 8 Now, before I go any further with that,
 9 Dr Macaskill, we have some considerable information from
 10 several union representatives, affiliates of the STUC,
 11 which do suggest that that was actually happening. Is
 12 that contrary to your understanding?
 13 A. So I'd want to say that we worked during the pandemic
 14 and since very closely with some of our trade union
 15 colleagues so that, you know -- because nine times out
 16 of ten we're saying the same thing, maybe with
 17 a different dialect. But it was our experience and the
 18 experience of our members at local level that there were
 19 instances where local trade unions were acting in
 20 a manner to suggest that providers at specific times
 21 were preventing staff from getting access to PPE. Now,
 22 I personally know of no such instances. What I do know
 23 was that the nature of the PPE required in guidance at
 24 specific times in the care home sector was not the same
 25 as the nature of PPE required of our colleagues in the

181

1 NHS, so it would appear, to all intents and purposes,
 2 that you could look at a care-home worker who was not
 3 wearing appropriate PPE if your assessment of
 4 appropriateness was what an NHS worker should wear. My
 5 colleague, Karen Hedge, gave a description of how,
 6 particularly in the community, there were instances
 7 where a nurse or a carer -- a nurse appeared wearing
 8 almost the equivalent of a hazmat and yet the care
 9 worker went in just wearing an apron.
 10 So we are very aware and we've presented evidence to
 11 the Inquiry of the different stages of PPE requirement,
 12 and then in some instances, when it was not required to
 13 use particular PPE, we had to -- and were in dialogue
 14 with unions who were saying that providers were
 15 withdrawing PPE or withholding PPE, and that was not the
 16 case because it wasn't necessary. I don't know of any
 17 instance where any provider, deliberately knowing that
 18 you should use PPE of a particular nature and who had
 19 that PPE, withheld that PPE because why would they do
 20 that? I would be interested to see the evidence of the
 21 trade unions.
 22 Q. Okay, well, you will hear it in due course.
 23 Dr Macaskill, I'd like to, given the time, just go
 24 briefly to your lessons to be learned. You provided us,
 25 in paragraphs 117 onwards, with your views on the

182

1 lessons that you feel should be learned. A lot of these
 2 we have touched on in your evidence, but I wonder if
 3 I could ask you, sir, to read paragraphs 121 to 123
 4 inclusive, so that we just get that in your own words.
 5 A. "The keeping of provider bodies at arm's length during
 6 the pandemic was a critical error and meant that
 7 opportunities to benefit from the knowledge and
 8 experience of the sector were repeatedly missed.
 9 "This resulted in an inadequacy of guidance, lack of
 10 contextual awareness around clinical needs for example
 11 residents who had dementia and the operational realities
 12 of delivering care home and homecare services. The
 13 application of practice appropriate in one area
 14 (typically an NHS acute setting) to another area was
 15 assumed. The felt presumption of Scottish Government in
 16 its guidance was that the social care sector is an
 17 extension of a clinical NHS environment and it is not.
 18 It is still the case that the group overseeing pandemic
 19 preparedness does not have anyone on it from a direct
 20 social care delivery perspective. There is also no
 21 equivalent role to the Chief Medical Officer for social
 22 care within the Scottish Government.
 23 "Had it been invited to participate at an earlier
 24 stage, I believe that Scottish Care could have helped
 25 the Scottish Government to foresee some of the

183

1 challenges that arose in the care sector which would
 2 have helped to mitigate the subsequent impacts.
 3 I consider that it is essential that representatives
 4 from the social care sector are involved in future
 5 pandemic planning exercises."
 6 Q. Thank you. Dr Macaskill, as with all witnesses, we
 7 invite, at the conclusion of evidence, to address us on
 8 any matters that you feel require to be taken into
 9 account or that we haven't dealt with, so I'll offer you
 10 that opportunity now, if I may.
 11 A. I want to thank the Inquiry for giving me the
 12 opportunity twice now to describe the impact, and there
 13 is no substantial matter to raise other than maybe to
 14 recall a conversation I had last week with a front-line
 15 nurse at an event that I was -- two weeks ago -- at an
 16 event that I was attending, who came up to me and said,
 17 "The pandemic is not over for me. Every night I go to
 18 bed, I see the faces of those residents who are no
 19 longer here and every night I ask myself could I have
 20 done better". I think she's reflective of the vast
 21 majority of providers of care and front-line staff. We
 22 are always remembering those who are no longer here and
 23 asking ourselves, "Could we have done better?", and we
 24 leave it for others to decide that.
 25 MR GALE: Dr Macaskill, on that point, the Inquiry is very

184

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

185

1 INDEX

2

3 MS DALJEET DAGON1
 (called)

4 Questions by MS TRAINER1
 MS CAROL-ANN CROSSAN60
 5 GURUGE (called)
 Questions by MS TRAINER60

6 MX CASS MACDONALD97
 (called)

7 Questions by MR GALE97
 MR DONALD MACASKILL138
 8 (recalled)
 Questions by MR GALE139

9 (continued)

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

186

A
 abandoned (1) 116:17
 abbreviate (1) 107:6
 abide (1) 74:9
 ability (16) 2:24 12:12
 26:3,13 28:5,12,15
 46:15,23,23 144:2 148:21
 154:6 158:18 171:15
 173:18
 able (78) 1:22 9:17 12:8
 13:13 18:1,9 19:18
 20:6,16,17,18 22:3,4 24:15
 26:9 28:14,16,17,20,25
 30:5,21 31:16 32:15 33:1,9
 34:22,24 38:7,8 41:2
 44:24,25 45:24 46:24
 49:14,19 51:22 52:6 53:12
 55:19 61:9,17 62:18 63:25
 65:9 70:20 75:16 77:3,17
 79:13 82:2 83:1 91:2,3,18
 92:9,10 94:14 95:21 96:9
 101:7,13 103:6 107:11
 117:23 121:9,21
 128:8,12,16 140:16,16
 144:16 154:8 163:19,20
 176:18
 ableism (2) 116:25 122:1
 ableist (1) 104:22
 above (2) 10:18 108:4
 absence (2) 149:1 152:11
 absent (2) 166:22 167:12
 absolute (1) 154:25
 absolutely (10) 40:19 50:12
 65:11 78:23 90:17 136:8
 160:2 161:10 166:2 178:16
 abuse (14) 3:17,17 8:7,7
 11:24 19:11,23 48:19
 104:17,18 174:5,6,10,25
 abusive (2) 14:13 48:18
 accept (3) 38:22 40:16 138:3
 acceptable (2) 169:14 180:9
 acceptance (2) 138:1 139:24
 access (35) 5:13 6:22 12:4
 14:6 15:11,25 16:12 19:15
 27:24 29:21 32:5,21
 44:6,7,7 78:16 106:15
 116:24 121:6 123:11,11
 124:24 127:4,3 128:12,16
 131:19 132:13 134:4
 136:15 149:10 150:12,22
 174:7 181:21
 accessing (5) 10:16 11:12
 78:20 122:5 132:8
 accommodated (3) 55:17
 63:23 64:5
 accommodation (1) 84:15
 according (1) 164:22
 account (7) 110:9,14 120:1
 130:7 135:15 153:13 184:9
 accountable (1) 137:13
 accurate (1) 180:21
 accurately (1) 124:18
 accused (1) 175:8
 achieve (2) 142:18 155:19
 acknowledge (1) 164:7
 across (14) 20:5 64:22 85:24
 94:6 104:8,14 120:4
 135:23,24 146:18 148:2
 154:11 170:18 171:9
 acting (3) 58:3,6 181:19
 action (1) 70:10
 actions (1) 174:19
 activation (1) 101:18
 active (2) 124:8,9
 activities (2) 15:10 17:12
 activity (1) 9:2
 actual (2) 43:14 98:19
 actually (109) 4:10
 5:7,8,16,18,20 6:1 8:6,9
 9:10 11:5 12:12,24
 17:17,18,24,25 18:5,6
 19:17 20:12,14,25 21:1,17
 25:8,22 26:13 28:18 30:2
 31:13,15 32:5,23,25
 33:1,14,16 35:1 37:6 38:23

39:3,8,19,25,25 40:10,21
 41:4 42:14 44:6
 45:4,8,9,9,14,15,20 46:25
 48:4 49:19,22 51:22
 52:4,15,18 53:16 54:15,19
 55:16 56:3,5 57:10,21
 59:15 65:20 66:2,11
 68:5,11 70:11,20 71:22
 73:7,15,15 76:2 79:20,24
 86:1 87:23 89:12,13
 95:15,17 107:19 112:8
 115:23 119:3 120:19
 129:10 134:8 137:17
 145:22 167:4 171:23 172:2
 181:11 185:18
 acute (1) 183:14
 adapt (2) 18:10 79:13
 adaptable (1) 40:14
 adapted (1) 79:16
 added (1) 130:3
 addenbrookes (1) 112:17
 addition (2) 12:18 48:15
 adding (1) 139:7
 addition (2) 63:11 101:2
 additional (5) 11:8 24:5
 118:19 199:9 161:21
 address (1) 184:7
 addressed (3) 152:7 164:22
 177:18
 addressing (2) 167:7 179:14
 adequacy (1) 169:21
 adequately (3) 33:9 110:8
 127:15
 adjourned (1) 185:24
 adjournment (1) 97:10
 adjustments (5) 116:24
 117:5 121:8,22 122:12
 admin (1) 39:10
 admit (1) 170:25
 admitted (1) 180:4
 adopted (1) 179:12
 adopting (1) 13:4
 adult (2) 36:4 134:8
 adulthood (1) 35:14
 adults (3) 28:4 47:17 72:24
 advantage (1) 164:10
 advancing (1) 164:9
 advantage (2) 148:9 159:24
 advantageous (1) 147:10
 advantages (1) 44:6
 advertise (2) 43:3,3
 advice (5) 35:17 143:9
 144:10 151:23 172:1
 advisory (2) 107:18 111:15
 advocate (4) 89:3 152:20
 159:11 164:11
 advocating (3) 111:21 129:3
 145:14
 ae (1) 87:18
 aerosolgenerating (1) 114:10
 affect (1) 5:3
 affected (6) 99:11 101:19
 120:18 121:17 125:24
 126:22
 affiliates (1) 181:10
 afford (1) 9:19
 afraid (2) 54:25 185:12
 after (19) 30:12 38:8 47:10
 62:24,25 77:16 80:4 88:19
 95:22 102:12 109:10 111:2
 113:18 116:2 130:11
 134:1,2 162:13 176:24
 aftercare (3) 61:20 64:22
 90:20
 afternoon (2) 156:1,2
 afterwards (2) 37:21 113:16
 again (38) 15:1 31:8,11
 33:10 47:5 52:12 57:5 59:6
 75:18 76:1,20 77:24 78:2
 81:24 82:2 85:15 86:8 95:3
 99:11 110:3 116:13 118:14
 121:10 122:19 124:24
 125:3 127:24 131:22 133:3
 135:9 136:24 149:3 162:23
 165:6 168:18 169:25 174:4
 177:23

against (6) 108:19 113:4,4
 117:8 170:8 176:9
 age (5) 14:25 109:12 123:24
 166:9 175:9
 aged (3) 20:15 36:1 51:20
 agencies (4) 20:6 25:5 28:4
 30:18
 agency (1) 25:8
 aggressive (1) 58:7
 aggressively (2) 101:7
 175:16
 agile (2) 29:12,17
 ago (4) 1:25 149:17 164:6
 184:15
 agps (1) 114:3
 agree (12) 86:3 103:25
 127:18 151:9 152:23 153:5
 156:5,13 157:13 164:14
 167:3 168:12
 agreeable (2) 97:24 98:4
 agreed (4) 66:15 70:11 97:19
 142:17
 ahead (1) 173:3
 aim (3) 64:17 142:18 156:18
 air (6) 6:25 18:19 110:19
 119:6,12,15
 airborne (6) 110:11,13,20,25
 111:22 113:8
 alcohol (10)
 15:3,6,8,12,12,20,25
 16:10,12,16
 alice (1) 137:3
 aligned (1) 73:14
 alive (1) 156:19
 allergic (1) 101:17
 allied (1) 119:18
 allocating (1) 181:6
 allow (3) 154:9 156:6 162:7
 168:19 169:3
 6:10 17:7,19 18:3,15 30:19
 40:8 43:13 45:5 82:11
 87:25 154:9
 allowing (5) 151:16 152:2,2
 154:9 159:4
 allows (1) 156:10
 alluded (1) 122:18
 almost (8) 34:24 70:3 71:3,4
 77:4 130:25 155:14 182:8
 alone (1) 130:6
 along (3) 47:11 105:13 131:6
 alongside (3) 28:5,16 29:14
 alpha (1) 115:19
 already (18) 2:22 4:25 37:13
 43:9,10,10 67:15 89:7 91:5
 102:17 139:7 148:10,11
 149:15,23 158:10 168:19
 170:9
 also (120) 2:8,9,20 4:5
 6:2,21 8:1,13
 11:9,14,21,24 12:3,6,10
 13:16,25 14:1,3,6,15,17
 15:25 16:2,15 18:4,17,20
 19:9,20 21:12,13 22:14
 23:25 25:6,10,14 26:2,6,13
 27:8 28:24 29:23,24 30:23
 31:20 32:8 35:12 37:22
 40:23 42:11 43:17,17,25
 44:7 46:14,15 49:2,4,13
 51:23 52:5 53:5,18 55:20
 61:22 64:12 65:24 68:23
 70:5 73:13,20 74:20
 77:8,15 84:7,13 86:14
 92:14,17 95:2 99:4,21,23
 106:5,13 107:15 109:20
 112:7 113:9 114:4 115:18
 119:19 120:25 121:14,25
 123:18,23 125:16 128:18
 129:20 131:1 132:3,18
 134:21 135:12 139:9,17
 142:9 149:12 150:20
 153:10 159:19 160:2,8
 167:13 171:16 172:12
 179:24 183:20
 alterations (1) 174:7
 alternated (1) 67:1
 alternative (2) 2:17 29:5

alternatively (1) 124:7
 although (8) 7:7 9:16 12:3
 48:16,18 96:4 115:20
 121:21
 always (23) 9:5 10:9 11:4,7
 18:9 25:1 27:8,17 29:3
 33:18 39:10 64:19 65:18
 77:1 85:15,19 86:7,11
 120:8 140:10,18 158:22
 184:22
 amazon (1) 22:25
 american (1) 119:11
 amongst (5) 15:3 106:15
 123:23 148:21 149:20
 amorphous (1) 162:2
 amount (1) 135:23
 amplification (1) 98:1
 amplify (2) 25:9,10
 analysing (1) 155:16
 anchor (1) 61:21
 anecdotally (4) 13:22 15:1
 19:24 133:20
 anecdotes (1) 21:18
 anger (2) 138:1 175:23
 angry (1) 174:12
 anne (1) 168:21
 anes (4) 153:17 159:5
 168:19 169:3
 annoyance (1) 175:4
 annual (2) 54:11 132:24
 anonymous (2) 99:24 100:3
 anonymously (1) 99:19
 another (23) 15:1 23:17
 34:1,10 74:20 81:23
 82:17,17 115:3 118:25
 119:2 129:19,19 147:25
 151:17 152:3,4 154:10
 155:12 156:2 166:17
 175:12 183:14
 answer (12) 72:9 75:19
 152:16 161:7 162:23
 166:24 167:3,6,7
 172:4,20,24
 answered (1) 167:1
 answering (2) 129:9 136:23
 answers (3) 137:5 159:20
 164:5
 anticipating (1) 42:15
 anxiety (1) 150:5
 anybody (7) 20:7 140:24
 143:15 146:9 158:17
 159:17 180:14
 anyone (1) 138:7
 anyone (5) 19:17 25:20
 71:20 72:16 183:19
 anything (9) 9:3 32:8 58:25
 62:16 65:25 92:12,22
 96:20 137:14
 anyway (5) 67:17 75:12
 91:2,17 105:8
 anywhere (1) 89:1
 apart (1) 166:21
 apnoea (1) 100:24
 apologise (1) 119:22
 apparent (3) 98:9 142:9
 144:7
 apparently (1) 118:17
 appear (4) 101:7 110:8
 113:21 182:1
 appearance (1) 25:7
 appeared (2) 110:13 182:7
 appearing (1) 61:7
 appears (3) 110:22
 111:10,13
 application (10) 146:3
 147:7,17 153:9 155:7,16
 157:3 164:12 167:13
 183:13
 applications (2) 117:24
 118:1
 apply (3) 87:12 134:19 167:5
 applying (3) 123:21 134:14
 152:19
 appointed (1) 159:21
 appointment (1) 88:20
 appointments (5)

88:12,15,16 121:7 129:9
 appreciate (4) 9:11 19 97:3
 115:13 165:8
 appreciated (1) 24:6
 apprenticeship (2) 36:1,2
 approach (4) 27:13
 72:13,14 120:15 129:1,4
 135:11 139:18 145:9,13,16
 146:16 147:4,8,11 148:3
 151:17,25 152:3,20,21
 153:23 154:2,4 155:3,6,22
 156:3 161:3 162:21 163:10
 164:8,10 165:2,2,21
 166:25 167:5,6,24 172:12
 approaches (1) 151:14
 appropriate (7) 7:16 49:12
 119:8 153:11 181:6 182:3
 183:13
 appropriately (1) 162:12
 appropriateness (1) 182:4
 april (16) 1:1 100:14 102:13
 110:14 142:4 143:24,25
 149:19 151:8,11 152:15
 154:13,16 171:6 179:2
 185:25
 apron (1) 182:9
 area (7) 26:23 128:25
 151:15,24 175:6 183:13,14
 areas (4) 74:3 109:5 120:2
 174:3
 arent (6) 44:20,21 57:11
 127:22 136:23 146:2
 argue (3) 117:1 157:22
 159:22
 argued (3) 157:6 161:24
 162:4
 arguing (1) 114:17
 argument (3) 152:14 157:12
 164:8
 arguments (1) 19:12
 arise (1) 166:20
 arisen (1) 103:4
 armed (1) 105:14
 arms (1) 183:5
 arose (1) 184:1
 around (33) 8:9 13:4,4,5
 15:5 19:7 22:14 34:16,21
 39:18 51:7 52:20,22 57:25
 61:5 67:18 80:14,16,19
 81:7 85:9,25 92:7
 106:12,13 110:15 115:23
 127:9 159:2 164:17 171:19
 177:13 183:10
 arrange (1) 5:15
 arrangements (2) 68:18 89:9
 arrangements (3) 11:17
 81:13 101:25
 aware (2) 20:2 70:5 85:21
 112:3,4 127:15 131:3
 135:10 140:13 149 142:14
 144:11 145:23 147:3,4
 157:18,23 160:6 168:20
 170:3,10 182:10
 awareness (2) 48:21 183:10
 away (4) 13:12 35:5 49:1
 77:9
 awful (6) 106:12 110:18
 124:22 130:3 132:13
 175:11

136:20 152:2 153:2 167:17
 182:3
 assessments (4) 21:14 46:25
 75:12 153:11
 assist (1) 9:15
 assistant (1) 62:15
 assisting (1) 139:6
 association (1) 156:22
 assume (4) 7:10 59:9 110:19
 179:4
 assumed (2) 164:24 183:15
 assumes (1) 129:10
 assuming (1) 117:4
 assumption (2) 16:17 110:7
 assurance (2) 141:8 179:6
 assured (1) 119:25
 asthma (1) 100:13
 asthmatic (2) 122:20 123:2
 asthmatics (1) 109:20
 asymptomatic (1) 61:23
 atrocious (2) 178:16,17
 attached (2) 61:21 126:22
 attempt (2) 31:21 117:19
 attempted (1) 122:12
 attend (2) 77:2 109:23
 attendance (2) 117:7 133:1
 attended (1) 164:21
 attending (2) 88:12 184:16
 attention (4) 11:3 14:20
 32:25 113:25
 attributed (1) 55:5
 audit (1) 102:6
 august (2) 102:11,14
 aunt (1) 138:10
 aura (1) 115:18
 authorities (6) 2:10 21:12
 45:21,22,24 167:20
 authority (26) 2:25 3:23
 4:2,5,17 6:8 11:3 14:1,17
 43:7,11 44:14,15 55:8 56:1
 62:23 64:5 66:14 70:13
 80:5 82:20,23 83:5,21 84:5
 92:17
 autumn (2) 160:25 165:14
 availability (3) 109:14
 131:18 132:15
 available (5) 96:17 120:11
 121:23 147:12 170:4
 average (4) 108:1 115:8,9
 171:9
 aversion (2) 144:25 171:20
 avoid (1) 16:22
 avoidable (1) 108:14
 avoidance (1) 166:23
 avoided (1) 151:20
 awakening (1) 126:12
 awarded (2) 134:9,15
 aware (22) 20:2 70:5 85:21
 112:3,4 127:15 131:3
 135:10 140:13 149 142:14
 144:11 145:23 147:3,4
 157:18,23 160:6 168:20
 170:3,10 182:10
 awareness (2) 48:21 183:10
 away (4) 13:12 35:5 49:1
 77:9
 awful (6) 106:12 110:18
 124:22 130:3 132:13
 175:11

B

b (1) 9:14
 baby (2) 47:10,11
 back (51) 3:9 8:25 13:23
 16:13 17:18 19:10
 20:11,22 21:3 66:3 67:6
 68:4,24 69:15 70:6 71:15
 77:2,17 79:19 81:10 90:7
 91:19 92:11,23 93:19 94:1
 96:1,13 102:12 103:16
 106:19 107:2 113:19
 115:25 121:7 130:13
 132:20,23 133:2,9,12,25
 135:18 138:25 139:5,15
 156:7 165:13,19 180:24
 185:1
 backed (1) 107:25
 background (4) 1:24 100:6
 145:11 155:2
 backs (1) 27:19
 backtoback (1) 50:10
 bad (4) 6:6 75:24 103:12,13
 bags (1) 22:23
 balance (3) 41:25 59:22
 149:9
 balanced (1) 180:9
 balancing (1) 150:13
 band (1) 102:3
 banks (3) 42:19,21,21
 banned (1) 114:13
 bargaining (1) 138:1
 barnardos (14) 1:16 25 4:3
 54:4 60:22 64:24 66:14,18
 70:13 71:25 73:14
 85:22,25 94:18
 based (6) 4:17 62:11 106:23
 109:1 110:7 164:18
 basic (6) 9:21 50:23,23
 52:18 57:16 146:10
 basically (6) 3:9 6:13 19:3
 66:22 118:20 125:21
 basis (2) 17:15 113:5
 bathroom (1) 5:23
 battle (1) 106:4
 bbc (1) 107:16
 bearing (5) 44:14 158:3
 beads (12) 165:11 176:17
 hears (1) 1:19
 beautiful (1) 67:13
 became (13) 12:20 25:9
 31:11 83:1 85:21
 111:16,16 141:2 156:24
 157:1 164:20 170:14
 171:18
 become (1) 43:1
 becomes (3) 35:10 43:14
 160:3
 becoming (1) 14:12
 bed (2) 16:6 184:18
 bedtime (1) 32:13
 before (27) 8:14 17:20 22:2
 32:23 37:19 47:20 49:6
 53:7 59:5 64:10
 65:6,14,20,25 66:13,23
 67:5 75:21 104:24 123:14
 126:10,13 129:23 168:24
 178:23,25 181:8
 beforehand (1) 130:2
 began (3) 1:25 17:17 177:8
 begin (1) 130:11
 beginning (6) 10:24 77:11
 83:2,23 102:23 116:14
 begins (1) 123:12
 begun (1) 148:15
 behalf (4) 94:18 97:23,25
 106:1
 behave (2) 34:23,23
 behaved (1) 176:1
 behaviour (7) 25:6 57:19
 58:6,14,16,19 176:7
 behavioural (1) 33:17
 behaviours (3) 167:14
 175:1,20
 being (106) 3:16 6:9 7:24
 8:2,10,17 11:13 12:1 13:20
 14:6 15:7 16:19,22 17:4
 19:9,18 22:18 23:13 26:9
 28:14 30:10 31:16 33:6
 36:5,18,25
 44:1,2,12,17,24,25
 45:13,14 47:25 51:25
 52:20,22 55:17 56:2 57:3
 58:7 69:2 74:2 77:16
 80:4,22 81:7 83:15 84:13
 88:10 89:5 91:14 95:18
 107:24 108:25
 109:4,13,21,21 117:7,14
 122:3 126:7,15,16 128:24
 130:3 131:6 132:19
 134:15,23 135:3 136:10,10
 137:6 139:25
 140:14,16,16,20,23,25

148:8 150:12 153:2,25	bottle (3) 15:14,22,23	136:24 138:7,10,11,12	chairs (1) 122:8	chosen (1) 42:22	commission (3) 148:13	113:21 135:12 137:3
156:17 157:5 159:14	bottles (1) 15:15	167:23	challenge (9) 25:14 32:6	christmas (1) 10:4	166:13,14	168:11
160:18,22 162:2,25	bottom (1) 125:7	capacity (7) 2:21 4:21 5:9,20	37:6 147:25 158:12 159:2	chronic (7) 100:13,19 101:2	commissioned (2) 4:1 40:9	considered (1) 180:7
163:19,20 165:14,22 166:3	bought (2) 122:6,7	28:14 54:14 55:5	169:20 171:10,12	103:4,8 117:8 121:3	commissioners (3) 38:11	considering (2) 119:8 161:4
173:4 177:21	boundaries (3) 32:12	capture (1) 73:21	challenged (1) 146:25	chunks (1) 53:7	62:17 148:22	considers (1) 130:17
180:4,5,13,14	40:19,25	car (2) 88:20,22	challenges (10) 20:3 24:24	churning (1) 59:16	commitment (1) 177:6	consistency (5) 89:17
belief (2) 121:1,11	bow (1) 23:22	cardiac (1) 100:21	33:13 36:22 40:18 42:18	circumstance (5) 153:14	committed (2) 42:2,3	90:5,10 153:3 154:5
believe (29) 72:22,23 98:18	boyfriend (1) 23:19	cardiology (1) 126:2	59:14 169:18 173:13 184:1	154:19,24 155:7 165:6	committee (3) 106:8,9 125:2	consistent (1) 102:18
100:15,24	boys (3) 17:2 58:5,9	cardiovascular (1) 130:8	38:12 43:2 56:17 160:9	166:19 168:11 173:14	committees (1) 178:25	consistently (1) 149:8
103:7,11,14,15,16 104:4	brackets (1) 149:12	care (146) 2:24 11:16 21:13	167:11	87:22 114:7 122:19 134:9	common (2) 120:5 164:12	constant (2) 79:9 149:5
106:21 108:24 109:13,15	brain (2) 101:8,10	44:5,14,22 64:19 70:25	chance (1) 3:10	166:19 168:11 173:14	commonplace (2) 178:22,23	constantly (4) 24:10 65:19
110:9 115:18 116:9 117:13	breaching (1) 16:18	71:2,6,8,9 72:19,24,24	change (9) 21:14 25:6,6	city (1) 2:11	communicable (1) 171:13	74:22 75:11
120:14,25 125:22	break (7) 38:14 49:17,20	73:1,6,10 80:5,6,10,11	65:10 89:8 111:11,11	claire (1) 103:3	communicate (1) 45:24	constrained (2) 172:25
127:16,18 128:13 130:5	52:25 60:12 101:22 138:22	81:9,10,15 85:2,24 91:14	127:6 134:8	class (9) 30:11,12 33:25	communicated (2) 144:8	176:16
135:5 136:16 183:24	breakdowns (1) 64:4	93:5 106:15 107:14 109:2	changed (6) 46:5 65:16	34:1,3,10,10,18,25	150:10	construction (1) 69:21
believed (1) 20:19	breakfast (3) 9:18,24 24:9	119:17 123:11,12 134:19	111:2 150:1 151:5 156:20	classes (1) 34:22	communicating (3) 29:3	consultant (1) 110:12
bell (2) 30:4 34:17	breaking (1) 57:18	136:2,14 139:14,21,24	changes (5) 75:1 89:5 131:1	classmates (1) 34:4	87:8 144:16	consultation (1) 128:19
belligerent (1) 126:24	breaks (1) 72:4	140:18,18,24 141:12	156:15 169:10	classroom (1) 30:15	communication (3) 84:13	consumed (1) 16:15
beloved (1) 147:16	breathe (1) 144:2	142:6,8 143:7,8,13,24	changing (7) 74:22 75:13	clause (1) 168:25	96:5 141:10	contract (27) 13:21 19:17,17
beneficial (2) 16:21 18:4	brick (1) 125:5	145:1,5,10,17 146:5,10	79:23 114:22 117:19	clean (4) 119:5,12,15 168:17	communications (3) 80:21	26:19 42:10 45:23 80:21
benefit (9) 1:19,19 61:7	briefly (5) 61:17 119:9	147:22,22 148:4,11,14	130:24,25	clear (8) 30:1 40:15 54:24	83:14 139:23	81:1,11,14 82:5,12
64:20 134:11 138:15 144:3	176:14 177:23 182:24	149:4 150:17 151:16,23	chapped (1) 10:9	83:25 85:16 143:3,4	communities (1) 163:14	83:2,5,14,17,25 85:1,7
160:18 183:7	brilliant (2) 17:4 178:15	152:9 153:14 154:3,7,8,22	characteristics (1) 137:8	180:18	community (12) 63:5 120:11	86:13 96:10 133:8 142:22
benefits (7) 37:8 40:24 68:18	bring (7) 12:22 47:8,10	156:17 157:20	charge (4) 90:18 94:4 108:18	clearly (6) 54:6 71:7 104:21	125:16 129:2 132:5 136:7	144:18,24 150:9 153:19
117:22 118:1 134:4,12	122:17 145:9 169:20	158:3,6,10,16,18,19,24	113:4	135:12 146:14 162:9	140:19 160:4 176:7 177:1	contained (1) 142:12
best (10) 13:13 28:10 31:5	173:11	159:1,15,17,21,25	charities (1) 143:14	clinic (1) 126:6	179:25 182:6	contains (1) 107:7
59:7 89:16 93:6 103:2	bringing (1) 70:6	160:4,4,7,11 161:16	charity (1) 5:8	clinical (10) 164:17,22	comorbidities (1) 180:2	content (2) 119:9,13
122:13 151:4 177:5	broad (4) 98:18,20 106:2	162:2,6,15	chatting (1) 20:12	166:10,16 178:13,21 179:5	companies (3) 115:19	contention (2) 119:9,13
bestow (1) 162:5	115:20	163:1,12,13,17,23,25	check (2) 66:10,20	180:19 183:10,17	172:11 173:7	141:25 148:19 149:18
betrayal (1) 137:14	broadbased (1) 98:16	164:23 167:8,10	checking (1) 130:24	clinicians (1) 179:23	company (1) 154:14	155:9,15,16 164:16 165:13
better (11) 18:25 29:6 31:24	broadcast (1) 98:6	168:6,10,12 169:2	chief (2) 166:7 183:21	clients (1) 129:3	compare (2) 42:15 112:14	174:10 178:24 179:1,19
33:11 41:24 45:7 83:1	broadener (1) 141:14	170:3,6,10,11,22 171:14	child (41) 2:6,20 3:14,19	clockwork (1) 44:10	compared (1) 162:11	contexts (2) 147:5 174:25
147:2 175:3 184:20,23	broadly (2) 169:11,13	172:9,10,16 174:7,22,23	11:2,4 12:12 14:23 17:22	close (4) 56:6 58:24 86:16	compassionate (1) 175:21	contextual (1) 183:10
between (14) 32:4 33:7 80:2	brother (1) 35:25	175:17,21 176:4	18:19,20 19:6 20:23 28:20	142:20	compensation (2) 105:13,14	contingency (1) 72:4
83:6 85:18 87:23 131:4	brothers (3) 11:20 13:10	177:1,1,15,20	29:6 31:1 33:18 36:17	closed (4) 4:19 43:19 46:20	competitiveness (1) 11:21	continually (1) 150:13
148:22 155:11 157:19	52:22	178:9,10,10,13,14	46:2,11,13 47:16,19	106:11	compile (1) 46:24	continuation (1) 172:18
163:12 178:2,3 180:12	brought (2) 119:16 180:19	179:13,24 180:8 181:5,24	48:3,5,12,19,20,25 49:1,2	closely (3) 62:24 119:17	complete (2) 142:5 162:18	continue (8) 22:2 27:1 58:21
beyond (3) 30:6 119:4	bubble (2) 82:16,18	182:8 183:12,16,20 222:24	50:2,12 54:2,3 55:16 59:24	181:14	completely (2) 46:5 108:23	94:4 95:12 102:9 122:10
177:20	build (5) 37:16 40:10,11 52:1	184:1,4,21 185:2	69:11 74:8 81:14 101:15	closing (1) 143:23	complex (1) 132:1	162:7
bias (1) 116:25	53:9	careers (5) 35:16,17 118:7	136:9 138:4	club (1) 23:13	component (1) 158:13	continued (7) 39:13 49:23
big (9) 67:15 71:17 92:18	building (9) 4:18,19,22,23,24	136:9 138:4	childhood (1) 125:23	clyde (1) 120:16	compromise (1) 13:4	64:19 77:16 139:4 158:9
95:7 104:17,23 105:23	12:15 34:11 67:21 92:21	carexperienced (2) 87:14	children (163)	cmo (1) 167:9	compulsory (1) 76:6	186:9
106:16 128:1	bulk (2) 15:16,18	93:7	2:14,16,19,22,25	coached (1) 7:24	computer (1) 78:13	continuing (1) 126:21
bigger (2) 34:8 115:23	bullying (1) 117:11	carefully (1) 98:10	3:2,4,13,16,18,20	coalition (7) 97:16,23,25	concentrate (1) 119:24	continuity (1) 153:19
biggest (2) 24:23 49:22	burnt (1) 74:24	caregiver (1) 157:22	4:6,10,11	99:20 106:1 107:6,7	concentration (1) 101:11	continuously (1) 146:23
bill (1) 168:25	busier (1) 55:4	caregivers (2) 158:5,9	6:9,16,20,21,24,24	coerced (6) 8:2,10 14:6 15:8	concern (4) 145:2 157:2	contraception (1) 14:6
birth (4) 80:18 82:11 83:6	business (1) 174:15	carehome (1) 182:2	7:2,6,17,23 8:1,4 9:16	16:14 19:18	163:2 171:18	contract (3) 102:13 117:15
84:18	buy (2) 15:15 22:25	carer (2) 11:19 182:7	10:16,25 11:6,9,10,11,25	coercing (2) 9:8 19:4	concerned (6) 4:12 25:22	121:10
birthdays (1) 10:3	buying (5) 9:23	carers (7) 2:19,24 12:10	12:3,6,7,14,19,24	coffee (2) 28:10 53:2	116:1 151:1 163:18,18	contracted (4) 100:14,15
bit (34) 5:15,18 26:10 45:21	15:14,17,18,19	17:23 18:18 159:10 163:6	13:3,7,20,24	cognitive (2) 101:9 140:15	concerns (10) 24:15,19,21	112:19 133:11
52:25 67:19 68:4 71:16,24		caring (3) 88:11 95:19	14:6,11,14,19,24 15:7,11	cohort (2) 144:23 150:20	25:12 26:2 27:11 106:10	contracting (1) 107:21
73:2 79:7 82:25 85:16		109:17	16:11,14,18,20 17:14	coldcall (2) 27:15,16	136:18 137:10 180:13	contractors (1) 148:22
86:23 89:10 92:25 93:3,11		carolann (3) 60:17,21 186:4	18:1,3,22 19:4,8,11,15,20	collaborative (4) 27:13	151:4	contracts (1) 117:12
102:18 103:23 104:1 105:3		carried (2) 108:7,8	24:7,8,10,18,22	152:8,10,21	collusion (4) 112:10	contrary (1) 181:12
111:9 114:1,17 122:5		caseload (3) 51:16,16,18	25:8,10,23 26:7 27:25	colleague (2) 39:20 182:5	164:9,11 184:7	contribute (1) 158:19
126:11 133:20 139:15		cases (6) 28:21 56:6 106:22	28:1,6,11,15,21,23 29:25	colleagues (21) 14:15 22:21	condition (14) 100:10,22	contributed (1) 133:13
167:21 171:8 178:5		117:13 122:11 124:21	30:3,7,18,19,20,23	39:18 40:22 49:24 66:12	101:18 103:4,10,12	contribution (1) 144:5
185:11,11		cash (10) 97:13,14,20,22	31:2,6,10,14,17,18,22	70:9 104:13 114:18 116:16	121:3,18 124:5,11,14	control (7) 17:16,18 102:6
bizarre (1) 30:7		111:18 118:21 135:17	32:1,3,8,16	130:21 132:3 136:5 143:3	125:20 126:3 127:9	111:15 114:20,21 161:19
black (2) 146:2 155:15		137:16 138:14 186:6	33:7,14,15,15 34:5,6,19	163:23 169:12 173:12	conditions (6) 25:18 100:13	controlled (1) 100:20
blanket (5) 153:11 154:20,23		categorise (1) 73:6	37:9 38:8 40:11 46:12,25	178:14 180:20 181:15,25	109:3 117:8,10 124:15	conversation (4) 6:18 52:7
164:24 165:7		category (3) 3:6 33:5 84:9	47:3,4,7,8 51:6 52:15	collection (1) 136:21	condolences (1) 136:4	148:16 184:14
bleed (1) 131:24		cause (1) 11:8	53:16 55:9,13,15,23,24	college (4) 87:3 114:2	conference (1) 48:4	conversations (6) 14:17
blind (1) 157:7		caused (3) 10:17 57:4 176:12	56:1,15,19	140:5,7	conferences (2) 46:3 47:19	28:13 48:23 52:11 57:11
block (1) 89:24		causes (1) 122:15	57:2,7,9,11,15,20,24	colouring (1) 10:1	confidence (3) 30:21 141:8	158:24
blog (3) 142:12 144:7,13		caveat (3) 18:8 173:3,22	58:2,6,7,15,18,20 59:8	come (40) 3:6,22,23 5:21	146:24	cooped (1) 11:25
board (1) 171:9		cdc (1) 119:10	60:1 72:25 73:1,22 74:13	14:20 18:17 32:23 38:15	conflict (2) 146:13 150:25	cope (1) 58:17
boards (6) 108:11,20,22		celebration (1) 10:4	75:5 80:19,25 81:19,20	41:21 63:1 64:23 72:5	conflicting (3) 146:1 147:18	core (4) 46:13 63:11 94:25
113:5 120:4 131:5		cell (1) 101:18	82:10 84:3,8,14 86:20	73:21 75:23 78:19,19 81:5	151:14	153:5
bodies (4) 111:15 166:12		centre (2) 46:13 59:24	87:13,13 88:6,11 91:10,15	82:13 83:22 88:25 96:11	confusing (1) 85:16	coronaviruses (1) 112:6
178:2 183:5		ceo (1) 145:10	93:6	100:8 104:8,13 106:19	congregated (1) 158:14	correct (11) 60:24 62:5
body (1) 152:15		cereal (1) 9:20				

131:17,18,20,22,23,25
counsellors (1) 132:16
counting (2) 106:22 124:18
country (2) 161:15 178:16
couple (5) 72:15 149:17
 159:12 180:22 185:14
course (15) 36:12 39:12
 56:24 65:12 99:23 106:19
 120:17,21 134:19 147:20
 150:1 156:5 173:22 175:24
 182:22
cover (2) 60:25 61:15
covered (2) 59:1 96:21
coverly (1) 19:20
covid (97) 6:3 8:17 17:15
 18:23 20:9,10 25:18,18
 56:24 76:15 86:21 90:23
 93:23,24 98:15,21 99:2,11
 100:11,14,14,17,21
 101:2,4 102:19,24 103:1
 104:10,12 105:17
 106:6,10,14,18,22
 107:3,3,15,21,22,24,25
 108:2,3 109:10,12,17
 110:7,10,24 111:2
 112:17,19 113:1 114:14
 120:18 123:16,23,24
 124:4,6,10
 125:1,9,15,19,19,25
 126:16,18,21,23
 127:8,14,15,18 128:3,23
 129:2,24,24 131:11,11,18
 132:2 133:11,13,16,25
 134:18 135:6 136:3,7,11
 163:18 166:22
covid19 (2) 106:8 125:2
covidpositive (2) 171:1 179:5
covidsure (1) 4:23
cpag (1) 179:15
crazy (2) 84:23 86:2
create (3) 71:1 82:8 150:25
creates (1) 152:11
creating (3) 130:6 145:17
 172:17
creation (2) 155:8,23
credit (1) 173:9
criminal (1) 2:7
critical (3) 108:21 179:17
 183:6
critically (1) 142:1
criticism (1) 181:3
criticisms (2) 108:17 110:21
cropped (1) 174:8
crops (1) 101:17
crossan (3) 60:17,21 186:4
crosscorrelating (1) 21:25
cup (1) 37:20
curie (1) 140:5
current (3) 61:12 119:13
 169:11
currently (6) 43:12 51:16
 56:9 103:6,17 123:16
cut (3) 68:8,10,22
cycle (1) 7:2
cygnus (1) 137:3

D

dad (1) 11:19
daft (1) 23:10
dagon (4) 1:7,8,14 186:3
daily (3) 17:15 30:8 101:3
daljset (3) 1:7,14 186:3
damaing (2) 59:8 151:6
danger (1) 45:16
dangerous (2) 130:18 157:7
dare (1) 155:21
data (13) 102:7
 106:17,19,23 107:13 108:1
 123:14,17 124:1,16 125:2
 135:5 136:21
dated (1) 154:13
daughter (2) 69:17 70:17
dawson (1) 160:19
day (14) 6:7 16:2 18:15
 19:19 23:12 90:7,9 101:16

102:11,14 109:18 114:2
 126:19 130:25
days (14) 18:23 68:8,13
 72:15 90:3 103:12,13
 110:24 124:23 140:10,12
 165:10,18 185:14
daytoday (1) 127:7
dead (2) 40:15 41:21
deal (10) 57:6 99:3 104:7
 117:7 120:13 129:8 132:10
 146:4 150:16 169:18
dealing (7) 52:1 57:14 94:2
 114:23 122:1 136:12
 149:22
dealings (1) 165:20
dealt (3) 154:15 180:24
 184:9
death (2) 162:17 163:1
deaths (4) 151:12 171:14
 175:19 176:4
debate (4) 114:17 149:20
 155:24 162:4
decide (2) 147:1 184:24
decided (5) 66:1,5 82:21
 89:14 106:9
deciding (1) 114:11
decision (16) 45:20 92:18
 111:3 114:9 121:9 146:3
 156:17 162:11 166:16
 167:25 170:17 177:19
 178:7 179:11,18 180:13
decisionmaking (3) 145:24
 166:11 167:20
decisions (16) 3:1 5:3,3 6:8,9
 26:4 36:4 47:18 54:18
 109:16 131:2 144:25
 145:25 164:17 167:11
 177:22
decontamination (1) 102:5
decreased (1) 177:12
dedicated (1) 159:21
deemed (1) 141:23
deficiencies (1) 115:6
deficiency (1) 146:18
deficit (3) 148:24,24 179:8
definite (1) 167:2
definitely (7) 24:23 37:2
 39:18 55:7 57:10 77:21
 90:15
definitive (3) 152:22 156:17
 172:23
degree (5) 123:6 125:24
 152:5 153:8 156:8
delay (3) 6:10 118:2 129:20
delayed (4) 1:3 5:4 102:25
 103:23
delays (5) 46:22 109:3
 129:16,21 135:2
deliberate (2) 47:25 53:20
deliberately (4) 7:21 8:11
 53:19 182:17
delineate (1) 140:9
deliver (1) 23:18
delivered (2) 23:11,14
delivering (2) 148:4 183:12
delivery (2) 147:22 183:20
demands (3) 55:22 143:21
 149:9
dementia (1) 183:11
demographic (1) 91:11
demographics (2) 91:9,10
denial (5) 41:1 138:1 150:5
 161:25 165:1
denied (1) 149:6
department (3) 83:21,23
 84:5
departments (3) 3:24 29:23
 120:12
depending (3) 31:2 81:12
 120:15
depends (5) 64:1,7 78:11
 134:23 176:20
depleted (1) 177:8
deployed (1) 30:17
depression (1) 142:23
describ (6) 3:3 19:22 63:19

69:2 86:15 184:12
described (1) 4:14
description (2) 180:21 182:5
deserve (1) 176:9
deserved (1) 163:9
deserving (1) 180:14
designed (2) 115:7,8
desire (1) 145:9
despairing (1) 180:11
desperate (1) 149:25
desperately (1) 151:1
despite (1) 125:21
detail (8) 52:4 102:18 107:10
 116:19 119:8 135:23
 139:16 178:21
deteriorated (1) 53:6
deterioration (1) 142:23
determine (2) 46:14 139:21
develop (3) 108:17 148:21
 169:13
developed (5) 100:21,22
 148:12 152:19 161:20
developing (5) 91:1 113:6
 133:13 167:18 168:1
development (1) 128:10
device (1) 32:4
devices (2) 5:13 19:15
devon (1) 105:11
diabetes (1) 109:7
diagnosed (3) 100:23 101:1,4
diagnose (1) 181:17
dialogue (1) 182:13
diaries (1) 50:9
didactic (1) 157:4
didnt (10) 5:8,13,14
 6:15,21 7:16,21,22,23
 8:8,11 9:22 12:5,11,14
 14:5,7 16:9 17:12 20:10
 21:17,24 24:17
 26:4,12,17,24
 27:17,19,24,24 28:4 29:23
 30:5 31:6,18,19 33:25 34:6
 41:20 42:11 44:16
 45:1,7,11,17 46:17 47:8,9
 48:2 49:11 52:4,5,10
 57:6,25 65:24 67:23,25
 68:4 69:18,19 71:10 73:21
 74:18 76:18 77:18,22 78:1
 79:2,20,25 82:8 84:10
 85:11,25 86:3 87:4
 88:24,24,25 89:1
 93:20,21,21 94:1,15 95:16
 110:14 113:21 131:11
 134:19 137:2,17 142:14,25
 150:8,9 151:10 162:21
 174:12
died (1) 141:3
diet (1) 101:19
difference (4) 23:24 80:1
 148:18,20
different (45) 2:10 10:10
 11:11,12 12:6,24,24,25
 21:11 22:11 30:13 32:1
 34:22 42:5,8 71:24 73:7,8
 80:7 82:15 86:10 91:9
 94:16,20 95:25 114:8
 115:24 120:15 121:5
 131:10 143:2,21 144:21
 149:24 150:3 152:3
 154:22,22 162:11 166:2
 171:3 174:24 180:10
 181:17 182:11
differently (7) 73:8,11 91:21
 92:11,12,23 93:17
difficult (45) 13:16 26:14,17
 31:15 33:6 35:11,15 36:7
 38:6 41:15 47:7 48:15,23
 49:3 56:15 70:14,22
 73:5,19 75:14 76:21 77:6
 78:21 80:14,22 81:23
 83:15 87:5,12,19
 88:3,12,15,21 91:19 92:4
 96:2,12 107:2 118:10
 127:1 130:23 134:4 140:11
 156:13
difficulties (4) 4:18 94:7

115:10 170:9
difficulty (8) 27:5 29:11
 74:20 88:10 156:16
 169:3,24 173:21
digging (1) 111:10
digital (1) 96:5
digitally (1) 87:8
diminishing (1) 162:16
dinner (1) 24:9
direct (3) 13:24 14:13 183:19
directly (5) 3:21,23 81:6
 90:25 144:8
director (1) 62:15
disability (2) 134:8 137:8
disabled (4) 113:12,19
 116:17 126:10
disablement (1) 134:11
disadvantages (1) 44:11
disagreement (1) 146:12
disagreements (1) 158:24
discharge (5) 178:7,15
 179:4,14 180:20
discharging (2) 179:23 180:14
discharging (1) 178:20
discovered (1) 115:21
discovered (2) 175:16,24
discrepancy (1) 45:5
discrete (1) 62:3
discretion (2) 154:1 156:10
discuss (8) 22:4 66:20 72:18
 76:12 78:24 80:18 121:8
 123:8
discussed (5) 66:11,14,19
 91:5 117:16
discussing (3) 16:25 70:9
 85:23
discussion (7) 70:11,13
 71:18,19 84:14 85:9,18
discussions (7) 55:25 65:21
 66:3 70:8 81:7 85:4 95:1
disease (2) 103:7 171:13
disorder (2) 101:5 132:1
display (1) 167:5
disproportionate (1) 142:7
disproportionately (1) 107:9
dispute (1) 155:11
distance (3) 70:1 75:23 82:3
distanced (1) 82:5
distancing (1) 65:21
distinct (1) 51:4
distinction (3) 44:1 87:22
 143:11
distress (2) 118:2 176:13
distressed (2) 58:4,13
distributing (1) 94:17
dival (1) 10:4
diverse (1) 154:19
divisive (1) 31:11
doctors (1) 126:6
document (7) 147:12,19
 148:6,8,18 149:2 152:1
documentation (2) 147:14
 148:10
documents (1) 148:19
does (16) 24:19 54:22 90:3,4
 98:20,24 103:22 110:8
 121:21 125:15 137:19
 156:6 167:22 169:1 172:7
 183:19
doesnt (2) 45:12 147:19
dogs (3) 37:24 38:1,1
doing (39) 9:15 10:1 12:25
 13:11 15:13 18:6 22:22
 35:1 40:7,22 44:18
 45:1,4,10,15 49:19
 53:8,14,14 56:7
 57:15,15,20 60:2 71:8
 72:16 89:22 94:11,20
 95:5,10 99:1 100:2 102:2
 111:23 119:22 128:11
 174:14 175:21
domain (1) 104:11
domestic (3) 8:7 19:11 48:19
dominant (1) 171:19
donald (2) 138:24 186:7
done (32) 9:5 11:4 13:1 15:5

21:20 22:8 27:7 28:6 31:23
 33:11 37:19 50:4 77:12
 79:17 93:14 98:17,19
 99:21 109:9,22 111:9
 112:16 125:1 126:17
 146:23 147:2 152:9 155:19
 165:25 184:20,23
dont (80) 6:3,6 8:16 9:13
 16:4 17:20 18:6 20:2 24:6
 25:19,23 28:3,4 31:12,25
 37:3,4,16 39:24 49:8
 53:19,22,24 54:20,22 58:2
 59:20,21 64:4 69:6 71:6
 72:9,13,16 77:1 79:14
 80:13,16 83:7 88:5,23
 91:15 92:22 93:1 96:1,23
 98:11 104:4,4,5 106:21
 110:15 111:8 113:24
 116:11 117:10 118:11
 127:18 128:5,15 130:4
 133:2,5 134:20,21 137:1
 138:3,7 144:22 145:15
 149:21,22 158:17 160:4
 163:14 167:4 171:23 176:9
 177:3 182:16
door (5) 6:19 9:2 10:7,9
 117:21
doors (3) 68:3 142:20 144:23
doorstep (1) 6:13
dots (1) 20:6
double (3) 68:12 107:20,21
doubt (2) 55:7 166:23
down (26) 38:14 40:7 66:9
 68:9,10,22 73:18 74:17
 75:24 108:25 112:23,24
 116:7,8 117:25 118:1
 124:12 125:18
 134:3,3,5,12 142:20
 156:17 177:12,13
downing (1) 105:20
downside (1) 53:11
downstairs (1) 67:17
downwards (1) 121:13
dr (12) 139:5 164:3
 171:22,25 172:14,19
 180:23 181:9 182:23
 184:6,25 185:5
drafted (3) 156:6 165:23
 168:10
dramatically (1) 150:14
drastically (1) 68:4
dressed (1) 16:5
drinking (2) 16:2,2
drives (1) 134:22
driving (1) 16:8
drop (3) 38:5 134:3,3
droplet (2) 110:19 113:8
droplets (5) 110:8,18,24
 111:12,22
drugs (1) 15:8
dubiety (1) 154:4
due (8) 3:16 13:20 86:21
 106:19 129:24 133:10
 148:25 182:22
dunbartonshire (2) 2:11 4:20
dundee (1) 2:8
duration (1) 65:16
during (29) 7:11 19:19 20:20
 30:10 37:20 38:9 42:3
 43:5,20 50:14 51:14 53:5
 55:14 57:12,24 70:2 76:15
 84:18 108:7 115:21 143:16
 150:1 152:25 162:10
 175:24 176:21 177:16
 181:13 183:5
dusted (1) 50:4
dying (2) 107:21 140:21
dynamic (2) 145:20 150:14
dynamics (1) 25:1
lysautonomia (1) 100:25
dysfunction (1) 101:9

E

earlier (12) 16:13 55:19 84:7
 97:5 116:15 122:19

138:18,19 145:7 166:1
 169:15 183:23
early (14) 18:23 44:7 110:24
 114:12 124:23 133:13
 142:4 153:1,6 154:13,16
 165:18 166:22 178:8
ears (2) 55:12,12
eased (1) 160:24
easier (2) 73:16 93:25
east (2) 2:11 4:20
eastern (1) 112:7
easy (5) 5:6 15:12 26:19
 71:12 76:23
eat (1) 24:10
ebola (1) 116:1
economic (2) 133:17 138:7
economy (5) 12:12
 134:22,23 135:6,7
edinburgh (1) 140:6
educated (1) 30:24
education (17) 4:5 9:18
 12:3,4 26:8 29:18,20,23
 30:25 31:10,22 32:5,8,18
 34:20 36:22 52:15
effect (8) 57:9 116:20
 127:11 142:22 172:15,16
 175:9 176:14
effective (4) 49:25 50:1,2,12
effectively (7) 55:5 62:11
 76:7 95:20 122:25 143:20
 147:1
effects (2) 113:17,24
efficient (4) 49:25 50:1,2,12
effort (1) 6:19
ehlersdansson (1) 100:19
eid (1) 10:4
either (9) 11:19 12:9,19 28:8
 81:10 82:19 141:19 144:8
 147:10
element (1) 154:1
elements (1) 29:16
ellis (1) 179:15
else (2) 7:22 8:8 24:22 29:6
 35:4 48:2,1 53:4
 54:2,7,18,19,22 57:1 58:25
 109:8 115:1 122:4 136:7
 137:14 168:18
elsewhere (3) 143:12 145:3
 179:21
email (2) 154:12 170:23
emanating (1) 141:18
embed (2) 146:7 147:4
embedded (1) 147:12
embedding (2) 147:24 148:3
embrace (1) 59:19
emergence (2) 113:6 124:10
emergency (1) 159:7
emerges (1) 175:6
emerging (4) 109:1 110:10
 113:1 124:1
emotional (6) 3:17 23:9
 33:17 53:6 122:16 174:11
emotionally (1) 32:24
empathy (1) 147:24
emphasis (3) 11:7 140:24
 145:13
employed (2) 45:22 116:22
employer (4) 102:3
 120:14,20,21
employers (2) 107:2 136:13
empowered (1) 78:6
empty (1) 155:6
enable (3) 155:13,19 163:10
enabled (3) 5:5 6:9 152:9
enables (1) 153:18
enacted (3) 153:18 169:6,8
encephalomyelitis (1) 101:1
encountered (1) 170:23
encourage (2) 140:8,13
encouraged (2) 19:14 179:3
encouraging (1) 141:8
end (10) 6:7 34:10 35:23
 128:23 139:25 140:10
 141:14 165:15,16 176:17
ended (3) 77:17 133:25
 139:12

energy (3) 22:13,14 177:7
engage (18) 5:1,5,25 8:16
 12:8 15:10 17:12 26:13
 28:18 29:9,10,23 30:20
 31:22,24 32:18 33:1 54:16
engaged (6) 5:17 32:17
 106:25 169:22 175:20
 176:6
engagement (1) 37:9
engaging (7) 5:9 15:9 17:11
 33:4 36:3 62:17 105:24
enjoyed (1) 157:17
enough (14) 20:24 23:18

109:8 115:1 120:1 136:8
142:15 169:15
evidence (38) 1:22 60:8
61:10 84:8 97:1,25 98:1,5
101:23 106:12 111:5,18
113:15 115:5 138:15
139:7,9,10,12 143:13
146:21 149:16 152:16
160:15 162:14,18 165:12
166:6 167:15,24 170:2
171:24 177:6 182:10,20
183:2 184:7 185:3
evident (2) 71:11 168:3
evolving (1) 117:17
exactly (2) 38:15 79:19
examine (1) 172:3
example (21) 51:13 57:16,16
78:14 87:15 91:3 92:21
103:3 109:6 112:6
114:13,15 122:7,18
124:15,21 127:24 130:8
152:4 181:4 183:10
examples (10) 17:1 63:24
75:1,3 88:9 91:20,22 99:18
124:6,9
exception (1) 118:22
exceptional (1) 106:9
exceptionally (1) 124:13
exclude (1) 58:17
excludes (1) 124:22
exclusion (1) 151:7
excuse (2) 8:18 17:5
exercise (10) 6:25
18:15,16,19,21 19:8 20:21
37:24 105:3 126:8
exercised (1) 153:2
exercises (2) 137:2 184:5
exertion (1) 122:16
exhausting (1) 129:7
exhaustion (1) 177:7
exist (6) 19:25 24:17 125:16
163:4 168:12 169:19
existed (10) 14:3 29:18,19
65:6 106:17 112:5 120:8
148:10 150:19 152:14
existence (1) 144:1
existing (2) 130:4,6
exists (2) 127:18,18
expartner (2) 48:18,22
expect (4) 38:11 39:6,6
68:23
expectancy (1) 163:11
expectation (2) 36:25 40:5
expectations (8) 38:7,12
39:5 40:9,15 41:2 43:2,4
expected (8) 34:20,21 36:13
39:8 109:9 117:9 118:14
119:3
expecting (1) 118:25
pects (1) 43:7
expense (1) 180:8
experience (40) 13:17 29:22
31:21 33:19 35:16 36:9,19
41:4 42:5 48:15 49:3,10
56:13 76:25 77:14 85:14
86:24 90:23 91:13 95:16
106:14 115:24 118:4
121:14,14 125:9 126:23,24
127:17,20 130:1 132:2
133:19 134:7 135:19
140:23 160:2 181:17,18
183:8
experienced (14) 13:22 42:1
59:4 65:25 78:25 94:8
101:16 117 117:10 126:1
131:13 132:19 133:21
experiences (5) 36:7 57:12
76:4 87:3 132:4
experiencing (6) 3:21 116:25
118:2 120:6 127:2,3
expert (1) 173:4
experts (2) 103:2 145:17
explain (21) 3:8 7:15 27:10
38:20 43:5 46:2 73:2 74:1
75:16 103:1 107:10 114:7

116:20 126:25 132:20
140:2 141:21 161:11 170:6
173:13 178:4
explained (2) 27:20 103:2
explicit (2) 135:13 180:16
explicitly (3) 166:4 167:9,16
exploitation (14) 2:6,7
3:20,21 4:2 8:8 15:6,6
17:21 19:23 27:4 28:21
48:13 51:17
exploitative (1) 14:12
exploited (1) 56:2
exponentially (1) 19:16
exposed (12) 16:23 18:22
19:20 20:24 48:19
51:24,25 55:13,14 57:24
58:20,21
exposure (1) 107:23
expressed (4) 144:6 150:5
163:5 173:15
expression (3) 103:21 132:20
139:19
expressions (1) 175:3
expressly (1) 166:25
extend (1) 136:5
extended (1) 102:25
extension (1) 183:17
extent (5) 101:16 104:6
145:5 161:15,24
external (1) 16:23
extra (1) 53:15
extremely (4) 105:5 107:1
118:3 130:23
eye (2) 23:25 157:7
eyes (6) 7:6,6 24:18,22
55:12,12

F

face (24) 7:9,9 36:14,14
37:10,10 38:17,18,22,22
76:25,25 77:17,18,22,22
78:3,3,4,5,18,18 115:9
125:20
faced (6) 45:16 74:21
148:10 150:19 152:14
faces (1) 184:18
facetime (1) 70:16
facetoiface (3) 36:21 49:6
78:8
facilitated (1) 96:7
facilitating (1) 150:18
factor (2) 88:2 104:17
factors (4) 121:19 123:25
164:4,7
fail (2) 143:18 165:7
failed (2) 108:12 113:10
failing (2) 142:7 143:19
failure (1) 181:2
failures (1) 49:22
fair (6) 44:23 100:12 122:4
123:8 146:20 172:21
fairly (1) 126:24
falls (1) 172:3
familiar (1) 62:14
families (68) 3:5,11,11 4:7
5:13,19,24 6:2,6,10,15
7:1,18 8:5,6,14,15,21,24
9:9,12,19,22,25 10:11,21
11:14 15:13,20 17:22 18:1
23:15 24:2,12 25:15
27:6,22,23 28:2 31:12,13
34:14 37:9 39:9 40:11
42:20 51:6,12 54:21
55:9,18 56:19 66:9,16,17
80:18,18 81:11 82:11 83:6
84:18 93:9,17 95:3 141:12
149:21 161:5 175:14
family (68) 2:9,12,13 3:25
4:6,13 5:17,25 6:12 9:11
10:24 11:2,6 19:12
27:4,10,16 28:19,19
32:9,11 36:18 47:23 48:6,9
50:3 52:23 54:13 16:69-24
70:7 71:3 73:16 74:18
78:16 80:13,16
81:13,16,17,20 82:4,6,7

85:1 86:10,11 103:8
139:25 142:22 144:5
146:22 149:23 155:12
156:21 158:1,2,11,17,23
159:9 160:7,8,10,10
163:6,19 169:22
familyrun (1) 143:14
fantastic (2) 44:8 91:25
far (8) 20:2 41:22 51:9,9
105:8 106:21 133:14
173:19
father (1) 49:2
fatigue (2) 101:2 103:8
fault (2) 104:19 133:11
favourite (1) 26:9
fear (4) 149:13,14 162:24
164:2
feared (1) 150:11
fearful (1) 41:21
feature (1) 106:16
featuring (1) 165:22
feedback (2) 13:25 90:1
feeding (1) 13:22
feed (21) 57:4,8 78:18 89:1
90:11 91:11 101:21 116:17
127:16 130:21 133:6
136:18,20 137:19 145:11
146:16 148:5 165:25 169:9
183:1 184:8
feeling (5) 26:11,12 88:22
108:23 116:20
feels (4) 34:4,4 39:14 101:16
fell (1) 84:9
fellow (4) 104:16 105:11
126:9 136:6
felt (26) 18:22 19:8 20:18
22:19,20 33:8 45:6
47:24,25 66:8 74:14 81:8
89:19 95:11 96:8,16 99:16
133:8 135:22 140:2
141:2,6 163:24 168:8
174:24 183:15
female (1) 115:9
few (10) 36:20 61:5 63:2
66:12 77:21 138:18,19
150:2 163:10 165:10
ffp3 (3) 112:12,18 114:25
fidget (3) 9:3 10:2 22:24
fife (3) 2:9 15:16 15:24
fight (3) 58:12,13 106:4
fighting (1) 122:15
figure (3) 123:15,18,20
figures (1) 108:5
filtration (1) 110:16
finally (1) 109:11
financial (3) 44:3 118:2
136:15
find (13) 11:1 23:5 41:15
44:24 54:2,7 75:17 78:20
99:9 115:22 125:3 127:25
171:15
finding (2) 38:23 180:19
finds (1) 130:20
fine (2) 95:24 185:8
finished (1) 97:4
first (26) 1:23 4:13,16 10:17
23:5 26:20 29:22 30:4
39:22 40:3 46:9 52:13
64:12 66:16 68:9,16 83:13
94:5 139:23 159:13 165:18
166:3,11,25 167:1 174:6
firstly (1) 80:25
fiscal (1) 171:11
fit (5) 115:9,18 134:23
154:25 155:2
fitted (2) 116:7,11
fitting (3) 115:3,14,24
five (6) 32:4 49:18 62:22
63:7,7 137:25
flat (1) 125:14
flavour (2) 108:20 120:7
flawed (5) 108:25 109:18
110:3,6 138:8
flexibility (9) 40:12 153:13
155:23 157:4,5 161:24
162:3,6 173:18

flexible (5) 39:2 40:13
155:21 157:8 163:9
fling (1) 144:23
flu (2) 113:19 137:1
flux (1) 171:4
focus (3) 35:4 158:21 169:7
focused (2) 52:3 72:24
focusing (1) 21:22
fog (1) 101:8
folk (1) 38:3
folks (1) 180:12
follow (3) 73:12,14 153:23
followed (3) 65:13 74:16
176:1
following (7) 66:24 67:1
82:15,23,24 149:5 177:24
food (8) 9:16 23:13,15 24:5
42:19,20,21 94:21
footnotes (6) 98:10,12,13,14
99:12,14
forced (2) 18:5 132:24
forces (1) 105:14
foreign (2) 101:13,14
foremost (1) 64:12
foresee (1) 183:25
forgot (7) 20:13,14 92:3
94:15 138:1 163:11 174:22
forgot (1) 46:9
forgotten (4) 91:12 107:16
116:17 163:25
form (6) 1:21 34:23 158:14
168:25 169:9,11
formed (1) 105:10
formulated (1) 172:2
forth (8) 107:4 112:13
114:16 122:1,8 125:4
128:4 130:9
fortnight (1) 21:24
forward (1) 165:5
foster (1) 80:6
found (13) 12:4 27:23 37:23
39:4 41:12 42:6 49:9,10
68:5 75:6 99:12 102:9
107:1
four (9) 39:22 40:3 51:19
68:2,9 104:2,2 111:14,16
foursix (1) 142:21
frailty (1) 166:10
framework (2) 166:15 167:19
frameworks (2) 146:3 155:13
freedom (1) 107:1
freeing (1) 159:24
freeman (1) 157:21
frees (1) 158:20
frequently (4) 108:14 125:9
148:3 159:16
fresh (2) 6:25 18:19
friday (5) 1:1 8:25 156:1,2
178:20
friendly (1) 79:14
friends (3) 31:3 131:11 136:5
frightfully (1) 156:12
front (7) 16:7 36:17 37 39:9
88:3 107:17 142:25
frontline (1) 45:2,9 143:17
146:25 148:15 149:16
150:13 169:22 173:18
184:14,21
frustrated (4) 127:20
174:11,17 176:5
frustration (3) 174:18,21
175:23
frustrations (1) 174:24
fulfill (1) 155:20
full (7) 24:13 43:4 60:20
103:14 104:6 146:7 178:21
fulltime (3) 85:13 86:6,7
fully (3) 119:3 169:1 172:2
function (1) 103:16
functional (1) 101:5
fundamentally (1) 59:23
functioning (10) 4:4 42:11 43:18
56:3,11 63:14 126:6 127:5
130:5,5
funDS (2) 43:22,24
185:2
funnily (1) 23:18

funny (2) 3:9 20:13
furloughed (1) 69:20
further (10) 3:8 73:2 74:1
146:16 128:9 136:19 158:7
164:16 168:4 181:8
fuss (1) 10:6
future (5) 121:10 152:7,17
166:20 184:4

G

gained (1) 154:11
gale (28) 97:12,14,19,21,22
138:14,19 139:2,3,4,5
146:20 153:21 157:14,17
164:6 165:11 171:22 172:6
173:2,23 184:25
185:9,13,16,22 186:7,8
gales (1) 166:24
gap (1) 147:21
garden (1) 12:14
gardens (2) 6:22 82:4
gargling (1) 125:10
gatekeepers (2) 127:13
139:20
gather (3) 106:25 107:11
137:11
gathered (1) 107:13
gathering (1) 102:7
gave (7) 100:1 106:12
112:13,18 126:19 170:2
182:5
gazebo (1) 82:3
geared (1) 79:5
general (16) 51:2 56:22
62:19 85:24 86:14,19 91:4
94:7 103:22 104:6 110:4
115:5 123:7,9 139:17
140:7
generality (2) 19:25 116:13
generally (8) 51:4 62:15
78:24 80:2 81:11 88:10
89:5 99:10
generic (3) 81:1 83:17 85:17
genuinely (1) 150:6
genuineness (1) 104:12
geographic (1) 151:15
germany (1) 135:5
germs (1) 6:4
get (60) 8:4 9:14 12:15,22
16:5 17:6,19
18:16,19,19,20 24:10
26:10,13 27:1,7 28:5,16
29:14 30:4 31:15,21,24
34:11,12,15,22 35:2 43:18
45:7,11 47:2 50:3 52:4
70:18 72:4 83:12 93:24
97:5 104:4,18 107:2
117:4,6,22 118:18 127:21
128:8 134:2,8 135:1,2
139:16,21 146:18 160:5,12
171:1 183:4
getgo (2) 179:21,22
gets (1) 17:22
getting (25) 5:6 6:17,24,25
16:4 18:16 22:24 23:1 24:3
41:23 42:24 58:11,13
74:24 80:2 93:23 112:16
126:3 134:13 155:24 162:3
163:18 174:14 181:21
185:10
gillian (1) 173:15
give (29) 20:17 32:20,20
44:24 49:18 51:13 56:3
57:16 62:19 66:8 87:15
90:4 91:3 98:1,5 108:20
120:7 122:18
123:9,13,15,17 124:14
135:18 144:22 152:16
154:1 162:23 179:19
given (19) 44:17 77:8,10
78:2 99:19 110:1 118:12
122:22 127:5 130:6 135:8
139:7,14 146:24 150:12
153:25 169:17 182:23
185:2
givers (1) 172:10

gives (2) 53:15 155:22
giving (6) 13:7 101:23 136:1
138:14 147:6 184:11
glasgow (3) 2:11 114:3
120:16
glass (1) 35:2
glasses (1) 18:24
glory (1) 155:5
gloves (1) 141:4
goes (5) 1:23 126:15 130:13
154:19 175:11
going (80) 8:24 9:14,15
11:5,11 16:13,19 17:17
18:5 19:2 22:6 26:7,10
30:2 31:5,6,10
33:21,22,23 34:5,11,12
42:20,21 43:10,12 45:17
48:3,24,25 52:16
53:21,23,25 54:1,4,5,6
59:21 66:4 67:24 69:21
70:6 73:20 74:7,9 75:15,16
77:5 78:12 79:3,24,25
80:13 82:6 83:3 87:2,3,9
93:21 97:6 110:18 113:2
117:9 118:22 128:16
132:14 133:3,12 135:18
161:3 162:10 170:17
174:15,15 177:20 178:4
180:24 185:18
gone (9) 25:3 41:24 55:10,24
56:10 60:4 99:12 136:9
167:24
gonorrhoea (1) 14:2
good (30) 1:5,6,8 7:8 8:17
18:7 33:19 56:8 57:11
60:10,14,19 79:15 82:2
91:25 92:6,7 93:13,15
95:14,16 96:14 103:12,13
105:3,4 128:15 138:20
150:20 185:8
government (35) 21:16 24:4
44:12 72:23 73:13 94:18
106:22 108:11,19,21 113:4
116:18 119:10 120:19
127:5 141:18 142:10 143:3
144:9,11 145:1 162:20
165:20 166:4 168:9 170:5
173:10,14 179:10,18,23
180:20 183:15,22,25
16:5 17:6,19
18:16,19,19,20 24:10
26:10,13 27:1,7 28:5,16
29:14 30:4 31:15,21,24
34:11,12,15,22 35:2 43:18
45:7,11 47:2 50:3 52:4
70:18 72:4 83:12 93:24
97:5 104:4,18 107:2
117:4,6,22 118:18 127:21
128:8 134:2,8 135:1,2
139:16,21 146:18 160:5,12
171:1 183:4
getgo (2) 179:21,22
gets (1) 17:22
getting (25) 5:6 6:17,24,25
16:4 18:16 22:24 23:1 24:3
41:23 42:24 58:11,13
74:24 80:2 93:23 112:16
126:3 134:13 155:24 162:3
163:18 174:14 181:21
185:10
gillian (1) 173:15
give (29) 20:17 32:20,20
44:24 49:18 51:13 56:3
57:16 62:19 66:8 87:15
90:4 91:3 98:1,5 108:20
120:7 122:18
123:9,13,15,17 124:14
135:18 144:22 152:16
154:1 162:23 179:19
given (19) 44:17 77:8,10
78:2 99:19 110:1 118:12
122:22 127:5 130:6 135:8
139:7,14 146:24 150:12
153:25 169:17 182:23
185:2
givers (1) 172:10

gives (2) 53:15 155:22
giving (6) 13:7 101:23 136:1
138:14 147:6 184:11
glasgow (3) 2:11 114:3
120:16
glass (1) 35:2
glasses (1) 18:24
glory (1) 155:5
gloves (1) 141:4
goes (5) 1:23 126:15 130:13
154:19 175:11
going (80) 8:24 9:14,15
11:5,11 16:13,19 17:17
18:5 19:2 22:6 26:7,10
30:2 31:5,6,10
33:21,22,23 34:5,11,12
42:20,21 43:10,12 45:17
48:3,24,25 52:16
53:21,23,25 54:1,4,5,6
59:21 66:4 67:24 69:21
70:6 73:20 74:7,9 75:15,16
77:5 78:12 79:3,24,25
80:13 82:6 83:3 87:2,3,9
93:21 97:6 110:18 113:2
117:9 118:22 128:16
132:14 133:3,12 135:18
161:3 162:10 170:17
174:15,15 177:20 178:4
180:24 185:18
gone (9) 25:3 41:24 55:10,24
56:10 60:4 99:12 136:9
167:24
gonorrhoea (1) 14:2
good (30) 1:5,6,8 7:8 8:17
18:7 33:19 56:8 57:11
60:10,14,19 79:15 82:2
91:25 92:6,7 93:13,15
95:14,16 96:14 103:12,13
105:3,4 128:15 138:20
150:20 185:8
government (35) 21:16 24:4
44:12 72:23 73:13 94:18
106:22 108:11,19,21 113:4
116:18 119:10 120:19
127:5 141:18 142:10 143:3
144:9,11 145:1 162:20
165:20 166:4 168:9 170:5
173:10,14 179:10,18,23
180:20 183:15,22,25
16:5 17:6,19
18:16,19,19,20 24:10
26:10,13 27:1,7 28:5,16
29:14 30:4 31:15,21,24
34:11,12,15,22 35:2 43:18
45:7,11 47:2 50:3 52:4
70:18 72:4 83:12 93:24
97:5 104:4,18 107:2
117:4,6,22 118:18 127:21
128:8 134:2,8 135:1,2
139:16,21 146:18 160:5,12
171:1 183:4
getgo (2) 179:21,22
gets (1) 17:22
getting (25) 5:6 6:17,24,25
16:4 18:16 22:24 23:1 24:3
41:23 42:24 58:11,13
74:24 80:2 93:23 112:16
126:3 134:13 155:24 162:3
163:18 174:14 181:21
185:10
gillian (1) 173:15
give (29) 20:17 32:20,20
44:24 49:18 51:13 56:3
57:16 62:19 66:8 87:15
90:4 91:3 98:1,5 108:20
120:7 122:18
123:9,13,15,17 124:14
135:18 144:22 152:16
154:1 162:23 179:19
given (19) 44:17 77:8,10
78:2 99:19 110:1 118:12
122:22 127:5 130:6 135:8
139:7,14 146:24 150:12
153:25 169:17 182:23
185:2
givers (1) 172:10

151:3,4 161:18
growing (2) 91:1 156:24
growth (1) 87:7
guess (3) 69:22 71:24 75:14
guessed (1) 159:18
guidance (61) 12:2 35:17
59:16 66:24 72:19,22,25
73:10,12,13,14,17,24
74:2,8,17,21 79:5
82:15,20,22,23,24
91:6,13,14 93:15 98:18
108:24 110:2,3,5,8,23
111:17 114:22 130:24
139:17 140:21 141:17,21
142:10 147:9,15 149:5
151:15 153:24,24 157:3
160:25 164:25 165:7,22
167:9 168:1,9 169:19
179:12 181:23 183:9,16
guided (1) 36:5
guruge (3) 60:17,21 186:5

H

hadnt (9) 14:3,20 26:16
27:1

164:4,6 166:16 167:10
168:11
hazmat (1) 182:8
head (2) 13:11 171:23
heading (1) 148:8
headlines (1) 57:17
heads (1) 126:7
health (57) 4:5 12:17
14:1,10,15 25:17 86:15,21
87:11,17 88:10,10
100:10,18 106:15
108:11,15,19,22
109:2,3,4,9,11 113:4
117:25 118:9 119:16,20
120:3,4,8,9,12 121:4
123:11 124:5 131:4,14,21
132:5 136:2,9,13
137:19,24 141:12,13
146:6,9 148:23 151:1,2,3
164:18 173:25 176:13
179:13
healthcare (22) 97:15,23
99:20 104:16 105:15,25
106:1 107:9,13,20
108:4,6,12 113:19 116:18
125:15 126:9 127:4
128:2,7 131:8 138:5
healthy (2) 100:17 134:24
heap (1) 44:20
hear (3) 104:25 168:5 182:22
heart (12) 49:24 111:18
114:1 115:5 123:18
124:3,9 149:3,15 150:16
151:13 158:10
hearing (5) 25:11 47:15
78:8,15 185:24
hearings (17) 46:3,10,17,22
47:2,13
76:10,12,14,18,21,21,25
77:12,18,21 104:9
heart (6) 59:24 105:6 141:6
144:25 153:9 154:19
heavily (2) 87:6 91:24
hed (1) 89:1
hedge (3) 167:15 176:3
182:5
hell (1) 163:9
help (6) 6:8 29:24 34:17
77:4 98:24 145:24
helped (6) 76:1 91:18 153:4
169:13 183:24 184:2
helpful (2) 60:7 132:9
helping (3) 2:25 52:15,16
helps (1) 146:11
heta (1) 110:16
here (23) 14:25 21:21 32:21
35:8 40:3,8 50:9 56:2
57:14 71:5,6 100:7 103:22
126:17 155:25 169:4,16
180:25 184:19,22
185:13,15,18
heroes (2) 107:17 136:10
heroic (1) 177:4
herself (1) 48:15
hes (6) 35:25 36:1,1,2,2
110:12
high (3) 34:6 176:25 177:13
higher (4) 107:15,24,24
112:21
highest (1) 177:17
highland (4) 61:20 63:15
64:22 85:23
highlands (2) 60:25 61:2
highlights (1) 180:15
himself (1) 36:5
hindrance (1) 158:12
hindsight (2) 21:8,19
hit (2) 43:11 125:4
hits (1) 105:6
hockey (2) 23:12,13
hold (7) 26:13 137:13 141:3
144:16 163:7,19 167:11
holding (1) 52:14
holistic (1) 128:25
home (136) 2:16,23 5:22
7:20,21 11:15,15,18 13:16

15:20 16:3,10 17:4,8,19
18:2,7 19:12 25:16
26:10,15 28:8,24,24 31:17
32:11 35:1 37:5 38:4 39:21
40:1 41:7 42:1 44:16 47:7
48:16,16,22,23 52:9,21
58:1 59:7,8,9,10,14,16
61:19
62:11,12,13,15,17,22
63:6,8,21,25 64:3,11
67:12,13 69:10,25 70:21
73:6,7 74:6,9 76:23 77:6
81:15,17,17,21,22 82:6
84:16
85:3,7,9,10,13,15,15,19,20
86:1,6,7,10,11 88:13 90:11
95:6 122:13 139:22 140:24
145:18 149:4 150:7,17
151:16 153:14 154:8
157:20 158:6,10,16,24
159:15,17 160:4,7,11
162:2,6,16
163:12,17,23,25 164:23
168:12 170:3,10,12,22
171:14 175:17 176:2,4
181:24 183:12
homecare (2) 145:18 183:12
homes (42) 5:19 6:2 15:13
22:22 63:5 72:24,25 73:1
74:5,6,13 81:15 82:11 83:3
92:20 118:5,6 136:9
139:14 140:18 142:6
143:7,8,13,24 151:23
154:22 156:18 161:17
163:13 170:6 172:16 174:8
177:12,5
178:9,10,10,13,14 179:24
180:8
homework (1) 32:14
homogenous (1) 33:14
honest (1) 42:6
honesty (1) 145:15
honour (1) 167:18
hoody (1) 167:3
hope (11) 56:23 69:6 136:17
137:10,11,11,12 153:17
164:20 169:20 185:16
hopefully (1) 60:4
hoping (1) 104:4
horrendous (1) 44:4
horrific (1) 20:22
hospiers (1) 163:13
hospital (3) 112:17 180:4,14
181:3
hospitalisation (1) 126:18
hospitals (3) 88:5 178:8
179:24
hour (4) 19:18 50:4,4 53:8
hours (12) 18:15,16,21 19:7
20:21 37:24 38:9,9 89:8,22
133:22 141:24
house (16) 6:5 16:5,22 20:18
22:10 24:8 28:12 66:23
67:15,17 74:3,11 81:25
82:1,4 92:19
household (3) 81:23
82:16,17
households (2) 82:16 83:1
however (10) 37:8 103:3
117:9,20 121:21 127:8
131:22 159:22,23 171:5
hpt (1) 148:22
hubs (6) 29:18,20 30:16,25
31:1,10
huge (13) 37:8 42:17 52:2
109:3 116:3,9 118:8 131:8
137:23 138:5 170:15 171:7
173:17
hugh (1) 179:15
human (35) 135:9,14 145:24
146:1,7,10
147:15,17,23,24 148:13,16
153:9 155:1,2,6,13,14,20
156:3,20,24 161:5,25
164:8,10
166:4,13,13,21,25
167:4,5,12,17

humanity (1) 177:5
humanrightsbased (17)
135:11 145:8,13,16 146:16
147:4,11 148:3 149:1
162:21 165:1,2,21 166:20
167:19,23 168:2
hundreds (1) 105:6
hurt (1) 174:12
husband (5) 69:17,20
70:11,18,19
husbands (1) 141:3
hypermobile (1) 100:18

id (17) 41:3 70:19 89:1 97:4
99:7 102:14,17 106:5
123:8 131:16 135:17
165:17 174:3,5 176:21
181:13 182:23
idea (7) 71:21 84:23 86:2
89:22 90:5 113:7 124:4
identified (2) 125:1 164:4
identify (2) 22:5 51:5
identifying (2) 22:25 155:18
identities (1) 137:23
ill (12) 51:13 57:15 70:15
102:1 104:2 107:6 117:25
125:6 164:20 172:21 184:9
185:18
illness (1) 134:11
im (68) 11:22 14:23,24
17:6,13,19 18:5 20:2 24:7
31:5 32:7,12 35:18 38:20
40:8,15 41:19 42:2 50:8
53:18,25 54:4,14,25 55:2
58:12 59:20 72:16
78:12,13 83:23 85:16 88:1
97:7 99:23 101:7,13
102:15 104:3,4 105:8,25
114:9 115:11 118:14,16,19
126:24 134:9 142:6,15
145:16 153:21 156:13
159:13,22 171:24
172:6,19,20 174:9 175:6
177:25 178:22
185:5,10,11,18
imagine (4) 67:8,23 116:5
168:15
immediate (1) 133:23
immediately (2) 4:19 159:1
impact (37) 10:15 31:13
43:21 46:7 70:7 77:20
78:24 86:1 89:11 90:22,23
91:3 95:15,17 122:17
130:10 133:17 135:6,7
143:25 144:20 151:7,10
153:6 154:18 156:23
162:15 171:13 172:8,23
173:5,7,16,18,24 177:9
184:12
impacted (10) 86:14 89:12
136:2 146:22 155:17,18
171:14,17 176:19 177:21
impacting (1) 138:13
impacts (7) 4:15 88:9 133:15
135:3 139:13 172:8 184:2
impinged (1) 155:18
implement (2) 154:6 168:23
implementation (5) 148:17
164:24 169:3,18,19
implemented (2) 159:6
169:17
implication (2) 44:3 114:5
implications (2) 102:19
103:5
importance (5) 100:3
123:22,23 139:24 147:3
important (18) 46:4
50:5,15,17,20,24,25 57:8
59:1 78:22 94:23 96:21
141:9,22 142:1,2 157:2
172:1
impression (1) 144:22
improved (3) 106:20 119:14
163:4
improving (1) 104:3

inability (2) 145:4 146:15
inadequacy (1) 183:9
inadequate (2) 127:6 136:13
inappropriate (2) 49:5 150:6
incidence (2) 107:15,25
incidents (1) 109:1
incidentally (1) 44:19
incidents (1) 137:1
include (2) 59:25 172:10
included (7) 15:17 44:19
59:25 100:2 114:19 141:17
166:12
includes (1) 144:3
including (4) 124:20 125:10
166:6 171:19
inclusive (1) 183:4
income (3) 118:6 134:13,16
inconsistency (2) 152:5,12
incorporated (1) 172:13
increase (4) 15:2 24:20
162:25 171:6
increased (3) 15:20 19:16
86:21
increasing (1) 21:17
increasingly (3) 142:7 163:14
164:1
indemnity (3) 170:2,4,12
independent (1) 181:5
index (4) 176:23,24 177:12
186:1
indicate (2) 99:14 100:8
indicated (1) 170:9
indicates (2) 98:12,13
indication (2) 118:13 165:21
indirectly (1) 144:8
individual (25) 2:13,19 10:25
13:8 50:16 64:2,7 99:25
111:6 123:9 127:17
129:6,8 133:11 143:8,10
151:25 153:19 155:19
159:8 161:25 164:18
165:3,3 176:12
individualised (1) 84:25
individually (1) 165:8
individually (1) 32:6
individuals (22) 99:10 106:14
111:4,6 112:4,15 125:14
132:23 137:6 138:6 142:8
143:7 144:19 149:21 151:3
158:8 160:9 162:8 168:7
172:11 180:1
industrial (2) 107:18 134:11
industry (3) 69:21 170:11,12
inequality (1) 135:12
inevitably (1) 177:7
infected (5) 104:24 112:16
116:2 131:9 162:10
infection (8) 101:4 102:6,12
109:11 111:15 112:22
114:20 161:19
infections (3) 13:18 14:2
107:3
inflexible (1) 136:12
influence (1) 173:17
influencing (1) 26:4
influx (1) 120:13
information (32) 1:21 13:24
14:13 20:5,7,8 22:1 32:2,3
33:2 61:9 69:19 79:8,22
106:17,25 107:1,2,11,20
112:5 125:3 130:17,22
131:5 132:21 137:11
139:15 152:16 174:1,4
181:9
informationgathering (3)
48:8,10 136:22
informed (1) 170:24
inherent (3) 129:16,20
135:13
inhouse (1) 159:25
initial (2) 52:13 128:19
initially (5) 11:17 66:11 79:2
83:16 111:1
initiated (1) 168:20
injuries (1) 107:18
injury (3) 3:17 104:19,23

injustice (1) 136:16
inquiry (18) 1:18,22 61:6,9
99:1 106:6,9,11 115:6
119:7 135:10 136:1 137:12
149:15 165:17 182:11
184:11,25
inquiries (1) 177:21
insist (1) 104:18
insisted (2) 36:21 39:17
insofar (1) 100:10
inspection (1) 171:16
inspectorate (6) 21:13
44:5,14,22 73:10 148:23
instance (19) 6:22 10:23
14:2 22:23 23:11 26:17
29:5 37:24 39:13,16 41:18
42:1 46:16 57:19 147:8
151:23 152:1,25 182:17
instances (11) 174:19
175:15,24 178:19 179:6,14
180:19 181:19,22 182:6,12
institution (1) 74:14
institutional (1) 117:1
institutions (1) 74:13
instruction (4) 153:25
154:6,20,23
instructional (1) 155:22
insufficient (2) 113:5 178:21
insurance (23)
154:11,14,15,18
170:3,7,14,15,20,20,21,24
171:1,2,12,15,15,17
172:24 173:5,7,8,16
insured (2) 154:8 170:8
insurer (1) 154:9
integrate (1) 96:13
intended (2) 141:10,11
intending (1) 173:20
intensive (2) 6:12 32:9
intent (1) 175:12
intentions (1) 27:12
intents (1) 182:1
interact (1) 30:20
interaction (1) 76:14
interactions (1) 30:11
interest (1) 33:4
interested (5) 171:25 172:20
175:6 177:25 182:20
interesting (6) 12:6 20:11
38:25 51:13 125:23 159:12
interests (1) 13:13
interpretation (2) 112:24,24
interpreted (1) 84:2
intervene (1) 55:19
interview (2) 37:4 38:21
into (86) 4:4 5:21 6:1,5 8:2
9:9,22 14:7 15:8,9 16:14
17:11 18:5 19:4,9 20:20
22:9 23:20 25:4 28:9 29:24
30:11 33:9 34:5 41:21 52:4
58:11,13 64:11 66:22
70:6,7 73:16,21 74:7 75:23
81:12 82:17 83:2,3 84:9
88:16 89:21 95:25
104:9,10 106:6,10 107:19
110:9,14 112:8 113:11
116:19 129:6 130:7
132:20,23 134:20 135:15
136:19 137:3 139:21
140:24 145:10 150:2,7
153:24 155:7,24 158:6,9
159:2 161:3 162:3,14
165:19 176:15 177:11,11
178:3 179:2,24,24 180:4
184:8
introduce (1) 177:19
introductions (1) 99:9
intubating (1) 114:24
intubation (1) 114:15
invaluable (1) 141:5
inverness (1) 67:14
invested (1) 12:21
invite (2) 28:9 184:7
invited (2) 173:13 183:23
involve (1) 122:11
involved (17) 15:18 25:21

27:10 32:10 33:21 52:5
85:22 90:24 95:19 99:23
115:11,14 141:11 145:20
166:21 169:12 184:4
involving (1) 125:17
ip (1) 114:20
ipad (1) 32:20
ipc (1) 171:16
irrefutable (1) 152:15
irregardless (1) 105:15
irrespective (1) 154:24
irresponsible (1) 130:18
irritation (1) 158:12
islands (1) 61:1
isnt (5) 26:7 40:7 87:9,25
156:14
isolation (2) 87:1 168:10
issued (4) 139:24 140:7
144:7 168:9
issues (22) 3:15 12:17,18,18
47:24 48:10,16 56:15 57:3
98:14 100:18 104:6 110:15
119:18 126:1 130:8
132:8,9,15 136:19 171:19
178:1
issuing (1) 142:10
its (157) 2:16,18,23,25 3:9
4:3,18 6:7 7:10 9:8,9
17:4,21 18:23 20:13,24
23:10 24:6,8,9 26:8,8,9
34:7,8,35 37:7 37:2,19,22
38:6,15,25 41:3,15
42:7,17,20 43:1
46:11,11,13 50:11,20,22
51:13,21 53:9 54:1,12,23
56:11,18,18 57:14,19
58:15,16 60:21 62:22,25
63:5 64:9,11,14,24
67:13,14,14,14,15 70:15
73:5 74:6 75:24 76:20
78:2,3,12,18,19 80:6,5
90:9 91:19 93:4,5,5,14
95:24 97:19 98:18,20 99:3
100:12,16 101:9 103:11,23
104:19,20 122:2 105:12
107:18 108:2,3
110:11,19,20 111:10
112:24 113:9 116:1
118:10,19,21 119:6,9,14
121:1 124:17 125:6
126:6,11 127:1,4 128:13
129:14 131:23 132:11,12
132:16,11 138:2,13 140:10
146:20 147:15,17 153:15
155:8,16 156:12 157:7
160:16 169:4,13,16 171:23
172:13,21 173:26 177:16
183:16 185:20
itself (2) 83:24 115:24
ive (40) 9:5 17:5 18:6
25:3,5,6 35:8 37:23 38:16
40:20 42:6,19 49:24 53:3
56:12,20 58:9 60:4 61:8
100:20,21 101:4,6
104:1 108:5 110:1 115:11
117:21,22,22 118:9 126:17
134:10 143:12 145:2 146:8
169:15 174:19 179:21

january (1) 160:16
jeane (1) 157:21
job (10) 39:3 40:17 59:23
69:23 116:16 122:22
131:10 147:2 175:21
176:24
jobs (3) 41:24 134:25 136:9
join (3) 20:6 78:13 95:5
joining (2) 116:6 137:7
joined (1) 116:15
joint (1) 116:15
journalist (1) 176:2
journalists (1) 176:9
judgments (1) 153:11
julian (1) 110:12
july (1) 134:10

jumping (1) 176:2
june (2) 101:3 179:16
jurisdiction (1) 173:17
justification (1) 114:8
justly (1) 166:19
juxtapose (1) 108:6

K

karen (1) 182:5
keegan (1) 173:15
keen (1) 18:18
keep (16) 2:16 26:2 48:25
64:17 70:15 74:25 75:13
83:8,11 85:19
117:4,10,14,21 156:18
168:17
keeping (8) 10:6 23:25 49:1
59:23 75:5 142:19 144:21
183:5
kept (5) 8:24 27:22 96:2,4
163:3
key (11) 44:2,13,18 99:22
105:9,14 107:13 127:11
136:6 157:20 176:21
kick (1) 49:7
kickback (1) 145:12
kind (71) 2:5,15,20 3:18
5:4,25 6:10,19 7:4,18 17:3
18:20 19:2,4,13,18 20:6,13
21:11,25,25 22:5 23:1
26:1,20 27:9,12,21 28:10
29:13 30:10 32:13 37:16
39:2 40:4 43:5 52:12
61:18,21 63:5,24 64:14,25
65:15,16,21,23 66:18
67:19 68:12,25 71:5,22
75:20 77:12,24 82:5 88:3
89:13,23 90:5,14 94:25
95:4,6,25 96:9 106:2
125:23 127:22 136:15
kindly (1) 126:19
kinds (1) 115:17
kingdom (2) 106:13 116:2
kitchen (1) 55:2
knew (10) 66:4 69:15,15
79:12,12 113:16,18 144:11
167:21
know (233) 6:13 7:5,22,24
8:8 9:1,4,10 12:15
13:5,10 14:9 15:7,9,16,22
16:4 17:4,24 18:1,4
19:13,16,25 20:23
21:8,9,21 22:9,11
23:2,8,23 24:4,11 25:23
26:7,11 27:17,18,19 30:25
32:4,6,16 33:25
34:18,20,22,24
35:3,13,16,19,19,21
37:7,15,17,20
39:1,7,11,20,24,24
40:2,13,14,23 42:4,16,19
43:11 44:19,25 45:14,17
47:17 48:2,9
49:5,14,15,17,20 50:3,5,10
52:3,12,17,18,22,24 53:4,4
54:17 58:19 59:4,21 64:3
67:23,25 69:18 70:9,15,24
71:4,21,25 72:7,9,10,10,15
73:6,9 74:2,4 76:16,19
79:9,20,25 82:14 85:8 87:1
88:5,24,25 89:23 91:15
92:9,20,21 94:1 96:7
99:25 100:16 103:11,14
104:1,20 106:21 109:1
111:4,7 112:19 113:23
114:12 115:15
116:11,19,22 117:11,23
118:3,9,11 120:16,25
122:1,5,8,11 125:14,17
126:1,6,25 127:2,3,7,16,19
128:7 129:8 130:23
131:4,7,10,23
132:23,25,25 133:2,7,12
134:1,2,13 135:2,4,18
136:12 137:12,25
138:1,4,9,10,12 140:11,17

141:25 144:7 148:2
 149:21,22 151:10 155:9,13
 156:1 158:23 159:13,15
 160:5,12,24 163:14 164:20
 167:2 174:12,15 175:1
 181:15,22,22 182:16
knowing (2) 49:13 182:17
knowledge (11) 72:12 128:9
 143:17 145:22 147:23
 152:18 153:5 156:9,22
 163:16 183:7
known (7) 3:10 14:21 28:22
 132:7 142:14 174:20
 175:18
koper (1) 177:10

L

lack (15) 12:2 32:22 106:17
 109:14 130:17,22 145:21
 153:3,4 161:24 169:7
 178:2,17 179:1 183:9
lacking (3) 31:23 125:3
 167:22
lacks (1) 146:6
land (1) 82:1
languages (2) 101:13,14
laptop (2) 32:20,24
laptops (1) 26:18
large (4) 5:8 10:21 126:17
 170:20
largely (2) 98:14 100:17
larger (3) 31:9 34:8 143:15
last (22) 3:10 39:16 99:22
 100:24 102:11,14,14
 105:19 118:11,15 119:15
 134:10 135:8 138:2 140:12
 141:24 154:12 156:16
 163:10 170:1 180:25
 184:14
lasted (1) 170:18
late (2) 161:3 162:13
later (10) 8:13 11:23 112:10
 149:19 152:25 153:10
 154:18 159:7 162:21
 170:23
latter (1) 140:10
launching (1) 91:23
lawyer (1) 173:4
layout (1) 92:18
lazy (2) 105:1,2
lead (2) 150:24 162:11
leadership (2) 147:16 169:7
leads (1) 131:16
learn (2) 41:5 128:16
learned (4) 56:23 136:25
 182:24 183:1
learning (5) 12:7,9 32:1
 39:19 75:20
least (6) 118:25 140:14
 143:16 157:12 163:9
 185:16
leave (15) 9:2 20:18 31:16
 47:7 69:11 88:4 113:11
 118:22 132:24,25 133:25
 134:18,25 147:1 184:24
leaving (1) 177:11
led (2) 11:24 131:8
left (13) 26:1 28:23
 35:17,19,22 40:25 41:1,16
 57:3 119:2 129:25 160:7
 176:3
legal (2) 99:3 145:17
legally (1) 76:7
legislation (4) 59:17 156:6
 169:20,23
legitimate (2) 142:18 156:18
length (3) 54:12 180:12
 183:5
lengthy (1) 130:11
less (13) 17:2 24:17 41:4
 46:23 54:25 90:6,8 112:14
 152:9 154:1 163:17 178:20
 180:21
lessening (1) 162:15
lessens (1) 103:24

lessons (4) 56:23 136:25
 182:24 183:1
let (7) 6:4 25:20,23 27:24
 29:24 72:10 130:6
lets (4) 49:17,20 59:25
 154:23
letter (7) 81:1,5 83:17,20,24
 84:10 169:16
letterbox (1) 6:18
letting (6) 7:24 8:24 25:16
 27:22 140:24 175:8
level (16) 43:22 108:18 113:3
 121:13,17,17 128:18 145:2
 149:8 153:3,3 159:17
 172:17 177:6,17 181:18
levels (4) 10:18 11:12 57:18
 154:22
liberal (1) 151:17
life (11) 30:8 42:9,16 124:10
 139:25 140:10 141:14
 144:1,4 156:21 163:11
lifelong (2) 103:9,17
lifestyle (1) 120:17
light (1) 24:21
lights (9) 62:4,6,18 63:4,17
 64:23 65:2 80:20 94:5
like (143) 3:11 4:7 5:22,23
 6:7 7:1 8:10 9:2,15,20
 10:1,2,8,22 14:14 16:4
 20:25 22:9,22,25 23:24
 24:4,6 25:1 28:25 31:4,8
 32:8,19,25 33:8,18
 34:7,16,24,24 35:3,6,18,22
 36:15 37:3,12 38:3 39:15
 40:8,25 41:13,13 44:10,25
 45:10,12 46:2 47:5,10,14
 48:3,11 53:3,16 54:14
 55:21,23 56:4,5,18 57:12
 59:5,12,20 65:25 70:16
 71:25 72:4 74:4,11,14
 75:25 76:2 77:1,1 78:4,12
 79:17,20 80:7 81:9,20 88:6
 90:11 92:2 93:17,22 94:21
 95:2,8 96:12 98:11,22 99:8
 100:13 101:8,9,16,22
 102:17 106:5 108:3 110:11
 111:6 118:8 120:2
 122:8,12 125:25 126:2
 127:24 131:16,23,23
 134:25 135:17,19,21,24
 136:1,10 137:1,2,5,8,20
 138:12 141:3 158:25
 165:17 166:12 174:3,5
 177:3 180:12 182:23
liked (3) 68:6 89:25 156:10
likely (3) 16:14 148:1 153:7
limit (1) 149:11
limited (3) 107:12,25 122:7
line (5) 107:17 142:25
 160:17,17 167:12
lines (1) 105:13
list (6) 53:19,21,24
 114:14,16 131:25
listen (4) 136:18 143:18
 144:19 145:4
listening (2) 146:21 179:6
lists (1) 126:14
lists (5) 130:2,4 132:5
 135:1,2
literacy (1) 12:11
literary (1) 167:13
literally (7) 67:4 141:24
 142:20 156:18 160:8 176:3
 179:22
literature (1) 112:11
little (26) 31:21 67:19 68:4
 86:22 100:6 102:18 104:1
 107:10 108:20 114:1
 119:19 120:7 123:10
 126:11 133:19,20 139:16
 153:5 157:4,14 161:11
 167:21 170:1 171:8 178:4
 179:19
live (12) 63:17 81:15 84:18
 85:14,15 86:10 136:11
 137:15 163:3,17 165:9

175:8
lived (3) 74:18 81:21,25
lives (5) 62:21 127:7 136:11
 138:13 163:3
living (19) 21:21 23:4,6
 37:25 42:12,17,24 48:16
 52:9,21 69:16 75:17 81:21
 84:15 95:13,20 96:4 125:9
 158:14
local (39) 2:25 3:23 4:1,4,17
 6:8 11:2 13:25 14:16 21:11
 43:7,11 44:14,15
 45:21,22,24 55:8 56:1
 61:18 62:23 64:5 66:14
 70:13 80:4 82:20,23
 83:5,21 84:5 92:16
 148:21,23 149:8
 153:2,3,13 181:18,19
located (1) 92:17
locations (1) 176:11
lock (3) 66:9 142:20 156:17
lockdown (8) 8:17 16:18
 65:1,9,14,20 66:5 68:16,17
 71:11,16 73:16 75:22
 84:19 88:19 89:14 92:1
 94:14
lockdowns (2) 65:22 77:16
locked (2) 73:18 75:24
locking (1) 74:17
log (1) 37:18
logistical (1) 4:18
loneliness (1) 159:18
long (64) 14:3 63:2 67:23
 68:1 69:11 72:14 98:15,21
 99:2,11 100:11,16 101:2
 102:19,24 104:5,10,14,18
 105:17 106:6,10,14,18
 107:3,15,25 108:3 117:6
 118:11 120:6,18
 123:16,23,24 124:4,6,10
 125:1,9,15,19
 126:16,18,21,23
 127:8,14,15,18 128:3,23
 129:2,24 130:2 131:14,18
 132:7,7 133:13,16 134:5
 135:6 136:3,7
longer (11) 5:5 16:2 35:8
 51:12,21 53:10 56:19
 101:13 160:12 184:19,22
longerterm (3) 57:4 89:10
 90:21
longstanding (1) 117:1
longterm (13) 2:24 3:1 5:4
 6:8 57:9 62:25 64:9,14
 68:11 113:17,24 118:13
 132:11
look (16) 11:5 14:18
 25:24,25 47:10 62:24,25
 71:15 102:17 112:8,8,14
 120:2 124:19 148:7 182:2
looked (12) 65:25 79:20 80:4
 88:6 89:15 92:2 93:17,22
 107:19 136:19 162:13
 165:12
lookedafter (4) 73:22 84:3
 91:10,15
looking (14) 2:17 13:5 18:24
 29:4 73:12 91:19 111:1
 112:5 116:13 117:18
 128:20 172:6,7,8
loose (1) 155:21
lordship (1) 152:23
lordships (1) 157:1
lose (1) 41:11
losing (2) 118:5 134:15
loss (4) 133:23 137:19,22,23
lost (16) 43:17,20 50:5,14,24
 118:5,6,6,9,10 129:24
 136:4,8 137:23,24 174:12
lot (90) 4:3 6:2 7:19,21
 9:19,21 10:10 11:3,21,22
 15:13 16:10 17:9,20
 18:3,22 19:3 22:6 26:6,14
 27:21 28:2,2 30:1,7,7,23
 31:3 35:21 37:12,17,24
 39:15 41:18,19

43:18,19,20 44:15 45:8,12
 51:21 52:13 56:14,19
 59:19 65:22 67:14 68:23
 69:2,19 70:24 71:4 74:14
 81:8,16 82:1 85:1 87:5
 90:1 93:14 94:17,25
 98:10,20 101:19 103:15
 104:22 106:12,23
 110:17,18 115:8 117:24
 118:1 121:25 124:22
 126:12 127:16 128:1
 129:8,12 130:3 132:3,13
 134:11,24 138:6 174:1
 183:1
lothian (1) 102:4
lots (9) 6:21 19:12 32:3 42:8
 53:12 57:17 58:9 61:4
 75:18
lottery (1) 127:25
louder (1) 146:24
love (1) 150:8
loved (4) 136:4 150:10 151:2
 174:16
lucky (11) 67:12,20 74:16
 81:24 82:1 92:5,14 96:13
 116:22 117:22 131:20
lunch (5) 9:19,24 24:9 30:12
 53:3

M

macaskill (16) 138:24,25
 139:5 164:3 171:22,25
 172:11,14,19 180:23 181:9
 182:23 184:6,25 185:5
 186:7
macdonald (3) 97:13,15
 186:6
mad (1) 71:16
main (1) 11:19
major (2) 131:24 171:18
majority (4) 29:22 143:13
 173:6 184:21
makes (1) 86:22
making (24) 5:3,3 10:2,5,5
 23:7 24:11 32:15 47:17
 59:24 75:6 78:5 93:6,8
 95:9 96:16 121:8 131:2
 142:4 144:25 167:25
 170:16 178:3 180:18
male (1) 115:8
manage (10) 2:5 41:2 43:15
 68:24 73:15,17,20 77:4
 108:12 162:6
managed (7) 8:20 40:19 73:8
 89:17 96:14 117:4,22
management (3) 92:7
 120:17 133:8
manager (17) 1:16 39:5
 40:6,21 44:19,23 54:9
 60:22 62:3,9,10 63:12
 94:4,4 109:7 112:9 121:24
managerial (1) 121:13
managers (10) 37:15 61:4
 122:10 143:8,17,22 148:15
 149:4,16 162:6
managing (6) 38:14 52:21
 69:25 82:24 90:25 163:1
mandatory (1) 146:9
manifest (1) 18:12
manipulated (3) 8:11 14:7
 17:11
manipulating (2) 9:9 15:9
manner (4) 155:14 162:7
 176:1 181:20
manufact (1) 115:11
manufacture (1) 115:12
many (44) 21:11 22:10
 47:11,14 55:20 63:10
 68:25 76:18 89:23 94:12
 102:20 104:7 116:4 117:16
 118:4 120:6 124:8 126:1
 127:10,10 129:2 130:20
 136:3,8,12 137:6 138:2
 141:23 148:14 149:4
 154:15 158:3,4,7,8 161:1,1

163:15,24 174:22,22
 176:23 178:8,9
map (1) 20:9
march (7) 62:2 99:22 112:1
 113:14 139:10 156:16
 179:2
marchapril (1) 165:19
marginalised (1) 137:5
marie (1) 140:5
market (1) 170:16
mask (5) 112:15 114:8,25
 115:2,17
masks (8) 109:16 111:13
 112:12,10,21 114:6
 115:3,20
maskwearing (1) 114:5
mass (1) 165:3
massive (4) 36:14 43:21
 127:11 171:10
massively (2) 128:4 174:11
mast (1) 101:18
masters (1) 179:15
match (3) 42:23 64:8 119:10
matching (1) 64:8
material (1) 99:13
matter (11) 8:14 83:12
 119:9 128:18 168:4 169:25
 172:3,22,23,25 184:13
matters (8) 22:4 96:19
 135:12 139:18 169:15
 173:11 180:22 184:8
maximum (1) 134:2
maybe (30) 2:3 7:10,15
 8:15,17 13:15 16:6 18:23
 21:4 22:4 24:18 29:17
 30:12 36:25 39:20 50:25
 63:18 71:25 73:2 82:8
 85:6,8 86:22 87:25 92:25
 96:11 145:21 160:9 181:16
 184:13
meckirdy (1) 114:2
message (1) 6:6 7:4,5,17 8:22
 9:1,4 13:10 15:4,16,22
 19:10,14 20:23 21:22
 23:2,23 24:11,19 25:1
 26:11 27:18 32:5,16 33:13
 34:18,23 35:3,16,18,21
 37:7,12,15 39:7,11,24
 40:2,13,14,23 42:4,20 43:4
 44:20 45:14 49:21
 50:3,5,10 52:3,13,24
 53:4,5 54:17 55:7,21 58:19
 79:9 81:19 93:12 109:18
 110:15 133:22 145:22,23
 155:4,9 167:22 176:20
meaning (2) 84:2 144:4
meaningful (1) 136:15
means (8) 17:5 29:5 103:9
 110:23 111:21 135:1 142:2
 146:11
meanstested (1) 45:6
meant (9) 74:24 107:24
 133:23 140:25 141:22
 147:8 149:18 160:25 183:6
measures (4) 119:15 161:20
 179:11,19
mecsfs (1) 127:24
media (7) 19:15 79:17 80:3
 142:13 175:9,25 176:1
mediation (2) 156:10,11
mediative (1) 156:12
mediatorial (1) 155:14
medical (5) 103:2 125:11
 134:14 166:7 183:21
medically (2) 102:15 117:23
medication (1) 101:20
meet (9) 18:17 38:17,22
 65:17,18 96:6,10,10 142:7
meeting (20) 19:4 23:3
 37:18,18,20,20 40:20
 46:11,13,14 48:7,9
 49:6,6,11 50:4,16 55:21
 157:18 173:13
meetings (14) 20:4 25:2,3,4
 39:9,13 46:4 49:23 50:10
 77:17 95:1 144:16 157:24

173:9
member (12) 51:14 123:7
 131:19 155:12,12 158:2
 159:1,9,21 175:17 176:3,3
members (39) 46:16 47:23
 52:23 78:16 94:19
 120:13,17 125:17 130:12
 132:18 133:21 139:25
 142:9,15 143:1,4,5,6,10
 145:12 146:14,19,25
 147:13 148:6 157:20,20
 158:2,4 159:24 174:4
 175:7,10,25 176:1,10,12
 179:3 181:18
memory (2) 68:3 101:6
men (1) 176:25
mental (13) 12:17 14:10
 86:15,21 87:11,17 88:9
 100:17 131:13 132:5
 173:24,25 176:13
mention (12) 36:24 63:14
 69:7 76:5 77:15 84:13
messages (3) 42:23 64:8 119:10
 167:4 178:1
mentioned (15) 4:16 8:14
 15:1 89:7 92:24 94:3
 102:17 127:13 159:12,19
 166:4,24 167:1 168:19
 171:5
mentions (2) 125:19 147:15
merely (1) 172:9
merits (1) 164:8
mers (1) 112:7
messages (2) 79:18 80:3
messaging (1) 79:4
met (7) 6:2 12:18 28:7
 48:5,5,21 157:21
middle (1) 112:7
midpoint (2) 43:8,13
midscale (1) 43:8
midwife (1) 105:10
midwifery (1) 118:16
might (34) 11:14 15:15 30:6
 48:7 66:1 71:15
 78:7,7,14,16,16,17,19,20,20,22
 80:12,12 81:16,20 84:9
 90:11 94:8 121:4
 143:11,21 148:10,19
 155:5,18 158:23 159:2,20
 164:3 165:10
milk (1) 9:21
millions (1) 127:9
mind (10) 10:6 44:15 69:6
 111:8 150:21 158:3 159:13
 162:13 165:11 176:18
mindful (1) 93:11
mine (1) 105:11
minimal (1) 174:9
minister (1) 173:14
ministers (1) 173:11
minor (1) 131:1
minute (1) 75:24
minutes (9) 34:25 35:7,8
 49:18,18 168:5 54:25
 138:18,19
mirror (1) 5:23
missed (5) 9:18 34:19 35:15
 36:2 183:8
missing (4) 15:21,21 55:24
 78:22
mistrust (1) 27:21
mitigate (1) 184:2
mixed (2) 80:21 83:14
mobility (2) 12:18 118:10
model (2) 72:10 90:2
models (2) 145:24 155:13
moderate (1) 100:23
moment (9) 63:12 105:21,24
 129:5 132:10 141:5 164:5
 172:5,8
moments (2) 140:20 141:24
money (4) 45:8,12,13 134:20
months (8) 26:20 51:7 68:3
 134:1 163:11,12,13,16
morale (1) 173:25
more (78) 8:20 10:11

13:17,20 15:12,13
 16:2,10,14 41:25 48:8,10
 55:20 56:7,14,21 57:8
 63:23 72:24 75:2 76:17
 79:7 80:12 81:4 83:1 86:23
 89:10,22 90

174:25	nuance (5) 144:24 156:7,9	133:24 138:10 156:7	177:7 184:17	166:14,23 167:1 171:21	95:5,8,11,23 96:3,15,17	71:9
necessary (4) 38:21 140:2,4	157:1,7	133:24 138:10 156:7	overall (1) 95:15	177:19	101:8 103:11,14 104:1,18	physically (2) 8:1 32:25
182:16	nued (2) 156:3,4	133:24 138:10 156:7	override (2) 56:25 57:1	participate (2) 136:3 183:23	106:12,23 110:11,16,17	physicians (2) 114:2 140:6
necessity (1) 153:7	number (19) 38:24 41:17	136:5 151:2	overriding (1) 163:2	particular (48) 11:4 14:16	113:13,17 114:17 115:18	physiologically (1) 142:24
need (56) 9:7 12:21,22,22	80:10 82:3 87:17 112:4	113:11 116:3 125:7 129:22	overseeing (1) 183:18	17:2,3,21 23:4 26:5,15	116:1,22 117:11,24 121:25	physiotherapy (1) 120:24
17:18 19:19 21:6,10 24:8	113:11 116:3 125:7 129:22	149:3 158:16 167:16 168:5	oversubscribed (1) 128:4	29:16 33:5,11 36:24 46:11	122:9 124:9 125:9,17	pick (5) 23:17 38:5 54:12
36:16,17 38:1,4,4,7,8 39:4	149:3 158:16 167:16 168:5	170:15 175:18 177:10	overtaken (1) 22:6	48:11 63:18,20 79:4 87:15	126:1,12,25 127:2,3,7	115:16,17
50:13 53:17,22 54:1,7,2,3	170:15 175:18 177:10	178:7 180:7	overweight (1) 104:20	100:7,9 104:10 107:14	129:25 130:3,7 131:14	picked (4) 24:15 44:9 111:14
55:23,24 56:2	178:7 180:7	139:13	overwhelmed (3) 26:12	110:21 114:6 115:16	132:13	142:13
58:2,14,17,18 59:6,22	numbered (1) 123:13	online (28) 4:21 5:6	59:18,20	116:12 128:22 129:11	133:5,7,15,18,24,25	piece (5) 53:9 93:15
60:3,3 64:2 70:1,3 72:9	numbers (6) 47:15 94:12,12	7:7,8,11,21 8:12 15:13	own (42) 4:3,11,18 13:8 16:1	144:15 151:16,25,25	134:12,13,23,25 136:23	166:11,21 169:23
86:9 88:14 99:5	31:22 36:12,16,18,20	31:22 36:12,16,18,20	21:12 23:4,6 24:20 25:10	153:15 155:7,9 157:17	137:13 138:2,6,9,11	piecemeal (1) 128:21
119:14,16,24 122:2 126:8	numeracy (1) 12:11	37:8,12,18 39:14 47:20,21	26:1 28:1,8 37:1,25 46:16	160:6,13 164:21,25 165:20	139:13,20 140:13,17,20,23	pieces (2) 98:17 110:1
132:13 133:4 136:19,21	numerous (5) 17:1 141:21	48:2 49:23 76:19 77:16	63:5 67:14 69:7 71:24	174:6 175:23,25 179:2	141:8 142:19 144:21	placement (2) 5:21 19:5,6 21:2
137:14 142:14,25 144:20	144:19 146:20 173:9	78:16,17,19 87:4 104:17	100:6 104:19 109:7,10	180:6 182:13,18	145:18,23 147:5 148:1	35:6 46:10 59:9 63:7
167:4 168:16	nurse (7) 102:3,7 105:11	ons (1) 108:1	118:4,12 120:21 121:1	particularly (35) 14:16 24:3	149:25 150:2,5,20	72:5,19 74:19 76:18 77:23
needed (9) 25:13 30:2 68:19	116:2 182:7,7 184:15	onwards (2) 112:1 182:25	122:19 128:9,11 133:19	36:9 37:25 48:1 57:1 58:5	151:3,6,18 156:19,23	81:2,12,18 89:9 90:16 93:6
86:12 87:17 89:4 92:8	nurses (2) 114:21 126:6	open (7) 10:7 47:6 64:20	134:7 135:19 150:21	61:1 76:21 80:22 86:16	160:1 163:3,11,15,21	178:11
94:13 96:16	nursing (3) 118:8,16 177:18	106:9 144:23 157:4,5	156:23 160:15,13 165:4	88:21 98:11 99:1 104:11	166:3 174:11 175:15,15	placement (2) 36:16 64:14
needs (27) 9:11 11:10 22:18	nurture (1) 22:23	opened (1) 161:15	183:4	111:19 113:14 118:7	176:24 177:8,11,15	placements (5) 36:13,20,21
23:3 28:11 33:17,18 47:1	O	opening (2) 77:24 150:3		119:16 124:8 133:24	178:7,20	63:1 64:9
50:6,16 54:18,19 55:10,17	observation (2) 99:7 176:18	operate (1) 73:11		136:17 138:5 144:12	peopled (1) 106:3	places (1) 21:6
64:7 65:17 80:8 81:12 92:9	observations (2) 10:15 98:8	operating (1) 135:2	pace (2) 25:21,23	145:25 149:18,19 150:17	peoples (10) 10:3 27:11,18	placing (2) 52:11 108:13
97:7 142:8 153:15 159:6	observes (2) 130:14,15	operation (1) 177:10	packed (2) 23:21 67:4	160:12 171:10,24 172:15	38:6 39:8 43:2 53:6	plan (5) 64:2 70:10 71:16
164:21,22 178:19 183:10	observing (1) 39:19	operational (1) 183:11	packs (1) 9:2	177:17 178:6 182:6	66:15,20 174:17	85:5 166:8
negative (2) 95:17 135:7	obstacle (1) 38:23	opinion (1) 86:8	paid (4) 71:5 113:6,21,24	partly (1) 113:9	per (1) 1:15	planning (2) 3:2 184:5
negatively (1) 166:7	obtain (1) 170:7	opportunities (1) 183:7	pain (2) 100:19 101:3	partnership (1) 61:22	perceived (2) 15:2 179:25	plans (1) 72:4
neglect (1) 3:17	obvious (4) 103:5,6 133:15	opportunity (8) 7:8 13:7	palliative (2) 140:11 141:25	parts (3) 119:23 134:16	percentage (1) 162:9	plaster (2) 131:24 132:12
negligence (1) 108:18	140:1	122:23 135:20,25 144:15	184:10,12	178:16	perfectly (4) 109:23 152:13	platforms (3) 5:10,13 96:5
negotiation (1) 13:4	obviously (5) 2:17 3:19	184:10,12	opposed (4) 2:13 99:4 113:8	pass (2) 38:15 105:7	162:5 172:19	play (2) 23:12 25:1
neither (1) 157:10	5:12 7:17 10:10 11:12 15:4	18:18 19:14 27:16 40:13	143:7	passage (1) 165:12	perhaps (37) 24:14 38:15	playlist (2) 30:10 34:16
net (1) 80:13	18:18 19:14 27:16 40:13	43:3 53:13 59:4 66:10,24	opposite (2) 13:1 16:20	passed (2) 108:25 131:6	57:3,4,7 82:12 87:22,24	please (7) 101:23 119:25
network (1) 56:17	67:9 70:12,21 81:11,18	67:9 70:12,21 81:11,18	opt (2) 78:7 83:2	past (12) 13:2,2 15:24 24:25	91:12 92:24	120:7 125:13 149:14,22
neurodiversity (1) 11:10	86:2 94:3,11,24 95:11,14	86:2 94:3,11,24 95:11,14	105:24 107:23 113:1 114:5	25:4,20 28:6 30:4,6 42:25	103:19,19,20,24 104:20	145:7 150:3 159:12 168:8
neurological (1) 101:5	119:7 120:8,10 121:12	119:7 120:8,10 121:12	122:14 123:8 124:17 128:9	60:10 71:4	111:10 116:15 119:4 122:5	171:3 180:25
never (20) 38:17 40:20 45:25	129:12 132:6 133:24	129:12 132:6 133:24	134:12,16,22 139:6 150:16	pastoral (2) 142:8 145:1	125:6 129:16 131:1,5	plus (1) 21:13
48:21 65:25 110:1 115:11	151:5,17 157:23 175:8	151:5,17 157:23 175:8	176:16 179:17	143:5,9 146:14 148:8	133:19 135:22,23 140:15	pm (4) 97:11 138:21,23
116:3,5,10,11 125:24	176:16 179:17	176:16 179:17	176:16 179:17	157:14 168:16 172:13	143:5,9 146:14 148:8	185:23
126:12 133:6 136:25 148:1	176:16 179:17	176:16 179:17	176:16 179:17	157:14 168:16 172:13	157:14 168:16 172:13	pointed (2) 120:23 141:4
159:17 163:19 171:17	176:16 179:17	176:16 179:17	176:16 179:17	157:14 168:16 172:13	157:14 168:16 172:13	pointing (1) 103:19
176:25	176:16 179:17	176:16 179:17	176:16 179:17	157:14 168:16 172:13	157:14 168:16 172:13	points (12) 102:23 104:8
nevertheless (1) 173:5	176:16 179:17	176:16 179:17	176:16 179:17	157:14 168:16 172:13	157:14 168:16 172:13	113:2,10 124:15 128:21
news (6) 41:22 75:7 79:9	176:16 179:17	176:16 179:17	176:16 179:17	157:14 168:16 172:13	157:14 168:16 172:13	145:7 150:3 159:12 168:8
91:24 93:22 126:15	176:16 179:17	176:16 179:17	176:16 179:17	157:14 168:16 172:13	157:14 168:16 172:13	171:3 180:25
newspapers (1) 126:14	176:16 179:17	176:16 179:17	176:16 179:17	157:14 168:16 172:13	157:14 168:16 172:13	police (5) 4:5 20:8,19,20
next (9) 9:1 21:23 34:17	176:16 179:17	176:16 179:17	176:16 179:17	157:14 168:16 172:13	157:14 168:16 172:13	55:22
59:25 97:5,6,14 172:13	176:16 179:17	176:16 179:17	176:16 179:17	157:14 168:16 172:13	157:14 168:16 172:13	policies (2) 59:16 131:2
185:11	176:16 179:17	176:16 179:17	176:16 179:17	157:14 168:16 172:13	157:14 168:16 172:13	policy (3) 117:7 179:11,18
nhs (17) 102:4 108:11,19	176:16 179:17	176:16 179:17	176:16 179:17	157:14 168:16 172:13	157:14 168:16 172:13	political (2) 147:16 169:7
109:22 110:2 117:2 120:16	176:16 179:17	176:16 179:17	176:16 179:17	157:14 168:16 172:13	157:14 168:16 172:13	politicisation (1) 181:2
135:1 147:22 167:10	176:16 179:17	176:16 179:17	176:16 179:17	157:14 168:16 172:13	157:14 168:16 172:13	poor (5) 12:10 45:20 58:16
170:5,12 180:8 182:1,4	176:16 179:17	176:16 179:17	176:16 179:17	157:14 168:16 172:13	157:14 168:16 172:13	118:14 179:14
183:14,17	176:16 179:17	176:16 179:17	176:16 179:17	157:14 168:16 172:13	157:14 168:16 172:13	population (6) 107:23 108:1
nicola (1) 17:7	176:16 179:17	176:16 179:17	176:16 179:17	157:14 168:16 172:13	157:14 168:16 172:13	161:18 162:16 163:8 180:1
night (5) 68:13 154:12	176:16 179:17	176:16 179:17	176:16 179:17	157:14 168:16 172:13	157:14 168:16 172:13	portfolio (1) 2:5
178:20 184:17,19	176:16 179:17	176:16 179:17	176:16 179:17	157:14 168:16 172:13	157:14 168:16 172:13	posed (1) 4:16
nights (2) 95:4,7	176:16 179:17	176:16 179:17	176:16 179:17	157:14 168:16 172:13	157:14 168:16 172:13	position (2) 126:13 133:6
nine (1) 118:15	176:16 179:17	176:16 179:17	176:16 179:17	157:14 168:16 172:13	157:14 168:16 172:13	positive (4) 85:2 87:7 90:1
nmc (1) 118:16	176:16 179:17	176:16 179:17	176:16 179:17	157:14 168:16 172:13	157:14 168:16 172:13	124:22
nobody (7) 12:16 21:7,24	176:16 179:17	176:16 179:17	176:16 179:17	157:14 168:16 172:13	157:14 168:16 172:13	positively (1) 89:12
24:21 124:18 158:21	176:16 179:17	176:16 179:17	176:16 179:17	157:14 168:16 172:13	157:14 168:16 172:13	possibility (3) 113:22
175:11	176:16 179:17	176:16 179:17	176:16 179:17	157:14 168:16 172:13	157:14 168:16 172:13	153:12,13
nodding (1) 124:11	176:16 179:17	176:16 179:17	176:16 179:17	157:14 168:16 172:13	157:14 168:16 172:13	possible (13) 3:12 6:17 7:9
nods (1) 157:25	176:16 179:17	176:16 179:17	176:16 179:17	157:14 168:16 172:13	157:14 168:16 172:13	13:14 22:22 23:7 85:12
nondriver (1) 109:24	176:16 179:17	176:16 179:17	176:16 179:17	157:14 168:16 172:13	157:14 168:16 172:13	92:5,20 97:6 137:12
none (10) 4:23 25:25	176:16 179:17	176:16 179:17	176:16 179:17	157:14 168:16 172:13	157:14 168:16 172:13	155:20 162:5
37:19,21 41:12 59:4 66:3,4	176:16 179:17	176:16 179:17	176:16 179:17	157:14 168:16 172:13	157:14 168:16 172:13	possibly (3) 103:2 138:17
112:18 136:24	176:16 179:17	176:16 179:17	176:16 179:17	157:14 168:16 172:13	157:14 168:16 172:13	163:16
nonlegal (1) 146:2	176:16 179:17	176:16 179:17	176:16 179:17	157:14 168:16 172:13	157:14 168:16 172:13	post (6) 20:9 43:3 125:19
normal (5) 5:25 10:18 87:20	176:16 179:17	176:16 179:17	176:16 179:17	157:14 168:16 172:13	157:14 168:16 172:13	126:18 176:19,20
134:1 164:2	176:16 179:17	176:16 179:17	176:16 179:17	157:14 168:16 172:13	157:14 168:16 172:13	postcode (1) 127:25
normally (4) 5:20 21:8 97:4	176:16 179:17	176:16 179:17	176:16 179:17	157:14 168:16 172:13	157:14 168:16 172:13	posts (1) 177:11
118:21	176:16 179:17	176:16 179:17	176:16 179:17	157:14 168:16 172:13	157:14 168:16 172:13	posttraumatic (1) 132:1
northern (9) 62:4,6,18	176:16 179:17	176:16 179:17	176:16 179:17	157:14 168:16 172:13	157:14 168:16 172:13	postural (3) 100:22 126:2,4
63:4,17 64:23 65:2 80:20	176:16 179:17	176:16 179:17	176:16 179:17	157:14 168:16		

182:3,11,13,15,15,18,19,19
practical (5) 9:6 33:17 36:25
 47:9 148:16
practice (9) 77:15,15 142:21
 146:8,11 147:17,20 168:1
 183:13
practices (2) 6:1 179:14
practitioner (4) 4:9 9:6
 62:13 63:13
practitioners (5) 37:12,14
 140:7 141:25 148:2
pre (1) 20:9
precise (1) 156:8
predominantly (1) 173:6
preexisting (4) 112:5,25
 124:5 137:7
pregnancy (1) 48:14
pregnant (2) 48:12 109:7
preliminary (1) 98:8
premiums (4) 170:17
 171:3,6,7
prepandemic (9) 30:1,9 39:8
 42:2,7 48:5 55:14 58:9
 178:12
preparation (1) 154:12
prepare (1) 34:7
prepared (5) 32:17 41:5
 45:18 133:18 170:21
preparedness (1) 183:19
prescriptive (2) 124:13
 153:24
present (10) 47:3 89:4
 128:22 139:25
 140:14,17,20 158:18
 159:10 177:2
presentation (1) 185:2
presented (2) 171:10 182:10
presenting (3) 13:17 14:4
 56:16
presently (2) 168:24 169:9
pressure (6) 53:15 71:20
 132:18 133:9,10 170:10
pressures (2) 38:2 128:13
pressurised (1) 132:25
presumably (3) 85:21 123:4
 129:20
presume (1) 61:3
presumed (1) 164:24
presumption (2) 110:22
 183:15
pretty (4) 15:6 50:17,20
 134:7
prevalence (2) 123:22,24
prevented (2) 83:5,7
preventing (1) 181:21
prevention (3) 102:6 114:20
 161:19
prevents (1) 38:23
previous (4) 68:18 136:25
 154:16 162:3
previously (9) 14:21 17:10
 51:12 62:13 65:14 136:22
 145:19 167:18 171:17
primarily (6) 2:8 3:13,18 4:6
 141:7 167:7
primary (4) 33:7,19 34:2
 134:19
primarysecondary (1) 57:23
principal (1) 111:21
principally (1) 100:11
principle (2) 159:4,7
principles (1) 93:1
prior (11) 17:15 28:22 51:8
 62:1 100:13,17 102:1,2
 108:7 121:2 124:10
priorities (2) 12:20 38:3
prioritisation (3) 6:23
 180:8,10
prioritise (1) 43:23
priority (3) 75:4,6 178:19
privacy (3) 7:23 28:12
 156:21
private (2) 52:6 134:17
probably (27) 11:23 21:20
 35:7 38:25 57:10 77:22
 79:7 86:24 92:11 101:15

109:18 117:2 119:2
 121:19,19 131:19 135:10
 140:1 142:14 147:25
 148:25 152:22 156:4
 158:3,4 173:19 174:24
purposes (12) 37:1 41:11
 58:6 115:23 116:9 117:2
 128:1,23 151:19,22,22
 156:5
problems (8) 101:5,11
 116:23 127:2,4 129:12
 133:10 151:13
procedure (1) 114:10
procedures (2) 114:15 133:1
proceed (1) 164:13
proceedings (2) 1:3 135:11
process (11) 32:2 43:5
 64:8,10 75:14 78:12 138:2
 152:10 156:12 166:15
 167:25
processes (2) 5:2 32:23
procurement (2) 115:15,16
professional (6) 1:24 148:25
 152:3 159:10 162:5 178:18
professionalism (1) 145:6
professionals (8) 47:22 85:18
 104:16 125:11,15 126:9
 128:2 178:14
professor (1) 179:15
profile (2) 63:18,20
prognosis (1) 118:13
programme (3) 1:15 107:16
 148:12
programmes (1) 102:8
progressing (2) 105:22 106:7
project (1) 62:14
promise (9) 59:18 91:23,23
 92:1,24 93:2,4,13,14
promulgated (1) 156:7
prone (1) 101:8
proper (1) 168:11
properly (4) 108:12 156:6
 161:4 168:2
proportionate (1) 142:18
proposal (1) 168:20
prospect (1) 163:15
protect (4) 66:7,7 75:9
 150:23
protected (3) 128:8,12
 161:17
protection (9) 3:14 14:23
 46:2 47:19 48:3 55:16
 123:6 141:13 151:24
protective (7) 24:16 57:25
 58:1 109:15 112:12 137:8
 140:25
proudly (1) 17:3
provide (3) 19:15 110:4
 121:22
provided (10) 1:18 26:16
 61:6 72:22 97:22 98:9
 115:19 130:13 174:1
 182:24
provider (6) 154:13 169:2
 170:24 171:5 182:17 183:5
providers (12) 141:12,23
 170:16 171:11,18,21
 172:15,16 181:6,20 182:14
 184:21
providing (1) 2:18
provision (2) 115:7 147:21
proxy (1) 166:10
psychological (4) 125:21
 130:1,10 156:22
psychologically (1) 142:23
psychologising (1) 125:11
ptsd (1) 132:3
pub (1) 174:15
public (15) 19:3 42:15,24
 103:22 104:6,11 109:25
 123:4,7 127:11 134:25
 141:12 148:23 167:20
 179:13
publication (1) 141:20
publicising (1) 126:21
publicly (2) 122:21 175:17

published (3) 98:4 106:11
 142:12
pull (1) 23:16
purported (1) 157:8
purpose (2) 99:15 144:4
purposes (2) 97:19 182:1
push (3) 40:18,25 111:11
pushed (3) 132:20,23 133:14
pushing (1) 18:20
puts (2) 4:3 53:15
putting (7) 22:23 54:10 74:7
 98:23 131:23,24 175:12
puzzles (2) 9:3 10:1

Q

q (218) 1:15,18 2:2,12
 3:3,8,22 4:13 7:10,15
 8:13,20 10:14 13:15,20
 14:22 15:1 16:17,25
 18:8,12 19:22 22:3 24:14
 26:22 27:1 29:16 31:20
 33:5 36:24 41:15 43:25
 45:21 46:2,7 51:11 56:21
 57:6 58:23 60:22,25
 61:3,6,15,24 62:1,6,18,21
 63:7,10,14,17,24 64:14
 65:1,4,8,12 67:3,8,22
 68:1,15,21 69:2,5,10,13
 71:14 72:9,18,21 73:23
 74:1,20,24 75:16
 76:4,12,17 77:8,15,20
 78:7,10,22,24 79:16
 80:1,18,25 81:4 82:10,19
 83:4 84:18,21 85:21
 86:2,5,13,19 87:15,22
 88:9,17 89:5
 90:11,14,16,18,21 91:4,18
 92:24 93:11 94:3 95:18
 96:19 98:4,8,22 99:1,7
 100:5 101:21,25
 102:9,16,23 103:19
 104:8,25 105:3,9,18,21
 106:5,19 107:5 108:5
 110:3,21 111:8,18 112:1,3
 113:2 114:1 115:3,5,13
 116:13 118:12,21,25
 119:5,19 121:12,17
 122:18,22,25 123:2,4,6,10
 124:3 125:6,13 126:14
 127:13 128:18 129:16,18
 130:10,20 131:16
 132:15,18 133:15 135:8
 137:16,22 141:10,16 142:3
 143:4 144:6 145:7 146:14
 147:10 148:5 149:3 150:15
 151:13 154:23 158:1
 159:12 160:14,22 161:11
 162:18 165:25 168:4,15
 169:8,25 173:19 175:3,6
 176:14 177:23 179:8
 180:22 182:22 184:6
qualification (1) 141:17
qualified (1) 42:22
qualify (1) 127:23
quality (1) 128:3
quarter (1) 60:10
question (14) 38:25 49:9
 83:10,11 160:23 164:5
 166:24 167:1,3 170:2
 172:4,7,14 175:19
questions (19) 1:11 38:17
 49:5,11 58:23 60:18
 75:18,19 97:21 129:9
 136:21,23 139:4 160:22
 165:14 186:4,5,7,8
quick (1) 59:3
quickly (6) 23:7 75:13
 170:14 171:4,6 174:20
quite (50) 3:9 4:24 6:2 8:17
 26:17,18,20 30:16 31:11
 34:4,4 35:11,15 39:15
 43:1,14,17,18 47:6,11,24
 48:14 49:3 54:4 56:17
 58:24 65:9,22 66:10
 70:3,22 71:7,11 73:24

75:8,8 85:2 89:22 94:11
 98:16,18,20 104:23
 111:2,9 114:17 115:19
 147:24 152:20 174:1
quiz (2) 95:4,7
quotations (4)
 99:11,13,15,16
quote (7) 99:10
 130:11,13,14,18 160:18
 179:5
quoted (1) 154:15
quotes (1) 123:13

R

race (1) 137:8
radical (3) 65:9,11 66:10
radio (1) 144:14
raft (3) 9:12 57:13 59:18
raise (5) 26:2 59:1 96:19,22
 184:13
raised (2) 171:23 173:8
raising (2) 26:3 180:12
range (4) 33:17 115:20
 122:2 124:15
rape (2) 17:13 48:14
raped (2) 20:16 48:13
rapidly (1) 79:23
rarely (2) 126:15 167:21
rate (4) 105:6 107:15 108:3
 162:17
rather (28) 7:7 15:14 16:3
 35:4 36:5 39:3 41:3,6 48:8
 54:2 58:7 60:2 72:24 78:13
 83:10 90:14 110:25 111:22
 127:7 128:25 149:1
 155:8,24 157:4,6 159:6
 163:4 164:19
ration (1) 121:2
rcn (3) 111:19 112:10,20
reach (1) 8:20
reached (1) 164:13
reaching (1) 140:12
reacted (1) 166:7
reaction (1) 49:14
react (8) 84:1 119:24 126:20
 142:15 161:6 162:22 163:6
 183:3
readily (2) 156:6,4
reading (4) 52:17 80:3 83:20
 148:1
reads (1) 126:14
ready (7) 1:9 32:17,24 60:15
 63:3 121:7 139:2
real (13) 37:5 42:16 45:19
 47:1 56:11 147:21 149:20
 152:8 166:11 170:14
 175:13 176:10,21
realise (2) 104:6 108:16
realised (1) 116:3
realities (1) 183:11
reality (2) 143:23 157:10
reallife (1) 99:18
really (103) 8:16 9:10,21
 10:14 15:21 18:7 19:24
 23:10 24:22 26:14 33:19
 35:19 36:3,8 37:2,13
 38:6,11 41:20,20,21,23
 45:20 50:11,23,23,23
 52:17 53:17 54:19,23
 56:18 57:4 59:6 62:10
 65:23 68:6,7,7,14 69:18,22
 70:14,16 71:17 73:5,19
 74:12,12,24 75:13,20,25
 76:1,2 77:6 78:21 79:13
 80:15 81:23 83:15,18
 87:5,7,12 89:12,25 90:4
 91:24 92:3,6,14
 93:13,15,23 94:22
 95:14,16 96:2,12,14,15
 99:5,17 102:23 104:8
 105:7 111:23 121:6
 122:2,9 127:1 135:17
 136:17 141:9 142:1 143:24
 144:20 148:20 157:1
 165:15 173:8 176:7
rearticulated (1) 140:22

reason (11) 7:18 18:7 25:21
 33:22 51:21 53:24 94:15
 95:21 114:11 150:21 172:6
reasonable (7) 116:24 117:5
 121:8,22,23 122:12 142:18
reasoning (1) 122:13
reasons (12) 7:15 9:12
 14:19,19 32:10 56:12,20
 63:24 71:24 78:7 80:10
 145:4
reassess (1) 177:8
reassurance (1) 79:23
recall (10) 72:16 74:2 77:11
 81:6,6,7 83:24 91:13
 114:17 184:14
recalled (2) 138:24 186:8
receipt (1) 172:9
receive (1) 84:10
received (4) 83:16 141:10,11
 172:1
receiving (2) 178:13 179:3
recent (1) 177:22
recess (3) 39:16 63:23
 126:20
receptive (1) 143:9
recognise (4) 56:24 71:15
 140:16 158:11
recognised (4) 44:12 45:19
 47:1 68:17
recognises (1) 143:16
recognising (3) 9:16 25:12
 52:8
recognition (3) 47:4,5,16
recommendations (2) 142:5
 173:1
record (2) 21:9,18
recorded (2) 98:5 167:15
recording (2) 1:19 21:7
recordings (1) 40:1
recover (1) 41:20
recovery (6) 103:1,15,23
 104:5 106:8 125:2
recruited (1) 51:14
recruiting (2) 37:1 38:24
recruitment (4) 37:21 42:7
 43:1 176:15
reel (2) 74:3,10
redacted (1) 111:6
reduce (1) 133:22
reduced (1) 56:11
reels (1) 41:22
refer (9) 97:20 98:20 101:9
 118:17 119:20 123:14
 20:15 31:1 33:18 48:3,11
 58:9 70:14,24 71:7 75:21
 80:21 83:15,16,24 107:16
 137:16 140:5 167:14,16
 179:24
remembering (2) 10:3
 184:22
remit (3) 106:2 137:12 172:3
remitting (1) 103:12
remove (1) 122:12
removed (2) 2:22 154:4
rendered (1) 124:6
rep (1) 117:16
repeatedly (1) 183:8
repeating (1) 162:24
repetitive (2) 12:4 33:3
replaced (1) 41:12
report (5) 24:19 54:11 99:21
 106:11 125:1
reported (2) 16:11 62:15
reporting (3) 16:1 22:8 125:4
reports (1) 46:24
repository (1) 98:23
reprehensible (2) 169:4
 176:8
represent (3) 97:15 102:21
 168:6
representative (1) 168:22
representatives (4) 111:19
 168:7 181:10 184:3
represents (1) 172:11
request (1) 154:14
require (3) 132:11 170:7

regardless (2) 93:7 173:17
regards (1) 113:5
region (1) 61:1
regions (1) 61:4
register (4) 3:14,16 55:16
 118:15
registered (8) 44:5,13,21
 45:3 62:3,9 63:12 159:4
registrars (1) 125:19
registration (1) 128:10
registrations (3) 14:18,22,23
regretted (1) 174:20
regularly (3) 62:23 70:19
 75:7
regulated (1) 76:7
regulators (1) 159:2
reinforced (1) 148:7
reintegrating (1) 95:22
reiterate (1) 140:2
relapsing (1) 103:11
relate (2) 98:14,16
related (6) 104:20 121:20
 125:22 132:2 152:24
 171:20
relates (1) 100:10
relation (12) 2:6 19:25 33:11
 88:13 99:2 110:22 119:11
 135:14 139:17 153:25
 157:24 173:1
relational (1) 145:20
relationship (10) 27:6 29:7
 37:16 52:1 153:4 155:8,23
 158:13 178:13,15
relationships (8) 34:23 37:14
 40:10,12 87:6 95:12 96:3
 148:21
relative (6) 158:5,19
 159:15,20 160:3,13
relatives (15) 139:22 149:25
 150:8,11,17,22,23 151:19
 157:20 158:4,25 160:5
 163:24 169:22 174:23
relax (1) 82:25
relaxed (1) 96:9
relaxing (1) 150:18
relevant (3) 29:4 58:5 130:22
relief (2) 17:9 18:4
reluctance (2) 25:14 29:13
reluctant (2) 25:15 27:25
rely (1) 87:6
remain (3) 100:3 161:9,12
remains (1) 167:6
remember (2) 4:7 18:23
 20:15 31:1 33:18 48:3,11
 58:9 70:14,24 71:7 75:21
 80:21 83:15,16,24 107:16
 137:16 140:5 167:14,16
 179:24
remembering (2) 10:3
 184:22
remit (3) 106:2 137:12 172:3
remitting (1) 103:12
remove (1) 122:12
removed (2) 2:22 154:4
rendered (1) 124:6
rep (1) 117:16
repeatedly (1) 183:8
repeating (1) 162:24
repetitive (2) 12:4 33:3
replaced (1) 41:12
report (5) 24:19 54:11 99:21
 106:11 125:1
reported (2) 16:11 62:15
reporting (3) 16:1 22:8 125:4
reports (1) 46:24
repository (1) 98:23
reprehensible (2) 169:4
 176:8
represent (3) 97:15 102:21
 168:6
representative (1) 168:22
representatives (4) 111:19
 168:7 181:10 184:3
represents (1) 172:11
request (1) 154:14
require (3) 132:11 170:7

184:8
required (7) 28:13 41:6 65:9
 109:8 181:23,25 182:12
requirement (3) 146:9
 180:18 182:11
reregister (1) 118:15
research (4) 98:19 118:19
 126:16 170:18
researched (1) 98:10
reserved (3) 172:2,25 173:5
reside (1) 85:2
resided (1) 84:8
resident (3) 153:20
 155:11,12
residential (17) 61:19
 62:4,7,12 70:25 72:11,19
 76:5 80:5,10 81:15,17
 84:15 85:24 88:13 95:6,20
residents (19) 67:10 142:24
 153:15,16 158:16 159:16
 160:6,7 161:1,5
 162:1,1,10,12 163:6,25
 164:23 183:11 184:18
residing (1) 80:19
resistance (4) 144:24
 145:12,21 150:4
resistant (1) 150:3
resolved (1) 151:21
resort (1) 149:4
resource (2) 169:21 180:3
resources (5) 54:22
 120:15,22 132:14 166:9
respect (4) 100:4 145:5
 152:8 170:5
respected (1) 45:15
respiratory (3) 109:15
 112:7,12
respite (4) 11:18 12:13 26:10
 86:9
respond (2) 21:11 92:9
responded (1) 68:6

rights (39) 49:3 64:6
135:9,15 145:24
146:1,7,11
147:15,17,23,24
148:12,13,16 153:9
155:1,2,6,13,14,18,20
156:3,20,24 161:5,25
164:8,10
166:4,13,14,21,25
167:5,5,12,17
rightsbased (1) 147:8
rigorous (1) 161:19
rise (3) 14:2 42:12 61:20
rises (2) 42:16,25
risk (19) 21:14 56:24,24
75:11 86:20 107:20,21
108:9,15 109:11,22 112:21
118:5 136:20 144:25 152:2
153:2 171:20 175:14
riskassess (1) 21:14
risks (2) 45:18 170:7
road (1) 40:7
role (13) 61:12,24 62:6
87:24 94:20 105:24 120:10
145:6,10 146:17 158:23
159:3 183:21
roles (4) 2:2 94:16 117:18
178:18
roll (1) 70:3
rolled (2) 120:19 148:14
rolling (1) 16:6
rolls (1) 15:18
roof (3) 55:10 56:10 171:9
room (10) 5:24 7:22
47:12,16 48:2 49:13
110:17,18 155:22 156:23
rooms (1) 67:16
roots (1) 105:12
rosetinted (1) 18:24
rota (3) 65:15 89:14 122:3
round (3) 13:6 74:11 82:1
roundedup (1) 123:18
rounding (1) 56:21
route (2) 130:14,15
routine (2) 9:23 44:9
routinely (4) 20:4 21:18
32:17 36:10
routines (3) 32:12,13 65:6
royal (1) 47:14
rows (13) 114:2 140:5,7
rpe (2) 111:1 136:20
rude (1) 126:11
rules (2) 16:19 165:7
run (1) 143:19
running (6) 2:4 58:24
62:11,17 143:7,15

S

sack (1) 133:3
sacrificial (1) 177:3
sally (1) 158:15
safe (16) 2:16 48:17,25 52:9
59:9,10 63:6 71:1 75:5
76:20,22 77:2 109:23
110:1 142:19 144:21
safeguard (2) 28:15 79:21
safeguarding (2) 24:15,21
safely (3) 82:25 83:9 85:6
safer (2) 48:17 70:12
safest (2) 66:6 92:5
safety (1) 80:13
salaries (1) 43:8
salary (1) 133:23
saloon (1) 3:10
same (29) 5:24 16:9 26:3,4
27:15 33:3 40:14 41:16
46:20 56:13 73:9 82:6 87:9
103:7 111:17 112:10 123:6
129:9 134:18,21 144:14
151:15 157:8 164:9,11
169:2 174:24 181:16,24
sars (4) 112:6 113:12,15,18
saw (12) 15:2 19:18 24:20
33:14 45:25 70:20 86:23
91:16 93:24 131:12 170:15
171:4

saying (40) 8:3,9 15:11 17:3
18:8,14 21:5 25:11 33:2
39:3,5,25 40:2 41:19 42:3
53:25 54:6 56:1,3 58:17
60:20 65:8 71:7 91:7 122:2
142:17 143:5,18
144:13,19,23 146:15 147:6
154:13 163:3,22,23,24
181:16 182:14
scaffolding (1) 93:8
scale (6) 43:4,9 106:17 107:3
126:17 136:24
scales (1) 43:14
scarce (1) 180:3
scared (4) 6:4 41:21 79:12
80:12
scary (6) 70:3 75:8,9 80:15
93:23,23
scenario (2) 115:25 141:1
scenarios (1) 147:18
scepticism (3) 104:10 121:18
126:22
schedule (1) 122:3
scheme (2) 105:13,14
school (39) 9:17,17 24:16
26:5,7 28:7
30:3,3,6,14,17,22,23
31:3,10,14,16,18 32:16
33:8,20,20
34:2,6,8,9,15,21
35:14,17,19,22 38:5,9,9
52:16 57:18,19 87:2
schools (8) 11:12 24:5 29:24
46:19 47:6,6 57:17 58:17
science (6) 109:1 110:10
112:25,25 113:1,6
scientific (2) 98:19 152:18
sciwt0314000001 (1) 61:8
sciwt0465000001 (1) 97:17
sciwt0485000001 (1) 1:20
scope (1) 177:20
scotland (20) 1:16 2:8 60:23
61:4 93:6 106:1,13
109:21,22 110:2
111:4,11,13 123:21 126:5
129:3 148:23 158:25 173:7
179:13
scotlands (2) 107:9 143:13
scots (1) 123:16
scottish (36) 2:11,16 44:12
72:23 73:13 94:18
97:15,23 99:20 105:25
106:5 108:11,19 115:16
116:2 119:10 120:19 127:5
136:2 139:24 144:9,11
145:10 148:13 161:2
162:20 165:20 166:13
168:9 173:10 179:10,13,18
183:15,22,24,25
scoil (1) 49:8
scratch (1) 138:3
screen (7) 16:8 47:25 61:7
78:14 95:7 98:11 185:19
scrutiny (1) 73:9
second (4) 59:11 68:17
166:23 185:1
secondary (4) 33:8,20 35:14
100:24
secondarydalthood (1)
57:23
secretary (5) 144:17 157:21
173:10 179:22 180:17
section (2) 99:9 123:12
sections (1) 99:18
sector (28) 24:25
42:15,23,24 49:24 134:17
140:18 144:12 145:5 146:5
148:14 152:9 154:3,7,10
167:8,10 168:8 170:4
176:15,19 177:1 181:3,24
183:8,16 184:1,4
sectors (1) 117:3
secure (3) 5:12 34:4 63:6
security (1) 80:16
see (43) 6:16,19 8:14 12:22
17:6 18:12,16 21:18 22:23

28:20 29:9 30:24 38:8,8
39:15 40:22 49:14 51:7
53:13,14 55:23 57:17
58:5,6 88:9 97:4 100:7
118:18 121:5 138:8,9
139:22 149:25 151:20
152:13 159:17,24 165:21
171:7 174:16 182:20
184:18
seeing (19) 8:3 10:19,19
13:17 14:1 23:7 25:8
26:8,9 46:21 55:15,18 58:7
75:8 87:9 93:22 127:6
155:17 163:19
seek (1) 25:4
seekers (1) 61:23
seeking (1) 105:12
seem (8) 30:6 45:12 110:14
113:10 117:17,18 124:14
172:7
seemed (5) 18:25,25
112:13,21 125:25
seems (5) 35:7 52:17 117:20
124:18 140:1
seen (11) 25:5,6 46:25 90:21
108:5 120:7 121:4 130:4
131:15 135:3 161:16
172:7
selected (1) 31:2
selfharming (1) 58:14
selfreported (1) 124:25
selfreporting (1) 106:24
sending (2) 79:18 131:3
senior (5) 40:21 62:13 63:13
92:7 143:22
sense (16) 3:5 18:4 23:10
50:6,14,24 53:21,22 115:5
143:6 144:4 149:12,13
155:4 164:12 176:11
sensible (1) 164:13
sensitive (4) 143:23 145:19
151:6,8
sent (2) 70:18 128:24
sentence (1) 156:11
sentences (1) 83:13
sentiment (2) 163:5,7
separate (4) 95:18 119:17
148:8,18
separated (1) 12:25
separation (1) 13:6
september (2) 157:19,19
serious (3) 76:1,3 108:15
service (54) 2:21 3:10,12,22
4:13,15,17,21 5:1,6,19,21
6:13 8:15 10:17 11:1 13:22
126:20 25:21 26:23 27:21
45:3 54:17 56:5
61:4,20,20,21,22
62:7,10,18 63:14
64:21,22,23 65:18 78:25
85:3 90:19,20,21,25 91:1,3
92:6 94:10 103:8
129:11,21,25 131:21
134:25 146:6
services (35) 2:3,5,10,12,15
3:20,25 4:3 5:17 7:19 9:13
14:20 32:9 43:6 44:4,21
51:17 60:22 61:15 62:3
72:12 73:18 89:6 94:6
106:15 115:16 125:18
127:12,23,24 129:6
130:6,7 131:14 183:12
servng (1) 46:8
set (8) 5:22 24:17 30:16 34:3
41:16 116:9 120:16 141:4
sets (1) 141:21
setting (6) 7:6 48:8 55:12
140:18 144:12 145:5 146:5
148:14 152:9 154:3,7,10
167:8,10 168:8 170:4
176:15,19 177:1 181:3,24
183:8,16 184:1,4
sectors (1) 117:3
secure (3) 5:12 34:4 63:6
security (1) 80:16
see (43) 6:16,19 8:14 12:22
17:6 18:12,16 21:18 22:23

13:21 17:13 19:23 48:13
sexually (1) 13:18
shadowing (1) 39:21
shame (1) 45:20
shape (1) 169:13
share (1) 46:24
shared (3) 11:16 20:5 158:14
sharp (1) 97:4
shed (3) 20:16 48:12,13
shelves (1) 105:16
shes (1) 184:20
shield (2) 109:21 122:23
shielding (5) 22:16,19
41:18,20 124:13
shift (2) 90:14 95:25
shifts (4) 65:16 68:12 90:7,8
shock (1) 36:14
shopping (1) 15:14
shops (2) 43:19,19
short (5) 60:12 97:10 117:6
128:1 138:22
shortage (2) 147:14 177:17
shortterm (6) 101:6
131:20,22,22,25 132:9
should (51) 1:20 55:15 60:2
61:6 66:9 73:3 77:8 78:2
79:5 81:2 85:5,12,14,15,19
86:7,11 91:8 92:25
101:21,21 102:24
114:18,18 119:10,21,21
121:11,22 139:1,18,21
150:24 151:19 153:12,22
156:3 158:2 161:21 162:5
165:25 169:8,10 170:25
172:20 179:11 180:10,14
182:4,18 183:1
shoutint (5) 20:14 56:25
57:1 109:24,25
shouted (1) 146:24
shouting (2) 6:14 10:8
show (1) 71:2
showered (1) 16:5
shown (2) 162:15,16
shut (3) 20:19 21:6 81:9
sibling (3) 10:22 11:24 31:9
siblings (1) 81:21
sic (1) 103:8
sick (3) 117:9 132:24 133:3
sickness (1) 134:1
sign (1) 104:3
signed (1) 152:1
significance (4) 103:24
140:14,19 141:14
significant (17) 113:11,16
116:23 129:22 134:16
143:25 156:25 158:16
159:5 162:9,15 165:5
173:8,16 175:18 177:10
178:7
significantly (1) 177:12
silent (1) 34:24
silly (1) 49:8
similar (7) 72:13,13 95:3
112:6,6 114:25 170:12
similarly (1) 123:22
simple (6) 9:10,20 22:22
23:23 32:19 103:19
since (12) 61:12 100:20
101:3,14,15 102:3,14
113:1 119:14 125:25
134:10 181:14
sincere (1) 136:4
single (3) 37:3,10 138:13
singularly (3) 167:12,22
177:8
sir (2) 136:18 183:3
sisters (3) 11:20 13:10 52:22
sits (3) 107:17 131:13 177:14
sitting (7) 16:7 35:6,8 50:9
130:23 185:10,15
situation (21) 82:25 86:14
100:9 114:24 131:8 140:11
181:10
sounded (2) 9:21 54:18
155:17 156:8 157:17
159:8,8,14,19 161:14
166:16 167:8 168:15 180:3

situations (7) 28:24 109:17
146:4,12 155:10 174:23
175:13
six (6) 26:20 66:21 71:22
109:10 134:1 163:16
size (2) 43:16 92:21
skill (2) 41:16 116:8
skilled (1) 17:24
sleep (2) 68:12 100:24
sleepover (1) 67:16
sleepovers (1) 90:3
sleeves (1) 70:4
slightly (1) 119:17
slipped (1) 140:15
slower (1) 53:5
small (2) 44:16 143:14
smaller (3) 53:7 171:11
172:16
smart (1) 16:7
snacks (1) 24:9
sneak (1) 19:13
soandso (3) 17:5 18:2 40:7
social (45) 3:24 4:2 14:15
19:15 25:24 26:15 27:9,14
28:18 29:8 30:11
36:10,11,11 38:21
39:16,20 42:22 45:22
55:22 79:17 83:4,21,22
84:4,22 91:14 106:15
107:14 109:2 118:18
119:16 123:11,11 136:2,14
146:10 147:22 175:9
177:20 181:5 183:16,20,21
184:4
socialisation (2) 13:5 52:19
socialise (1) 138:12
socialising (1) 174:16
socially (3) 65:21 75:23 82:5
society (3) 135:3 164:1
174:14
sofaped (1) 67:19
soldier (1) 50:8
solidarity (1) 136:6
solution (2) 82:7 132:12
solved (1) 116:12
solway (1) 115:19
somebody (27) 20:24 29:6
37:16 41:4,4,5,6 47:9 49:7
54:17,19,21 87:23 109:6
114:11 122:2 124:7 126:19
139:21 140:12,15,21
159:3,15 163:12 170:25
179:4
somebodies (1) 22:10
someone (2) 55:25 107:17
something (55) 10:19 13:21
15:21 18:6 30:13 35:4
45:10 53:4,21,22,23,25
54:2,4,5,7,7 58:8,15 59:5
70:2,7 80:6,15 85:22 90:16
92:11 101:17 103:19,25
104:13,21 108:3 114:19
118:3,21 119:6,7 125:6
126:15,17 130:20 131:3
135:21 141:19 143:1
149:15 153:24 160:14
166:18 167:21 168:18
169:6 172:22 174:8
somethings (1) 58:11
sometimes (21) 4:5 8:14
11:11 12:23 24:25
28:17,22 29:2 31:8 34:15
47:24 48:6 49:15 52:8 58:2
101:10 106:3 130:25
137:25 150:9 174:17
somewhere (1) 78:13
soon (3) 53:23 65:8 133:14
sooner (1) 159:6
sort (8) 68:9 70:18 73:9
79:17 90:2,2 154:4 163:21
sought (1) 173:11
sounds (2) 9:21 54:18
soup (3) 23:19,20,22
source (2) 111:10 123:17
space (12) 52:6

67:10,11,16,20,21 71:1
76:20,22 77:2,7 156:24
spaces (1) 82:8
span (1) 32:25
speak (8) 46:15 57:6
70:19,20 86:24 89:19,20
101:13
speaker (1) 130:16
speaking (5) 48:9 101:14
113:13 114:11 147:5
special (3) 97:7 133:25
134:18
specialist (4) 128:24,24,25
129:18
specialistlevel (1) 128:20
specialties (1) 126:2
specific (16) 30:16 34:25
72:23 85:3 91:16 92:22
94:11,12 106:9 109:6
120:2 122:3,3 124:14
181:20,24
specifically (11) 2:6 9:24
18:13 19:7 29:20
85:7,17,25 88:13 91:7 99:5
specificity (1) 153:14
specifies (2) 110:5 124:19
speech (1) 101:11
speedily (1) 144:20
spend (14) 37:5 41:25 43:23
53:8 75:10 81:16 85:7
107:14 109:2 159:25
160:4 163:10,20
spending (3) 82:6 134:21,22
spent (2) 36:12 41:22
spike (1) 171:7
spit (1) 40:4
spoke (5) 14:10 18:13 66:16
89:18 99:17
spoken (5) 19:11 57:3
131:12 146:24 169:2
spouse (1) 163:20
spread (3) 94:6 110:7,20
spring (4) 19:1 162:25 169:5
170:19
springboard (2) 90:19,24
stability (4) 66:8 176:23
177:6,12
stable (1) 34:5
stacking (1) 105:16
staff (114) 5:16 13:22 20:12
22:4,15,15,19
23:3,11,16,17 25:3 30:17
33:21 35:24 37:1
41:1,19,24
42:11,23,23,19,21 43:9,13
44:1,16,17,20 45:1,11,13
51:14 54:9 56:13,14
59:12,13,15 63:10,11
65:15,18 68:5,11,24,25
69:3 70:7 71:17 73:19
89:20 94:13,14,19
95:10 12:96 1:7,8,11,15
109:2 112:18,19 113:19
116:3,10 117:20
120:10,13,17 129:24 131:9
141:12 143:17 146:22,25
147:13 148:24 149:8,16
150:13 151:22 152:4
155:10,12 158:11,20
163:5,22 169:23 173:25,25
174:5,6,21,22
175:7,10,12,17,20
176:2,2,3,10,12 177:17
181:7,21 184:21
staffing (1) 133:10
stage (13) 22:3 135:18
140:16 153:6 161:17
162:14 163:8 164:12,25
166:1 168:4 178:8 183:24
stages (3) 137:25 166:22
182:11
stand (1) 105:6
standard (3) 112:17
119:11,11
standards (1) 119:13
standing (1) 180:17

start (13) 1:12 8:16 47:3
60:19 103:6 113:13 120:9
133:1 141:20 142:19
149:18 150:4 177:19
started (7) 51:14,15,18
61:24 62:2 95:24 102:4
starting (6) 14:18,19 35:25
36:1 65:4 138:3
stated (1) 179:21
statement (61) 1:15,18,23
3:3 4:14 7:12 8:13 10:14
19:24 20:17 29:19 41:11
43:25 50:17,20 56:21
61:6,11 65:4 69:9 69:8
71:14 72:18 76:12 91:5
97:16,22,24 98:2,4,9 99:8
102:19,24 107:5 114:4
116:14 119:5,21,23,25
120:1 123:12,25 125:8
133:17 135:9 137:16 139:8
140:8 141:7 142:3 143:12
145:3,7 149:7 150:24
163:7 174:3 177:25 180:23
statements (1) 181:4
stating (1) 83:17
station (1) 20:20
static (1) 20:19
statistic (1) 51:7
statistics (3) 19:25 21:7
107:12
status (1) 157:22
statutory (3) 46:21 49:24
54:21
stay (19) 16:22 17:8 18:2,7
30:3,6,12,21 34:24
63:21,25 64:3,18 67:10,11
81:10 85:9 122:15 163:17
staying (4) 59:7,8 63:2 76:8
step (1) 19:2
sterilisation (1) 102:5
sticking (3) 16:7 131:24
132:12
sticks (1) 11:2
stigma (2) 125:10 126:22
still (25) 5:17 22:19,20 30:13
39:14 45:17 68:11,12
77:23 85:2 95:10 116:22
127:2,3 131:13 134:9
146:6 161:1 163:7
167:6,11 169:5 176:24
179:13 183:18
stood (1) 177:2
stop (7) 49:17 54:3 70:17
72:8 127:8 128:6 161:23
stopped (7) 33:4,21,22,23
81:22 106:22 126:5
straddled (1) 2:10
straight (1) 27:13
straightaway (2) 4:22 27:18
strain (1) 162:14
streamlined (1) 129:15
street (1) 105:20
strength (1) 135:24
stress (7) 10:18 11:8 13:15
14:10 122:16 132:1 140:21
148:13 158:10
strict (2) 32:13 47:11
stricter (2) 179:11,19
strike (1) 59:22
striking (1) 108:17
structural (1) 145:4
structure (2) 32:11 57:25
structures (1) 40:20
struggle (4) 47:2 87:16
122:10 136:14
struggled (3) 41:20 122:9
152:5
struggles (1) 148:4
struggling (6) 5:1 36:3 50:11
65:23 117:4 151:2
stuc (1) 181:10
stuck (1) 12:14
student (1) 39:16
students (3) 36:10,11,12
study (2) 113:15 124:17
study (6) 112:16,20

124:19,20 128:8 135:4
stuff (10) 7:21 9:24,24
 23:1,22 24:5 33:3 39:9
 72:6 74:4
sturgeon (1) 17:7
styles (2) 12:7 32:1
subject (2) 173:3,21
submit (1) 43:7
submitted (1) 111:5
subsequent (1) 184:2
subsequently (1) 111:14
substantial (1) 184:13
substitutes (1) 115:22
suctioning (2) 114:15,24
sudden (1) 120:12
suddenly (3) 34:19 35:10
 111:2
suffered (1) 80:11
sufferers (1) 131:18
suffering (4) 12:17 113:17
 123:16 132:3
sufficiently (1) 127:15
suggest (4) 71:16 164:3
 181:11,20
suggested (1) 164:14
suggesting (4) 120:5 142:15
 153:22 181:5
suggestion (2) 103:21 158:1
suggests (2) 169:6 177:4
suitcase (1) 67:4
suited (1) 28:11
summarise (1) 2:3
summation (1) 108:16
summer (2) 61:12 170:19
superhuman (1) 177:5
supermarkets (1) 105:16
supervision (3) 12:2 40:20
 76:7
support (72) 2:9,12,13,18,20
 3:25 4:13 5:17,18 6:12
 11:10,13 12:12 13:14
 14:12 19:18 22:21 24:4
 25:4 26:5 27:4 29:14
 30:2,10,11 32:9 33:9
 34:7,12,15,17 35:18,23
 38:10 52:18 53:17 54:13
 56:2 59:22 63:3 64:25 77:4
 86:11 87:20 88:14 89:2
 92:6,15,16 93:8,18
 94:17,25,25 108:12 118:19
 119:20 120:4 121:2,12,17
 126:3 127:22,25 132:8
 136:15 158:19 159:9
 169:1,17,21 178:22
supported (17) 5:16 24:12
 30:20,22 31:7 33:6 35:21
 36:5 38:2 57:22 64:23
 72:7 92:8 94:15 162:12
 178:10
supporting (11) 2:22 22:14
 23:25 24:2 32:14 53:17
 56:9,14 61:22 88:18
 150:21
supportive (5) 48:18 66:17
 72:1 158:6,22
supportively (1) 180:17
suppose (35) 5:25 8:22 9:5
 10:22 13:3 14:9,11 15:9,17
 19:8 21:3,25 22:3,12 23:8
 35:12 66:3 90:11 95:18
 108:6 112:23 115:6 128:18
 129:18 132:15 139:1
 151:13 152:23 153:8,21,23
 159:18 165:17 167:7
 176:20
supposed (2) 35:5 114:25
sure (33) 7:5 8:1 9:23 10:2,5
 11:22 22:17,19 23:8 24:11
 29:3 32:15 38:20 50:8 54:5
 59:24 64:11 72:3,3 75:6
 83:23 84:22 88:1 93:8
 94:13,22 95:2,9 96:17
 111:4 156:13 159:13,22
surgeons (2) 114:3 140:6
surgical (5) 109:16 111:12
 112:15,21 115:2

surrounding (1) 98:14
surveillance (2) 102:7,8
susceptible (1) 124:6
suspect (3) 97:5 132:2
 149:15
suspected (2) 130:14,15
sustainable (1) 68:8
swap (2) 72:5,6
swine (2) 113:19 137:1
switch (2) 32:21,23
sympathy (1) 38:16
symptoms (3) 104:7 106:24
 122:17
syndrome (7) 100:19,19,23
 101:2,18 112:7 126:4
synonym (1) 156:2
synonymous (1) 102:25
system (3) 56:17 76:14
 134:21
systems (3) 74:11,19 116:18

T

table (4) 49:7 66:15 71:20
 166:3
tachycardia (2) 100:23 126:4
tactics (1) 17:25
tailored (1) 73:3
taken (12) 54:12 56:11 77:9
 102:25 111:3 113:15
 120:1,14 135:15 178:11
 180:13 184:8
takes (2) 52:25 129:12
taking (13) 12:19,24 15:8
 31:17 43:11 50:5 53:9
 85:13 119:9 123:19 128:18
 129:14 172:12
talk (26) 10:15 13:8,16
 19:22,23 24:14,18 26:22
 33:5 43:25 45:21 51:2 67:8
 86:13 89:5 124:16,16,24
 125:8 129:14 145:16
 153:16 154:18,23 177:24
 179:8
talked (4) 66:12 136:14
 170:6 171:20
talking (21) 14:5,23,24
 17:13 30:5 32:12 35:24
 51:24 54:10 51:11 58:22
 64:15 67:22 68:21 114:3
 115:2,21 127:8 139:12
 145:17 162:13
talks (1) 110:12
tariq (1) 160:19
tasks (1) 39:10
tax (1) 134:20
taxed (1) 42:14
taylor (1) 103:3
tea (1) 37:20
teacher (3) 26:9 29:7 34:3
team (27) 22:15,20 23:3,11
 39:13 40:20 54:9 62:9
 63:12 66:1,12,21 73:19
 89:18 92:6,7 95:4,16 99:4
 102:6 105:23 129:4 133:9
 158:3 159:1,21,25
teams (9) 22:15 67:2 96:6
 132:6 141:13 148:22,22
 151:24 178:15
technical (2) 47:24 83:11
technology (1) 46:18
teenagers (2) 74:8 87:5
telephone (2) 47:20 96:17
television (1) 144:14
telling (6) 1:12 58:3,11,12
 142:16 143:2
tells (2) 1:24 61:11
tempting (1) 7:10
ten (5) 49:18 51:7 54:25
 63:11 181:16
tenants (1) 4:24
tend (3) 62:25 63:1 115:17
tended (2) 38:1 65:15
tender (2) 43:7,14
tenders (1) 43:10
tends (3) 63:4,21,22

tension (5) 10:18 11:8 13:15
 14:10 19:11
term (4) 117:6,7 128:1
 174:10
termed (1) 140:13
terminated (3) 102:13
 117:13 121:11
terminology (1) 158:25
terms (11) 2:9,20
 3:1,16,19,22,25 4:2,20 5:2
 6:3,12,22 7:24 10:22
 12:3,13,20,21,23 14:9,17
 15:4,7 17:25 18:5 19:23
 20:7 21:4,6 23:8,24 24:1,4
 25:5,15 26:3,11 27:3,4
 28:14 29:25 31:16 32:1,24
 33:15 34:7,13,25
 36:9,10,22 37:8,11,21
 38:3,6,12 39:10
 42:9,9,11,17 43:1,2,21,22
 45:6,7,9,15 47:25 49:8
 51:23 54:12
 56:5,8,11,12,14,21 57:23
 62:18 63:17 86:19,25
 87:7,11 91:4 92:1,18 93:17
 94:12 95:1,15 110:4
 117:15 118:10 126:16
 129:4 135:13 154:5,21
 162:23 165:16 166:5
 167:13,13 169:23 176:6,16
territory (1) 169:14
test (1) 124:22
tested (3) 116:4 179:25
 180:15
testimony (1) 123:9
testing (8) 66:24 67:6
 120:10,11 124:24 177:23
 180:21,21
tests (3) 129:10 180:4,7
thank (52) 1:10 39:1 41:8
 50:22 51:1 60:6,7,9,16
 84:12 96:24,25 97:1,2,8,14
 98:22 99:7 100:5 101:24
 102:16 107:5 114:1 119:19
 136:1 137:15
 138:14,15,17,20,25
 139:3,5 142:3 149:3
 153:21 168:4 169:25
 173:2,19 176:14 177:23
 180:22 184:6,11
 185:3,4,5,7,9,20,22
thankfully (1) 162:16
thanks (1) 99:5
thats (100) 2:21 3:18 6:15
 8:11 13:20 16:11 17:14
 18:17 19:3 21:19 26:23
 34:13 35:10,20 37:5
 38:10,10,11 40:4,19 41:2,6
 43:21 46:12 50:17,23,25
 52:2 53:19 54:14 55:11
 57:8 58:5,13,20,21
 60:4,24 61:14,24 62:5
 63:23 65:3 68:22 86:9
 89:12 90:20 91:11 97:5
 98:3,12,12,19,21 101:15
 104:5 111:20 113:2
 118:8,8 121:11 122:4,16
 123:8 124:2,12 127:11
 129:2,7 131:17 133:10,17
 134:1 135:17 136:16 137:9
 141:25 142:21 147:20
 152:11,13 155:15,21
 156:15,25 157:12 159:5
 162:10 164:23 165:4
 168:19,21 169:17 170:2
 173:19 176:23 177:18
 185:8,9
theatres (2) 102:4 115:25
theme (1) 102:18
themes (3) 21:9 22:5 120:5
themselves (5) 4:6 138:9
 174:23 175:12,14
theoretical (1) 155:4
therapeutic (1) 51:23
thereabouts (1) 113:20
thereafter (2) 143:24 165:15

therefore (6) 43:23 54:1
 103:9 110:21 113:22 172:3
theres (34) 7:19 10:21
 21:1,2 31:4 35:3 36:21
 37:19 40:12 41:1 47:14,14
 53:21,22 55:12,15 56:4
 64:10 72:9 86:9 90:6,8
 93:14 96:20 105:23 110:18
 111:6 117:21 118:1 121:19
 135:20 137:25 165:17
 169:21
theyd (2) 17:10 35:2
theyll (3) 68:12 78:18 128:10
theyre (32) 13:11 18:2 40:7
 41:2 49:25,25 50:1,1
 54:5,16 56:4 62:21 63:3,25
 64:18,23,24 73:8 76:22
 78:5,6 80:11 98:16 117:25
 128:8,12 132:7,25 133:1
 134:12,15 143:18
theyve (22) 4:10,11 7:18
 25:17,18,18 35:15 38:1,17
 46:15 53:1 54:13,22 78:5
 80:11 100:3 103:14,15
 116:12 118:6 122:12 126:5
thing (25) 4:16 10:17 15:1
 18:9 21:4,20 23:5 32:19
 35:12 36:8 37:23 59:7,11
 66:10 70:23 71:13 92:5,13
 96:2 104:23,25 131:16
 137:16 147:23 181:16
thinking (16) 3:9 6:23 13:12
 20:11 21:1 25:12 31:12
 35:18 36:16 49:20 54:3
 57:21 93:16 95:18 147:7
 171:24
thinks (1) 41:7
third (1) 177:14
though (3) 109:24 128:2
 141:5
thought (12) 29:17 36:15
 59:1 70:15 71:23 72:1
 73:23 80:1 92:25 93:23
 96:21 123:20
thoughts (2) 144:12,12
three (13) 15:15 21:15 25:19
 26:20 66:13 68:10,13
 71:18 90:2,3,9 156:13
 163:16
through (28) 1:23 3:12 6:18
 9:2 18:24 23:13 29:9,17
 31:12 40:19 55:10 56:10
 57:22 61:17 64:24
 99:12,19 101:10 102:18
 112:14 141:6 144:7
 151:11,11 163:9 165:15
 167:25 171:9
throughcare (2) 61:19 64:21
throughout (3) 27:1 165:4
 171:4
throughput (1) 56:4
tickbox (1) 147:6
tier (1) 117:23
tightly (1) 163:1
time (140) 2:9 3:21 5:15
 7:11,16 10:7,12 13:6,11
 14:3 16:19 19:8 20:9,16
 22:5 27:2,3 31:3 32:15
 33:23,24,25 37:4,10 39:6
 40:3,15 41:22,25 44:23
 45:16 46:12 50:11,14
 51:5,20 52:25 54:12 57:6
 58:24 59:25 60:5
 62:9,12,16 63:2 65:1,17
 66:13 67:18,23
 69:11,14,14,16,20
 75:4,14,24 72:1,17
 75:4,10,23 77:13 79:10
 80:23 81:8,16,24 82:6,24
 83:15,25 84:14 85:7 87:10
 88:1 90:24,25 91:22,25
 92:4,13 95:13 96:16,24
 99:6 101:22 102:2 109:20
 113:16 114:22 116:8
 119:14 120:10
 128:6,8,11,12,15

129:13,15 130:23 132:8
 141:18 142:11 144:15
 147:25 148:4 151:5
 152:14,17 153:10
 156:16,19,19 157:8 158:20
 159:25 160:5,12
 161:13,14,25 162:4 163:20
 164:7,16,22 166:3,25
 170:1 173:15 179:1,10,17
 180:12 182:23 185:1
timeframe (2) 134:18 177:21
timelimited (1) 121:25
timely (1) 132:8
times (11) 19:19 25:19
 102:12 117:16 146:20
 150:14 153:5 174:13
timescale (1) 64:15
tired (1) 104:1
today (13) 59:2,15 96:22
 97:19 98:2,5 101:7 131:13
 154:12 163:12 170:1
 177:14 185:9
together (12) 12:1 22:24
 23:15,16,22 24:1 54:10
 75:20,20 97:25 98:23
 140:4
toilet (2) 15:18 35:3
told (16) 16:19 21:15
 82:12,19 109:21,21 110:2
 117:5,14 120:20,22 122:4
 125:14 126:7 133:1 170:8
tol (1) 130:1
tomorrow (1) 8:25
too (13) 39:2,2 41:22 68:25
 95:14 96:18
 133:4,12,14,14 136:3
 157:2,3
took (16) 5:15,19 39:16
 66:18,19 76:18 82:19
 94:16,19 103:20 120:9
 130:1 177:7 179:10,17
 180:12
tool (1) 146:11
topped (1) 24:12
totally (2) 22:7 168:14
touch (3) 8:13 70:15 173:24
touched (3) 133:16 170:1
 183:2
towards (2) 79:5 161:4
toys (3) 9:3 10:2 22:24
trade (4) 181:4,14,19 182:21
traditionally (2) 28:3 46:4
trainer (21) 1:5,6,9,10,11,12
 41:9,10 51:2 55:1,2
 60:6,15,16,18,19 83:11
 84:13 96:24 186:4,5
training (5) 36:23 128:3,6,14
 147:20
transcript (4) 139:6,8,10
 160:16
transfer (2) 178:3,4
transferred (1) 131:7
transition (3) 33:10 35:14
 89:17
transitioning (1) 33:7
transitions (1) 57:22
transmission (6) 110:23,25
 111:22 113:8 130:15,16
transmitted (1) 13:18
transport (2) 109:25 123:4
trauma (3) 80:11 125:23
 162:24
traumatised (1) 58:4
treacle (1) 101:10
treat (1) 103:18
treated (5) 103:7 136:10
 137:6 166:17 175:16
treating (1) 162:1
treatment (7) 127:14 128:20
 132:6,11 139:13 176:8
 180:2
treats (1) 165:2
trends (4) 21:9,19 51:2 94:7
tricky (1) 122:5
tried (13) 5:19 7:4,8,11,13

10:12 22:20 28:25 29:1,12
 44:23 102:11 125:3
trust (10) 28:3,4 39:23 40:1
 121:1 148:21,24 178:2
 179:1,8
trustbased (1) 152:10
trusting (1) 152:21
truth (1) 150:24
try (17) 6:19 8:11 9:6 10:9
 29:9,10,13,14 39:1,2 47:2
 64:8 73:17 122:15 127:21
 140:13 166:15
trying (50) 2:16 5:14,24
 6:7,16,25 7:1 8:4 13:2,13
 14:11 16:12,18 26:13,18
 37:15 48:23 51:25 52:18
 58:8,15 68:24 69:23,24
 71:1,1 73:15,20 74:5,12
 75:3,9,13,14 83:8 85:5
 92:4 99:17 101:10 105:2
 106:25 116:23 122:14
 127:4 132:10 134:4 143:1
 146:18 147:3 151:18
tuesday (6)
 185:10,13,15,19,20,25
turn (2) 153:23 169:25
turned (7) 113:10 117:25
 118:1 125:18 134:5,12
 157:7
turning (1) 4:13
tweaked (1) 68:19
twice (4) 130:25 180:15
 184:12 185:6
twothirds (1) 45:10
twoway (1) 5:23
type (2) 12:8 16:25
types (3) 19:22 114:6,8
typical (1) 63:24
typically (3) 8:16 82:12
 183:14

U

uk (4) 106:22 113:20 123:21
 173:14
uki (6) 139:8,9 160:15
 162:19 164:5 165:12
ukwide (2) 105:18,19
ultimately (3) 147:14 152:1
 163:2
unable (5) 88:19 102:9
 127:10,19 160:10
unacceptable (1) 176:7
unaccompanied (1) 61:23
uncertain (1) 140:23
uncertainty (3) 52:2 152:6
 172:17
uncomfortable (4) 49:10,16
 174:10 175:10
unconsciousable (1) 108:14
unconscious (1) 116:25
uncrc (1) 59:18
undeniable (1) 159:11
underfunded (1) 128:5
underfunding (1) 120:6
undergoing (1) 129:9
underline (1) 141:13
underlying (4) 25:17 100:12
 109:3 110:22
underprepared (2) 109:14
 137:4
underresourced (1) 128:5
underresourcing (1) 120:5
understand (4) 1:20 17:20
 25:17,19 34:21 38:15
 40:23 58:2,14,18 59:21
 65:24 78:17 79:2 80:12
 84:12 86:20 97:24 122:22
 136:25 137:2 146:15
 149:13 168:16
understandably (2) 149:24
 174:17
understanding (9) 32:22
 65:24 83:4 101:12 109:5
 141:14 146:7 178:18
 181:12

understood (4) 31:25 33:22
 103:3 174:21
undertaken (3) 166:12
 167:17 174:19
undoubtedly (1) 143:21
unofficially (

video (1) 70:18
 views (7) 135:8,16,19
 146:1,4 147:19 182:25
 violence (1) 57:18
 violent (2) 48:22 58:7
 virologist (1) 110:12
 virtual (1) 78:3
 virtually (3) 77:12,13 78:1
 virus (9) 69:18 93:20 113:23
 149:20 150:7,12 151:10
 153:6 175:8
 viruses (1) 112:6
 visa (1) 177:20
 visit (5) 25:24 27:9 158:17
 160:10,11
 visiting (23) 139:17
 140:8,9,22 141:15,22,23
 142:5 147:9 149:6 150:18
 151:17,19 152:2 153:2
 154:23,25 157:3 161:22
 162:8 167:9 168:10 176:6
 visitors (4) 150:19 154:10
 160:11,24
 visits (4) 6:14 27:14 39:21
 82:4
 vividly (1) 20:14
 vocal (1) 147:6
 vocation (1) 118:8
 vodka (1) 15:22
 voice (3) 25:10 59:25 136:1
 voices (3) 25:9 60:1 89:21
 volume (2) 98:12,13
 voluntary (5) 24:25 42:23
 43:22,24 159:3
 vouchers (1) 24:5
 vulnerabilities (1) 31:2
 vulnerability (4) 25:22 48:24
 175:13 176:11
 vulnerable (5) 3:6 29:20
 42:11 137:6 149:23

W

wade (1) 101:10
 wait (5) 54:13 88:20 131:14
 132:6,14
 waited (1) 134:7
 waiting (12) 53:19,20,24
 118:18,19 130:2,4,4
 131:25 132:5 134:10,10
 waits (2) 120:6 134:6
 wales (1) 105:11
 walk (3) 7:2 96:11 105:7
 walkways (1) 74:4
 wall (1) 125:5
 wander (1) 168:16
 wanting (5) 7:25 8:1
 149:9,10 174:7
 ward (1) 112:17
 wards (1) 131:9
 warmer (1) 18:25
 warning (1) 110:13
 wary (1) 49:4
 wasnt (5) 4:23 5:6 9:17
 12:5,5 15:23 20:16,17,18
 21:4 26:19 29:17,17 30:22
 32:7,19,19 33:21 34:18
 42:14 45:13,18 48:4 49:13
 52:9,9,23 58:1 68:7
 69:6,22 70:19 71:12 76:23
 82:5 85:3,25 90:24,25 91:6
 96:12 109:10 110:1 131:9
 144:18 145:21 150:8
 171:11 172:1 179:6 182:16
 watched (1) 149:17
 watches (1) 126:14
 watching (2) 41:22 75:7
 water (1) 35:2
 wave (1) 6:17
 way (34) 6:6 15:8 17:17 18:1
 20:8 22:1 27:15 34:20 39:1
 44:24 45:4 46:20
 49:5,12,15 58:3,10,12,13
 87:20 100:16 103:3,20
 104:12 108:13 116:1 126:8
 151:20 152:6 165:22 166:9
 170:11 174:9 181:4

ways (3) 18:12 136:13
 144:21
 wear (3) 111:12 114:25
 182:4
 wearing (6) 114:6,8 141:4
 182:3,7,9
 weather (2) 18:25 82:2
 wed (7) 6:1 9:1,2 11:16 13:1
 65:24 96:11
 wednesday (6) 23:11,21
 66:23,25 67:1,1
 wee (2) 5:15 6:17
 week (21) 9:1 23 21:23
 23:19,20,21 66:22
 67:3,3,4,5,7 68:25 72:16
 89:14,23,25 100:24 126:15
 184:14 185:11
 weekend (1) 38:10
 weekends (1) 85:8
 weekonweckoff (1) 67:22
 weeks (9) 21:15 39:22 40:3
 104:2 109:10 142:21
 149:17 161:2 184:15
 welcome (1) 138:25
 wellbeing (7) 5:4 23:9 53:6
 95:1 151:1 164:18 173:25
 wellcontrolled (1) 100:13
 wellreasoned (1) 152:14
 went (17) 15:21 31:3
 47:20,21 67:6 68:2,9 71:11
 87:4,8 102:4 133:25 151:5
 158:5 162:19 171:8 182:9
 werent (64) 4:22
 5:9,11,12,24 6:9,24 8:24
 9:17 11:13 12:1,19 15:20
 16:8 17:16 20:3,3,6 24:15
 27:14,22 28:16,25 29:12
 30:5,14 31:1,4,6,11
 32:17,17 33:9 35:1,6 42:3
 45:2,4,8 46:20,21,25
 47:1,6 49:14,18,19,20
 51:22 52:16,20 55:11,18
 57:22 77:10 82:10 93:19
 94:14 95:10,13 96:4
 112:15 124:7 170:17
 west (1) 2:8
 westminster (1) 173:12
 weve (61) 4:7,8 6:3 11:4
 15:5 17:7 20:7 28:3 29:25
 35:24 36:8,11 37:3 43:8
 50:6 53:11 54:14
 55:8,20,20,23,25 56:1,6
 58:16 59:17 61:22 63:22
 64:18 65:16,17 81:25 91:5
 96:13,14 97:4 103:21
 104:8,15 107:11 111:18
 115:5,10 118:6,9 123:17
 124:9 125:3,4 132:7
 136:9,14 137:23,24 149:3
 150:15 151:13 165:12
 170:5 171:20 182:10
 whatever (16) 7:3 10:5
 15:15,19,23 16:9 22:24
 25:7 28:10,10 29:1 39:21
 89:4 94:14 95:21 134:19
 whats (10) 9:14 26:10 32:25
 59:21 70:10 77:5 80:12
 90:19 126:25 168:23
 wheelchair (2) 100:8 105:8
 whenever (1) 144:14
 whereas (8) 13:6 17:17
 25:20 44:16 78:19 89:1
 112:20 141:24
 whilst (4) 31:17 59:19 164:7
 172:21
 white (2) 146:2 155:15
 whole (19) 2:13 9:12 10:24
 11:6 33:16 34:19 36:4 43:5
 44:20 49:10 57:13,21
 59:11,13 116:4 118:3
 123:20 129:21 152:10
 wholly (1) 176:8
 whom (3) 178:3,9,9
 whose (2) 44:21 55:10
 widely (2) 125:16 142:13
 wider (8) 5:16 89:18 94:6

99:4 102:6 115:16 120:11
 127:12
 widespread (1) 104:10
 widow (1) 141:1
 wifi (1) 5:14
 willing (1) 41:5
 willingness (1) 69:2
 window (4) 6:15,18 10:8
 19:13
 wine (3) 15:14,15,23
 wish (1) 100:4
 withdrawing (1) 182:15
 withdrawn (1) 171:13
 withheld (1) 182:19
 withholding (1) 182:15
 witness (4) 97:5,6,14,20
 witnessess (6) 118:21 124:4
 135:20 149:4 168:5 184:6
 woman (1) 20:15
 women (4) 17:2,3 123:23
 176:25
 wonder (8) 1:12 2:3 7:15
 57:2 60:19 61:16 69:15
 183:2
 wondered (15) 3:8 31:22
 33:10 51:11 55:5 57:8
 58:25 73:2 74:1 80:1 89:9
 90:21 91:11 96:20 139:15
 wont (1) 39:1
 worded (1) 169:24
 wore (2) 112:15 115:2
 work (108) 3:4,24 4:9 6:25
 10:11,21,24,25 11:5,6 13:3
 14:15 15:5 16:8 23:20
 25:24 26:16,24 27:4,5,14
 28:5,19 30:9 34:13,14
 35:15 36:10,11,11,14,25
 37:6 38:7,10 39:8,16 40:17
 41:6,21 42:22 44:16,18
 45:2 51:3,22,23 52:13,23
 53:7,9,13,18 55:22 61:21
 62:24 63:10 69:22,24
 70:6,25 71:5 73:10,21
 74:25 75:23 83:21,22
 84:4,22 86:16,16 88:24
 90:3,14 93:14 98:17
 99:1,3,20 100:2,15
 102:10,12 105:24 108:6,8
 109:23 112:19 116:24
 118:14,25 119:3
 121:4,7,10 122:3 127:10
 132:20,24 133:2,12,22
 134:13 138:7 166:12,21
 175:11
 worked (24) 3:11,19 4:7
 16:21 20:15 28:3 30:1,4,8
 31:9 32:3 33:15,16 37:13
 44:10 58:10 65:15 86:25
 92:13 102:3,11,15 116:18
 181:13
 worker (14) 10:12 27:9
 29:8,8 39:21 62:14 87:25
 99:22 105:9 118:18 128:7
 182:2,4,9
 workers (49) 4:2 10:10 12:24
 14:1 26:14,15 27:17 28:18
 38:12,21 42:22
 44:2,11,13,14,15,18
 45:8,9,22 46:21,21,24 55:8
 57:14 59:12,14,19 77:3
 83:4 97:16,23 99:20
 105:14,25 106:1
 107:9,13,14,14,20
 108:4,7,13 127:11 136:2,6
 148:15 168:6
 workforce (7) 59:17 66:7
 93:10,19 94:3,5 96:14
 workforces (1) 95:19
 working (56) 1:25 3:13,20
 7:17 8:2,6 9:9 11:14 12:8
 16:3 22:16,21 24:1,25
 26:15 27:14 33:18
 37:5,9,11,13 41:25 45:2
 46:20 51:6,11,18 55:9,9
 56:19 59:13 62:6,65,1,5
 73:4 89:8 98:11 102:1,5

105:25 114:21 115:25
 122:13,15 123:24
 134:17,24 136:13 146:9
 147:18 152:8,11 155:10
 167:18 177:15,15
 workplace (1) 41:25
 works (5) 51:17 64:22 68:14
 69:21 154:21
 world (4) 77:24 80:15 105:3
 127:9
 worried (5) 4:11 41:23 69:23
 150:6,12
 worries (2) 13:9 27:11
 worry (3) 54:10,11,15
 worrying (2) 13:9 54:3
 worst (1) 104:4
 worst (1) 151:11
 worth (1) 179:6
 wouldnt (15) 15:10 29:23
 30:4 63:20 69:5 71:10
 91:2,2 92:10,12,19 117:6
 119:2 171:1 174:25
 wraparound (1) 64:25
 write (1) 142:16
 writing (2) 52:17 167:25
 written (3) 141:1,2 151:9
 wrong (3) 58:11 83:12
 104:21
 wrote (5) 120:19,21 143:25
 144:13 151:7

X

x (1) 25:25

Y

y (1) 25:25
 yeah (96) 2:5,15 3:25 4:20
 7:14,17 8:19 16:24
 18:11,13 22:7,7 24:13,23
 25:16 26:19 27:3 29:25
 38:19 40:24,24 41:14,17
 44:4 46:1,6 51:10,13
 56:10,18 61:2,5,14,18,18
 62:5,20 63:9 65:7,11,14
 67:12 68:20,22,22
 69:4,9,12 71:18 73:5,25
 74:23 76:16 77:11,19,21
 78:23 79:7 80:9,24 81:3
 83:19,22 84:6,11,17,20,24
 85:18 86:4,18 87:21 88:18
 90:13,15,17,17,20 93:4
 95:24,24 98:25 99:3
 111:1,25 112:2 124:12
 129:17 130:19 150:24
 157:9,11,13 167:7 175:11
 year (17) 34:19 39:17 102:14
 105:19 118:15,18 134:10
 139:11 152:25 154:17
 160:16 165:9 170:23
 171:3,4 176:22,24
 years (15) 1:25 15:5,5 51:19
 52:14 58:10 63:2 101:15
 102:14 104:2,2 113:18
 119:1,2 154:15
 yesterday (4) 20:12 35:24
 54:9 55:21
 yet (6) 157:8 161:16,20
 172:24 174:16 182:8
 youid (1) 144:7
 youll (5) 11:22 30:25,25 35:5
 129:14
 young (127) 7:7 10:16
 13:17,25 14:4,14 15:3,25
 16:18,20 17:1,1,2,9,15
 18:13 20:15 25:8
 29:10,14,20 30:2
 33:5,12,16 35:13,21 36:6
 51:18,20 52:11,19 53:1,5
 55:10 56:8 57:21 60:1
 62:22 63:7,7,21
 64:4,8,10,13,16,18,20
 65:22 66:6,7,19 68:6 69:10
 70:23,25 71:2,4,7 74:14,18
 75:5,10,16,21 76:6,20,22

77:1,6,8 78:2,9,11,17,24
 79:2,6,23 80:2,4,9 81:8,12
 83:16 84:1,3,24,25
 85:6,13,14,16,19
 86:1,6,8,9,14,20,25
 87:1,13,13,16
 88:1,7,14,18,21
 89:13,16,20,25 90:4,10
 91:10 92:2,8,10 93:9
 95:5,8,11 96:3,15
 younger (3) 13:9 35:25 88:7
 youngperson (1) 79:14
 youngpersonfriendly (1) 91:6
 youre (45) 1:9 18:14,16
 22:3,3 30:5 34:2 35:5
 36:16 48:1 49:6 51:11
 55:4,4 60:15 61:17 65:8
 67:22 68:21 71:2,5,6,8
 91:18 93:7 98:4 100:7
 101:22 104:25 115:21
 122:14,19 124:11 128:16
 132:14 133:3,18 135:10,18
 139:2 143:19 157:18,23
 168:19 179:17
 yourself (3) 30:25 35:3 82:21
 youse (1) 75:23
 youth (2) 29:8 61:21
 youve (44) 2:2 11:9
 34:3,3,5,8,9 35:9 49:16
 54:25 57:3,13,16 89:7 98:8
 100:8 102:17 110:3 116:15
 127:13 128:21 129:16
 133:4,16 135:8,14,22
 137:17 139:7,14 145:7,9
 150:15 158:10 159:12
 164:8 165:11 167:24
 168:19 169:25 170:8,9
 174:1 185:2

Z

z (1) 25:25
 zeros (1) 136:10
 zone (3) 35:10 74:10,10
 zones (2) 74:3,3

1

1 (4) 42:13 98:12 186:3,4
 10 (1) 30:6
 100 (1) 40:3
 101 (1) 55:3
 103 (1) 174:2
 11 (1) 60:10
 1100 (1) 60:11
 1115 (1) 60:13
 113 (1) 56:22
 114 (2) 174:2 175:7
 1159 (1) 97:9
 116 (1) 174:2
 117 (1) 182:25
 12 (2) 51:20 119:1
 121 (1) 183:3
 123 (1) 183:3
 125000strong (1) 105:19
 128 (1) 97:11
 12hour (1) 65:15
 13 (1) 170:21
 130 (1) 97:7
 138 (1) 186:7
 139 (1) 186:8
 14 (2) 63:22 163:12
 15 (2) 72:21 160:17
 1516 (1) 51:20
 16 (7) 14:25 20:16 48:12
 73:23 88:1,8 170:20
 164 (1) 160:17
 165 (1) 160:17
 16yearolds (1) 14:24
 17 (1) 3:3
 175000 (1) 123:18
 18 (3) 157:19 160:16 163:13
 18plus (1) 64:18
 19 (2) 1:1 65:5

2

2 (2) 98:13 117:23
 20 (5) 36:1 39:10 53:8 119:2
 133:23
 2008 (1) 113:20
 2010 (1) 113:16
 2012 (2) 102:4 116:7
 2020 (22) 2:4 51:15,19 62:2
 65:1 100:14 101:3
 102:2,13 110:14 112:1
 113:14 142:4 152:15,25
 154:7 157:19 160:25 161:3
 165:14,19 179:16
 2020early (1) 176:22
 2021 (8) 61:12,24 90:18
 102:11 150:22 153:1 161:3
 176:22
 2022 (7) 105:10 150:2 161:4
 170:19 176:17 177:11,19
 2023 (4) 99:22 118:3 134:8
 177:12
 2024 (3) 1:1 169:5 185:25
 21 (3) 64:18 67:9 160:17
 22 (2) 120:3 139:10
 23 (1) 185:25
 238 (1) 138:21
 247 (3) 113:12 121:24 8
 25 (1) 71:14
 257 (1) 138:23
 26 (4) 1:25 4:16 64:24 131:8
 28 (1) 68:15
 29 (2) 7:12 142:3

3

31 (1) 74:20
 315 (1) 138:17
 32 (2) 10:14 123:13
 33 (1) 125:8
 34 (3) 16:17 108:3 149:7
 35 (3) 34:25 35:7,8
 36 (1) 24:14
 37 (1) 130:12
 3m (1) 115:18

4

40 (3) 101:15 137:18 168:25
 417 (1) 185:23
 44 (1) 76:13
 45 (1) 26:22
 48 (1) 118:24
 49 (1) 79:1

5

5 (2) 102:3 108:4
 50 (1) 29:19
 500 (5) 44:17,24 45:1,12
 171:9
 51 (2) 180:23 181:1
 52 (1) 31:20
 56 (2) 80:20 83:12

6

6 (1) 16:4
 60 (4) 51:16,17 186:4,5
 65 (2) 41:10 86:19
 66 (1) 87:15
 67 (1) 119:3

7

7 (3) 16:4 61:15 107:5
 70 (1) 177:14
 71 (1) 177:24
 73 (1) 178:1
 75 (1) 179:8
 76 (1) 179:9
 77 (1) 45:23

8

8 (4) 16:6,6 102:11 116:14
 80 (3) 39:6,8 91:6
 8020 (1) 40:4
 80s (1) 177:13
 850 (2) 51:16 171:6
 87 (1) 154:8

9

90s (1) 177:13
 9100 (1) 42:16
 91000 (1) 123:16
 930 (4) 1:2 185:19,20,25
 943 (1) 1:4
 945 (1) 185:19
 95 (1) 174:2
 97 (2) 186:6,7