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Scottish Covid-19 Inquiry

Day 41

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(9.30 am)

THE CHAIR: Good morning, Mr Stephen.

MR STEPHEN: Good morning, my Lord. The first witness this morning is Robert Pollock.

MR ROBERT POLLOCK (called)

THE CHAIR: Good morning, Mr Pollock.

A. Good morning, my Lord.

THE CHAIR: When you're ready, Mr Stephen.

MR STEPHEN: Thank you, my Lord. For the record, the Inquiry reference number for the witness statement here is SCI-WT0354-000001.

Questions by MR STEPHEN

MR STEPHEN: Good morning. Can I ask you to confirm your full name, please?

A. My name is Robert John Pollock.

Q. Your age and contact details are already known to the Inquiry so I won't ask you for those. You've helpfully provided a written statement already which the Inquiry has seen. Are you content for that statement and the oral evidence that you give today to form your evidence to the Inquiry?

A. Yes.

Q. Are you happy for that evidence to be recorded and published?



A. Absolutely, yes.

Q. Thank you. Everything you've said in that statement will be taken into account by the Inquiry even if we don't touch on every single aspect of that today.

A. Thank you.

Q. Just a final reminder, before I start to ask you some more questions, that a restriction order is in place so please do not name any specific individuals. If you can keep it at a higher level, if that's all right.

A. No problem. Thank you.

Q. What's your current role?

A. My current role, I'm a clinical advisor paramedic based in Cardonald, Glasgow, the control room. I acquired that position as a consequence of my own health problems, as a front-line paramedic. When COVID first evolved, I was risk-assessed and deemed not suitable now to front-line patient-facing, so I had to find an alternative role through time now to sustain my future within the Ambulance Service.

Q. How long have you held that role for?

A. This is my 24th year, I believe.

Q. In that role?

A. No, this role is basically from 2021. So it's my 24th year within the Scottish Ambulance Service.

Q. Before that, before you undertook that role and prior to the pandemic, am I right in thinking you were a front-line paramedic?



A. Yes, I was based in Glasgow South Station, Govanhill, Glasgow.

Q. Am I correct in saying that -- I think near the start of the pandemic you say in your statement that you had to leave duties as a paramedic and then undertook other roles instead.

A. Yes, I did -- I done a variety of roles on behalf of the Scottish Ambulance Service to keep myself employed, if you like, active and doing something productive. I done flu vaccines, for example, for members of staff. I also carried out stores' deliveries of personal protection equipment. I delivered that within the local area and out to different stations, fire stations, et cetera, et cetera, to ensure that the levels further on and after the commencement of COVID -- but just to ensure that the levels were topped up on a frequent basis.

Q. I think you've just confirmed already that you've worked for the Scottish Ambulance Service for, what, 23/24 years?

A. It's my 24th year I'm on just now, yeah.

Q. How many people does the Scottish Ambulance Service employ, do you know?

A. Approximately -- 5,500 I think now is a reasonable -- it



fluctuates obviously, but I think that's about fair now.

Q. Across Scotland?

A. Yes, yes, obviously a variety of roles: the patient transport, the paramedics, technicians, admin staff, office staff, control room staff and others, logistics et cetera.

Q. I think you say in your statement it's something -- 230, I think it is, vehicle stations --

A. Yeah, again I think that's reasonable. There or thereabouts.

Q. I wanted to ask you about your role with the GMB Trade Union, if I may. You're also branch secretary for the GMB Trade Union for the Scottish Ambulance Service Branch; is that right?

A. That's correct.

Q. How long have you carried out that role for?

A. I've done that role for about six years in total, but prior to that I was a branch president, so I've done a kind of high-level role for about 12 years now.

Q. How many members are there in that particular branch?

A. Approximately 2,000.

Q. What in high-level terms does the branch do for its members?

A. Well, we're involved in negotiations, working in partnership with the Scottish Ambulance Service

management. We have a kind of Government scheme whereby we're now -- working in partnership is critical to the ongoing now discussion, negotiations, problem-solving. We do negotiation for salaries, look after members' interests, deal with disciplinaries, grievances, et cetera; the whole range of workplace issues that may arise.

Q. We'll come on to the subject of PPE in more detail, but suffice to say for now I understand from your statement that, when the pandemic hit, you were given the task on behalf of GMB to monitor PPE levels and quality for the Scottish Ambulance Service; is that right?

A. Yeah, I was the nominated person to attend the meeting with the Scottish Ambulance Service senior management on a frequent basis.

Q. Thank you. I'll ask then for you to cast your mind back to the start of that pandemic and at paragraph 8 of your statement I think you say that the Scottish Ambulance Service started to hold regular meetings, I think daily meetings, I think you say, regarding COVID. Were those in person or virtual?

A. They were virtual -- yeah, virtual. They were set up initially daily. It changed to probably every second day or, if something unforeseen popped up, it was quickly arranged again for -- it could be have been the



next day again, if that makes sense, but fluctuation -- but initially it was each and every day, Monday to Friday.

Q. You attended those meetings. What was your role at those meetings?

A. My role was predominantly -- my responsibility was to look after my members' interests and the members were advised that I was available now for any of their concerns, so a bit of a hotline, for want of a better word, where they could contact myself looking for advice, help or pass on their concerns regarding now different issues that the pandemic created for them.

Q. Thank you. What were the frequent and main concerns that members were raising with you to raise at those meetings?

A. There was a variety. Initially I think -- "panic" would be the wrong word but certainly a lot of high-level concerns regarding the availability of the personal protection equipment and the standard of it. Now, what was available wasn't what they expected to go from face-patient services. They wanted a much better level than what was currently available at that time.

Q. How did you keep abreast of what was happening in each of those -- we talked about how many vehicle stations there were, how many staff there are. How were you



getting that information in order to feed it back?

A. Obviously I was getting phone calls from -- we cover the whole of the Scottish Ambulance Service as a trade union. We were getting phone calls from different locations, north, south, east and west, remote and rural, and that gave me a quick picture of, "Now, there's something badly wrong regarding distribution of personal protection equipment and the availability of it". So when I was made aware of that, I set up different people in different areas to keep me in regular contact. They'd update me, basically daily, saying what the levels of stock and their location were, and if they were based in Inverness, for example, they would also pick up the local stations around the north of Scotland and give me as best an update as they could do now regarding the availability of a variety of personal protection equipment.

Q. Thank you. At paragraph 10 of your statement I think you say that the Scottish Ambulance Service listened to your input. I wonder if you might give the Inquiry an example or examples of where your feedback meant that they changed what they were doing.

A. Well, if, for example, I got a phone call from Inverness -- I use that as an example again -- "We've got ten FFP3 masks, we've got 100 surgical masks",



et cetera, et cetera, I would update the Scottish Ambulance Service and say, "There's not enough there". We've got now 30 staff per day and approximately now ten different masks depending on your patient involvement, so you'd require now maybe 400 for that particular station on a daily basis. So I'd update them and say, "This is not sufficient and we have to ensure we get supplies there rapidly, as quick as possible", and I'd give them a run-down of the information I had and what was lacking badly within a given area as much as possible.

Q. I think it's paragraph 12 of your statement that you say that "at these meetings they would often over promise and under deliver", "they" I think being the Scottish Ambulance Service.

A. Yeah.

Q. What do you mean by that when you say it in your statement?

A. During these meetings they would give us an update on stock availability in a central location, not overall locations, and what their expectancy was for delivery of now more appropriate or even more levels of the existing PPE, and I took that in good faith obviously. So if they, for example, told me we were getting 5,000 Solway now FFP3 masks on Monday morning, I would relay that to

try and minimise the concerns of our members, the people out there front—facing, "Bear with us now, they're doing their best to get the equipment you're demanding and hopefully by Monday it will be here", and more often than not it didn't materialise.

Q. What would you say then was the impact upon your members of, as you describe it, being over—promised and under—delivered on this material?

A. I think the key one was that myself —— I'm quite well known within my trade union and they're relying upon myself for facts now and support. If I gave them facts and support in good faith and it didn't materialise, it put myself in a position under the spotlight now. But I don't think —— as I said in my statement, I don't think it was a deliberate attempt to mislead. I just think, as I said, they were over—promising and maybe let down by other third parties in the cycle of delivery. But the information was given in good faith and, if it didn't happen, it was probably more damning than not giving the information, if that makes sense.

Q. Was that a source of concern to your members when this ——

A. Oh, absolutely, because they're working under pressure with the perception —— initially it was based upon perception because the virus —— the consequences of it



was a bit unknown to everyone apart from what you could see on the national television from other countries, Italy, for example. A good example, at the initial onset of COVID here, is some of the scenes on the national news were horrific and I think that set the tone for the fear and anxieties, "This is coming here next", if that makes sense.

Q. Yeah, thank you. Now, you'll be aware this Inquiry is obviously looking at the Scottish Government's response ——

A. Yes.

Q. —— strategic response to the pandemic, so I'm interested to know your awareness or knowledge of whether the concerns that you were raising at these meetings about PPE and anything else that you raised —— do you know if that was fed back to the Scottish Government, whether that was through the Ambulance Service itself or through GMB? Was that relayed, do you think?

A. So my personal involvement was with the senior level of management within the Ambulance Service, whoever —— we do know —— by dialogue and they were then communicating with the Scottish Government now, for obvious reasons. And the tea—time broadcast from the First Minister at the time would kind of reflect the conversations we had on that day and also that was then brought to the table



for the meeting the next day or the next day the meeting took place, so it was quite obvious there was a dialogue now happening. With who and when, I can't tell you, but I just know by the conversations and the sharing of information that it must have been taking place.

Q. To summarise, then, you didn't directly necessarily deal with the Scottish Government but, as far as you're concerned, those concerns were being relayed down the track by senior management?

A. Yes, absolutely.

Q. You briefly mentioned this earlier but I'd like to ask you about this GMB hotline. This is at paragraph 13 you mention this. When would this hotline have been set up and what was the purpose of it?

A. It was set up basically in March of 2020 and the purpose was to give our members a direct access now to help, support and some facts. They had a variety of concerns, not just about their own personal protection, with the available PPE or the lack of it, they also had fears about them taking the virus home and going to be exposed to people with COVID —— knowingly going to a job with people with COVID. And they had fears about —— for example, they looked after elderly grandparents or parents, you know, they had caring responsibilities at home, so they'd do their job and they were worried about



what they're taking back to their home, now their parents or their children at that time, because —— the unknowing part of COVID and it didn't materialise now there and then so you could have it unknowingly and if you did then spread that to now parents or anyone you're responsible for, the fear factor was that you could give them something —— maybe have now severe consequences to their health.

Q. Who was manning this hotline?

A. Myself.

Q. And what was the volume of calls that you were receiving?

A. Well, initially, as you can imagine —— I called it the "hotline" for a reason —— it was non—stop. Hundreds of now calls and calls waiting now, messages left. I had to filter my way through them hour by hour when I got a space in the day, attending meetings and get back to missed calls, et cetera, et cetera. I'm trying to update people as frequently as possible but be as factual as possible on any information they were trying to now get. A lot were trying to get some confidence from what I could tell them, but I had the responsibility to make sure I only told them what was factually correct. I couldn't give them respite from their fears and anxieties because I didn't have the

information that would equate to that at that time.
Q. You mentioned I think people looking after elderly relatives or living with them. Are there any other particular groups that you would highlight that were using this hotline?
A. Yeah, again, the Ambulance Service do have some procedures in place now —— policies, procedures, for different illnesses and ailments and workforces have got now different problems. COVID being now a mainly respiratory—type virus, anybody who had asthmatic problems, COPD, other high blood pressures —— there was a whole range of staff who weren't quite in the bracket of protection but thought they should be. And it took a bit of time for the Ambulance Service and the Healthcare Scotland, the WHO —— they were all giving advice on who should be shielded, if that makes sense —— I think "shielded" was a word that was used quite commonly then —— protected now from front—line—facing —— some were given alternative duties, like myself, now doing something functional but not a front—line role. Other ones were just now given respite from employment at that time depending on what their personal health circumstances were. The fear and anxieties was that a lot of the people were not included initially and they thought they should have been, and eventually there were



some concessions given and we expanded now the amount of people that were encompassed within protected levels.
Q. When you say "not included", do you mean within the shielding cohort, that they felt they should be but they hadn't been initially? Is that what you mean?
A. Yeah, well, they stipulated protection —— they had certain criteria. They didn't meet the criteria in the eyes of the Scottish Ambulance Service so it took a bit of pressure from myself and a wee bit of negotiation, discussion and evolving evidence to say, "Yes, now, there is more people, we'll have to expand this area to make sure that everybody that needed protection was protected". And that could be just the fact that they were full carers for very, very vulnerable people, not themselves personally with an issue.
So there was a whole range now —— the physical people that need —— asthmatics, COPD and others, pregnant women —— pregnant women within the Scottish Ambulance Service, to be absolutely fair, are normally removed from front—line duties as soon as they're confirmed that the pregnancy is ongoing, if you like, the first positive test, but they still done some operational duties and they'd still be facing paramedics or technicians or patient transport service staff come back into the area where they worked, so we had to get



a system that was safe.
Most pregnant women at that time preferred to work up now —— do something till maybe the date of their expected child delivery and that then gave them more time with the child on maternity leave. So they were still in premises and on that basis we had to now make sure that they were protected even —— despite the fact they weren't front—facing —— that they were removed from potential cross—contamination of other staff within the buildings.
Q. It was obviously a difficult time. Was there a tension between those who were obviously having to shield and therefore away from front—line duties and the impact that that might have had on the rest of those that were working as paramedics?
A. Obviously they expressed their personal concern. I can give myself as a good example. When I was removed from front—line responsibilities after the risk assessment by my team leader at the time in Glasgow —— initially he told me I was fine, I'd passed now the risk assessment. A few moments later he came into the mess room to advise me that part of the criteria was my age, and at that time I was 60, and once they incorporated my age into the risk assessment I failed miserably. I felt a bit guilty about that, that I'd been removed from now



responding to the patient as my colleagues were, but it was outwith my hands. But it still didn't take away my personal feeling about guilt. I think that's the best way to describe it. I felt a wee bit that I'm letting them down.
Q. Thank you. Do you think there was any resentment from others that were having to still plough on, as it were, and be paramedics ——
A. I wasn't aware of any specific resentment, but given the pressure and the anxieties, those people being excused now from the traumas that they had to go and face —— so I can only think now, logically, that, yes, some people saying, "They've got away with it kind of thing and we've got to go and do it", for want of a better word. Nobody came to me personally and had any negative comments to me, but I still feel it was definitely there now and I certainly felt now a wee bit strange that I'd been excused from it and others had to go and do the job now.
Q. Thank you. I'd like to ask you now about PPE. You raise quite a lot of questions in your statement. I'd like to ask you about those. I think —— yeah, you say there's a wide range of concerns and questions that came to you in your capacity at the branch. I'd like to ask you first —— in paragraph 14 you talk about all—in—one

suits and their availability, so I want to ask you about their supply. What was the issue there and what was the information you were receiving from your members about that?

A. Okay, so we did -- I mean, prior to COVID we had different now contagious patients, et cetera, and you'd don -- put on basically for a common word -- you'd put on protective equipment. Now it's an all-in-one -- it's almost like a boiler suit but it's material that keeps invading bacteria away from your own personal uniform and your personal self. They were there but very limited supply. We didn't have much usage of them. They sat in stores and very, very infrequently you had to access them.

However, when COVID presented itself and given the unknown aspects of it initially, people were obviously looking to get these cover-all suits to give themselves as much protection as possible. And the availability was very, very poor and size-wise were XXX -- XXXXL, and for a 5-foot male or female is absolutely ridiculous, not fit for purpose. And it took a long time to get now more appropriate sizes and quantity of these particular now suits that they would offer some protection.

Q. When you say "a long time", could you --

A. Months. It took months. And every day that went by



when people couldn't access them, then obviously they get more anxious. There was news reports from other now health boards, London, for example. They were showing now taking patients to and from hospital, arriving there with now all the suits and the best protection. It was visible to others to see and they were asking the question, "Why are we not getting the same availability now, the same level of protection?". There was no protection known that would absolutely exonerate you from now contamination from COVID but myself and the people who actually carried out now the job were expecting the best available now to be there for their use and it wasn't.

Q. Would you say, therefore, given what we're saying about all-in-one suits and them being of a massive size that didn't necessarily suit everyone else -- did that, do you think, place colleagues at a greater risk if they weren't able to utilise them?

A. Oh, yeah. The equipment is designed to minimise now contamination of your body, your uniform, et cetera, and if you're doing four, five, six patients, sometimes more, per day, you've got three uniforms in total and they have to be laundered, so your cover-all suit would protect your uniform now from bacteria so your next patient wouldn't be cross-contaminated.



I think the key is a lot of people were suspect of COVID. There was no confirmation at the time when the Ambulance Service picked them up. You could highly suspect it, given their presentation, a high temperature, coughing, headaches and a whole range of things presentation-wise, but you certainly couldn't now say that they're definitely COVID-positive. That came later. Your fear was, "If I pick up Mrs Jones for my first call and then go to Mrs Brown in the second call, what are you doing to each and every patient?". You had to minimise that risk by the appropriate PPE, you removed it safely, and then you attended the next job and you took the necessary steps regarding what PPE you had to reapply for the next patient, depending on the call it was and what was reported on the 999 line for help basically.

Q. Thank you. At paragraph 16 of your statement you mention a possible difference between the PPE that was supplied or available to those in I think specifically London -- but England -- paramedics and those in Scotland. Why do you think that was and how did that come to pass that you noticed this?

A. I just think they were maybe more prepared in some parts of the country. The GMB are a national trade union, we are GMB Scotland, however, but we do have national



meetings with others and we're having now really conversations into a central base about what was available nationally. I didn't get involved in that specifically, but we were getting reports now of availability and lack of availability in some other parts of England; for example, Yorkshire had issues. But the London ones seemed to be quite frequently on the news reels and you could quite easily see them arriving, the paramedics, with the full monty, for want of a better word -- your PPE, your visors, the FFP3 masks, gloves, boot covers; lots of things that wasn't available to us over the first several weeks of this virus.

Q. I think you say in your statement that you kind of pled for that same level of PPE to be provided for those --

A. Absolutely.

Q. Were those pleas heard or not?

A. They were obviously recognised as concerns, but -- again, I think the management team were doing their level best to obtain, but due to availability, I think they missed the boat, for want of a better word, and I don't think they were prepared for a virus. And one of the concerns for me was that -- I can't remember the name -- we had an exercise, I think, "Firing from the hip". I think it was 2017 -- we had an exercise, almost

a dummy run, if you like, for a potential pandemic, and that highlighted now a lot of failings, that currently we didn't have enough equipment, didn't have enough people, what would happen if a pandemic did arrive on these shores, and I don't think, personally, they picked up the lessons that that brought to the table. I think if they had done, I think they would be in a much more ready state when it did arrive, if we'd learnt from the rehearsal, if you like, for want of a better word.

It was an exercise based upon the facts available from other countries having now other issues, bird flu, way back —— lots of things can cause serious Public Health concerns and there was a lot of lessons learned from that and I think it demonstrated that we didn't have —— we weren't quite ready for it if it did arrive and, despite that exercise taking place and the passage of time, we certainly —— in my opinion, we were nowhere near ready for now a COVID—type virus.

Q. Just for completeness, was that lack or apparent lack of parity between, say, paramedics in London and what you were seeing in Scotland —— was that fed back to the Scottish Government, to your knowledge?

A. Yeah, again, obviously I highlighted grave concerns at the next available meeting, but when people were seeing that through their own eyes, again their hotline would



maybe go, "How come they've got? We've not got ...", obvious questions. We're demanding the same level of protection, we're covering the same virus with the same potential recipe for disaster for themselves or their families, so they wanted the best available equipment. And if you see someone else now a couple of hundred mile away having it and you've not got it, it just created more pressures, more anxieties and a bit of discontentment between employees and employer. They felt let down by their employer.

Q. I want to ask you now about out—of—date masks. I think that's something in paragraph 18 that you talk about.

A. Sorry, I've come off a flight and my ears are not ——

Q. That's fine. I'm happy to repeat it. I wanted to move on, I suppose, to the quality, if you like, of PPE. Having talked a little about supply and quantity, it's the quality now and it's about out—of—date masks I wanted to ask you. It's something you talk about in paragraph 18 of your statement.

A. Yeah.

Q. What were your members telling you about that as an issue?

A. So the base equipment that was available in Ambulance Service stations for routine jobs were surgical masks, paper masks that were freely available



to the public, and they were there and obviously they came in pre—packed —— I think there was 5,000 per box of these particular masks. They came in a brown box similar colour to the table with the identification of the contents, how many, contents and an expiry date now for when you should dispose of them once the expiry date has elapsed.

There was a lack of even these basic masks in the early stages and eventually we got some stocks in but, instead of the plain cardboard box, there was an A4—size label placed on the outside of the box and it had new details about the contents. Somebody in Ayrshire —— I know who it was but I won't mention the name —— somebody in Ayrshire peeled away that label to expose the expiry date, that these were well out of date, the masks that had been brought in as new, and that obviously raised a red flag to myself, a bit strange. So I brought it up at the very next meeting, that that was causing grave concerns. The people's impression and perception was that their employer was covering up now the reality of the contents of these boxes, hoping now that nobody would recognise it.

In reality, when I questioned the Scottish Ambulance Service management on this, they said that they had tested a small —— sample—tested one or two out of the



box of 5,000 and they were deemed fit to be utilised when the staff were using them because there's nothing else —— they've got a kind of —— almost a talcum powder type effect if they're disintegrating slightly by time. And they put them on and there's powder release and some of the elasticated straps that held them on at the back of their ears were popping. They were dangerous, for want of a better word. They weren't sufficient. Not every one was like that, but it only takes one —— if you're doing your job and if it fails its purpose, it puts you in a strange state of fear and alarm. As a consequence, you had to rely on what you had to protect yourself and others and, if you didn't have confidence in it, which they didn't, it caused extreme fear and alarms.

My thoughts —— and I think I mentioned that in my statement —— if they had done what they said —— and I haven't got any evidence to say they never now done a sample testing —— if they had done that and advised myself and others, we could relay that information to people to give them some comfort now prior to it, but just bringing them into a stock situation with the label covered, if you like, created a sense of insecurity and fear. They thought their employer was pulling the wool over their eyes and just mentioning, "This is what we've

got. Just get on with it", kind of thing. But the staff obviously identified they were now different from the other arrivals, therefore, they done their nosey and they had a look at the actual expiry date and the mislabel. That lack of communication, lack of knowledge, hadn't been given in advance. The service said that they had sense-checked the equipment and it was fine and fit for use. That lack of information prior to them arriving caused a lot of anxieties and discontentment between employees and employer.

Q. To be clear, you talked about "the employer" -- I'm just -- in terms of who you think was -- I'm not asking you to name individuals, but who do you think it was that was covering up these expiry or dates for the PPE, just so I'm clear in my own mind?

A. I don't know is the answer, but I do know they had a central store of equipment, so they had like a location where all the available equipment they could muster up came into and then it was distributed from there to different locations throughout Scotland. And that was one of the issues, because the mass volume of work for the Scottish Ambulance Service just by population is -- inner cities, you know, your Glasgows, your Edinburghs, your Dundees, Invernesses, et cetera -- but we've got the same people now carrying out -- one



person going to a patient in Outer Hebrides is still under now the same potential risk, so initially the availability in some of the outlying areas was very, very poor now -- extremely poor.

Q. Would one rationale for the supply of these masks -- you're saying a sample test was done -- for what I'm trying to paraphrase, I suppose, would be making the best use of what was available? I think you've talked about shortages. Do you think that would be one explanation as to why that might have been done?

A. Yeah, I think they had nothing else to offer and I think they're probably working on "something is better than nothing", but that -- that works in most fields but not in a health professional field, when your people, your paramedic, your technician, anyone -- your patient transport services are trying to do the job on a continuous basis, looking after patients to the best of their ability in a professional fashion but they still have their own personal fears -- for their own safety, as well as the safety of patients now, the masks not only protect them from you, it protects you from them, if that makes sense, and if you didn't have the confidence in the equipment, then it gave you a very anxious day at work -- a very stressful day.

Q. At paragraph 19 I think you say there was also a serious



issue with a type of mask, the 1863 FFP3 mask.

A. Yes.

Q. Can you describe what that issue was, please?

A. Again we had -- different people within our trade union were given the task of face-fitting. That involved kind of -- for want of a better word -- a small chamber where a non-toxic gas was inserted into the chamber, a controlled substance, and if they -- if me, for example, had the available mask, the FFP3, at that time the 1863, you place it on, you do a wee kind of jogging exercise under instruction, the tester would have a monitor and it would pick up any and variant toxins if the mask wasn't sealing to you, a particular contour of your face, your body. And if that was the case, it came up with a fail and you had to be tried for a different mask.

Now, you had to try one which actually it was adequate for your personal purposes. The 1863 had an absolutely horrendous fail rate and the people who were testing, being colleagues or people front-line-facing -- obviously information got shared quite quickly -- now, these masks are not sufficient for the job they're intended.

We then had -- I won't mention any names, but we had a senior manager saying that they were to be stopped to



be used with immediate effect and the next day -- even the same day, later on that day, anyone that had been previously tested with them and passed should continue to use them. So it was a kind of stop-start, "They're not good enough for some people but good enough for others", and again, that caused more fear, more anxieties.

One of the more concerning issues, the testing of the face-fitting, which is classified as face-fitting, it's a certified position, so you get trained by a specialist to allow you to carry out this testing, and what the Scottish Ambulance Service does, they got the people who had been -- passed this certification to speak to others to bring them into the loop, so it wasn't trainers training, if you like. It was just getting done domino effect almost. And that produced some bad habits. There was some bad instruction. People were told to pull the elastics now a lot tighter than what they should -- against the manufacturer instruction, which tells you not to do that. They were also changing the nasal bridge, the small metal section. They were squeezing that right in and basically it was almost a very, very tight facing mask, and it was quite evident they were trying to get more of a successful pass rate, but the consequences of not following the

manufacturer's instruction would be that, if it's too tight and it's causing now sweat, rashes, your tendency as a human is just to scratch your face and now go under the mask and that —— you've then exposed yourself, if that makes sense, because you don't know what you've been touching —— gloves on, you're then —— you're going under your mask, you're trying to relieve the irritation. That kind of thing happened and some of the masks were breaking during the actual physical use of them. If you're then dealing with a resuscitation patient, that pops off, you're then exposed for that moment in time, dealing with a very ill patient, and obviously that then created massive fears for the individual concerned.

Q. You say at paragraph 43 of your statement about members being frightened of carrying out CPR. You've talked about PPE disintegrating. I think you also talk about it as being —— it interrupted the ability of members to concentrate and amplified their stress levels.

I suppose my question to you overall, given what we've talked about about the availability and quality of PPE that was available, do you think that had an impact on the ability of Scottish Ambulance Service staff to do their jobs?

A. Absolutely. I think the Ambulance Service were working



on guidance to say that the surgical masks were sufficient except for intubated patients. Now, if you've got a very ill patient, a cardiac arrest patient, now they'd be intubated, now the tube down into the lungs to get a better airway and to protect their airway from vomit, et cetera, et cetera —— so it's a standard —— the gold standard for protection at that time was to intubate your patient, and the WHO detailed that as an airborne risk because you're pressing air in and air is coming out, you're ventilating the patient. Then you've obviously got an oxygen cylinder operating. And the sheer practice of intubation and bag and mask, oxygenating a patient created more of an airborne risk, and the Scottish Ambulance at that time said that that's the only time you really have to wear the full FFP3 protection mask.

That didn't go down well with the staff, but if they were wearing one of the lesser—branded ones and it didn't do the job, as in if it failed or it removed itself because the elastic string snapping and they're exposed now at high risk —— that was classified as high risk now —— ongoing CPR with chest compressions, airway management, was a high risk as often air is getting transferred and any virus that that patient may have had —— and you're suspecting the patient is now



succumbing to a combination of their existing medical conditions with COVID or sometimes just COVID in itself, people who had no previous —— no knowledge of any issues. So there's a full range of now different criteria, it's unknown, unspecified. Some were gravely ill, got COVID, and their chance of survival were minimised as a consequence; others were normally fit and healthy but succumbed now to the virus for reasons now unknown to me at that time.

Q. Thank you. Before we move on then, I just wanted to ask if you had any specific lessons learned you'd like to highlight to the Inquiry specifically on PPE.

A. I think one of the key ones, the Alpha Solway mask was the mask that the staff had the most confidence in and I think confidence is a big part of relieving personal stress and anxieties. So they had this product which they were comfortable —— I mean, it looked good —— now, it's looking like an old—fashioned car —— it looked good, it felt good, it fitted high. The face—fitting for that type of mask was in the high 90%, for example, as opposed to the 1863, which was now the low 20%, so it had a feel—good and a knowing good effect. People were comfortable with that.

I believe they shut that factory just at the start of COVID —— I think they were based in Dumfries at the



time —— and that was due to lack of finance from the Scottish Government, which is quite well detailed in the press, and one of the MPs made a statement about it at that time, that it's ridiculous that we have to rely upon other countries now outwith the UK for supply of PPE.

We should have a facility, in my opinion, that we can upscale very quickly. We have a supply availability now for the first two weeks, for example, but we should be able to produce by ourselves to ensure that we've got enough medical PPE equipment to minimise the risk to the people out there dealing with the next now pandemic if and when it comes.

Q. Thank you. I wanted to move on briefly just to talk about long COVID. At paragraph 46 of your statement you say this is something that you yourself suffer from. Can I ask you, when were you diagnosed as having long COVID?

A. Well, I'll give you a bit of background first of all. It will maybe help. As a consequence of not being able to do the front—face patient role, I done —— as I said earlier, I done lots of COVID —— sorry, flu vaccinations, I done store deliveries, I was keeping myself proactive and contributing in some way now to the efforts of —— the needs of the service and the needs of

the patients.

Longer term I had to try and find myself an equivalent position and sustain my own employment and there was a vacancy popped up for a clinical advisor paramedic, which is basically utilising your skills as a paramedic but on a telephone triage basis. So rather than going out to see the patients directly, I would call them on the telephone. I had access to a live feed if I wanted to visualise them or just audio vocal, vocal to vocal. And it was my job to ascertain what their status was regarding availability of ambulances on a priority basis based upon their current condition.

But I went for that particular post to maintain my own employment and part and parcel of that was to go to Norseman House in Edinburgh, one of the major head offices for the Scottish Ambulance Service, for C3 training, C3 being the computerised system that allows you to now develop a triage system via the telephone.

I arrived there on the Thursday and the tutor came into the room. They did have social distancing in place at that time, I might add, in that building. They had a one-way system for the canteen for accessing tea and coffees, et cetera. Unknown to me they had a major outbreak the weeks prior -- a significant outbreak within that building -- and when the tutor came into the



room we had social distancing, so a room that would normally hold eight people had four. As you walked in, the door there and the tutor's desk was this side, myself facing this way, another couple spaced out at the back of the room -- but he came in and he had quite a severe headache, bear with him, he was going to take some paracetamol and come back, which he did do. We were there for the Thursday, Friday, and by the weekend myself and all the others in that room were gravely ill, including the partner of the tutor. Ventilators for two of them. I was in intensive care, nine IV antibiotics each day for six days -- seven days in a row, 63 in total. And my consultant says that the fact that I hadn't smoked was probably the reason why I'm still here today.

Q. And you talk in your statement about the impact that long COVID has had on your own health and of course on your working life as well.

A. Yeah.

Q. At paragraph 52 of your statement, you say that members have witnessed their colleagues who have contracted long COVID being treated badly and they will not forget that. So I suppose my question to you, before I move on, is: are you saying that you think something could or should have been done differently in terms of the



handling of long COVID?

A. Yeah, I think that -- I mentioned that and again I just want to reiterate that my personal experience was not -- I'm not mentioning that for me. I want to get that absolutely clear. My personal experience -- I mean, a gross enlarged liver and widespread pneumonia as a consequence of it. It's not for me personally, but it's our people impacted in the same way.

My rationale for mentioning that, using myself as an example, is to ensure that if we have an outbreak in a building now, any building, then there has to be more consideration to who you're inviting into that building at that particular time. And that's the reason why I just want to make that clear for your last question, that it's not for me personally. It's everyone under the same restrictions as me should have been more protected and therefore minimise any risk to their health as a consequence. I just want to make that absolutely clear because it's not about me, it's about us, if that makes sense.

Q. Thank you. The final thing I wanted to ask you about then is do not resuscitate -- a section of your statement that's dedicated to that at paragraphs 26 to 30 -- and you talk about a practice I think it is of toe-tagging and a letter that you as paramedics or the



Scottish Ambulance Service received. Could you just elaborate a little on --

A. I actually tried to find the correspondence now via -- I couldn't find it, to be absolutely blunt. However, my recollection is absolutely clear. There was discussions around the age grouping for toe-tagging, for want of a better word. People under -- over a certain age now, your normal attempts at resuscitation would be minimised. And I think, just to make it clear, there is no age limit in Scotland for resuscitation of a patient. Any patient that is needing resuscitated, there will be attempt at resuscitation. A minimum of 20 minutes of advanced life support is recommended before somebody would say that life is extinct or beyond help, as the case may be. And a paramedic can certify, "Now the patient is beyond help". They can't certify death, but they can certify -- in other words, we can stop resuscitation after a certain period of time.

As a consequence of the discussions, they were mentioned now 70 and over initially. There was reference to the potential -- again I'm filing through my memory here, but I'm pretty confident the forecast -- the worst-case scenario was 3,600 deaths per day kind of thing, if it invaded the population to a gross extent. People were looking at the Italian version, the

people —— the high level of stress and anxiety, the doctors crying in the waiting rooms, people in the corridors. Now that was the fears that people were visualising. It didn't materialise in the same fashion here, it definitely never hit that type of level, but the fear was there because that's what we were seeing now on televisions and the —— sorry, your main point was?

Q. Well, no, I was just asking about the background to —— I suppose —— in paragraph 28 you talk about rumours that the Government —— and I assume you mean the Scottish Government but I would be grateful if you could clarify —— had a plan to reduce that age group you were talking about to the over 50s.

A. Yeah.

Q. Did that ever amount to more than rumour, as you'll appreciate, obviously looking at the Scottish Government's strategic response?

A. No, no, it was absolutely in discussion. They had a kind of 70, 60, 50, escalating process and that was really —— it was really done in a kind of strange fashion. HCPC, the Health and Care Professions Council, did send out correspondence to registrants. Now, that only includes paramedics in the Scottish Ambulance Service. It doesn't include your technicians or patient



transport services. They're not registered bodies. It's your paramedics and up as far as clinical skills are required. And it basically said that they realise there's tough times ahead and, if you had to work out your normal levels of professional expectations, they would support you greatly. And the way it was worded, I think the only interpretation that people could make would be now relative to this situation regarding not giving now your full attempt at resuscitating certain patients, depending on the age or condition in some places.

That didn't sit well. Every professional paramedic has got an in—built now —— we try to save every single life on every single occasion to the best of our ability until such time as it's futile. And that type of potential expectation caused a lot of fear and alarm. And, for example, for you personally as a paramedic and your mother was 75 or 80 years old, now what's going to happen now if they take unwell? So again there's a fear factor there. There's also the professional indifference. People didn't feel comfortable now that they couldn't do everything humanly possible for every patient. To what extent that materialised, it's a bit unknown, but it was certainly high in discussions and that, at that time, if the COVID invasion —— the



pandemic had increased alarmingly, more than it did do, that was certainly on the agenda now for action. That in itself did cause some grave concerns for every paramedic to my knowledge.

Q. You said "on the agenda" but was there any formal or informal messaging from the Scottish Government itself on this issue?

A. Unknown to me, but I do know or I say really the information from the hierarchy of the Scottish Ambulance Service was coming from somewhere now. They weren't decision—making on their own. They were relaying information given and putting people on alert to what may be around the corner, if that makes sense, pre—preparing people for that eventuality. I've no knowledge of what figures —— what people suffered detriment, as in lack of attempt —— I've no actual figures, but I do know it was discussed now and it was a possibility and the fact it was a possibility caused a lot of stresses and pressures.

Q. Thank you. I don't have any further questions for you, Mr Pollock. I'm grateful for your evidence both in writing and orally today. Was there anything else before we conclude that you'd like to add in terms of lessons learned or otherwise anything you think we haven't covered?



A. I just think in general —— I mean, the reason why I've volunteered to come here today is just to highlight now the initial concerns. The country now, not just the Government —— everyone has to be more aware of these pandemics, they have to be more prepared to minimise the risk to your front services, your healthcare workers, now, your people that work in care homes, nursing homes. We have to protect the people who are doing their best to ensure the best outcome for all patients and I don't think that was the case on this occasion and I hope it is the case going forward. I think we should be much more prepared.

One of —— I was on holiday in Portugal over the last two weeks and I got involved in a conversation with one of my colleagues who does care in the community type. It's a good example of poor treatment and I think it has to change. These particular people need a car to do their job efficiently and effectively and part of the criteria for having that car, you had to cover 3,000 miles per year. During COVID, 2021/2022, they didn't manage to achieve this because the restrictions placed upon them and these vehicles were removed, they had to remove them full stop, they didn't fit all the criteria, and then it left people with now having to find several thousand pounds to get a personal

replacement vehicle literally within weeks. Totally outrageous in my opinion.

As a person —— as a trades union spokesperson, people with long COVID who —— there's different degrees of long COVID. You've got people who can survive quite well, have long COVID —— myself, I've got a wee bit of memory issues, my sleeping pattern is shocking now, terrible. I can go to sleep in minutes, wake up two hours later, feel like I've slept for a week now and stop—start. Other people have got very restrictive physical issues as a consequence of long COVID, mental issues as well as physical. And initially we had protection. If these people with COVID weren't classified as a typical sickness absence —— so the Ambulance Service have got a staging process. You get a stage 1, stage 2, stage 3 for attendance management. You avoided that process if it was COVID related and that gave these people a bit of protection.

What's happened over the last several months, that protection has been removed so anyone who exposed themselves to high risk, looking after the patients of this country, and suffered COVID as a consequence, I think for want of a better word, the governments are looking at it, "Well, you might have got it at the local shop, you might have got it elsewhere", rather than



taking a bit of responsibility for the people —— the percentage —— you're going out to face people constantly with COVID as opposed to the one or two out in the community. Long COVID for them —— now technically, going down for the next few months, if they've got continued absence problems, they could be basically out of a job quite quickly with no salary, no compensation, no way of feeding their family, paying their bills, et cetera, et cetera, and, for want of a better word, I think they've been dumped by now the current status within the Government/Scottish Ambulance Service.

But these rules and regulations come from outwith the Scottish Ambulance Service, and I think it's unfair that people who gave their all for the patients to better their health and to look after the country have now been exposed to financial detriment and possibly now losing their homes and very disrupted families as a consequence. I don't think it's fair. I think that's something that should be looked at.

MR STEPHEN: Thank you. Thank you very much.

THE CHAIR: Yes, thank you, Mr Pollock. That's all.

Quarter to 11 please, thank you.

MR STEPHEN: Thank you, my Lord.

(10.25 am)

(A short break)



(10.45 am)

THE CHAIR: Good morning, Mr Edwards.

MR EDWARDS: Good morning, my Lord.

My Lord, with your permission, if I can lead the evidence of Mr O'Connell.

MR JAMES O'CONNELL (called)

THE CHAIR: Of course. Good morning, Mr O'Connell.

A. Good morning, my Lord.

Questions by MR EDWARDS

MR EDWARDS: Mr O'Connell, could you give the Inquiry your full name?

A. Yes, it's James Jeremiah O'Connell.

Q. Mr O'Connell, you have provided a statement and you have a copy of that in front of you because I'll ask you some questions about it?

A. Yeah.

Q. And you are happy for that statement to be published?

A. Yes.

Q. And you're also happy for your evidence to be recorded?

A. Yes.

Q. The reference of your witness statement is SCI—WT0277—000001.

A. Yes.

Q. All right. Mr O'Connell, can you give the Inquiry details about your role within Unite the Union?



A. Of course. I am a regional officer for Unite the Union and I am the lead officer for health within Scotland so I cover the whole of the NHS and Scotland on behalf of Unite and lead on the national discussions and talks, et cetera.

Q. So you have a national perspective on the NHS?

A. Yes.

Q. If we look at paragraph 4 of your statement, you say that:

"In terms of health and social care within Unite we have approximately 20,000 [sic] members across the UK."

Do you know how many members you have in Scotland offhand?

A. It's approximately 150,000 across the whole of Scotland for Unite.

Q. Right, and a large number will be in the NHS and the social care sector?

A. Yes.

Q. You mention the split of your membership is across all age groups and ethnicity but is predominantly female.

A. Yes, across health and social care.

Q. Approximately two—thirds to one—third?

A. Yes.

Q. Now, you also say that you are responsible for health sector committees within Unite, bringing together all

health boards within Scotland. Can you say something about these health sector committees and what they do?
A. Of course. As a lay member union, our union is decided and our positions, et cetera, are decided by our lay membership. The committees for health cover —— there are a number of other sectors within Unite, as you would expect, but within health, that brings together all representatives across all boards and Scotland. And those committees come together quarterly, as I say, within —— those are the regulated ones, but we can meet as and when required to formally discuss Unite Scotland's position on health within specific matters, such as health and currently, as you would expect, just to give context, going through the —— some of the reduction in the working week, et cetera, within the NHS —— and our committee will come together to articulate what Unite's position is in relation to the —— how we advocate for our members on their behalf and it's the lay member structures of our union that determine that.
Q. Yes, thank you. Now, at the beginning of paragraph 7 of your witness statement, which is on screen, you mention that —— your title is the health and social care —— well, the title is "Health and Social Care" but I think you mean by that the health and social care sectors.



A. Yes.
Q. The membership of the union comprises people working in both sectors?
A. Yes.
Q. Now, just for the purposes of clarification , my Lord, can you just briefly explain what you mean by the "healthcare sector" and what you mean by the "social care sector"?
A. Of course. I think health is predominantly NHS, I think it's fair to say that. I think the construct of the health and social care sector in relation to how the contractual terms within Scotland are made up is why it becomes the health and social care sector. Social care particularly —— when I refer to "social care", I'm thinking about particularly community youth, not—for—profit third sector organisations, charitable organisations and elements of local authorities who provide home care, who provide care at home, care within care homes, personal assistants, support workers, covering children, young and adult services for individuals who require supporting throughout their life . It could be people living within people's housing settings across the piece. But that's what I refer to or what I would suggest is social care.
Q. So, for example, an elderly person living at home who



has a carer coming to visit twice a day to prompt them to take their pills or to help them make a meal and so forth, that would be classified as social care?
A. As social care provision through different contractual arrangements, yes.
Q. But there could also be healthcare provision in people's homes as well too?
A. Of course ——
Q. And that could be provided by the NHS?
A. Yes.
Q. So the union covers both sectors ——
A. Yes.
Q. —— and has members in both sectors, yes.
Now, following the structure of your statement, I will want to ask you particular questions in relation to both the impacts on what we're calling the "health sector", so mainly the NHS ——
A. Yeah.
Q. —— and also what we're calling the "social care sector". It's not just that, of course, but for example where care is being provided in people's homes; yes?
A. Yes.
Q. I'm also going to take matters chronologically, as your statement does. So in paragraph 10 —— between paragraphs 10 and 12 you have something to say about the



preparedness for the lockdown. So this is February/March 2020, when COVID was about to hit the UK. At paragraph 10 you suggest that the first formal dealings that you had as a union official in relation to COVID was around early March 2020.
A. Yes.
Q. And you mention a meeting, you think in the first week of March, when you got a phone call from the deputy director of the Health Workforce within the Scottish Government. That is Dr Stephen Lee—Ross. Do you want to say something more about that meeting or that phone call rather?
A. Yeah, I think first and foremost to acknowledge, from the deputy director of Health Workforce perspective, he phoned myself and other colleagues within other trade unions themselves. The purpose of that phone call initially was to provide an overview that, because we could see what was happening across Europe, there was —— this phone call was to give an update to say that the UK Four Nations are coming together to discuss a plan or a readiness in terms of what's going to happen across Scotland. As a trade union partner within the agreement through the NHS and the relationships with the civil servants within Scottish Government, it was a phone call to provide us with that update but then to set out the

parameters that there is going to be —— "This workforce leadership group is going to be set up initially to discuss what has came out of the four—country conversation so that you understand what impact that's going to be for your members". And I'm sure we may come on to it later on, but that organically grew to be something so much more than that. Very quickly it was an information—gathering phone call, giving us information to relay to our members and the impact, but, as that progressed very quickly, the whole parameters of that group changed.

Q. But it took time to do that?

A. Yes.

Q. You say towards the end of paragraph 10 that there was no sense of urgency at first.

A. No, there wasn't. I think it —— you know, but we were all seeing —— and I think I can fairly articulate that —— we were all seeing what was happening across Europe and —— China and Europe, but there was a, "We're going to have these discussions but it's not here yet, it disnae really impact us, it's no something that ...". That was the feeling I got from it. But it was, "We're having this discussion. We're just trying to get ourselves organised". But we then see that we weren't organised. We weren't ready for what happened.



I don't know how that was constructed, how that came about, but the feeling that I got initially was that, "We are discussing the potential and just trying to get ourselves kind of in a place", but, as I've reflected within my statement and hopefully today, that changed very dramatically very quickly.

Q. Now, if I can move on then to particular impacts on your members and focus first on the health sector. You deal with this in paragraph 13 onwards of your statement. What you highlight, as many others have done, is the lack of PPE and you go on to discuss particular problems with PPE once it was available. If I can put it this way, there are problems of hierarchies in that who is entitled to PPE and problems of effectiveness in relation to different types of PPE, with particular issues around face masks.

A. Yeah.

Q. If I can deal first with the availability problems. What do you remember about that?

A. From a health perspective initially it was —— it became very clear that there wasn't enough PPE circulating within the system to reach the demand. The risk assessments that the individuals could partake in themselves to identify which mask, for example, they would prefer were not readily available. We also had



issues where —— and I talk about the kind of hierarchy, about where initially there is —— and I think I say it in my evidence, that, for example, porters, et cetera, who transport patients across hospitals were told that they do not need masks because they're pushing the patient away from them, so they were then explained that they don't need masks to carry that function out. However, if that individual was in a ward, then the employees within that ward would have been subjected to the PPE requirements to ensure the safety for themselves and the patient, but as they then started to be transferred through the hospitals, the porters were told that they did not require a mask to protect themselves in relation to that.

Q. So if we could just explore that briefly. It's in paragraph 14 that you specifically mention this example. And you say there that, as an example —— this was an example of hierarchies. So those at the lower levels of the hierarchy, like "hospital porters were told that they didn't need to wear a mask when transporting patients because they were behind the patients when they were pushing them". On one level that's anecdotal, but can you perhaps explain who told them that and whether that was a pattern or one isolated example?

A. I think that who —— you say "anecdotally". It was our



elected representative that it actually happened to and took place across different sectors or different areas of the hospital. I think that it was —— initially it was a potential belief of local managers, which then comes down to the communication of the guidance that was being provided. I think in a lot of circumstances local managers who were required to implement guidance were left in potentially a vulnerable position due to some of the communication of that evidence, which then created unnecessary conflict.

I think that, as we started to progress, particularly within the NHS, it was easier to address those situations very quickly because of the contacts that we have. But if you then transfer those particular situations into a social care setting, because of the under—representation of trade unions across the sector, the workforce within social care were placed in a more vulnerable situation because it was not easily accessible to address the situations that were being reported to us because we didn't have the direct contact with the individuals.

When we raised these concerns in moving this forward, it was addressed within the health sector, it was addressed very quickly, and managers were then appropriately advised about the guidance, about what

needed to happen, and then there was —— appropriate PPE was then provided. But it became the requirement of the individual to stand up and say, "I'm not doing that until such time that you provide me with the appropriate PPE", and that was unnecessary in my view.

Q. We slipped a little bit there into social care and I want to keep that separate for a moment because I want to come to it.

If we can continue just to focus on the healthcare sector for the moment. The issue of hierarchies and effectiveness is also mentioned in effect in paragraph 16 of your statement, when you discuss the particular impact on members of not being able to access PPE in the first place.

A. Yes.

Q. What sorts of impacts were those?

A. As I say in section 16 of my statement, our members had to —— and I think that this is fair to say for across the whole sector. I think that health workers sacrificed a whole lot and so did social care workers and so did all key workers, et cetera. But focusing on health workers, they sacrificed a whole lot of their own personal life, their own circumstances, to ensure that patients were supported and that the system continued to run. Tragically people lost their lives and our members



and our representatives are advocating for those members who tragically couldn't do it for themselves any longer because they weren't there.

One of the first tragedies within healthcare was very close to our representatives within a hospital setting and the workforce were, you know, absolutely devastated. I think people have all seen photographs of health workers breaking down in tears. I think it's important to reflect that that's real, that happened and it continued to happen throughout. It wasn't an isolated incident. But our members and our reps were obviously grieving for one of their colleagues. The reality that was hitting them at that point of "That could have been me" was then hitting home. But because of the pressures they were under, the healthcare sector at that time, it then became, "I'm really sorry but we need you to get back to your job", so there wasn't that time to grieve, that time to process.

The difficulty that we have —— and it is anecdotal evidence —— is because of how all this stuff was reported throughout the health and social care sector, but there was a load of questions to say —— from our members and from our reps to say, "Well, actually, if we had appropriate PPE, if we had FFP3 masks ..." —— because of the amount of time spent within that hospital



setting, it was very —— it was, you know, clear to those individuals that the only place you could catch this tragic disease was in that setting.

Q. Yes. So it's fair to say, with everything else going on, with dealing with the unknown, with people falling ill, with shortages of staff, with uncertainty about how one contracted COVID, the problems with PPE and not being able to access it aggravated the difficulty?

A. Absolutely. It exacerbated the situation and that was not required.

Q. Now, if we can turn to the social care sector now, the particular impacts of these issues of PPE problems in the social care sector. You deal with this in paragraph 17 onwards of your statement.

A. Yeah.

Q. I mean, again, in paragraph 17, you begin with hierarchies, the hierarchy or difference between the healthcare and social care setting in that —— what you say in paragraph 17 is:

"For those working in a social care setting ..."

So that's like people going to care for elderly people in their homes, for example.

A. Yeah.

Q. "... at the beginning at least, PPE was not automatically provided and staff were asked to reuse



single use masks or not use them at all."

I mean, is that because of availability problems?

A. Yes.

Q. Yes. And, again, where would these orders or these instructions be coming from?

A. They were coming from the line management of those individuals, who were obviously then seeking advice and guidance from their appropriate management teams because, particularly within the social care sector, there is obviously a chain of command; there is that organisational chart. But being asked to reuse single-use masks, the clue is in the title. They're single use. That should never be the case. That should never be happening.

When you talk about —— and I've referenced that —— when you talk about community nurses, district nurses, district physios, they're employed by NHS so it was clear that they would go into a house setting, unknown what they were walking into, and when they came out, they would take their PPE off, put it in a bag and then dispose of it.

Within social care settings, within other kind of charitable organisations, community youth, not-for-profit, third sector, that was not the case. People were wearing masks —— the same masks for the

whole day, whereas there was —— they should [sic] have been reusing that. When there was masks available, they shouldn't be reusing it. They should have been taking that off to ensure that there was continued protection there. But that was all down to the availability of PPE and probably the cost constraints that were being placed on organisations due to the way that the social care sector is set up in terms of the Government procurement processes and whether or not that's part of the contractual conditions or not.

Q. Because social care is largely a local authority responsibility, isn't it?

A. It comes through —— local authorities are the registered providers as such, the commissioning bodies, but that is then filtered down through into a load of charitable organisations, who do great work and provide support to people they support and vulnerable individuals throughout our country. But it's all done through that —— contracting mechanisms, through health and social care partnerships and IJB.

Q. So of course one feature of the social care setting then, in comparison to the health care setting, is that there are many more actors, many more operators?

A. Yes. Red tape.

Q. In paragraph 18 you do say there was some evidence ——



you yourself call it "anecdotal evidence" —— of PPE getting locked away in cupboards and being rationed. Would you say the reason for that is because of concerns about shortages?

A. Yes.

Q. Now, you do say, to be fair, in paragraph 19 that the system did improve. Are you saying that it improved because of increasing availability or people getting used to using it or ——

A. I think that it became —— it improved because of availability and because there are —— there were organisations who were repurposing themselves to provide PPE. There was —— particularly the Dental Hospital, for example, within Greater Glasgow and Clyde, they then went into production of visors, masks, et cetera. There was universities that were making PPE, single use, visors, et cetera, to try and provide support. So as the pandemic grew on and grew forward, we ended up in a situation where we were getting PPE.

I think it is important to say that there is a difference between the PPE that was provided initially to where we ended up to —— sorry, where we ended up. There was what was called "tiger masks", "tiger goggles". They were just procured because of —— we needed masks, but those masks were not fit for purpose.



They did not provide the adequate protection that was required so they were removed from circulation. And the PPE system, through the national hub that was created by the Scottish Government, then allowed us to access PPE for particularly social care settings at a later date —— to say, "We need masks and we need gloves and we need aprons to be sent to this organisation", and that was then fulfilled.

Q. We'll come to the issue of masks in a moment. You deal with it at paragraph 22 of your statement, the subject there. It's quite a large part of your statement on the actual protection provided by PPE, but if we could —— before we just finish on particular impacts of the lack of PPE on the social care sector, you do raise an interesting point at paragraph 20 about the use of laundry facilities and you highlight a difference between the healthcare sector —— perhaps an inevitable difference between the healthcare sector and the social care sector in relation to the availability of facilities to clean uniforms and PPE. Do you want to say a little bit more about that?

A. Yeah. So within the healthcare setting, the guidance was then created and clear that says, "If there is laundering facilities available, then healthcare staff can and should use the laundering facilities". We did



end up in situations where —— and that may be communication that we'll come on to if I've time —— that then became an issue that, "No, you can't use the laundering facilities", et cetera. But we fixed that and sorted that out. Healthcare staff who worked within hospital settings where laundry services were available, they could wash their uniform, so that they weren't taking it home. They weren't then going out into the community with it.

If you fit that into a community setting and a social care setting, individuals were using the same uniform, going in and out of different houses —— because the plastic gowns that they were wearing were not suitable. They would rip. They wouldn't cover their uniform in its entirety. But they would leave one house and then go into another house wearing the exact same uniform. But within an NHS setting that never happened, that couldn't happen.

There was no laundering facilities for community staff or social care staff, so they were then having to take their uniform off, put it in a bag and then take it into their house to wash within their own house. Obviously there was guidance on how to do that. But the difficulties that were faced, particularly within social care settings, was the PPE that was provided did not

cover the uniform in its entirety and that same uniform was worn for the full day, as you were going in and out of care homes, in and out of houses, in and out of the people that you were supporting. But within a hospital setting that didn't happen.

Q. Yes. Of course this was combined with the difficulty of people not knowing how COVID was transmitted?

A. Of course.

Q. Yes. Well, my Lord, if we could just turn now to the protection provided by PPE and some of the particular difficulties with that, which begins at paragraph 22 of your statement, Mr O'Connell. You've already mentioned that, as I understand it, one solution to the lack or difficulty with sourcing PPE was to use —— in relation to masks, to use tiger masks and goggles. But you then go on to contrast the differing approaches between England and Scotland in relation to masks, and this relates to the effectiveness particularly of masks. So you discuss this in paragraph 24. Do you want to say a little bit more about what the difficulties were with type 2R masks as opposed to FFP2 masks?

A. So in Scotland, the Scottish Government took a decision, as we progressed through, that the go—to mask and the minimum standard, for want of a better expression, would be a type 2R mask, which provides greater protection



than an FFP2 mask because there is —— the other mask that provided the most protection was an FFP3 mask, but the difference between a type 2 mask —— a type 2R and an FFP2 is that the type 2R masks are fluid—resistant and provide a greater protection than what an FFP2 mask is. Although, for visual purposes, they're the usual kind of blue surgical mask that you put on, but there were still gaps —— there would still be gaps down the side of those masks, they weren't face—fitted, so therefore there was —— people were concerned that, when they were in circumstances or situations where they were close to a patient, as required to do so, they would potentially be coughed —— the patient would cough, et cetera —— that the particles within the air could penetrate that mask through the gaps in the side whereas, if you had a face—fitted FFP3 mask, that couldn't happen.

Q. What you're saying in paragraph 22 is that certainly tiger masks and goggles are of no effect at all.

A. Yes. The tiger mask and tiger goggles came into circulation because that was what could be procured at that time. But when —— a lot of our senior representatives across Unite are scientists and they could obviously provide some further expertise in relation to that. And it was identified very early on from a Unite perspective that those tiger masks were not



fit for purpose. They did not provide the adequate support and protection required to carry out.

So the advice that was provided by Unite and later then followed by Scottish Government was not to use these masks and to bring them back and out of circulation, the difficulty being that there was not a register that maintained where all of this PPE was going. It was just put out there. So it was about, "How do we effectively communicate to staff and members to ensure that they know not to use these masks because they don't provide that protection?".

Q. Now, in relation to the availability of FFP3 masks, they were focused on the health sector?

A. Yes, predominantly.

Q. That's what you say in paragraph 25.

A. Yes.

Q. And you admit or you accept in paragraph 26 that, although FFP3 masks were the safest, they were limited and so couldn't be given to everyone?

A. Yes.

Q. Did they eventually get rolled out in the social care setting?

A. No.

Q. No?

A. No, they didn't.



Q. Another issue that you raise, which is related to the effectiveness or may be related to the effectiveness of PPE generally but face masks in particular, is the question of it being past its sell—by date, if I can put it that way. It's out of date.

A. Yeah.

Q. You talk about this in paragraph 27 onwards. So the concern here is that employees in both the healthcare and, where they were getting masks, the social care sector were being provided with masks that were out of date.

A. Yes.

Q. I think you say that sometimes there were in—date stickers. In paragraph 27 you say that in—date stickers were simply placed over the old date ——

A. Yes.

Q. —— on the supplies ——

A. Yes.

Q. —— and Unite has photographic evidence of that.

A. Yes.

Q. What do you think the reason for people doing that was?

A. My own personal view is that the reason that was done is because they couldn't —— because there was no other way to get the appropriate and required numbers of PPE. The reason that these dates are on this PPE is because

that's the protection that it provides in terms of what is put into these masks, gloves, et cetera. When we then started to challenge why these PPE —— the PPE supplies were then redated, revalidated, "Who revalidated? Who done them? Why did it come about?", there was no answer. Initially it was, "Oh, they're safe to use". Well, respectfully, we needed that proof. We needed to see and understand for our members, "Why are these now safe if they've gone over the date, they've not been recalled, and there's stickers now just being placed on these and then distributed out —— if they've not been recalled by the manufacturers, et cetera, how are they safe? What proof have you got that these are now safe?".

Q. How was this eventually resolved?

A. The Scottish Government civil servants, I have to say, maybe a month to two months down the line, provided a certificate to say that they were —— that they had been revalidated, but with further investigations into that. Particularly by some of those individuals I referred to who have the knowledge and expertise in relation to that, that certificate was questionable in terms of, "How did you reach that revalidation point?".

But for our members and for ourselves, we then had a bit of paper that put the onus on an organisation or



the Government to say, "You're now saying these are safe but, because the guidance allowed for an individual to carry out their own risk assessment and determine what is appropriate for them to wear while carrying out their duties, we would obviously advise our members to consider what that revalidation of PPE would look like".

Q. Thank you, Mr O'Connell. If we can move on to another issue which the Inquiry has heard from —— has heard about before, which is the problems associated with the dissemination of guidance and the volume of guidance. I'll take this a little bit more briefly, but you also highlight similar problems of hierarchies and effectiveness. What you say in paragraph 31 is that there was a very hierarchical system in the way that guidance was issued and digested. So what do you mean by that?

A. So when —— particularly within the health and social care sector —— and I'll try and cover both here because I think it's important —— within the health sector there would be a communication sent from Scottish Government to the chief executive, HR directors, finance directors —— you know, the senior corporate management team within the health board. That would then start to try to —— start to flow through their processes to say, right, chief exec sends it to a director, director is



then responsible to send it to a head of and head of then sends it to this person or that person. As you start to filter through, it then gets lost in translation. Does it actually get to the appropriate person because the local management team that were responsible for implementing this guidance were also clinicians who were running about doing their clinical job, trying their hardest to protect patients as well. So when it then came to a situation where they were required to implement this guidance, it then became questioned on —— around about the interpretation of what that guidance actually says.

So I think that there then became responsibilities and expectations that it was reaching the appropriate levels, whereas in practice, when you were then beginning to say, "Well, have you seen this guidance?", the answer was coming back saying, "Well, no, I'm not aware of that". But I think that that's reflective of the guidance changing sometimes every hour of every day and then how that was getting through. So you would get a piece of guidance that would then go down into the system, but then it would change. It would change an hour later, two hours later. And obviously we're saying, "Well, we need to get that back down the system to ensure that was communicated accordingly".



Within a social care setting, the Government would send it to local authorities, local authorities would send it out to the providers or they would send a link to the COVID—19 page on the intranet, to say, "Here's where the guidance is". There wasn't a, "Here's what the guidance is and here's what it means and here's what your responsibility is to ensure that people continue to be protected". When I say "people", I mean patients, the people that are being supported as well as the staff as well, because it is a whole —— it's very cliche, but it is a whole system approach because I think that the important thing is to ensure that the patients and the people that are supported are protected because they're there because they're extremely vulnerable and I think that the application and interpretation of the guidance at that local level was where it became problematic.

Q. Now, the guidance can cover the whole gamut of things that you touch on in your witness statement, so it can be about the use of PPE, the use and availability of masks, it can be about testing, it can be about rules and special leave and so on.

A. Yeah.

Q. And quite a lot of —— and also the impact on pregnant workers. Was there any guidance on that?

A. Initially there wasn't any guidance on pregnant workers.

I think that this is really important to recognise because initially, when this situation started to break, understandably so, expecting parents -- expecting mothers were concerned for their unborn child and the impact that COVID could have on it. So what should be happening for pregnant workers is a continual risk assessment, continued recognition of what stage they're at within their pregnancy and the impact that that may have. Because of the lack of guidance and the lack of understanding, it was, "Well, you could ..." --

Q. Can I ask you just to pause there? My Lord, if we could look at paragraphs 49 and 50 of the statement. So we're still on the issue of guidance but I just want to drill down a little bit on the initial guidance, if there was any, and the change in guidance in relation to pregnant workers. So we're talking about the initial guidance.

A. Yes, initial guidance, there was no specifics round about pregnant workers, but as we progressed through, it became apparent that pregnant workers should not be in a situation where they could come into close contact with individuals who are COVID-positive. So if you were in a COVID-receiving ward, if you were in intensive care, if there was potential within the community that you -- because you don't know what you're walking into, et cetera -- then the impact on a pregnant worker was



such that, "You should not be there. We should be looking at alternative duties, we should be looking that you're protected and that your unborn child is protected".

Initially that was not the case, that didn't happen and there was an expectation that pregnant workers would continue as normal and that they would come to their work and they would do what they would normally do despite the fact that the concerns from expecting parents, expecting mothers, was as such to say, "This could have a detrimental impact on my unborn child and I'm extremely scared, I think -- I'm scared, I feel vulnerable for my child", and, you know, an expectant mother is -- that's their priority. But the unintended conflict or requirement to do that is, "But the guidance doesn't say that so therefore you need to come to work". Then that put things in place where we know that there were members -- the stress and anxiety that that caused, they then removed themselves from the workplace.

Q. Was there any difference in relation to the approach to pregnant workers between the healthcare and the social care setting?

A. Initially, no. I think that --

Q. But eventually did it change at any point?

A. I think that the pregnant worker guidance became quite



known. I think -- personally, I think it was disseminated out there to ensure that and I think --

Q. Was that general guidance or was that guidance for a healthcare or a social care --

A. It was general guidance through the -- because the guidance that was presented for pregnant workers related to all pregnant workers, but I think that the important bit to note on that was how was that disseminated and how was that then reflected within practice, particularly within social care, because they potentially didn't have the same access to the guidance as a healthcare setting would because of how it was sent out.

Q. Yes. Returning to the effectiveness of guidance in paragraph 32 of your statement, although you're talking about FFP3 masks, what you say there is that local managers often advocated that FFP3 masks were only required for staff working in intensive care --

A. Yeah.

Q. -- but even there you think the guidance got lost in translation?

A. Yeah, because an FFP3 mask is face-fitted. It needs to be face-fitted to you so that it's tight. I think from people explaining to me, they are not comfortable to wear. They are not something that people would be



actively saying, "Please give me one of those masks because it's really comfortable". They were asking for that mask because that is what gave them protection.

The guidance that I referred to in relation to how that was being interpreted -- the guidance was clear that, if a worker carried out their own personal risk assessment, which they were advised to do, and requested an FFP3 mask, they should get one. But because you had to -- because they had to be face-fitted, what local managers were saying is, "You can't get an FFP3 mask because you're not fitted for it" or "You are not required to wear one because you do not carry out an aerosol-generating procedure", which creates its own issue. But staff could have requested an FFP3 mask, as they so wish.

Q. You deal with aerosol-generating procedures in paragraph 33. Can you briefly explain what that is?

A. Yes, it's -- particularly within COVID-receiving ward, within Ambulance Service, when -- chest compressions, et cetera, that creates an aerosol -- that is an aerosol-generating procedure. It creates the molecules coming from the mouth, et cetera. But if you take a speech and language therapist who -- for example, that carry out a specific duty around about people's throats and put tubes in throats, the liquid and the generation

of those is created, but that was not determined as an aerosol—generating procedure so therefore speech and language therapists did not require an FFP3 mask despite doing that.

If I can, I think it's important to recognise that individuals from a specific ethnic background or they have specific religious beliefs could potentially —— it would have been difficult for them to wear an FFP3 mask because of facial hair or head scarves, and I think it's important to recognise, from a Scottish Government perspective and a trade union perspective, that was fully respected and understood and that, if that was the case, then an individual was then —— there was alternatives sought for individuals to respect their beliefs or they were removed from that particular area so that we could —— so there was a respect of individuals' beliefs, et cetera, which I think is an important impact on that human right of the individual.

Q. Thank you. If we could just turn to one or two issues around testing. You talk about, in paragraphs 38 and 39, that the roll—out of testing was important in terms of helping to protect people, but an issue was the complete reliance on testing despite the acknowledged lag in time between when a person became symptomatic and when they actually tested positive. We've touched on



that before. But you make the point in paragraph 39, in terms of contact tracing, that employers often insisted that identified close contacts continued to come to work.

A. Yes.

Q. Is that true again both in the health and social care setting or more one than the other?

A. I think they would be more in social care, if I'm being honest. I think that, because of that, there's a very slight delay that, if you are identified as a close contact and tested as a potential —— or there was a potential for you to test negative for the first day or two and then you would test, but whilst you may have been testing negative, you had contracted —— you had potentially contracted COVID.

I think that it was more prevalent within the social care setting, not so much healthcare, because I think, within a healthcare setting, if you were identified as a close contact, then you would have received full pay, you would have been told, "Go home, isolate for ten days and do what you need to do". In a social care setting, that was not the case. There was a lot of difficulties with accessing funding. There was a lot of employers —— because they did not receive the money from the Scottish Government, then they would say, "Well,



actually we can't pay you if you are required to isolate for those number of days", but the test was then —— became the key. It was like, "Are you testing positive?"; "No"; "Well, you've no got COVID so you can come to your work".

What that did is it put the individual in a very difficult, vulnerable position. Because they had been identified as a close contact, they were going into the workplace or going into support an individual that could have a devastating effect on the individual if they had contracted COVID, but if they'd stayed off, they wouldn't have been paid. So therefore they're in a situation, because of the way that social care is set up and the pay —— that that issue then exacerbates things for them and continues to stress.

Q. Are these inconsistencies a result of lack of guidance or wrong interpretation or conflicting interpretations of guidance or ——

A. I think all of the above but at the same time I think that it comes —— also comes down to the construct of the contracts in terms of —— because of what was happening within —— across Scottish Government and what they were trying to do and supporting particularly public sector and social care —— that organisations and employers were reluctant and they were —— they wouldn't pay people



fully until such time that they knew that the Scottish Government was going to pay for it. So it was then —— it was more about what was their budget and what's their bottom line.

Q. And the problems are similar in relation to COVID special leave, as you discuss then in paragraph 42 onwards of your statement.

A. Yeah.

Q. This is again —— there's a difference of approach between the healthcare sector and the social care sector in relation to how COVID special leave worked.

A. Yes. And, as I articulated previously, it's the same principle that, within a healthcare setting or even a local authority setting, people were off and they were fully paid. As you start to go into your community youth, not—for—profit, third sector and charitable providers, that was not the case. So much so that, as we progressed through coming out of the pandemic —— and obviously —— I'll use the words "coming back to normal", because I can say that people within this sector are not back to normal; it still impacts them to this day. Health and social —— the health sector maintained COVID special leave so much longer than what a social care provider did. I think COVID special leave only finished January this year or December this [sic] year.

Within a social care provider setting, that was long gone.

THE CHAIR: You have ten minutes left, Mr Edwards.

MR EDWARDS: Thank you, my Lord.

There's just really two main issues that I want to touch on. Very briefly, vaccinations, in paragraphs 45 to 48. There's two issues there I just ask you to comment briefly about. The first is a hierarchy issue again, which we've touched on before, that it's higher priority staff and lower priority staff.

A. Yes.

Q. And I'm assuming that social care staff would be in the latter category rather than the former; is that correct?

A. Yes, very much so.

Q. Then in paragraph 48, briefly, you say that there was conflict between UK-wide organisations and, if I can put it this way, devolved organisations.

A. Yeah.

Q. In that there was conflict between who required a vaccine to come to work and who didn't.

A. Yes, so ——

Q. What was the impact of that?

A. Within Scotland there was a recognition that it was a choice for an individual whether they receive a vaccine or not. It was not mandated in Scotland that



you must be vaccinated whereas within England it was. It was mandated that you need to be vaccinated. Where the conflict came was, if you had an English employer who were based in England, would then be operating within Scotland, that there would be an attempt to apply the England position in Scotland despite Scotland having a different approach. So it then got to a stage where our members were then threatened with disciplinaries, dismissal, if they did not go and get vaccinated to ensure that they were able to do their work.

When we raised that with Scottish Government, the Scottish Government made it clear that, if you are in Scotland, operating in Scotland, then you will be bound by the Scottish Government guidance and that guidance was that it was not mandatory to be vaccinated. And I would suggest even to this day there are people who have not been vaccinated because that is their choice to do so, and I think that the Scottish Government respected that choice and gave the individuals the opportunity to determine it for themselves.

Q. Yes. Reporting COVID in the workplace, very briefly. In paragraph 55 you talk about the union's concerns in relation to employers' reluctance to allow COVID transmission in the workplace to be reported. That was true both in the NHS and in the social care setting, was



it not?

A. Absolutely. I would say probably even more so within social care. Because of the mechanisms that exist within health, there was an opportunity to do so, but refused, but even more so within social care, that that mechanism may not have existed.

Q. I think the reason for that —— I don't want to put words in your mouth —— but a reason for it was concerns over liability?

A. Potentially.

Q. Finally, before I ask you about lessons learned, you talk about the definition of "key workers".

A. Yes.

Q. And that is a difficult and still a sore point, I think, between the healthcare and social care settings.

A. Yes. I think that the definition of "key" and "essential workers" —— and I think that it's important for me to applaud, support, give every word I possibly can —— to thank the individuals who day in, day out, came to their work, whether it be supermarket workers, whether it be waste services operatives and important health and social care workers. Without those individuals, who knows where this country would be? We're forever indebted to them and the work that they done.



But the £500 COVID bonus that was announced at a political party's conference was not discussed, not suggested, nothing. So we had all of this workforce leadership group who decided guidance, discussed everything. This came out of the blue. And it's commendable to recognise the work that individuals have done, but it was incredibly divisive because you then have a situation where you are determined as an essential worker and you need to come to your work but you're not a key worker, and there is a distinct difference because the COVID bonus —— every single person working in the NHS received the COVID bonus, every person.

You then go into a social care setting, not everyone received the £500 bonus but they were required to be at their work. If you then go into a —— I know this is focused on health and social care but it's to demonstrate this disparity, Mr Edwards, as the —— the waste services operative, the people who pick up our bins, were determined that they must be at their work, they must —— they need to be there; you have our building services operatives who go into people's homes to ensure that they are heated. They ensure that they have running hot water in emergency situations. Those individuals were just as vulnerable as others because

they were going into households.

Those individuals were not —— it was not applicable for them to receive the £500 COVID bonus despite them being out every single day in the same way everybody else was, despite the work that they were doing to ensure that this country functioned and continued to operate as it did. So therefore the divisive nature of the £500 bonus then became an issue, and particularly within social care, where you have what's determined as front—line workers, so people who come into contact with the patient, the individual, they received a bonus but support staff who are integral to ensure that that support is provided didn't receive the £500 bonus.

Q. Yes, you talk about divisive. Divisiveness can have a legacy, can't it?

A. Indeed, and it still is, particularly when we discuss our —— we touched on the committees, et cetera, but within Unite, when you're talking about pay claims, when you're talking about all these things, we still have members saying, "Well, I wasnae —— it wasnae appropriate for me to receive the £500 bonus, so how can you use the type of work that I do and classify it in such a way when it suits you, but now, when it doesn't suit you, ie to pay me £500 for the work that I done throughout COVID, I wasn't as required or wasn't ...".



Q. So that legacy, if you like, takes us to the last point. Towards the end of your statement, you talk about lessons learned. If you were to identify two lessons that you would hope to be learned from the pandemic, what might they be?

A. For myself, I think that my reflection is particularly round about how prepared we were. I talk within my statement that the Scottish Government had already carried out pandemic preparedness that identified that we weren't ready for a pandemic; that we weren't ready if God forbid it ever happened. And the frustration for me is that that is gathering dust on a shelf instead of actually actioning what was in it.

So if we are going to learn lessons, it should be that, if you're going to carry these things out and identify that there are issues and concerns, then we should be seeking to resolve those issues and concerns so that we are prepared for that. I think that that's extremely important.

I think the other element for myself is —— particularly within social care —— is to learn the lessons of the interaction with the trade unions that happened particularly within the Health Service. You know, we done everything we could in the relationships that we had within the health sector to address concerns



at a very early stage. Within social care that doesn't exist. The Government have committed to collective bargaining, sectorial bargaining, within social care and committed funding to it until a couple of weeks ago, when they removed that funding, so that then becomes an issue.

I think that, as a society, particularly within social care, we need to ensure that the individuals within social care are better protected, because they're not, and we should be learning from how we manage to achieve some of the positive outcomes from a healthcare perspective which then slowly but surely rolled into social care but are now being lost because it is a "back to normal" situation. We need to be really concentrating on social care, we need to be concentrating on the value that social care workers and that that whole sector provide to our country.

Q. Yes. Mr O'Connell, thank you very much. Your evidence —— your statement, sorry, and your evidence will stand as a whole before the Inquiry. I want to thank you for what has been a very clear and sophisticated and detailed elaboration of your witness statement and I'm very grateful for that.

A. Thank you.

Q. Is there anything else you would like to add before



I conclude?

A. No, just that I think for myself it's important to re—emphasise that as a country we need to be extremely thankful for what every single individual provided to ensure that patients and the people that required support in our country continued to operate the way it did throughout COVID because, without them, who knows where we would be today? Thank you.

MR EDWARDS: We can certainly all agree on that. Thank you, Mr O'Connell. Thank you, my Lord.

A. Thank you, my Lord.

THE CHAIR: Yes, very good.

Thank you, Mr O'Connell. 12 o'clock for the next session.

(11.45 am)

(A short break)

(12.00 pm)

THE CHAIR: Good afternoon, Mr Stephen.

MR STEPHEN: Good afternoon, my Lord. The next witness is Peter Hunter.

MR PETER HUNTER (called)

THE CHAIR: Good afternoon, Mr Hunter.

A. Good afternoon, my Lord.

THE CHAIR: When you're ready, Mr Stephen.

MR STEPHEN: Thank you, my Lord.

Questions by MR STEPHEN

MR STEPHEN: Could you confirm your full name please?
A. Peter Matheson Hunter.
Q. Thank you. Your age and contact details are known to the Inquiry so I won't ask you for those and you've helpfully provided a witness statement already in writing. For the record, the Inquiry reference number for that is SCI-WT0478-000001. Are you content for that written statement and the oral evidence you give today to form your evidence to the Inquiry?
A. I am.
Q. And you're happy for that evidence to be recorded and published?
A. I am.
Q. Thanks. Everything you say in that statement will be taken into account even if we don't touch on it in oral evidence today.
A. Thank you.
Q. The last reminder just before we begin. There is a restriction order in place, so please don't name any specific individuals when you're giving your evidence.
A. Okay.
Q. Thank you. I understand that you're employed as a regional manager with UNISON; is that right?
A. That's correct, yes.



Q. Which region is that?
A. So the Scottish region.
Q. And, what, that covers the entirety of Scotland?
A. So, yes, within our structure Scotland is a region and within Scotland I cover the north of Scotland, so pretty much from Perth and Dundee northwards, Highlands and Islands, Aberdeen. And there are functions that I cover within the organisation, the legal service, the education, the equalities function and various other -- it's a complex structure.
Q. How long have you held that particular position for?
A. Nine years now.
Q. And how long have you worked with UNISON more generally?
A. I joined in 2001, so 23 years.
Q. Thank you. What is the size of the UNISON membership in Scotland, roughly speaking?
A. 163,000 people.
Q. I understand from your statement the bulk of those members are in local government; is that right?
A. Approximately 90,000 in local government, so there would be some care services within there, children's residential care, social care that's delivered in-house by local authorities, and then between 15,000 and 17,000 social care workers in contracted services and then perhaps 40,000 NHS workers. I'm anxious the arithmetic



might not add up there, but broadly speaking.
Q. Thank you. Around sort of high-level terms, then, what was the role or function of UNISON in assisting these members that you have?
A. So we look after people as individuals, so from their arrival within public services through access to apprenticeships and training and progression, and many employees take advantage of our learning facilities to -- for continuing professional development or for their career progression. We look after people as individuals if they get into difficulty in relation to grievance or disciplinary matters. And then collectively we negotiate the pay and working conditions for employees, so their annual pay rise, their grading structure, equal pay between women and men.

For specific groups we negotiate equality arrangements and strategies for entire groups. So I'm particularly involved in work that we do with black workers within public services in Scotland but also I co-ordinate our equal pay work, which has been a big, time-consuming and very litigious area of activity for us, so to change systemic inequalities between groups separate from that which we can achieve by negotiation. So it can be individual, it can be collective, it can be by occupational group, by service or it can be by



communities of interest, young workers, older workers, women, black workers, disabled workers.
Q. Thank you. I'd like to take you back now to the start of the pandemic and the impact I suppose on UNISON. At paragraph 31 of your statement you talk about the importance of the union having a democratic mandate and having to create during this time -- "a virtual democracy" I think are the words that you use -- following this move to operating in an online environment because of COVID. How did you go about doing that as an organisation?
A. It was a challenge. I mean, I would be critical of public sector organisations for not having long-term plans for the pandemic and then for not being alert to the immediate implications of what was happening in China in January, February and March. The same criticism could be directed at us. We didn't have long-term plans and we sat looking at hospitals being built rapidly in China without thinking that the same challenge might await us. So we had to very rapidly create arrangements by which we could support members to continue to work in the way that we traditionally work.

There might be a stereotype of trade union barons like me intervening aggressively and without a mandate on behalf of workers to create trouble. That's not my

experience of UNISON. We are precisely the reverse. I'd like to think I have a relatively low public profile. We support members to do things in their own name, which is the slower and more cumbersome way of doing things but we think it's ethically the correct way to do that. So that involves adult education, skills training in relation to workplace advocacy and in particular support for disadvantaged groups who might not automatically have access to and progression within workplace arrangements, so younger workers, disabled workers or women.

So to maintain those arrangements during the pandemic, when nobody is meeting in person, then we have to have training programmes to bring people through and virtual meeting spaces for people to prepare for engaging with the employer and then virtual spaces for the meetings with employers. I would say, notwithstanding our relative lack of preparation, we did that well.

Q. Thank you. You mentioned education there and you said at the outset that your own role involves that. How did you adapt your educational programmes? I think I saw reference in paragraphs 39 and 40 of your statement to hiring an American organisation to help you with that; is that right?



A. We did. So one of the features of American industrial relations is that some of the trade unions are systematically excluded from sectors of the economy so they work online, and we thought it would be a good investment to benefit from their skills and experience and we hired them and that was very helpful.

In relation to our own adult education programme, we're very keen that it be member—led, so we survey members about their needs, which very often are about literacy skills, digital skills, cyber security, and there was a massive shift. Workers wanted to know about COVID, they wanted to know about safety, they wanted to know about bereavement, trauma, stress and coping with mental health. So our adult education programme moved from literacy and numeracy and personal development to mental health awareness, trauma awareness, trauma—informed practice, through to the point of creative writing to help people process the experience that they were going through. So that was the adult education work.

More specifically in relation to the technical side of our work, we had, obviously, an exponential rise in the need for health and safety reps, so we would organise drop—in online sessions maybe in the early evening where people could come and ask questions and



get into conversations about the new COVID safety environment. And from those conversations or from social media—based survey questionnaires, we identified people who might step up to —— not be a full health and safety rep but very specifically a COVID safety rep. So we weren't teaching them control of substances hazardous to health or manual handling. We were focused very, very specifically on a syllabus in relation to COVID. And hundreds of people volunteered for that and then were deployed by us, either virtually or in real life, both during the pandemic and in the return to work. I would say that my colleagues, unnamed, who delivered that programme and the volunteers who participated in it did an exceptional job.

Q. Thank you. You talk in your statement of having to be innovative in communication because of what was happening. I think one communication tool in particular you reference in your statement at paragraph 42 is the use of surveys.

A. Yes.

Q. You've touched on that there. When were these surveys carried out and what was the size of the sample that you were getting back?

A. So we were surveying quite regularly and sometimes the surveys were to gather detailed information for dialogue



with employers, so we were very concerned from the start of the pandemic about the disparate impact on disadvantaged groups. So, in our experience, the people who were able to work from home tended to maybe be middle class, maybe disproportionately men, disproportionately white, whereas front—line social care workers or cleaners, not exclusively, but disproportionately, were black and ethnic minority and lower—paid working—class women. And we were very concerned to read that —— I forget the precise percentage —— but something in the region of three—quarters of the deaths amongst clinical staff at the very start of the pandemic were from a black or minority ethnic background, and we were very keen to find out what —— from our experience, what might be contributing to that. So that was more of a policy survey.

Sometimes we would use a shorter two— or three—question survey, "Are you concerned about the pandemic?"; "Do you feel supported?"; "Would you like more information?", and that's more of just a method of contacting people and building the relationship, perhaps to see who might want to then receive information, share it with their colleagues and possibly become a COVID safety rep.

Q. Thank you. Yes, you've mentioned the differences perhaps between, say, black or ethnic minority workers and others, and I was going to come on to that because you talk about that in paragraphs 44 and 45 of your statement about the survey results on that issue. What do you attribute those differences to? You mention perhaps the nature of your employment or -- but what would be your answer to that?

A. So our concern was that this was being -- this debate was being pathologised, that in some way black and ethic minority workers were inherently less healthy and therefore more susceptible to either infection or disease arising from infection, and we were intrigued to see whether there was any evidence for that or whether or not there were structural factors.

So the type of work that people were doing, data was coming out from Government about infection rates and death rates in particular occupations and it struck us that there were particular jobs which, by virtue of the frequency of the contact with the public, were more susceptible to infection and that, within particular aspects of the economy, the level of protection, for example, in contracted care or health services might be poorer than it was within the NHS, which might have more elaborate employment systems.



We were keen to establish what that was and generally speaking we found some evidence that our membership were disproportionately in sectors where our presence was weaker, where there weren't health and safety reps, where the safety culture was poorer, and they also expressed a fear of reporting hazardous working arrangements and in some cases victimisation or reprisals for any whistle-blowing that occurred. We saw those as being potentially significant factors that should form part of the wider debate.

Q. And did you publish those findings?

A. We did.

Q. So was the Scottish Government aware of those findings?

A. Scottish Government were aware of those findings and we pushed Government on them and the NHS. From memory, we agreed some guidance where black workers could have a personal risk assessment, which was helpful, and there was a continuing debate. There were working groups set up. We were able to populate those working groups with our own workers -- not me, but with workers who had participated in the design of the questionnaire, the analysis of the results, and they then sat on those working groups with Government and employers to seek to improve the position of black workers, particularly those who felt more vulnerable. So that was, I think,



productive in terms of raising the profile.

We did have a specific case where there was a worker who raised concerns about their safety and they were absent from work and they were dismissed. We provided the employer with a copy of the research to say that it is understandable that a black worker in the current situation should be stressed and anxious about the risk that they face over and above the baseline anxiety of all workers and that the employer should review their decision in light of that evidence and the person was reinstated. So that's a microscopic example of the type of thing we were looking to achieve.

Q. Those working groups that you mentioned earlier, were they running throughout the life of the pandemic? Was it an iterative process in terms of the feedback you were giving?

A. They were. There was one hosted -- there's an organisation called BEMIS, which is a Scottish Government funded, multi-party, multi-agency approach to race equality, and the Equality and Human Rights Commission did their own inquiry into the issues that we had raised, to do it in a level and a depth that we weren't able to, and our people participated in those processes.

There was a degree of hyperactivity at the time,



I think possibly as an outlet for the stress that people had. It wasn't uncommon for emails to start moving around at half 5/6 in the morning, meetings to start at 9 and then continue on until 8, 9, 10 at night, and many of these people were unpaid public sector workers who were doing these projects as a voluntary commitment.

Q. I want to move on now to -- you mentioned health and safety so I'd like to move on to that and PPE in particular. At paragraph 55 of your statement I think you say -- in terms of health and safety, you describe being required to go from the normal standard to the "Olympic standard" overnight, I think is the way that you put it. In your view, where was the social care sector on the list of priorities for access to the supply or PPE?

A. Well, generally, in health and safety terms, within health, local government and social care, then third. Within the supply chain for procured PPE, third at best. And, generally speaking, my perception and my reflection is that the Clap for Carers movement stemmed out of a realisation collectively that there are these people who perform a vital role in society generally who are now particularly vulnerable, so we're only now realising how valuable they are and how vulnerable they are, and we need to celebrate them because, notwithstanding the

fact they've been overlooked and undervalued in the past, they are now in the front line on behalf of all of us, for our loved ones but also for the spread of the disease generally.

I think that reflects the fact that social care, elderly residential homes but also care at home, home care services and other social care functions for disabled or vulnerable people in the community —— that that vital work had been overlooked and was suddenly now recognised as being as crucial —— as it has always been, but now crucial and vulnerable in the context of the pandemic.

Q. Thank you. Specifically what was the feedback you were receiving from members as regards the availability and the quality of PPE being provided in the social care sector?

A. Um, excuse me.

Q. Take your time.

A. I'm kind of being taken back to the moment of sitting at home and being in meetings with workers in extreme distress and being unable to help them and being unable to advise what they can do and their very evident trauma arising from the realisation that the infection is out of control, that they're being required to continue to work in care roles, knowing that they're exposing



themselves to infection, fearing that they are bringing infection to the person who they are caring for and the dissonance between that, "I am paid to care for you, but I might be bringing in the infection that kills you", and the inevitability that in some cases that did.

People's knowledge of the fact that, despite the lockdown restrictions, they were going to work, coming home and their family had become infected, quite possibly by them, or family members had become infected, they'd continued to go to work, service users and service user family members had become infected and died. Processing and living with the reality of that was visibly traumatising for our members in a way that I will never forget.

In that context, to have people ask whether or not it's appropriate to receive one single—use mask at the start of the day and be required to use it until the end of the day and knowing that the answer to that is "No" but that there's no solution to that is beyond frustrating. To be having conversations with people, saying, "Well, I just got bin bags and cut them up and wrapped them round myself", "I wore my wellingtons" or "I used Marigolds", and the various other improvised PPE that people were required to use —— in all that time I don't remember an NHS nurse contacting us with that



level of distress or with examples of the extreme improvisation that social workers were forced to adopt in order to do the best that they could to keep people safe. It didn't happen in the NHS in my experience, it didn't happen in local government, but it was prevalent in contracted services.

Q. Thank you. I wanted to ask you also about out—of—date PPE. Did you get any feedback from members on that being used or recommended that that be used?

A. The supply chain problems —— there was a lack of supply, so we had PPE kept under lock and key. PPE that was only available if the worker reported that their service user was symptomatic and then getting into arguments with employers around whether that was too little too late. There was examples —— so the adequacy technically —— so some employers were purchasing masks that were designed for other purposes or gloves that were designed for other purposes, so did the particular piece of equipment fit the specification contained within the Government guidance for that setting.

I spent an inordinate amount of time hearing reports of the equipment that had been given, looking at phone images of equipment that had been issued, checking it against the guidance. And the efficacy of the advice we were giving on those specific points —— you know, was



a B&Q DIY paper mask as helpful as a genuinely medically designed single—use PPE, who knew? So there was issues about the quality, the timing, the volume of supply, the repeated use, the cleaning of PPE and the reuse of PPE, staff being instructed to retrieve PPE from the bin, clean it or leave it so that the infection risk would subside and then reusing it.

Every —— looking at it as an end—to—end business process, there were weaknesses —— potentially fatal weaknesses at every stage, and those enquiries were far more common in the independent contracted service than they were either in the NHS or local government. I mentioned the example in Glasgow City where we had two days of debate with a large west coast local authority about the adequacy of PPE supply and we thought, "Well, we won't agree to our people working if there is no PPE", and spent a bit of time preparing how to communicate that to the employer, and the employer was like, "No, no, if there isn't adequate PPE, we'll suspend the service. Don't worry". And that's an entirely different conversation than the ones we were having with contracted social care services.

Q. You used that word "weaker" and I saw it in your statement in several places. At paragraph 59 you describe the private voluntary independent sector as ——

"systemically weaker" I think is the way you put it. Why do you use that description to describe that sector, "systemically weaker"?

A. So first of all, as a preface, I would say that there are organisations in my experience in the independent sector who deliver exceptionally high quality services, who are very open to progressive employment relations, who work with us, but structurally those services are procured from the independent sector in order to drive costs down. We no longer talk about compulsory competitive tendering but that's what we do without using the name, and therefore organisations are compelled to work to a different cost regime in that sector whether they like it or not, and our experience is that we could have far more effective employment relations in that sector —— and we know that consensus exists —— if the funding was adequate. And the consensus relates both to the paying conditions but also the safety cultures that would exist. So it's a cost problem and it manifests itself in different ways.

Influence and purchasing power within the procurement supply chain is just one dimension. I think there's an analogy with the oil industry here in relation to what happened offshore before and after Piper Alpha, and in that sense —— and it was my



experience, bizarrely, that the start of the pandemic was not unlike an explosion, which it shouldn't have been. It was a gradual spread of an infection from China but the impact of it was as if it had —— it had the sudden impact of an explosion because of the lack of preparation and people were looking at the wreckage of public services to see what could be improvised by way of mitigation strategies.

The reason I say there's an analogy with offshore is that the offshore operators prior to Piper Alpha said, "We don't need trade unions, we don't need the Health and Safety at Work Act, we want our own arrangements. People offshore can join trade unions if they like but they don't tend to. We're not against trade unions, they just don't happen to join. We'll make our own health and safety arrangements", and that is the culture in independent social care.

And I think the Cullen Inquiry correctly identified that it's not the technical knowledge about offshore safety that makes trade union representatives particularly valuable; it's the culture around which their observations are made. So if a trade union safety rep says, "This system is not safe", they've been trained, they have awareness about how to do a risk assessment, about the adequacy of the information and



training that's required to go to colleagues to have a safe culture as well as safe equipment, but then a slightly higher degree of confidence that if they petition management and say, "Social distancing is breaking down here" or "The PPE is not adequate" —— you can never eliminate victimisation of whistle—blowers from any system completely, but it is less likely in a trade union environment where people are supported than it would be without trade unions. So it's a cultural point that I'm making, that the independent contracting sector is a systemically and culturally weaker safety practice than we get in the Health Service and in local government.

Q. Thank you. At paragraph 60 you go on to describe the decision to discharge patients from acute settings into, as you've described it, the weaker part of the system, ie those with poor access to PPE, as the "ingredients" for "disastrous problems". You say in that paragraph that this was entirely foreseeable. So the question I'd ask you is that that's your view. Do you consider that the Scottish Government should have foreseen that this would be an issue?

A. Yes. The reason I say "yes" to that is because it's obvious; secondly the Fair Work Convention reported in February 2019 that the poor employment conditions in



social care were not just bad for the workforce but were contributing to the crisis in care because the sector could not attract and retain either the number or the quality of staff required to meet increasing care demands or to raise the quality of care within the contracted care sector. And Government accepted that report, I believe in good faith, and embarked on a Fair Work in Care implementation programme, which they were working with us in January 2020 when the pandemic broke. So I would say that was recognition that there were systemic weaknesses in the sector which were affecting care quality generally and implicit within that is safety.

I don't know what alternatives Government had. The pressure that was predicted for acute settings was enormous. They wouldn't have built the emergency facilities, the Nightingale Hospitals, were that not the case. The pros and cons of spending time and money giving the Scottish Nightingale Hospitals a different name from the English Nightingale Hospitals I think is symptomatic of a need to be slightly Scottish in relation to everything that we do. I think that was perhaps trivial but symptomatic of a —— you know, one of the focuses and the priorities in Government at the time.

I don't think there was a ready solution to the anticipated crisis in acute settings, but that point —— you know, notwithstanding that point, the likelihood that there would be an adverse consequence of moving people from safe settings to settings that were known to be less safe, for me, was obvious.

Q. I want to move on now to sick pay. It's an issue you highlight in particular at paragraph 64 of your statement. Why was that issue being raised by your members during the pandemic?

A. So members would quite often come to us having had a difficult conversation with their employer, on differing levels of tension or difficulty, whether to work or whether not to work. Sometimes they thought they should shield and the employer was saying, "No, you shouldn't shield". Sometimes they thought they should isolate because they'd been exposed, they'd been maybe told by the tracker that they should isolate, and the employer was saying that they should work. Sometimes they were saying that they should isolate or be absent on grounds of poor health because they were testing positive and the employer was compelling them to work.

One element within that debate was the fact that, in contracted services, the culture is not to pay contractual sick pay. That's the norm within the NHS



and within local government, so on average a person who is absent for reasons of sickness and health in local government will get £600/£575, something like that, per week as their contractual wage.

In contracted services, it's statutory sick pay, day one, zero, day two, zero, day three, zero, day four, £22, day five, £22, so it's a drop from whatever their normal weekly wage is to £44 per week. And that is a very unhelpful structural feature of the market which compelled those people who were in poverty or who had debts to service —— which would nudge them towards working when track and trace was saying "Isolate" or a positive COVID was saying "Isolate".

The Scottish Government responded quickly and effectively and set up what we referred to, under the Coronavirus Emergency Regulations 2020 —— set up what we called the "COVID Sick Pay Fund". They didn't have the devolved power to pay sick pay or compel employers to pay sick pay, but they could set up this fund and encourage employers to pay contractual sick pay to make sure that people didn't work wrongly and then reclaim the money from the fund. That was helpful.

There was then a commitment that that would be continued permanently as a safety feature in the sector for good. That was welcome. Some employers said, "No,



we have a company policy of not paying contractual sick pay. If we pay it in Scotland, we will have to pay it elsewhere. We will not access the fund", so that —— it's like Government creating a reserve of PPE in order to raise the quality of safety on the ground and employers saying, "No, we would rather be unsafe". And, for me, that's a terrible example of how the contracted social care market is structured in a way that tips equity—backed, profit—orientated companies to place greed over need, to place profit over safety and to contribute unnecessarily and avoidably to infection rates and deaths.

Q. So are there particular lessons to be learned then? You touch on these in your written statement, but any you would like to highlight to the Inquiry, based on what you've just said as regards, well, sick pay?

A. The lesson was briefly learned in that the fund for sick pay was set up. It stayed in the memory of politicians for a couple of years but, in my view, it's my evidence that the pressing and political imperative for a council tax freeze in the autumn of last year meant that the fund to create a permanent contractual sick pay entitlement and to have that safety legacy from the pandemic was dropped. So we are now in a situation where workers are back on statutory sick pay and, if we



have a resurgence of COVID, that's a problem. In relation to conventional ordinary winter flu, that's a problem. Norovirus, any number of other viruses which potentially affect, infect and kill vulnerable people of all ages, but particularly the elderly, there is proven beneficial intervention which was adopted and has since been dropped. So if I am asked whether or not the lessons of the pandemic have been learned, my answer is "No". If I am asked whether or not I look back on Clap for Carers and think that that sentiment was sincere, my answer is "No".

Q. So in your view, then, what could or should be done differently if, as you put it, the lessons have only briefly been learned or not learned? What can or should be done?

A. Stand by the commitment. Either the £37 million investment in sick pay during the pandemic was unnecessary and it didn't create a material change in the safety of vulnerable elderly people, in which case the debate about sick pay is about equity for contracted service workers against their comparators or whether or not we can deliver it through our traditional trade union muscle or litigation or whatever else —— if we're going to have it as a sensible, mature, adult conversation about a lesson from the pandemic, some kind

of —— something that survives after the applause, which says, "We were ill—prepared but we learned quickly and we've embedded it for the future. Pay sick pay now".

Q. Thank you. I want to move on then briefly to shielding. At paragraphs 88 and 89 of your statement you describe shielding as a "bold move" and that broadly speaking it worked quite well but was not without its difficulties. You mentioned earlier that you carried out various surveys. Are there any particular difficulties or, again, lessons learned on shielding that you would highlight to the Inquiry?

A. So I'm reflecting as I speak about the fairness and the compassion that I am or am not showing towards the political community. Their long—term planning was poor. Their short—term planning, between January and March 2020, was particularly poor, as was ours, as was everybody's. In fairness to the Scottish political class compared to the English political class, we didn't routinely go around hospitals deliberately shaking people's hands, which is a marginal gain but it's an important public information message.

In relation to shielding, my perception is that falls within the class of very welcome, rapid improvisations; "We have medical data. We can sift that data quickly in relation to the adverse impact of



coronavirus on an underlying medical condition. Let's communicate with these people quickly and say, 'You should shield until we've got a better sense of what's happening in the pandemic'".

So I think that was very effective and, generally speaking, the majority of employers, public sector, health, local government and contracted services, responded to that positively. The difficulties were around the margins and those were particularly intense conversations, because everybody was anxious but those people who had underlying conditions which told them that either they should shield for themselves or particularly to shield for children, those were amongst the most traumatised and traumatising advice conversations that I've ever had or would want to have. And people quite commonly resigned their job rather than comply with an instruction to work if they felt that by working they would be putting their loved ones at risk. And we shouldn't have to be having those kind of conversations, not when it's avoidable.

Q. Thank you.

The last topic I wanted to ask you about was that of guidance, something the Inquiry has heard a lot about. At paragraph 100, you describe there being —— "constant tweaks" I think is the way you put it —— to the guidance



being issued and a danger of getting lost in it all. You also talk about information often coming out on a Friday and then having to be studied over a weekend and then you cascade it to your members in a rush, I think is how you put it at paragraph 102. I suppose two questions I had for you: firstly, was Unison consulted by the Scottish Government on these tweaks, as you put it, and was this a useful or helpful way, in your view, to disseminate this guidance?

A. It was —— I suppose that's perhaps more of a personal gripe about the experience. We were —— although I've been critical of many organisations and institutions in what I've said this morning, Government were very inclusive and approachable and we had phone calls from cabinet ministers after a live meeting, "We were concerned about your colleague; he seemed to be particularly stressed". That doesn't happen now but it happened then. So they were good, they moved quickly, they were agile, they were engaging.

I suppose it's a marginal point about —— I think maybe what was going on psychologically was that the economy is bordering on out of control, the health system is bordering on out of control, some of the social protests are bordering on out of control, let's tinker with the things we can tinker. Should it be



3 metres or 2 metres? To be honest, I think the marginal gain of some of that tinkering wasn't necessarily worth the effort that went into it, but it didn't do any particular harm.

But longer term, in terms of whether or not there's a compliance, a risk of compliance fatigue, I think a degree of consistency and stability in the guidance is something that's worth thinking about. But there will be behavioural psychologists who will give more robust advice on that than me.

Q. So put another way, perhaps control the things that you can control or feel like you can control?

A. Control the things you can control but don't just twiddle with the dial because it's the only dial that appears to work. There became a bit of a fixation about, you know, would Scotland go from 3 metres to 2 metres, and at the end of the day, in the scheme of things, given some of the big structural factors which I've talked about, to take somebody from a safe, acute setting and put them in an insecure contracted care setting, whether the staff were 2 and a half metres or 3 metres away didn't make any difference.

Q. Thank you, Mr Hunter. I don't have any further questions for you. I'm grateful, obviously, for your evidence both in writing and today. Before we conclude,

was there anything in particular you'd like to mention that we haven't covered or talked about?
A. I suppose I'd just briefly return to what I see as the analogy with Cullen. I think that, with the greatest of respect to public law, the judicial community, there are some inquiries that have had a lasted impact: Dunblane, Cullen; and there are other inquiries, frustratingly, Macpherson, systematic or institutionalised race discrimination, which have —— the ambition continues to elude us.
I think looking at social care there is a moment here where —— the Inquiry can't anticipate the grade of PPE that might be required the next time a particular virus affects us all, but I think if social care were reviewed and if we were respected and seen as being responsible participants who can help improve the culture, so we might not necessarily guarantee access to the right grade of PPE, but we can bring the training and the confidence and the knowledge of our safety reps to areas where service users would otherwise be exposed to an avoidable infection and a risk of death, then I think that would be good and I think the Inquiry could say something in that kind of territory. In addition to something like sick pay, that seems like a low—hanging fruit thing because it actually had been observed and



recognised as something that could and should be done, which has been temporarily lost. But if we could bring that back, that would be good.
MR STEPHEN: Thank you very much.
THE CHAIR: Very good. Thank you, Mr Hunter.
A. Thank you.
THE CHAIR: You're back after lunch, Mr Stephen. I think that's correct, isn't it?
MR STEPHEN: That's right, yes.
THE CHAIR: I don't know if the witness will be here but we've finished a little bit earlier. If you can start at ten to, I'm happy to do that.
MR STEPHEN: All right, I'll check.
THE CHAIR: Thank you.
A. Thank you.
(12.46 pm)
(The short adjournment)
(2.01 pm)
THE CHAIR: Good afternoon, Mr Stephen.
MR STEPHEN: Good afternoon, my Lord. The next witness is Ms Ruth Wakeman.
MS RUTH WAKEMAN (called)
THE CHAIR: Good afternoon, Ms Wakeman.
A. Good afternoon.
THE CHAIR: Right. When you're ready, Mr Stephen.



MR STEPHEN: Thank you, my Lord.
Questions by MR STEPHEN
MR STEPHEN: Could you confirm your full name, please?
A. Ruth Wakeman.
Q. Thank you. Your age and contact details are known to the Inquiry so I won't ask you those. You've already provided a written statement. The Inquiry's record reference number for that is SCI—WT0470—000001.
Are you happy for that written statement and the oral evidence you provide today to inform the Inquiry?
A. Yes, I am.
Q. Are you happy for that evidence to be recorded and published?
A. Yes.
Q. Everything you've said in that statement will be taken into account by the Inquiry even if we don't touch on every single aspect of it in your evidence this afternoon.
Finally, just a reminder, there is a restriction order in place so please don't name any specific individuals when you're giving your evidence.
A. Okay.
Q. Thank you. I can see from the badge you're wearing, but I'll ask you anyway, what's the organisation that you're representing today?



A. I'm representing Crohn's & Colitis UK.
Q. What position do you hold within that organisation?
A. I'm director of services, advocacy and evidence at the charity.
Q. How long have you held that position for?
A. I've been working there since October 2019, so about four and a half years.
Q. What does that role involve?
A. So I'm responsible for everything that we provide for people with Crohn's and colitis, so that includes our services, such as our helpline, our online information, also our policy and our advocacy work on behalf of patients, our work with health services and also our funding of research and our work to support research into the conditions.
Q. The charity you're representing is a UK charity; is that correct? It covers both Scotland and England?
A. Yes, that's correct. We're a UK—wide charity so we cover all four nations.
Q. Thank you. What services, more generally, does your organisation provide to those with Crohn's or colitis?
A. So we're often the first port of call for people who are newly diagnosed, for example, and their friends and family. So we have a huge amount of information on our website, so everything that somebody with Crohn's and

colitis would want to know, so what the conditions are, what the likely —— what may happen to them with the condition, the treatments, information about surgery, and then also lots of information about the impact of the condition on people's lives as well, so thinking about education, employment, transport and travel and so on.

Q. Thank you. How many people in Scotland are there living with Crohn's or colitis to your knowledge?

A. So there are no accurate records but research that we've commissioned suggests there's over 50,000 people living with Crohn's and colitis in Scotland, so that's about one in 103, and that's actually a higher prevalence rate than there are in other parts of the UK.

Q. Is there a particular reason for that that you're aware of?

A. No, because the causes of the condition aren't fully understood. We're not clear why the rate is slightly higher in Scotland than it is in the rest of the UK.

Q. In headline terms, then, obvious perhaps, but what is —— what are Crohn's or colitis? Can you expand —— you touch on this in paragraph 13 of your statement, but just for the benefit of those watching.

A. Yes, so Crohn's and colitis are very serious illnesses, they're life—long illnesses and there is no cure, and



you can be diagnosed at any age, but many people are diagnosed before they're 30, so about one in four before they're 30. So that means people are living with these conditions all their lives and they're relapsing remitting conditions, so people may have a period where they're well, when perhaps the conditions are controlled by medications or by surgery, and then they have what is known as a "flare", where the conditions get much worse.

The symptoms can have a really severe impact on people's lives, so we're talking about frequent and severe diarrhoea with blood, so maybe 20/30 times a day, a lot of pain, a lot of fatigue, and other parts of the body can be affected as well. So you can see, if you've got symptoms like that, it's actually very difficult to carry on with your normal life.

Q. And I think you say in your statement at paragraph 13 that there is no known cure for that, so how is the condition treated?

A. Yes, so there isn't currently a cure. The conditions are controlled by medication, so these are sometimes known as biologic medications, they can be immunosuppressive medications. People often have to try several different medications before they find one that works for them and then the medication may stop working after a period of time, so you can see there often isn't



a longer—term solution for many people. And surgery is often used as well, so many people could end up having surgery at some point in their lives. And surgery can sometimes be the answer for people, that it can completely relieve their symptoms. For some people though, it's repeated surgery, and we're talking about major surgery, so removal of part of your bowel and perhaps having to use a stoma bag either permanently or temporarily while your bowel heals up again.

Q. Thank you. I'll perhaps come on to some of the impacts that the pandemic might have had on the things you just outlined in a moment.

If we can start, though, just going back to the start of the pandemic and the impact upon your organisation. As a charitable organisation, what effect did the pandemic have, for example, on your fundraising abilities?

A. Yes, so there was an immediate impact on the charity, as there was with many other patient charities, in that at the time most of our income came from fundraising events, so things like the London Marathon, the Great North Run and so on. So almost overnight, as all of those events shut down, we were looking at potentially no income to keep the charity running. So we had to make some very difficult decisions. We put



most of our staff on to furlough and we focused on keeping the essential services that people with Crohn's and colitis would need during the pandemic, so that was provision of our online information, keeping our helpline going because the helpline became more and more important to people with Crohn's and colitis throughout the pandemic. The staff that were left all took a 20% cut in hours and a cut in pay and some of the senior team, myself included, took a pay cut but carried on working the same hours or more hours because of the crisis that was ongoing.

Q. You mentioned a helpline. What sort of queries were you receiving on that helpline? What were people concerned about at that time?

A. So the helpline has always been really important for people with Crohn's and colitis but it assumed a new importance during the pandemic because people couldn't get through to their teams in hospital and so they literally had nowhere to turn. So we had an enormous increase in calls, almost overnight actually, from March 2020 onwards. People would be calling up desperate for information, so they wanted to know were they more likely to catch COVID, were they more likely to be severely affected. And, of course, if you remember at the time there was a really strong fear that

people were going to die and people did die of course with COVID, so there was —— I think it could be safely described as "panic" for many people with Crohn's and colitis. They had no idea what this meant for them. They couldn't get hold of their teams in the hospital, the GPs weren't able to help and so they turned to us as a point of —— first point of call for information.

Q. You used that word "panic" and you say that in your statement at paragraph 35. You talk about immediate panic sort of setting in. What information was out there for those with Crohn's or colitis in terms of the risk of them catching COVID? What was available at the start of the pandemic to them?

A. So at the start of the pandemic there was literally no information at all. Nobody knew what this meant for people with Crohn's and colitis. If you think that Crohn's and colitis are known as immune—mediated conditions, which means there's a dysfunction of the immune system in the gut, so immediately you have a suspicion, if your immunity is affected, "Does this mean I'm more likely to catch COVID, I'm more likely to be more severely affected, I'm more likely to die?".

Then, on top of that, if you think about the medications that are used for Crohn's and colitis, they often suppress your immune system, so again that added



to your concern if you had Crohn's or colitis. Also immediately patients weren't able to get hold of their clinical teams at the hospitals and these conditions are mainly treated in hospital so they couldn't get hold of any information. They may have been in a flare at that point, they may have been at an early stage of diagnosis, and they felt very abandoned and alone at that point.

Q. Thank you. Why, in your view, did that information gap exist, do you think?

A. I think Crohn's and colitis is not generally well recognised or understood so lots of people don't know what Crohn's and colitis are. Because the conditions are often treated in hospital, the GPs may not have the information that they would need to support people with Crohn's and colitis and there were no records available, so nobody knew who had Crohn's and colitis, nobody knew who was on immunosuppressant medication. And that caused so many problems as the pandemic went on, first of all, identifying who was at risk, then later on who would be eligible for prioritisation for vaccines and boosters and then, towards the end of the pandemic, who was eligible for prioritisation for treatment if they caught COVID as well. So there was a huge information gap for people with Crohn's and colitis.



Q. Because you say at paragraph 43 of your statement, as you just mentioned, that there was no centralised way of identifying those at highest risk. Is that a state of affairs that's been rectified now? If we were to face a similar pandemic again, is this a problem that would now be defunct or ...?

A. Yes, this would exactly be the same problem again if there was another pandemic. So there is —— it sounds unbelievable, but there is no way of knowing —— there's no correct centralised way of identifying people who had the conditions and people who had the conditions and were taking immunosuppressant medication. And we heard —— we were desperately trying to find out at the time —— we knew that the letters going out about shielding were incorrect for many people, so we had lots of people contacting the charity to tell us that they'd either received a letter to say that they were very high risk, when they knew that they weren't, or vice versa, that they knew that they were high risk and they weren't receiving a letter.

We knew the letters were incorrect because we'd worked with the British Society of Gastroenterology, who developed a risk grid, and what they had done is they'd brought together expert clinicians and, by professional consensus, looking at all the information that was



available at the time, they classified whether somebody would be considered a higher risk, moderate risk or low risk, and then, as the patient charity, we created a decision tree for our website. So patients could look themselves, use factors about themselves and their condition, whether they were flaring or in remission and what medication they were taking. Immediately this disconnect became apparent between the official information that was going out —— or not going out in many cases —— and the true position of what somebody's risk status was.

Q. Thank you. And that lack of a centralised record —— obviously the Inquiry is interested in lessons learned —— is there a lesson learned there, do you think, for a future pandemic, the fact that there's a lack of record? What would you be suggesting to the Inquiry should change perhaps?

A. Yes. I think that is a really key lesson, lesson learned, because the impact on people was so severe. I mean, people were put at risk, people experienced harm, sometimes life—changing harm, for example, if they had surgery, emergency surgery and so on. And so we know that it had a really severe impact on people and of course people's mental health as well, with the fear. So we believe that there needs to be an accurate

centralised way of identifying people who are at higher risk in a future pandemic, and that would apply to people with Crohn's and colitis, taking immunosuppressant medication, but also to other conditions as well.

And we worked with other charities who were in a similar position, for example, charities for people with blood cancer, and there's a disconnect between secondary care, the hospital data and primary care, the GP data. So I think many people would assume, "Oh, my GP knows all the medication that I'm taking", but actually that is not the case. If medicines are prescribed mainly in hospital, as they are for people with Crohn's and colitis, the GP doesn't necessarily have that information. And what happened with the pandemic was GPs were the gatekeepers for access to vaccinations and treatments but often they didn't have accurate information to work from. So there needs to be a better way of sharing data between primary and secondary care.

And the impact —— it wasn't just on patients. Clinicians ended up wasting an enormous amount of time. So we spoke to clinical nurse specialists working in IBD in hospitals and gastroenterologists and they said they were having to scurry around using Excel spreadsheets to



try and work out a list so that they could send that in. It seemed shocking really, in this day and age, that there isn't a more accurate way of identifying people. And this would be exactly the same problem in a future pandemic.

Q. Thank you. Obviously this Inquiry is concerned with the Scottish Government's response to the pandemic and you're a UK charity. The register that you talk about or recommend would be a good idea, is that something you would expect to be UK—wide? Would the systems speak to one another? I'm thinking of practicality here, I suppose.

A. Yes, I mean, that would be great. The same problems occurred in all four nations so it was a UK—wide problem but it definitely was a problem that occurred in Scotland.

Q. Okay. You mentioned earlier a risk grid. I'll come on to that. Was that a response to the lack of information that you mentioned earlier? Was that the impetus for that risk grid to be created, the fact that those were Crohn's or colitis simply didn't know what their risk level was, for want of better words?

A. Yes, exactly, and the senior clinicians, people working with the British Society of Gastroenterology, immediately recognised that problem and some emergency



phone calls took place over that first weekend of the lockdown period and everyone worked together really rapidly to create this risk grid, which we know was accurate and patients could use it to self—identify as well. But the problems occurred because that grid wasn't recognised by the NHS or by the UK Government and so it would often conflict with information that patients were being sent centrally, so shielding letters through the NHS or information that GPs would be given to them. And you can imagine how confusing that was for people at the time, when there was so much fear —— understandable fear, concern and panic, as I've said earlier.

So there needs to be a better way of working with senior clinicians in the event that there's another pandemic like this so that these risk grids can be recognised and that expert clinical opinion can be used and recognised by the Government because it became a source of conflict. People would take their risk grid information to their employer, for example, and the employer would say, "Well, you haven't got an NHS letter, I don't believe you", or the GP would say, "No, I'm not going to prioritise you for a vaccine. You're not on my NHS list". So it caused a lot of unnecessary stress, worry, conflict, but also meant people just



weren't being eligible for support and access that they needed.

Q. So you've got these two information streams, you've got the risk grid on the one hand, the other messages/letters coming out on the other, so running in parallel or perhaps like ships in the night.

A. Yes.

Q. Did you, as an organisation, provide feedback to the Scottish Government about this conflict or a way to resolve that, this mixed messaging that was going out to those with this condition?

A. Yes, we did. So our policy teams wrote to all the governments across the four nations. We also lobbied. We worked with other charities, so at one point there was an informal coalition of charities, of people receiving immunosuppressing medication, many of whom had very similar problems. We wrote to the UK Vaccines Minister, we wrote to the Joint Committee for Vaccines and Immunisations and we were continually raising the situation for people with Crohn's and colitis.

However, what we found was, every time something new came out, again, people with Crohn's and colitis hadn't been considered and we would have to start our efforts all over again. And, of course, as a UK—wide charity, this was quadrupled for us because we were having to do

this four times across the four nations. So it was extremely difficult and ultimately very hard to get our point across. People with Crohn's and colitis definitely felt ignored, alone, forgotten through the pandemic.

Q. Thank you. For completeness, that risk grid was utilised by people in Scotland, to the best of your ——

A. Yes, it absolutely was, yes.

Q. I wanted to turn now to paragraph 60 of your statement. You talk about the Crohn's and colitis community's reliance on highly qualified nurses, IBD nurses, and your reliance on those. How did the pandemic affect the role of those nurses?

A. So IBD patients rely hugely on nurses and we have what are called "IBD clinical nurse specialists". "IBD" is the umbrella term for Crohn's and colitis. So the clinical nurse specialist provide a really key role for people with Crohn's and colitis. They are the first point of call, so they man nurse advice lines in the IBD services, many of them can prescribe, they oversee infusions, and they really fulfil a really valuable function in terms of supporting patients with appropriate information and advice, but also in helping to reduce unnecessary admissions to hospital.

I think that, because the role of IBD nurses was not



clearly understood within hospitals, in the pandemic, they were immediately redeployed. So the advice lines were closed, they were redeployed on to COVID wards and there was immediately then a drop in access to information and care. We've heard from clinical nurse specialists that many of them protested against this at the time and tried to raise their concerns within hospitals, but often it wasn't understood. And I do know of one clinical nurse specialist team in Scotland who actually started collecting data to show that the rate of unplanned admissions to hospital was going up as soon as their nurses were redeployed and in that particular hospital the nurses were deployed back to the IBD service, but that was quite unusual and in many services the nurses were redeployed for quite long periods of time.

Q. That was going to be my next question really, was to ask you about the impact of that redeployment. So the unplanned admissions, was that because they were ill or needed to receive emergency care because of that gap as you —— would be your view; is that right?

A. Yes, exactly. So, because people couldn't get through and couldn't get proper medical advice, then they became seriously ill. So it may be that they were flaring, so their condition had got much worse; it may be that the



medication had stopped working; maybe they were newly diagnosed and they hadn't yet been put on medication.

The impact for patients —— there's a lot of evidence now that, if Crohn's and colitis is not being well controlled by medication, the long—term outcomes for people are much worse. So you're talking about people needing surgery that perhaps they wouldn't have needed, and emergency surgery has worse outcomes than planned elective surgery. So this could have life—long impacts on people; people ending up with parts of their bowel being removed; stomas permanently that perhaps wouldn't have happened if they'd been able to access care immediately.

Q. You touch on that in paragraphs 63 to 65 of your statement about operations being cancelled, things like that. Were there any other treatments or procedures that you would highlight that were affected by the pandemic for those with Crohn's or colitis?

A. Yes. So many people are treated with infusions and they may come in every six to eight weeks for their infusion of their medicine. If somebody is being started on a new medicine, they may need to come in more frequently to start with, so they might be coming in on a week, three—week, six—weekly interval. The hospitals tried to keep the infusion clinics going but obviously there were



issues with delays in people accessing their medication. But the other impact that we found, that people were so frightened, because of the uncertainty of the situation for them and the fears about COVID being worse for them, that some people didn't attend their appointments and cancelled or stopped taking their medication because there was confusion that an immunosuppressive medication would mean that that would suppress their immune response to COVID as well, which wasn't actually correct. So this lack of information, lack of being able to access medical advice and information, to talk to somebody, meant that this would have a really severe impact on people.

Q. Thank you. You talk in your statement about conducting a survey, I think a life in lockdown survey ——

A. Yes.

Q. —— done between June/July 2020. When restrictions began to ease during the pandemic, in your opinion, were those with Crohn's and colitis still affected by what was happening?

A. I think in some ways that's when it actually felt almost worse for people with Crohn's and colitis because other people started to get back to some form of normality, but for people with Crohn's and colitis, they were still extremely concerned that they were going to be more

seriously ill or were going to die. And if you think about the age range of people with Crohn's and colitis, they might be in school, they might be in college, they might be a parent of someone who was going in and out of school every day, they may be someone who is in a front-line role. So we heard from lots of people who were teachers, nurses, doctors, GPs, people working in supermarkets and on essential transport. So, as some people started having to go back to normality, people with Crohn's and colitis were really, really terrified and, because they didn't have that official letter from the Government or the NHS, all sorts of problems began to emerge with people being asked to do things that would have put them at risk.

And also practical things affected people as well, so all the public toilets were closed. So for someone with Crohn's or colitis, they often plan their whole lives around access to a toilet, and so where other people started going out and about, people with Crohn's and colitis felt that they couldn't because of the lack of access to toilets. So there was a real feeling at that point from people with Crohn's and colitis that they were being left behind.

And you can imagine, if you're a parent, you've got Crohn's or colitis, you're really concerned and you've



got a child, for example, that's going in and out of school every day, you would be really, really worried and fearful. And we had people isolating within their own homes from their children, for example, which obviously the mental health impacts of that as well were really significant.

Q. You predicted my next question because we've talked quite a bit about physical impacts and that's exactly what I wanted to ask you, really, again, perhaps based on the survey results that you did or indeed any other feedback mechanisms. What was the mental health impact for those with Crohn's and colitis?

A. Yes, I don't think we can underestimate the impact on people's mental health and their general well-being. So if you're living with a fear that you're about to die from an inevitable illness or you're much more likely to be really severely ill and hospitalised, then you add on top that you can't contact your medical team, you perhaps can't access your treatments and then perhaps you've been waiting for an operation, you're in severe pain, you're going to the toilet multiple times a day and then that operation is repeatedly being cancelled, you can see the impact that that is going to have on your mental health. And then not being able to do some of the things that other people could do at that time to



help their mental health, such as starting to go out when that was allowed and starting to see people when that was allowed, because of the fear. And even a couple of years after the pandemic we still had people calling their helpline who said they were still shielding because they were so frightened and they'd never had an official letter to say, "It's okay, you can stop shielding now". So that fear has had really long-lasting impacts on people's mental health.

Q. You mentioned shielding, so let's talk about shielding. At paragraph 45 of your statement you talk about there being huge confusion for people and I think you've elaborated on this slightly already, but what -- would you attribute that confusion to that lack of information that we talked about earlier, the lack of that centralised register? Is that, in your view, why there was confusion around the concept of shielding for those with Crohn's and colitis?

A. Yes, there was huge confusion around shielding and I think most people would like to think they can trust the information they're receiving from the NHS or from the Government, so it caused incredible uncertainty and fear when people weren't getting the correct information. We know it wasn't the correct information because there was no way of correctly identifying people



with Crohn's and colitis. So we know that one in five received the wrong letter and we know that even a higher proportion didn't receive a letter when they should have received a letter. So that really undermined people's faith in the system and led to all sorts of practical problems as well. And we had a huge spike in calls from people ringing us, saying, you know, "I've got a letter. I don't know why. What does this mean? Do I need to stop going to work?" or whatever and then other people saying, "I can see from your decision tree that I'm high risk" or maybe even "My gastroenterologist has told me I'm high risk but the GP is telling me I'm not and I haven't had a letter and I haven't got access to that support and the protection that having that official letter would give". So huge confusion, distress and also risk of harm to people as well.

Q. You mentioned one in five not receiving the correct shielding information. What was the percentage in Scotland of those that weren't receiving that information?

A. It was very similar in Scotland. So that was really a UK-wide problem and Scotland had exactly the same problem. We've spoken to nurse specialists in Scotland and they said that, you know, they were trying to find out how were people's details being pulled.

Public Health had no way of knowing who was on the medications and they were desperately trying to find this information. We spoke to some gastroenterologists who said they had no idea where the data was coming from, but nobody had spoken to them about the patient lists.

Q. Again was the inaccuracy of these letters something that you were feeding back to the Scottish Government and other bodies?

A. Yes, that's right. We were continually raising the inaccuracies of these letters and the impact that having the wrong letter or no letter was having on people's lives but also on their safety.

Q. And was that feedback acted upon, to your knowledge, by Scottish Government or others?

A. No, not as far as we know. I mean, there were no changes in the letters. One thing that did happen was we were contacted by the Scottish NHS to help with information in a letter, so people who were being sent a shielding letter and who had Crohn's or colitis, we provided some information to help with that letter. But we don't actually know if that letter was ever actually sent to people with Crohn's and colitis and of course it wouldn't have helped all the people who were not getting the letters, who were inaccurately identified or not



identified at all.

Q. So again are there any particular lessons that you would want to highlight to the Inquiry on shielding specifically? Are there things that could be done better or differently next time, if there was a next time?

A. Yes, I think charities are trusted sources of information and we believe we should be treated as partners in the dissemination of information. We're there, we've got channels, we can reach people that official channels can't reach in many cases. But we were not getting the information in advance of the general public, so quite often it would be something on BBC News and we would be rushing around trying to update our website, times four, because all the information was different from the four nations, and the timing -- as I've mentioned in those statements, it often seemed to be late on a Friday evening, when our staff teams weren't necessarily working, and it meant we couldn't get ready for the next influx of enquiries and concern coming through from people contacting us through the helpline.

So we would really like Government and the NHS to work with patient charities. We are trusted as sources of information and it would be really good if we could



be considered and included so that we could help with getting information out to people quickly in future.

Q. On that issue of guidance being issued, what was the resource and time commitment your organisation was having to undertake to keep on top of all this information?

A. It was absolutely huge. So we basically -- we have an enormous amount of information. It all goes through checks with medical professionals and we update our information on a rolling three-year period to make sure it's always accurate and up to date. We are still not back to updating on a three-yearly basis. That's because the entire information team, for well over two years, totally only focused on COVID. It was a constant process of updating our information on COVID and then, of course, once the vaccinations and the boosters started, we had to continually update that information, when were the boosters coming out, who was eligible. That was different. And then, of course, towards the end of the pandemic, when treatments became available and some people were prioritised for access to treatment, the same confusion and misinformation arose. So we were having to keep working on that information, but also our policy teams as well, to continually keep raising these issues with decision-makers in the NHS and



in the four UK governments as well.

Q. You mentioned vaccines, and that was actually one of the final things I wanted to ask you about because at paragraph 86 of your statement you say:

"... it felt like ... crisis mode ramped up again when the vaccines started to become available."

I think the word I regularly see used in your statement is that of "battle" -- you know, having to battle. Why did you feel that way and why did it feel like a battle in the context of vaccines?

A. So it was obviously a huge relief for people in the UK when vaccines started to become available. However, for people with Crohn's and colitis, because they're immune-mediated conditions, they were obviously considered more at risk because of their medication or perhaps if they were in a disease flare or taking steroids, so they should have been prioritised for early access to the vaccines. However, that didn't happen.

And the same issue arose again: there was no accurate way of identifying who had Crohn's and colitis and who was on immunosuppressant medication. So we knew and we could tell from the risk grid and the clinicians were confirming that people with Crohn's and colitis should have been in the priority groups for earlier vaccination. Some of them were but many of them

weren't. And one of the reasons for that, there's something called the "Green Book", which is a sort of NHS Bible that is used to identify access for vaccinations, and Crohn's and colitis wasn't mentioned by name in the Green Book. That meant that GPs who were the gateways -- gatekeepers, really, for the vaccines, would be turning people with Crohn's and colitis away because they would believe -- and not their fault that they believed this -- that people weren't actually access for early vaccination.

So that became a big problem. It was actually a historical problem because we've had a very similar situation with flu vaccines for many, many years, and in fact Crohn's and colitis is still not mentioned by name in the Green Book chapter for flu but it took on a whole new significance with COVID.

Then, once the boosters started to become available, there was a concern that, because people were taking immunosuppressant medication, they wouldn't have a good response to the vaccine and they would need more boosters and more frequent boosters. So, again, they should have been prioritised for access to boosters but many people with Crohn's and colitis weren't. So you would have people who knew they should have been getting access, their gastroenterologist or their IBD nurse



would tell them they should have early access, and when they went to the vaccination centres or to their GP, they would be turned away from vaccination.

So we wrote to the JCVI, which is the expert body that advises the Government, and their advice is included in the Green Book. They didn't reply to us or we would get a very short reply saying, "We're looking at the evidence". I'm pleased to say now that Crohn's and colitis are mentioned in the Green Book chapter for COVID, but that actually happened fairly late on, and I think what would be really key is, in a future pandemic, there will be another new chapter on whatever disease is calling that pandemic, and we need to make sure that people with conditions like Crohn's and colitis are listed by name and, as we've said earlier, that there's a correct way of identifying people who need prioritising for vaccines and prioritising for access to boosters as well.

Q. Given everything you've said, do you think there was sufficient regard had to those with Crohn's and colitis when forming the response to the pandemic by the Scottish Government?

A. No, absolutely not. I think people with Crohn's and colitis are often forgotten. I think that the NHS and the Government focused on cancer, which is obviously



extremely important, but there was a lack of recognition that there are other serious conditions where people often need hospital treatment, may need surgery and that those people should be considered as well in the event of a pandemic, because it really felt to people with Crohn's and colitis that they were completely forgotten. And it also fell to the clinicians caring for people with Crohn's and colitis that they were redeployed into other areas and there was no recognition that their patients could become really very seriously ill without their advice and support and treatment.

Q. Thank you. I don't have any further questions for you, so really if there was anything that you think we've missed or skipped over, this is your opportunity, I suppose -- any lessons learned or you feel like there's something you want to share with the Inquiry, now is the time.

A. Thank you. I think there are three main areas which I have outlined earlier. The first is recognising charities as trusted sources of information and governments working with us in the event of any future pandemic or in fact any Public Health emergency. Involve us at the start, keep us updated, use us as ways of reaching people and I think really consider charities as partners in helping to support people in the event of



any future crisis.

I think as well it's about making sure that there's accurate data. It really does seem unbelievable in this day and age that there is no way of accurately identifying people who either have a condition like Crohn's and colitis or who are on medication that may put them at higher risk. And there needs to be a way of accurate data so that people can be protected in the future in the event of another pandemic.

I guess the third area for us is around vaccinations. We need to make sure that the JCVI are considering all conditions and that that information is really clearly set out in the Green Book so that that can support people working in primary care, working in GP practices, so that they can correctly identify people for vaccinations and boosters in future.

MR STEPHEN: Thank you very much.

A. Thank you.

THE CHAIR: Yes, thank you very much, Ms Wakeman. I'm very grateful.

A. Thank you.

THE CHAIR: Mr Stephen, we are again a little bit ahead of schedule. Shall we try and come back, if possible, at 3 o'clock?

MR STEPHEN: Okay. I think it is Mr Dunlop next so I will

check he is in the building, but yes.
THE CHAIR: Good. Thank you very much indeed.
(2.41 pm)
(A short break)
(3.01 pm)
THE CHAIR: Good afternoon, Mr Dunlop.
MR DUNLOP: Good afternoon, my Lord. There's one witness remaining this afternoon and that's Ms Claire Cairns.
MS CLAIRE CAIRNS (called)
THE CHAIR: Good afternoon, Ms Cairns.
A. Hello.
MR DUNLOP: Thank you. For the benefit of your record and that of the transcription, the statement number is SCI—WT0434—000001.
THE CHAIR: When you're ready, Mr Dunlop.
MR DUNLOP: Thank you, my Lord.
Questions by MR DUNLOP
MR DUNLOP: Good afternoon, Ms Cairns. You've provided the Inquiry with a signed statement? I think that's correct.
A. That's correct, yes.
Q. You tell us in paragraph 1 of the statement that you're the director of the Coalition of Carers in Scotland, which I'll refer to as "the coalition" in my questions today, just for brevity. In paragraph 4 of your



statement, you tell us a bit about the coalition, including that it represents and advocates for unpaid family carers and local carer centres. I'll have some questions about local carer centres later, but can you tell me what a local carer centre is?
A. So in Scotland there is a network of local carer centres, there is one in every local authority, and possibly the best way to describe them is a one—stop shop for carers. So they are part of the third sector, voluntary sector, they are generally funded through local authorities via contract and they have other funding through fundraising. Carers can refer themselves, other organisations can refer into them, and they provide a broad range of services, including information, advice and support, peer support, access to short breaks, counselling, advocacy —— a whole range of different services.
Q. Thank you. I think the key point I just want to take from that, they're provided by the third sector; they're not local authority provided?
A. That's right —— well, there's one or two which are local authority, but on the whole they're all —— they're generally third sector.
Q. Thank you. Does the coalition represent paid carers or is it just unpaid carers?



A. It is just unpaid carers and our membership also includes the local carer centres.
Q. And how many —— I suppose then you may have organisational members and you may have individual members. Do you know your membership numbers?
A. So in terms of organisations, approximately 50, and then, in terms of carers, about 200 or so. The carers who tend to be members tend to be ones who are more involved in local strategic planning and, you know, for example, local carers' voice groups and so on, having a voice in terms of the development of services in their local area.
Q. Thank you. At paragraph 27 of your statement you tell us that most unpaid carers do not engage with services. Am I correct that there's no accurate register of unpaid carers?
A. Yes, that's correct. There are different ways in which carers are registered. So, for example, whenever it came to letting carers know about the vaccine and it was their time to come forward, various ways of contacting carers. One way was through the carer centres themselves. They have quite often large lists of carers registered with them, but I would say —— estimate that's only about 10% of the carer population if you go by statistics in terms of how many carers there are in



Scotland. There's also carers who receive Carer's Allowance, so that was another route to look at carers. Some GPs have registers of carers, but there is a large cohort still who wouldn't be registered anywhere.
Q. Maybe one question arising from that. The absence of a national register, does that cause any difficulties for either your organisation or unpaid carers?
A. I mean, certainly there's been talk in the past it would be helpful to have a national register of carers. One of the difficulties is carers identifying themselves as carers. So very often people with a caring responsibility might not recognise that for quite a long time and, because of the familial relationship, they may say, "You know, I'm a parent of a child with a learning disability", "I look after my mum", but they don't necessarily recognise themselves as being a carer.
Q. In terms of —— you're talking about carers. Can I just —— to be absolutely clear, when you use the term "carer" in your evidence today, you're talking about unpaid carers?
A. Yes, I probably will use the shorthand of "carer" rather than "unpaid carer", but it will be less —— I would tend to use the phrase "care worker" when I'm referring to people employed.

Q. Thank you. You say at paragraph 47 of your statement that the primary objective for the coalition was getting information out to carers. Two questions or maybe three arise from that. What information was it that you were trying to get out?
A. Generally speaking, because throughout the pandemic and particularly at the beginning there was so much information coming out primarily from the Scottish Government on the rules around what you could and couldn't do and because there was quite a nuance in terms of how that impacted on carers, what we did was we tried to filter the information as much as possible so that we could give carer centres and carers the information that was most important to them.
Q. And you were filtering it and how were you then cascading it down? Was that through emails? Was that through face to face? How were you actually getting that information to the individuals and the care centres?
A. So we used a variety of ways. We quite quickly set up a WhatsApp group for carer centre managers and that was pinging away daily, so we got information to them very quickly that way; we also did a weekly briefing for them, which gathered all the key information together and sent that out; we had meetings throughout. For



example, for carer centre managers, they met online throughout the pandemic; and we had some learning and sharing groups for specific members of staff. So that was like the carer-centred side of things.

The idea was then that they would cascade that to their carers, so that was one route. Then we're very active on social media, so through our own Facebook account, for example, that was quite a hub for carers to get information quite quickly.
Q. Just moving on to paragraph 50, you state that carer centres remained open during the pandemic. Now, we've heard evidence earlier in the Inquiry in relation to day centres which were operated by local authorities, which essentially -- I think to use my words, not the witnesses that have spoken previously -- essentially closed during the pandemic. Can you perhaps explain to me if there's a difference in how they operate and in particular how the carer centres which you're talking about were able to remain open but the day centres run by the local authorities were not able to stay open? I appreciate there's a few questions in there, but perhaps if you can distinguish them first in the first place.
A. I think the major difference was, although carer centres pre-pandemic would have carers walking in the door, the



way they delivered services during the pandemic had to change but they were able to put a lot of their services online whereas day centres weren't able to because they're very much a kind of face-to-face service where somebody would come along and receive a service and then carers would receive respite through that. So how the carer centre did it -- and I have to say they were absolutely fantastic during the pandemic. They worked even harder and they extended the services they normally provide.

So quite early on, I think April/May time, they received -- there was a fund set up from the Scottish Government which gave them money to purchase equipment to make it easier for them to put their services online. So even before that, they had kind of -- as far as they could, the staff were working from home with whatever equipment they had, but that allowed them to do things like purchase iPads for staff or laptops so they could continue to work from home, Zoom licences, when Zoom came up and everybody was able to suddenly meet online rather than just phone calls, and they used a variety of methods.

So I know very much in the beginning they phoned around a lot of their carers to say, "How are you? Is there anything you need in terms of practical things,



like getting shopping, et cetera? How are you feeling about all this?", so just really keeping in touch with people and making sure that they were okay and checking in with them. And most of them did that throughout the pandemic with the carers.

Then, as time went on, they developed all sorts of interesting things, like online groups, you know, book groups, things which were -- you know, quizzes, et cetera; lots of things that the rest of us probably did with our family as well, but just to keep that contact, to keep the peer support.
Q. I appreciate that you're saying they used technology to keep in touch with those -- the people that would use the service prior to the pandemic. Is there a reason why -- I'll call them "day care centres" -- day care centres couldn't have approached the issue in the same way and had online bingo or games or whatever?
A. I can't speak for day services because they're not our members so I wouldn't like to speculate on that. I know that, generally speaking there, the carer centres always had a variety of ways of communicating and so that was extending what they normally did.
Q. Staying with carer centres, you say that the carer centres provided PPE support. What do you mean by "support"?

A. So what happened was very early on in the pandemic one of the first things that happened was the need for PPE, and that included unpaid carers. So one of the first things were concerns expressed by carer centres and members about carers not being able to get hold of PPE and concerns of passing on COVID to the people they were looking after.

That was resolved, I suppose, relatively quickly. Within about six weeks the PPE hubs were set up for social care and each area had a PPE hub which delivered it to various social care settings and also unpaid carers. The way carer centres worked was they were the referral source for carers, so our referral kind of protocol is developed, carers were able to phone their local care centre, get in touch with them and, if they were eligible for the PPE, then it was arranged for delivery either directly through the hub or sometimes the carer centres themselves were involved in delivering PPE directly to carers.

Q. And a couple of points arising from that. You said, "if they were eligible". What was the test for eligibility?

A. There was a whole checklist and one of the first questions was, "Do you deliver personal care?". So that was one of the first things. You know, the PPE was gloves, aprons and masks so it was particularly for



people delivering personal care. There was, like I say, a whole checklist, but that was generally the first thing.

Q. And in terms of the PPE that was delivered, was that suitable for purpose or do you know?

A. I believe so. There was some questions around whether the masks could have been at a higher level, that came out later on. But certainly the PPE that was provided was very welcome and the system worked pretty well until the hubs closed.

Q. And were those masks the blue surgical masks that we're kind of familiar with?

A. Yes, they were that level.

Q. And you said that the PPE could be delivered. How quickly was that delivered? Was that -- was there delays in getting PPE to carers?

A. I wasn't aware. We did check in with carer centres every six months or so to see if there were any issues and there didn't appear to be. Once the supply route was, you know, kind of set up and once the hubs were set up, very often carers were getting regular orders and I don't recall any issues around that once things had sort of settled down and they were running -- up and running.

Q. At paragraph 57 you go on to discuss shielding and



clinical vulnerability and you tell us that many unpaid carers were shielding due to concerns that, if the carer contracted COVID, this would then be passed to the family member who was being cared for. Did this mean that effectively there was people that were voluntarily shielding that weren't on the shielding list?

A. Yes, absolutely. In fact you could say that in two ways. I mean, the shielding information came out in early April, I believe, but there was still quite a lot of people who believed themselves to be vulnerable who weren't on the shielding list, and then a helpline was set up for them as well, kind of relatively early on. I think that was sort of towards the end of April. So there was quite a lot of people who believed that they were more at risk from COVID who may not have been on the official shielding list.

Then, in addition, carers because obviously, when they're providing particularly personal care but care within the home, if they contracted COVID, they would be at high risk of then passing it on. Even if the person themselves was shielding, if the carer still has to go out and get shopping and so on, there is a higher risk of then passing it on. So we knew and the carer centres reported an awful lot of carers were doing their absolute best to do the equivalent of shielding.



Q. You said a helpline was set up. Who set that up?

A. The Scottish Government set up a helpline towards the end of April and I believe that was to give advice and support to people who -- I'm not sure whether it was people on the shielding list but it was certainly as well people who had potentially more of a risk factor because of ill health.

Q. And you tell us at paragraph 67 about -- that the Scottish Government didn't initially accept that people with Parkinson's disease should shield but thereafter Parkinson's was a condition that was added to the list, and I think that was following the Scottish Government having been provided with more data; is that correct?

A. Yes, so it was the JCVI who made the decisions on the shielding list and obviously I'm sure they were learning as they went depending on the impacts of COVID on different conditions, so there were -- that was just one example. There were various changes that happened throughout the pandemic of some conditions that were put on that weren't on previously. In that particular case, it was one carer in particular who was campaigning and we were kind of -- you know, she was very involved with the coalition. It was particularly as well around antivirals, so Parkinson's disease wasn't on the antivirals list until much later. I think it went on --

I can't remember the exact date, but I think it might have been 2022 and eventually it was on the antivirals list.

Q. What was it the coalition were doing to support people that were trying to get other conditions added to the list?

A. So, for example, in that particular case there are a few things we did. In actual fact, communication around carers was pretty well set up in Scotland before the pandemic. So there are several national care organisations, of which the Coalition of Carers is one, and there's also a Carers' Policy Unit at the Scottish Government and we've always worked very closely together. So during the pandemic we were actually meeting weekly, and so, with the information we were getting directly from carers and from local carer centres and the weekly meetings, we would raise any issues that had come up and then they were able to, you know, take them up the line to whoever -- potentially ministers -- if decisions had to be made.

So those communications were already in place. In addition, with the particular carer who was campaigning around Parkinson's disease, we also had, during that period, two meetings with Humza Yousaf around it where this issue was raised and he said he would pick it up



outside. So we also were able to, at times, meet with ministers of -- or politicians.

Q. At paragraph 75 you talk about PPE again but you also identify that COVID testing kits were not initially available. You say a lot of these problems eased over the early months but a great deal of this was because of community volunteers. What was it that the community volunteers were doing in relation to the COVID testing kits?

A. I think it was more in relation to delivery. Some of the areas were getting PPE kits and I think tests as well delivered by volunteers, so it was just a case of dropping things off. But also there were a lot of volunteers involved in things like picking up shopping for people, which was really important, going back to people wanting to shield and lower their risk, so that kind of thing. It was very much locally driven, so each area would have had its own arrangements, but, for example -- I mean, my own mum in the Borders, she is in extra care housing, so we were able to get a volunteer to pick up her shopping and drop it off.

Q. We heard from a witness -- I say a couple of weeks ago, it may have been longer -- who lived in one of the islands and talked about the community spirit. Was there a difference or were you aware of any difference



between communities kind of pitching in and helping depending on whether it was a city centre or a rural or an urban? Was there any kind of -- did you notice a distinction between the community pitching in in different areas?

A. I don't know if I have that level of detail. My kind of general impression from carer centres was that there were good volunteer networks in every area. There may have been the odd area where there wasn't quite the same response but I'm not aware of it.

Q. In paragraph 80 you discuss infection control, PPE, testing and vaccinations. You tell us at paragraph 82 that you were on the Scottish Government PPE Advisory Group. Can you tell me, what type of topics were discussed and decisions taken at that group?

A. So that was specifically for the PPE hubs, the social care hubs, so initially it was a lot about supply and, you know, increasing the supply. They had to look at what amount of PPE they predicted would be needed and then it was making sure that it went out to different communities. And then, latterly, it was around how long, you know, the PPE hub should be left open and what other arrangements should be made in terms of PPE being sourced differently from that point onwards and going back to what used to happen, you know, with



organisations sourcing their own PPE rather than it coming centrally.

Q. In terms of -- you said one of the issues discussed was how long they should stay open. Jumping forward -- I'll come back, but jumping forward to paragraph 87, you tell us that the hubs closed. When was that, do you remember?

A. I think I made a note of it. Let's have a wee look. March 2023.

Q. Okay. And at that time in March 2023, was PPE still required for unpaid carers?

A. It had really dropped off. So it's something that happened quite naturally, I think, where carer centres were getting fewer and fewer referrals and people who had been receiving it didn't require it any longer. What happened after the PPE hubs shut was each health board was required to continue to have a route to offer carers PPE for another period of time -- I can't remember how long that was for -- and again that -- there still wasn't a lot of demand, so that has now ended.

Q. There was no charge for the PPE?

A. It was free.

Q. In paragraph 91 of your statement you state that the arrangements for the supply of PPE to unpaid carers in

England weren't as good as arrangements in Scotland. Can you just tell me -- you've told us obviously what the arrangements were in Scotland. Unless there's more to say, what was it that Scotland did better than England?
A. Well, again, this is just a personal opinion and that was just from what I saw on the news --
Q. That's what we're hear to listen to.
A. -- which everyone else saw on the news as well, just in terms of how they sourced it and the amount of money that went to private businesses, which didn't happen in Scotland. So that's kind of in terms of cost. I don't know if there's been a cost analysis, but I would imagine it was that a lot more money was spent in England. I thought the sourcing and then the hubs worked really well once they were set up and running.
Q. You go on to discuss vaccinations at paragraphs 93 through to 105 and in paragraph 93 you say that -- you tell us that the coalition approached the Government as carer groups were not on the list for early vaccinations. What was it that the coalition did in particular?
A. Well, as mentioned before, we had the weekly meetings with the Scottish Government. There were some meetings we had throughout that period with ministers and so,



even from before the vaccine was actually created, we were saying, "When there's a vaccine, you know, we really need to make sure that carers get it as soon as possible because of the situation with them shielding and putting their lives on pause". Of course, back then, whenever we talked about vaccination, we thought it was almost like immunisation. We thought that once you'd got it, you'd be clear, which didn't turn out to be the case. However, it does give people a lot of protection, so carers were extremely keen to get it as soon as possible. So, yes, we were advocating for it and then, whenever the vaccine was created and the Government produced the priority list, carers weren't initially on it, so we were advocating for them to be one of the early priority groups.
Q. And I think you discuss at paragraphs 98 and 99 that Jeane Freeman announced that unpaid carers would be in group two of the priority groups for vaccination. Despite that statement or assurance, is that what happened initially?
A. No, so what happened was I think the Government came to the agreement that carers should be a priority group and group 2 was social care workers. So initially we were told that carers would be in group 2 alongside them, and that had always been our argument, that, "If you are



giving social care workers vaccination, you should give unpaid carers the same level of support because they're providing the majority of care in Scotland". So Jeane Freeman did announce it was group 2. However, I don't know what happened, whether it went back to the JCVI or what happened, but it was then they were bumped down to priority group 6.
Q. And in terms of bumping down, as you put it, from group 2 to group 6, did that essentially delay the vaccination for unpaid carers?
A. It did, yes.
Q. Did anything change or did they remain in group 6? Sorry, did they remain in group 6?
A. Yes, they did remain in group 6, which was the same level as people with underlying conditions.
Q. At paragraph 112 you move on to looking at overall impacts in your statement. At paragraph 112 you tell us that assessments for care support plans were suspended. Firstly, can you tell us, when you say assessment for "care support plans", what are those?
A. So Scotland has the Carers Act that came in in 2018 and one of the rights in the Carers Act is any carer can have an adult carer support plan if they are an adult and a young carer statement if they're a young carer. But during the pandemic a lot of these things were



suspended and -- because, you know, of other priorities. So at that time adult carer support plans and young carer statements were suspended.
I mean, that didn't mean -- for example, they could still contact the local carer centre and get support, but it meant they weren't getting a formal assessment, which might have led to more services in normal times.
Q. And those assessments, who would normally have carried those out?
A. I'd say the majority of adult carer support plans and young carer statements are done by carer centres in Scotland. Some are still done by local authorities, so they are the ones that are the duty-bearers with the Carers Act but they can pass that duty on through contract to other organisations, so a lot of them have done that with carer centres. So, like I say, although carer centres weren't carrying out full adult carer support plans, they were still -- somebody would phone and they would do their best to support them. It just wouldn't be the full assessment.
Q. Was there -- perhaps there isn't -- but was there any impact as a result of those assessments being suspended?
A. I think probably the greater impact wasn't so much that the adult carer support plans and young carer statements weren't taking place; the greater impact was that a lot

of social care services were suspended or halted or reduced during the pandemic.
Q. Moving on to paragraph 115, you tell us that short breaks or respite was not available for carers. During what period was that suspended?
A. Well, it's quite difficult to quantify, but in terms of -- I mean, pretty much as the pandemic started a lot of these services were suspended or stopped because of risks of, you know, infection and so on. But as time went on and the Government was saying, "You can start to open up some of these services", there was still a reluctance from local authorities to do that or it could have been pressures on other areas of the system. But a lot of short break services and day care and so on was very slow to open up in Scotland and I think it is still the case that we aren't back to pre-pandemic support levels.
Q. Just a few follow-up questions from that. They were very slow to open up. In your opinion could they have opened up earlier?
A. Yes. I mean, certainly, for example -- even going back to sort of July 2020 or August 2020 actually, Jeane Freeman sent out a letter suggesting that respite and day services could re-open with certain measures in place, but a lot of that didn't happen. That is a kind



of continual story throughout the last few years, that now we're in the situation that, because there is a real workforce crisis in social care, even we're not looking at infection control or safeguarding anymore, we are looking at the difficulties in getting social care staff in to set these services back up again or bring them to the levels they were at pre COVID.
Q. In terms of when the short breaks, the respite, wasn't available, are you aware of whether that had an impact on either the physical or the mental health of either carers or the people that they were looking after?
A. Yes, absolutely. I mean, I suppose there's a few things to that. I think a lot of carers initially -- although everybody was impacted by the pandemic, but carers, without getting a break as well, were particularly impacted, but early in the pandemic they were accepting of that because they, like I say, wanted to protect the person they cared for. But, as time has gone on and people would have accepted a break and wanted a break and they're still not able to access it, then absolutely it does have an impact on carers. And carers', you know, physical and mental health has always been -- if you track it across the rest of the population, it's always been impacted by their caring role, but I would say, particularly now, having been through such



a difficult period and still not often being able to access any support or the level of support they need, there are large impacts on the health and well-being of the carer population.
Q. And impacts on the health and well-being of that population in terms of requiring medical intervention? I'm just wondering if that places additional pressures on the already-pressured NHS.
A. I mean, I suppose in terms of evidence, a lot of evidence we would get would be from local carer centres, who would say that people are coming increasingly to them in crisis and that the caring roles that they were now supporting are a lot more intense and complex than they were before.
Then you also have some survey evidence, so, for example, Carers Scotland, they do their "State of caring survey" every year and they look at impacts such as mental health impacts, physical impacts, et cetera. Their 2023 one -- I think they're giving evidence as well so they probably will give more of this -- but their 2023 one saw that 54% of carers had an impact on their physical health as a result of their caring role and 37% of carers on Carer's Allowance said their mental health was bad or very bad, so that would be worse than pre-pandemic times. Although, like I say, there still



would have been an impact for many people from their caring role, but you can chart that the caring population as a result of that, there has been impacts.
Q. Is it fair to say -- we've heard evidence previously -- that I suppose accidental unpaid carers arose throughout the pandemic as a result of there being less services available?
A. Yes, absolutely. And, you know, there are many examples and reasons for that. So one would be somebody in your family perhaps who was receiving sufficient care that you wouldn't have classed yourself as a carer and you didn't have that responsibility of looking after them, whenever services shut down, people had to take on caring roles for the first time or they had to increase their caring role, which then maybe had an impact on their employment, or there's a cohort of people who -- their family members became ill during the pandemic, either because they would have anyway during a time period like that or because of things like long COVID or because of access to health services, I'm sure, as well during that period. So, for various reasons, there were more carers and carers had to care for longer hours as well, and, like I say, Carers Scotland has done a bit of research in that area. I think at one point through their survey work they had calculated that the caring

population had gone up to 1 million during the pandemic.
Q. From what? Do you remember what the baseline is?
A. The official kind of Government figures are under 800,000, but around -- I think it's 759,000. But that brings together various surveys and we think that's probably slightly under-reported because, as I say, people don't always identify themselves as carers. So the 1 million carers during the pandemic would have obviously had a different methodology.
Q. Moving on to I suppose a new topic, you discuss, at paragraphs 116 and 117 of your statement, that local authorities clawed back underspend on benefits that people were entitled to but couldn't spend as there were no services available. I suppose it might seem reasonable to some that, if the money wasn't being used, to claw it back. I'm just wondering if you're suggesting that something else should have happened and, if so, what should have happened?
A. Yes, so that was primarily people who would have been receiving self-directed support option 1, which is when you're receiving social care support and you get a payment which means you can purchase services yourselves. During that time, because some of the services they would have purchased weren't available, some people would have built up some additional money.



But good practice during that time was the Government produced self-directed support COVID-19 guidance which said that people could use their direct payment more flexibly during that time in order to purchase different forms of support. That might have been things like -- there was all sorts of interesting things that people did, so, for example, purchasing a bike, so that they could go for a bike ride and have a break that way, garden equipment, so they could use their garden more or, for example, employing a relative, that was opened up as well during that period because it was difficult to employ other people during that time.

But there was a lot of variation in terms of how local authorities implemented that guidance, so for those who had their money clawed back, who weren't able to purchase a service, they may have been able to use that money, if they'd been allowed to, to do something else which would give them a form of a break.
Q. If there was inconsistency by local authorities in their approach, some are clawing it back, others are, if you like, interpreting this COVID-19 guidance to allow them to, you said, purchase different forms of support or services, did the coalition -- was that something that they raised with the Scottish Government, this inconsistency amongst the local authorities?



A. Yes, and we actually did two surveys around this. So we did one survey in July 2020 -- the new guidance came out in May 2020, so it was a few months after the guidance came out -- and we simply asked carers to tell us about their experience in terms of using the new guidance or how their self-directed support might have been used more flexibly. I mean, it was a snapshot. It was 208 carers who responded. We found that 60% had not been aware of the new guidance and being able to use their SDS more flexibly, which meant that local authorities weren't informing people as a matter of route in terms of the new flexibility. We also found only 28% of those who had been informed were told by their local authority. So they were hearing it from other carers, from organisations like ourselves. And of those who had requested to use their SDS more flexibly, 43% were denied.

So we repeated that same survey a year later and there was some improvement in terms of people's awareness of being able to use their SDS more flexibly and more people had been able to use their budget more flexibly during that time, so it went from one in five to one in three within that year, but there were still local authorities who didn't implement it as well as they should have.



Q. In terms of the sums of money -- you gave us an example of buying a bike, which I suppose would be hundreds of pounds -- is that the kind of level, in terms of money, sums, that we're talking about or is it thousands?
A. I'm not sure. I mean, it would be individual budgets, but, for example, employing a relative would have been a lot more costly and probably more similar to the service a person would have got pre COVID. But small kind of purchases -- for example, I know a lot of people with -- you know, parent carers looking after children with a learning disability, which was extremely difficult for them, getting away from their usual routines, having to make sure they kept them entertained and so on, quite a lot of them, for example, purchased a Disney subscription. That was something which was very helpful in terms of keeping them entertained. So it could be really small things which actually made quite a big difference or larger things, like I say, like employing somebody.
Q. The last section of your statement deals with the lessons learned, and that's from paragraph 136. I wonder -- I'm just going to ask you a few questions about those. At paragraphs 136 and 137 you identify that proper information and guidance should be issued at an earlier stage. At paragraph 138 you say that

communities should be given more support. What do you have in mind when you say communities given more support?

A. I suppose there's two ways to look at this. If they'd been given more support pre—pandemic and so there was —— you know, the third sector was better funded, sort of making sure communities have the right assets in terms of generating volunteers and support based within people's communities, then that would have been more effective when the pandemic came in. I mean, I think that's something which always bears fruit in terms of investment in community—led support. And more support during the pandemic as well. I mean, most organisations —— it tended to be the third sector who were generating a lot of this, so, again, more funding during the pandemic, pre and post, would have helped in terms of that.

Q. And you move on in paragraph 140 to discuss the success of the PPE hubs and that they could be set up quickly.

At paragraph 141 you state that the vaccination of unpaid carers could have been made more simple, including a single contact telephone number and clear instructions. What were the difficulties that unpaid carers were struggling with in terms of the vaccination —— the delivery of vaccination?



A. Yeah, so for most carers that kind of access their appointment through the portal, apart from those ones who were informed of it by letter through carer centres, et cetera —— and it tended to be that you would be allocated an appointment quite often in one of the large vaccination centres, and that worked for the majority of people, but for some carers it was problematic. So, for example, leaving the person they cared for at home when there was no other support or when it actually came to the person they cared for getting a vaccination, there were sometimes difficulties around that. So, for example, somebody with a learning disability wouldn't cope well with going into a vaccination centre like that. So some people needed more support to get their vaccination and health boards all did that differently.

So as a national organisation we were saying, "What advice can we give people in these circumstances? Is there like one number we can give them to find out what they can do?". And there wasn't one number, so each area was doing things differently, which made it very difficult to send out information on that.

Q. At paragraph 149 you tell us that local authorities were difficult to deal with as services stopped and the relevant people could not be contacted and contact still remains a problem. Looking in terms of lessons learned,



do you have any suggestions how that could have been improved during the pandemic?

A. I think people quite often just wanted again a number they could phone to speak to somebody, whether it was around —— so, for example, people who were wanting to use their direct payment in a different way, one of the issues was getting hold of somebody to ask permission, to get an agreement. You know, they would phone and, if they had a social worker allocated to them, they had maybe moved, they weren't in the same place, and then trying to find somebody and actually get somebody who was able to make that decision was often very difficult.

Q. Did your members experience a shift from telephone contact to email contact being the principal means of contacting bodies such as local authorities?

A. I'm not sure, to tell you the truth. All I know is that communication was often very difficult whatever means they were using.

Q. Thank you. Just finally, you've identified your hopes for the Inquiry and we have that in front of us at paragraph 154. Before I thank you for your time, is there anything further you would like to add today that we either haven't covered or that you think would be useful for the purposes of the Inquiry and the task that lies ahead of the Chair?



A. Yes, I suppose just to make the point that a lot of the problems experienced by carers during the pandemic were because of the pressures in the system before the pandemic and those pressures are continuing. And one thing I think carers would want to say was during the pandemic we know that they were disproportionately impacted, they were very often left without support for long periods of time, they weren't able to get a break from caring. As I said already, their health and well—being was affected. Throughout the pandemic, there was a hope that, when it ended, there would be support there waiting for them, to help them almost as a form of recovery, and we just haven't seen that happen.

I think that the social care system is under even more pressure than it was certainly pre pandemic and I don't see it having improved much since the pandemic. You know, funding is increasingly being cut, packages are being cut, it's very difficult still for carers to get breaks from caring and the support that they need. So I don't know how much of this is partly to do with the pandemic, but it's to do with many other things, workforce issues, you know, Brexit, et cetera, but I do think that's an important learning point, that having been through such a difficult period of time, there should have been support there for carers whenever the

pandemic ended.
MR DUNLOP: That just takes for me to thank you for your time, both today and for the preparation and participation in preparing such a comprehensive statement which is evidence before the Inquiry. Thank you for your time.
THE CHAIR: Yes, thank you.
MR DUNLOP: My Lord, there are no further witnesses this afternoon.
THE CHAIR: Very good. Thank you, Mr Dunlop. Thank you, Ms Cairns. It's back to 9.45 tomorrow morning. So 9.45 tomorrow morning. Thank you.
MR DUNLOP: Thank you, my Lord.
(3.44 pm)
(The hearing adjourned until Wednesday, 1 May 2024 at 9.45 am)



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