Scottish COVID-19 Inquiry

Statement of: Kathleen Jenkins – HSC0105

Introduction

1. My name is Kathleen Jenkins and my date of birth is Personal Data My details are known to The Inquiry.

2. I have met today, Monday 11 December 2023 with witness statement takers from the Scottish COVID-19 Inquiry team. I wish to provide a statement in relation to my experience of Covid 19 as Secretary of Scottish Hazards Charity.

3. I have signed the consent form provided. I consent to my information being contained within reports and published. I would provide evidence at any hearing if required.

Antecedents

4. I am a trustee and the charity secretary for Scottish Hazards.

5. From 1979 to 1989 I worked for Edinburgh Health Council then moved to NHS Lothian Health Promotion Department until 1999. From 1999 to 2002 I worked for the British Medical Association, alongside part-time teaching at Heriot Watt University on workplace health. From 2002 to 2008 I was self-employed,

6. From 1999 to 2015 I worked at the Universities of Edinburgh, Heriot Watt and Strathclyde Universities developing, co-ordinating and teaching a Masters level course on Workplace Health.

7. From 2008 I worked at the Edinburgh University, lecturing in the biomedical sciences departments. The course I helped develop and lead, Health Illness and Society, covered all non-biological causes of ill-health e.g., poverty, housing, gender, disability, globalisation and the like. This course incorporated subjects relating to occupational health and workplace health and safety. I did this for around 5 years.

8. I also have a master's degree in public health and health promotion. My dissertation was based on workplace health. It was from this research that I became involved in university lecturing and tutoring medical students.

9. I am now retired but still undertake some paid work, from time to time.

10. I have always been active in the trade union movement and it was whilst working at NHS Lothian that I was asked if I would be interested in specialising in workplace health, which I agreed to.

11. This brought together my trade union interest and my work, eventually putting me in touch with Jim Swan who set up the Scottish Hazards Campaign Group (now called Scottish Hazards).

12. I became involved with them in 1994, then quickly became part of its steering group and have remained involved with them ever since. I have held various offices, once being chair. I am now one of the six trustees and am the charity secretary.

13. I have always treated my time spent on Scottish Hazards as work even though it is an unpaid, charitable role. Prior to 1999 my Scottish Hazards Campaign role was, to some extent, part of my work at NHS Lothian as the responsibilities overlapped and complemented each other.

Scottish Hazards

14. Scottish Hazards is a Core Participant in this Inquiry.

15. Scottish Hazards is a Scottish Charitable Incorporated Organisation and our registration number is SC044785.

16. It was registered as such on 1 April 2014. Prior to 2014 it was known as Scottish Hazards Campaign Group ("SHCG"), which was unincorporated and formed in Edinburgh in 1993.

    Our primary objective is the advancement of health and the saving of lives in the work environment. We aim to achieve this through the provision of specialist information, advice, training and in-depth support intended to prevent work- related incidents and work-related disease which cause death, injury, physical and mental ill health.

17. We principally serve this objective in the context of occupational health. Our work is not restricted to UK Government reserved matters of health and safety. We also have an in-depth knowledge and experience of the Scottish Government devolved matters that impact on safety including devolved public health responsibilities and the enforcement thereof.

18. We also undertake education, seminars, and information provision and offer dedicated support to the families of those killed at work.

19. Scottish Hazards aims to provide support to vulnerable workers, whether workers, employees or the technically self-employed who do not otherwise enjoy the protection of a recognised trades union.

20. We operate a helpline and offer advice, support and representation through our casework.

Our Work During the Pandemic

COVID Helpline, Training & Casework:

21. At the outset of the pandemic Scottish Hazards set up a dedicated COVID Helpline for workers. This was aimed at providing advice, guidance and assistance to those who did not enjoy the protection of a recognised trade union. Where necessary we would take on their case and represent them, in a similar way that trade unions would for unionised workers.

22. In total we dealt with over 460 cases during the pandemic. This related to all sectors.

23. This additional work was in part enabled due to funding provided by the Scottish Government specifically for that purpose.

24. Prior to the pandemic Scottish Hazards providing bespoke training to various Union health and safety advisors and representatives, and other training around workers' rights and equality issues. As Covid hit, there was a clear need to increase this given the impacts on workers and workplaces, which was delivered through a more intensive electronic format meaning we could reach more people, faster. The training was very broad: examining rights and responsibilities, health and safety issues, making "fair work" real, leadership, discrimination. This training was carried out jointly with the STUC and was funded through the Union Learning programme.

COVID Safer Workplaces Group:

25. Prior to the Pandemic, Scottish Hazards was a member of the Partnership on Health and Safety in Scotland (PHASS). This was set up by Scottish Government and Health and Safety Executive (HSE) in the early 2000's because health and safety is a matter retained to Westminster. It aims to support tripartite collaboration between employers, employees and government to address broader work-related health and safety issues affecting Scottish workers, and to encourage and influence change related to workplace health and safety matters.

26. Membership of PHASS included Scottish Government, businesses, business federations, unions and relevant agencies like ourselves, the HSE, occupational health professionals and occupational hygiene specialists.

27. It was through our work on the PHASS network that Scottish Hazards were invited to join the Scottish Government's Safer Workplaces advisory group (initially called the Covid Restart Group and latterly the Covid Safer Workplaces Group) which was set up to identify, assess and mitigate emerging workplace issues which Covid brought to bear.

28. During the pandemic we submitted monthly reports to the Safer Workplaces Advisory Group, conveying the key themes, issues and concerns affecting the workers we represented, which was informed through our helpline, casework and other activities. We have provided these reports to the Inquiry. These reports brought the issues and concerns of workers and workplaces to the attention of the Scottish Government throughout the pandemic response.

29. The Group met twice monthly throughout the pandemic, and I represented Scottish Hazards in these meetings to speak to our reports and to highlight any other worker-related matters we wished to highlight to Government. On the rare occasions I could not attend, our Chief Executive would deputise for me.

30. Scottish Hazards' knowledge and our evidence (gathered through our helpline, casework and other activities) had a positive impact on the Group and was aimed at assisting the strategic response of the Scottish Government. It played a part in identifying worker/workplace issues which required attention, new guidance or changes to guidance (for example, the need to clarify what was 'essential work').

31. Subject specific subgroups were set up, looking at specific issues like ventilation.

32. Guidance was reviewed and commented on before it was published. Each of the Advisory Group members agreed to publicise each other's services which was great in terms of raising our profile with non-unionised and other vulnerable workers.

33. Scottish Hazards also provided specific COVID-related training and seminars and produced informational videos which were shared out through this central group, on issues such as PPE, the importance of workplace ventilation and working from home.

34. <u>Impacts of This Work:</u>

35. I believe that the establishment and activity of the Scottish Government Covid Safer Workplaces advisory group contributed positively to addressing and reducing the impact of the virus during the pandemic.

36. The Scottish Government's inclusive and consultative approach, including the Safer Workplaces advisory group, resulted in positive changes to guidance and better communication among key players including employers and workers.

37. It enabled improvements in workplace control measures: including working from home, travelling to work, social distancing, face coverings and hygiene measures resulting in reduced exposure to Covid and consequential ill health for workers and their families. It enabled a more coherent and consistent set of messages to be provided to workers and employers resulting in reduced work-related stress.

38. Scottish Government financial support for STUC and Scottish Hazards enabled additional case work and wider support for workers and, reduced exposure to Covid related ill health for workers and their families.

39. It also reduced broader work-related stress, not just for workers who consulted directly with us, but also when the advice and guidance we provided was shared with and implemented by employers.

40. Securing additional funding also enabled wider and more effective communication and publicity about the Scottish Hazards advice, support and representation service. This and the additional case work capability resulted in reduced risk exposure, stress and mental ill-health for hundreds, probably thousands, of workers and their families.

41. The same benefits were achieved as a result of the direct access which our caseworkers had with Scottish Government officials, discussing specific covid issues. This meant that we could seek support from government officials in engaging with reluctant employers.

42. In the future, the Scottish Government must take steps to ensure that workers know what their rights are and that they can receive support and advocacy where necessary, in particular for non-unionised, vulnerable workers.

43. Unfortunately, since the end of the pandemic, this group has been stood down. As part of current resilience planning for inevitable future pandemics or public health emergencies, the Scottish Government should consider replicating or, still better, continuing the Safer Workplaces Advisory Group, possibly on a less frequent basis. This would reinvigorate

and maintain the improved communication that resulted among all key players.

44. This statement deals with health and social care – our work and knowledge gained throughout the pandemic did, however, relate to all sectors.

45. My colleague, and our Chief Executive, will provide evidence on the particular impacts on, and the specific issues experienced in general by, the workers we represent.

46. This statement will set out the higher-level impacts flowing from systemic responses (or lack of responses) and the reasons for them, together with the disproportionate impacts suffered in relation to health and social care workers.

Vulnerable Workers & Health and Social Care During the Pandemic

47. There are some key themes which tend to identify people we generally consider as being vulnerable workers. Firstly, they are often on precarious "contracts", typically zero-hour, flexible, non-contract work. It also includes people who are low paid, without pensions, or who have to pay for their own training, and often includes young workers, older workers and those with protected characteristics under the Equality Act. Also, workers without trade union membership or union recognition in their workplaces do not benefit from the advice, support or protections that brings. Scottish Hazards therefore aims to provide a similar service to employees requiring that support, and did so during the pandemic.

48. There were also workers with (or who had someone in their family with) particular vulnerabilities specific to Covid placing them at significantly increased risk: suppressed immunity, underlying health condition/s, older workers, and pregnant workers.

49. In relation to health and social care, the majority of workers in the health sector (particularly within NHS and local authority care) tend to be unionised. Our work during Covid related predominantly to private and third sector care workers.

50. In terms of service provision in the care sector, 80% of care homes are private businesses, and the majority of "care at home", in Scotland, is private or third sector enterprise. Most of these workplaces are not unionised.

Impacts on the Workers flowing from Systemic Responses (Or Lack of Responses)

Austerity

51. There have been significant negative impacts on the working life of many vulnerable workers whom Scottish Hazards represents, especially in the care sector.

52. This transition in care provision away from the public sector is, and remains, about saving money. Private and third sector organisations bid for contracts, which has persistently driven down costs such that private and third sector health and social care workers are amongst the lowest paid workers in our country and tend to be employed on the most basic of terms and conditions of employment. Employers also tend to operate on ever finer margins

53. Overall, this caused a fragmentation of the care sector, with hundreds, if not thousands, of employers, which has resulted in little in the way of union support or protection. The result was to enter the pandemic with one of the lowest paid sectors, nationally, with poor working conditions and very little employee protection, and already stretched to the limit. We suspect that this fragmentation resulted in a lack of 'infrastructure' through which to oversee, digest and disseminate guidance and related workplace safety requirements, as compared, for example, to the Partnership model and pre-existing structures within the NHS, which include employee voice. We also suspect the impact of that would be inconsistent application, and issues of insufficient resource, within the care sector for each organisation to manage this. We would recommend the Inquiry investigate this likely effect.

54. The care industry was already in crisis leading up to the pandemic. - Covid did not create the crisis, it exposed and exacerbated the crisis already affecting this sector. The impacts on the sector, and those working within it, were extreme.

Lack of Preparedness

55. There was a widespread lack of preparedness and disaster planning for a pandemic or public health emergency such as Covid, despite information and forewarning about the risks existing.

56. Prof Andy Waterson, Emeritus Professor in Occupational and Environmental Health at Stirling University produced reports regarding UK wide public health exercises and their conclusions, which took place in 2009 and 2015. The 2015 exercise was Exercise Silver Swan. In short, he

identified that the conclusions and lessons learned from these exercises, were essentially ignored.

57. This resulted in avoidable delays in producing and communicating legislation and guidance, delays in putting in place control measures such as PPE, working from home, face coverings, social distancing. There were delays in establishing adequate test and protect mechanisms.

58. Each of these delays increased exposure to covid and resulted in ill health for workers, their families and the people these workers cared for.

59. We do not know the extent to which the limited previous planning (Silver Swan etc) consulted externally, but it is vital that any future planning exercises consult those representing workers' interests, including trade unions and those representing non-unionised workers.

Lack of Union Recognition/Membership in the Care Sector

60. There was a comparative lack of protection, information, advice and support for non-unionised employees. This underlines the fact, demonstrated by clear evidence, that unionised workplaces are safer than non-unionised ones (evidence of which we will provide to the Inquiry).

61. The lack of union recognition results in health and safety being led by the employer or by managers, without much in the way of meaningful employee 'voice', engagement or consultation. This can lead to a particular disconnect between those employees actually carrying out the job, "on the ground", and the management making the decisions affecting those workers and their jobs.

62. It was clear during the pandemic that many employers were not speaking to their employees regarding Covid related work safety issues. In many cases there were no satisfactory or sufficient risk assessments and, even when carried out, they had not been done in collaboration with employees. This left employees exposed to additional work related risk.

63. Before and throughout the pandemic we have always made the point that employers must consult with employees on H&S matters. This is not just good practice but is the law under 1977 and 1996 regulations.

64. Some employers required vulnerable people to return to work without undertaking an assessment of the enhanced risks or putting in place adequate control measures, including being able to continue working from home. This increased exposure to COVID and to serious ill-health for these workers and their families.

65. Even post pandemic, the Scottish Government guidance was that working from home was the default position, where possible, whereas some employers were pushing employees to return to work.

66. Part of the planning and preparedness process must include effective risk assessments for all work -crucial in identifying causes of infection spread, then addressing those risks, so that these risks can then be mitigated, reducing as far as possible specific and overall risks.

67. The lack of union support affected the ability and means for staff to safely raise workplace safety concerns with a third party who can then engage with the employer. It also, in practice, leaves a serious reluctance to use whistleblowing procedures. We would refer the Inquiry to the Scottish Government Report, Care Home Review – 1 November 2020 (`- which noted the need for improved systems to allow care home workers to whistle blow during the pandemic.

68. During the pandemic we saw a widespread reluctance of non-unionised workers to ask questions and raise concerns with their employer about working conditions related to covid exposure. This was commonly the case even if Scottish Hazards offered to raise matters with the employer anonymously.

69. This resulted in a lower employee voice which would otherwise be used to inform employer risk assessments to mitigate pandemic risks. This also meant there was less information shared by employees with their peers, which increased exposure to covid, ill health for these workers, their families and their colleagues.

70. The result is a lower employee voice, which is contrary to the mandatory requirements under Fair Work First procurement rules.

71. Thankfully the Scottish Government provided financial support for Scottish Hazards to enable us provide additional case work and wider support for the types of workers we support. We have little doubt this assisted many non-unionised workers and reduced exposure and potential Covid related ill health for them and their families.

72. It is important in planning for future pandemics / public health emergencies (and in all day-to-day workplace activity) that plans and arrangements are in place to provide health and safety information, advice, support, training and representation to non-unionised workers.

Sick Pay

73. A key issue during the pandemic was sick pay for care workers. Most working in the third/private care sector do not receive contractual sick

pay – their entitlement is largely to statutory sick pay. This tends to force workers to continue working when they are unwell, increasing the risk of cross contamination. Stepping back and risk assessing this, it is clear that this compounds the overall impact and spread of Covid. It placed workers, who would tend to have limited, if any, savings, to choose between working whilst feeling unwell, or staying off work but suffering financially. Also, some periods of absence were mandated due to covid or close contacts contracting Covid – which in the absence of sick pay, caused serious financial strain for workers.

74. By default, this forces some unwell workers to consider whether to continue working, which in turn risks their own health and increases the risk of cross contamination to their colleagues and those whom they care for, many of whom are already vulnerable members of our community.

75. There was an even more increased Covid related risk to black and minority ethnic workers, those with compromised immunity or with family members with compromised immunity, those with disabilities and those who were pregnant.

76. The Scottish Government set up and backdated a fund to allow employers to pay full pay when off sick. Unfortunately, some employers did not facilitate this, thereby not following Scottish Government guidance under the Fair Work statement that there should be no financial detriment for workers.

77. This resulted in some workers having to take annual or unpaid leave.

78. It is important to recognise the financial detriment caused by social care employers not following guidance in this regard. In future, it will be important to consider options to force compliance, and possibly the extent to which it is possible or practicable for such funds being provided directly from Government to employees, rather than via employers.

Staffing Levels, Training and Increased Duties and Responsibilities

79. The pandemic exacerbated the existing recruitment struggle (a 30% vacancy rate because they can't recruit) and the existing high staff turnover rates, which became more acute and placed greater strain and pressure on workers. Staffing levels suffered due to isolation, increased sickness absence, exhaustion and, we suspect, a reluctance of others to enter the profession at that time.

80. Training is often inadequate and sometimes it is self-financed, and to be completed in workers' own time. This too was exacerbated by the continual updates and changes to guidance as the pandemic unfolded.

Workers in the sector were already stretched. The increased staffing and training issues were compounded by an increase in procedures and duties (infection prevention and control), regular changes in guidance, a reduction in certain healthcare professionals visiting in person. Difficulties faced by staff were exacerbated by the fact that Care at home workers are most often constrained by a set time for each of those they care for, giving them little autonomy and leaving them feeling unable to give the care needed. They are sometimes not paid for the time and travel between those they care for. The health and safety risks include lone working, stress, long and uncertain working hours, lack of support and supervision.

81. The over reliance on agency workers means that sometimes carers are not aware of individual care requirements and this presents an array of health and safety risks to both carer and cared for.

Pandemic not being Categorised/Treated as an Occupational Health Emergency

82. The Covid Pandemic was an occupational health emergency as well as a public health emergency. This will remain the case in any future pandemic or public health emergency.

83. Workplaces and the activities and interactions of workers during any pandemic, are one of the key places and means of transmission of the virus.

84. However, Covid was not recognised by the Health and Safety Executive or the UK Government as an occupational health, as well as a public health, emergency.

85. Whilst the Scottish Government correctly used its devolved public health powers to implement measures impacting on the workplace, it did not categorise the pandemic as an 'Occupational Health' matter. The overriding message was very much one of 'public health'.

86. Consequently, employers and enforcement bodies, in general, tended to view the pandemic as a community-based concern. This led to a key lack of recognition from employers, enforcement bodies and government that COVID-19 was, for a significant proportion of the population, spread and contracted within the workplace.

87. In turn this led to a widespread failure to report workplace-related outbreaks or to recognised work-related Covid deaths. There was also a failure to inspect workplaces and workplace practices, ensure compliance with measures, and a failure to make adequate targeted interventions.

88. We believe this will have had a comparatively greater impact on non-unionised workers in private/third sector care given its relative lack of union presence and the general lack of information and support. In contrast, in the NHS local authority care sectors, and unions were better able to ensure, as best they could, that workplace guidance and measures were being implemented properly, that workers were aware of their rights, and to tackle non-compliance.

89. We believe this contributed to an increased and unnecessary risk of exposure to the virus, which will have resulted in increased ill-health for workers, their families and those being cared for, and corresponding financial losses for workers.

90. It also led (where applicable) to a practical lack of legal redress for employees in Scotland who suffered loss from legal wrongs in the workplace, given the presumption/defence that infection is/was contracted within the community.

91. In terms of pre-pandemic planning exercises, Scottish Hazards and other workplace organisations were not involved or consulted. This, together with the fact that this didn't happen early in the Covid pandemic, was a reflection of it being seen as a public health rather than occupational health matter.

Limits/Confusion/Issues caused by the Devolution Settlement

92. It is important to note that Health and Safety and health and safety enforcement is a matter reserved to Westminster. The Scottish Government's powers in relation to enforcement within workplace was, in part, hampered.

93. Whilst the Scottish Government correctly, and flexibly, used its use of devolved public health powers to implement measures/guidance impacting on the workplace, and should be commended for that, it is, nevertheless, important that there be an adequate means of ensuring that those measures are being followed. They should be accompanied by adequate penalties (where possible) together with an adequate means of policing breaches/enforcement. We do not feel that was the case, the reasons for which should be fully investigated by the Inquiry.

94. The fact that some powers (and therefore the measures, guidance and enforcement flowing from them) are devolved and some are retained can and did create confusion, and it will in future; and it can, did and will place constraints upon the Scottish Government's response. Some issues arose when Scottish Government and UK guidance differed. This confusion was used by some employers to try and defend not following Scottish Government guidance in Scotland.

95. It is important that the Inquiry investigates how (and the extent to which) the Scottish Government response was hampered by the retention of health and safety/enforcement to Westminster.

Lack of Investigation and Enforcement of Workplaces, Pandemic Guidelines and Regulations, and Lack of Reporting/Data

96. The Health and Safety Executive (HSE) is the UK wide health and safety enforcement body. It was established as a tripartite body of the government, employers and employees (traditionally through trade unions)

97. It is important to point out that the independence of the HSE has diminished. Historically, the Trades Union Congress nominees (drawn from a range of affiliated unions) were routinely selected and appointed These days, the employee representatives appear sometimes to be handpicked by the government. The chair is now also handpicked by Government.

98. In addition, its activities have been restricted such that HSE can now only proactively inspect high risk business areas, like nuclear and chemical industries. Proactive, unannounced inspections at most places of work including health and social care environments and education are now not permitted. The same rules apply for Environmental Health Officers, who work with HSE, even though they are local authority positions and devolved from UK Government.

99. Finally, funding for the HSE has been cut by approximately 50% since 2010.

100. The result being that on entering the pandemic, a time at which the need for assessing risk and implementing mitigation measures has probably never been greater, the HSE's ability and resource to inspect and enforce had been seriously diminished.

101. From our interactions and observations during the pandemic it appeared to us that there was some difference in the way the HSE and Local

Authority Environmental Health saw workplace spread of the virus, with the HSE consistently maintaining that it was community spread whereas those in Environmental Health acknowledged the importance of workplace spread.

102. During the pandemic the HSE did institute inspections but not using HSE Inspectors. Instead, they paid debt collector agencies to inspect businesses and do narrow Covid specific inspections, concentrating on narrow issues such as social distancing and wearing masks.

103. If there had been HSE Inspectors undertaking these inspections they would also have been obliged to consult the workforce, meet with the union H&S representatives and review all their H&S reports. They would then have to report back to these union representatives.

104. If no union representative was available, they would have to speak to whoever represents the workforce.

105. The debt collectors were not bound by the same obligations so there was little meaningful engagement or inspection.

106. The impact on workers in Scotland was that there was a further lack of compliance in certain workplaces and, in turn, an increase in exposure and risk to those workers.

107. There was also sometimes confusion about which bodies – the HSE, local authorities, public health, the police - enforced which laws.

108. It was and it remains obvious that there needs to be clearer identification of which enforcement bodies, whether UK wide or devolved, are responsible for investigating and upholding the adherence to guidelines and regulations by employers and other organisations.

109. This would allow employees and/or those representing them, to raise concerns, report or highlight failures and breaches to the appropriate and competent authorities.

110. Additionally, our experience is that the Scottish Government can significantly help reduce confusion and increase compliance by fully communicating within its guidance what the law says on employer obligations, and what the enforcement roles of other UK-wide law and regulatory bodies are, on matters which are not devolved. To some extent the Scottish Government did do this.

111. It is important that the Scottish Government work closely with all enforcement bodies to clarify roles and areas of responsibility between

and across each of them, ensuring good communication regarding inevitable areas of overlap.

112. It can also help remove some of the risk of the reporting and investigation of breaches and failures falling into the gaps between these organisations.

113. There were deficiencies in the reporting of covid data in relation to the pandemic and workplace spread throughout Scotland. Such data would have allowed better targeted interventions in specific areas, including workplaces within Scotland or specific work sectors. One area of inadequate data was in RIDDOR (Reporting of Injuries, Disease and Dangerous Occurrences Regulations, 2013), the reporting mechanism to HSE. This arose partly because RIDDOR reporting is generally not rigorous and partly because of the failure to treat Covid as an occupational disease. However, as this is reserved, it is difficult to say how the Scottish Government could have improved this. However, they through Public Health Scotland, could improve public health data collection.

114. This would provide a practical benefit and effect in Scotland, both in terms of identifying reporting mechanisms and understanding the nature and extent of health and safety breaches and failures.

115. It is important that the principles and protections for workers outlined in the Scottish Government's Fair Work agenda be emphasised and as far as possible enforced during any future pandemic or public health emergency.

116. The Scottish Government had public health powers to control public and to some extent workplace exposure to Covid however these were not used or enforced to their full extent and therefore were unable to adequately safeguard and protect vulnerable working groups. On the whole, however, Scottish Hazards believes that the Scottish Government tried hard to do what they could to uphold employers' workplace obligations, inspections and risk assessment, but it was constrained by the fact that broader Health and Safety legislation remains a UK Government matter.

Scottish Covid 19 Epidemiology Report

117. We have some concerns about the inferences which can be drawn from the epidemiological evidence commissioned by The Inquiry.

118. We believe the scope of the evidence provided by Dr Ashley Croft (witness) was very narrow and that the criteria he used to identify

acceptable evidence was not necessarily appropriate for public health interventions.

119. In particular, we believe that the report's conclusions undermine the importance and effectiveness of a number of control and mitigation measures, whether used individually or cumulatively.

120. These conclusions do not reflect the wider understanding of how effective these measures actually are, and the scientific evidence available in support of that.

121. We don't wholly disagree with Dr Croft; what he said in parts may be true within the very narrow scope he set himself. But he was looking almost entirely at "randomised control trials" (RCTs), as reviewed by Cochrane, which are very specific and have a very clear benefit to trialling medical interventions. Because they were very specific and controlled, they made complete sense for medical interventions. For example, for determining the relationship between a particular drug and a physical reaction or benefit.

122. In contrast, there is considerable scientific opinion that such trials are not appropriate for many of the complex social phenomena which encountered as part of evaluating the efficacy of public health interventions.

123. There is WHO research and evidence which indicates that random control measures are not the gold standard for measuring public health interventions.

124. Instead, it is necessary to use qualitative and quantitative research from different perspectives, which is a kind of triangulation method, to try and assess what public health interventions are effective or not. As an example, you cannot have Edinburgh wearing masks, whilst Glasgow will not, to establish whether face masks work.

125. There is research by Professor Agius, Emeritus Professor of occupational and environmental health at Manchester University which illustrates that what is needed is a whole package of measures working holistically and complementing each other.

126. We would also refer the Inquiry to what is known as the Swiss Cheese Model.

127. There are many scientific papers which show that masks are effective against airborne spread, and that more specialist make, such as FFP3, offer significantly increased levels of protection; whereas a potential inference from Dr Croft's report could be that masks were not effective at

all. We do not believe that is the conclusion Dr Croft intends to convey; indeed, in March 2023 the Cochrane Library issued a statement to clarify the Jefferson 2023 review because it had been widely misinterpreted, stating that "*Many commentators have claimed that a recently-updated Cochrane Review shows that 'masks don't work', which is an inaccurate and misleading interpretation.*"

128. We are not criticising Dr Croft, we are simply worried that this narrowness will mean that The Inquiry will start out with the baseline that nothing works, because that is not true.

129. In all, we are saying that Dr Croft may have made a fair reflection of what he was looking at, it's just that it was too narrow.

130. Ultimately, we are arguing that random control methods are not appropriate to effectively evaluate public health interventions. It is more complicated than that.

131. We will place before The Inquiry further research in this regard and submit evidence we have accumulated in relation to mitigation measures, their effectiveness and importance.

Aerosol Transmission; Ventilation & Facemasks

132. Along with the WHO, other international bodies and the UK Government, the Scottish Government did not listen quickly enough to scientific voices saying that Covid was subject to aerosol or airborne spread. This delayed the implementation of crucial protections, including for health and social care workers. These protection measures included adequate PPE, masks, and good ventilation. But, of course, we now know that Covid is aerosol generated, it is transmitted just by people breathing.

133. Even though pre-existing pandemic planning looked at aerosol transmission, this was ignored in the initial months of the pandemic. It was believed that, and initial responses proceeded on the basis that, Covid was passed more by touch, droplets and contaminated surfaces.

134. Eventually the World Health Organisation conceded that Covid was aerosol spread.

135. In support of all this, Scottish Hazards would refer to the Scottish Government Report, Care Home Review – 1 November 2020 (A rapid review of factors relevant to the management of COVID-19 in the care home environment in Scotland) which documents that "ventilation is not considered a control measure in care homes and is not currently (as at November 2020) a focus in guidance". It documents that only recently

had the WHO etc. recognised the importance of aerosol transmission. https://www.gov.scot/binaries/content/documents/govscot/publications/independent-report/2020/11/root-cause-analysis-care-home-outbreaks/documents/care-home-review-rapid-review-factors-relevant-management-covid-19-care-home-environment-scotland/care-home-review-rapid-review-factors-relevant-management-covid-19-care-home-environment-scotland/govscot%3Adocument/care-home-review-rapid-review-factors-relevant-management-covid-19-care-home-environment-scotland.pdf

136. Even when the importance of ventilation was belatedly recognised insufficient action was taken to improve it. Given workplaces were a key area for spread of the virus, it was important to recognise the importance of good ventilation. It was also important that employers were aware of pre-existing legislative requirements in this area, as our experience suggests that many employers were, and remain, wholly unaware of these requirements.

137. Hospitals have their own standards, but ventilation was crucial in care homes, care at home environments and on public transport, where generally the use and understanding of ventilation standards was not adequate or safe.

138. Part of the planning and preparation for any future pandemic or public health emergency must include providing education and guidance to employers on the importance of workplace ventilation. This includes educating employers about pre-existing legislative ventilation requirements.

139. In relation to face coverings, it was somewhat chaotic at the beginning of pandemic, especially the first six to eight months. There was not enough information about face coverings and PPE and the difference. There were inadequate supplies of both. Guidance was that most health and social care workers only needed surgical masks (face coverings).

140. However, we had always been clear that people providing intimate care, regardless of where this was taking place, should have been using PPE - at least FFP2 to FFP 3 category facemasks.

141. The masks we all ended up wearing whether to shops or on buses were not PPE; they were a public health measure.

142. Even in the health service there was insufficient protection because they only wearing FFP 2 or FFP 3 masks if they were involved in aerosol generating procedures, like using any type of respiratory machines. We will provide the Inquiry with evidence that FFP3 masks offer significantly increased protection than basic face coverings/surgical masks.

143. We repeatedly argued that all care workers should have been provided with the same PPE as those doing intense levels of care in respiratory or acute wards.

144. Each of the above failures meant that the importance of PPE, face masks and ventilation was not recognised in the initial phases of the pandemic, which caused a significant delay in the implementation of such measures. Even when introduced, the level of PPE, face masks and ventilation was generally inadequate, particularly in the care sector. This will have unnecessarily exposed many workers to unnecessary risk and exposure.

145. Statistically, social care workers and transport workers all had higher covid rates than the general workers. Many, including HSE tried to argue that these infections were community spread, nothing to do with the workplace. We would refer to Crown Copyright 2020, Deaths involving coronavirus (COVID-19) in Scotland Week 32 (3 August to 9 August 2020) which showed a disproportionate death rate among social care workers.

146. Now the Industrial Injuries Advisory Committee has clearly stated that Covid was a workplace disease for certain categories of workers including health and social care, but the government has not acted on this by declaring it an industrial disease.

147. Scottish Hazards believe they should because this would have a positive impact on the Industrial Injuries Disability Benefit. We think it should be declared an industrial disease especially for long Covid sufferers.

Precautionary Principle

148. Scottish Hazards believes that the Scottish Government must work with the UK Government and others internationally to develop robust disaster planning to meet a pandemic or public health emergency and, even where there is debate about the level of need or priority, the Scottish Government must take a precautionary approach.

149. The precautionary approach is a key principle of health and safety practice, which provides that when activity raises threats of harm to human health or the environment, precautionary measures should be taken even if some cause and effect relationships are not fully established scientifically. So this would be an approach that advocates for a range of control measures, even if there is some debate about how infection in a pandemic or public health emergency is spread.

150. It allows responses to be scaled back if the risk is not as severe as was initially anticipated.

151. Doing otherwise means that interventions are always reactive, not proactive and, simply, will not catch up with nor adequately deal with the risks or their impacts.

152. For example, in the initial period of the pandemic the mechanisms by which the virus was spread was not fully understood, in particular the extent to which it was an airborne virus. A precautionary approach would have protected against that even if it was unclear.

Disproportionate Impacts

153. There was a disproportionate impact on front line workers, workers on precarious contracts and workers on low pay.

154. The majority of our COVID related case work came from women – approximately 80%. This reflects the reality that health and social care remains a role primarily undertaken by women.

155. We believe the care sector also has a disproportionate number of workers from a black or ethnic minority background.

156. We would also reference the Crown Copyright 2020, Deaths involving coronavirus (COVID-19) in Scotland Week 32 (3 August to 9 August 2020) which showed a disproportionate death rate among social care workers. We would refer to the evidence provided by Scottish Women's Rights Organisations to this Public Inquiry. It identified the pandemic's disproportionate impact on women, including information on the impact on social care workers, who are low paid and often on precarious contracts.

157. In health and social care there was a disproportionate impact on certain workers with increased risk from contracting COVID, including black and ethnic minority workers, those with compromised immunity (or with family members with compromised immunity), those with disabilities, and those who were pregnant. Some employers required vulnerable people to return to work along with others without undertaking an assessment of the enhanced risks or putting in place adequate control measures, including continuing to work from home where possible.

158. The evidence provided by the Glasgow Disability Alliance (GDA) to The Inquiry also details the disproportionate impact of the pandemic on those with disabilities.

159. There was also a comparative lack of protection, information, advice and support for non-unionsed workers, for the reasons set out earlier in this

statement. There was a widespread reluctance by non-unionsed workers to ask questions and raise concerns with their employer about working conditions related to Covid exposure. This was commonly the case even when Scottish Hazards offered to raise matters with the employer, even anonymously.

160. There was a lack of consultation by employers with non-unionised workers. It is important that in a future pandemic or emergency that they have a 'voice', as set out by the Fair Work agenda.

Lessons Learned

161. A pandemic or other public emergency must be recognised and treated as an occupational health matter as well as a public health matter.

162. Non-unionised workers are at higher risk of workplace incidents and occupational disease.

163. Good consultation with and involvement of workers on health and safety matters is crucial to protecting health. There was a lack of consultation and involvement for most non-unionised workers during the pandemic. This lack of strong employee voice increased risk of exposure during the pandemic, and did not adhere to the Scottish Government Fair Work agenda.

164. Scottish Government support for Scottish Hazards enabled non-unionised workers and small businesses to access advice and support which allowed them to reduce the impact of the virus on workers and their families. The vast majority of social care workers are non-unionised, making this support crucial for this sector.

165. Lack of adequate risk assessment increased exposure to the virus of workers and their families. Risk assessment is a legal requirement. Strong guidance and enforcement are needed to ensure proper risk assessment.

166. The fragmentation of social care provision exacerbated failures in communication about and provision of various actions needed to protect staff and users.

167. The impact of the pandemic was particularly heavy for workers with low paid and precarious jobs. One aspect of this was lack of sick pay. The Scottish Government did attempt to address this but was only partially successful.

168. The pandemic posed particular risk to certain groups including BME workers, those with reduced immunity, those with disabilities, pregnant workers, and these workers were not always afforded extra protection.

169. There was a lack of preparedness for the pandemic and lessons learned from earlier health exercises were ignored.

170. The fact that health and safety is not devolved put constraints on the Scottish Government's ability to respond to the pandemic, particularly with regard to workplace spread of the virus. This was made worse by the HSE's refusal to treat the pandemic as an occupational health matter.

171. This and the number of enforcement bodies involved sometimes created confusion.

172. Scottish Government efforts to bring together all workplace health stakeholders, including enforcers, in its Safer Workplaces group went some way to addressing these two factors and played a positive part in addressing workplace spread of the virus.

173. Although committed in principle to the precautionary principle, neither the UK or Scottish Government took a precautionary approach to the pandemic, in particular with regard to early debate about whether transmission of the virus was through droplet/fomite spread or airborne spread. The precautionary principle would argue that preventative measures against both should have been taken in absence of certainty.

Hopes for The Inquiry

174. That the above lessons are incorporated into the Inquiry's findings and that strong messages are given to the Scottish Government about what will be important in addressing the role of the workplace and the needs of non-unionised and vulnerable workers in any future pandemic.

Signed

Dated